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THE SUPERIOR COURT
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CASE NUMBER:
RG15796121

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

MILTON McMATH, an individual,

Plaintiff,

v.

FREDERICK S. ROSEN, M.D.;UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND (formerly Children's Hospital & Research Center at Oakland); and DOES 1-100,

Defendants.

CASE NO.:

PLAINTIFF'S COMPLAINT FOR DAMAGES & WRONGFUL

JURY TRIAL DEMANDED

FACTUAL ALLEGATIONS

1. JAHI McMATH was born in Oakland, California, on October 24, 2000.

2. MILTON McMATH is the biological father of JAHI McMATH.

3. Defendant FREDERICK S. ROSEN, M.D. (hereinafter "ROSEN") is an otolaryngologist or ear, nose and throat (ENT) surgeon who holds himself out as a specialist in ear, nose and throat surgeries for children and adolescents.

4. At all times mentioned herein, Children's Hospital & Research Center at Oakland (hereinafter "CHO"), now known as UCSF BENIOFF CHILDREN'S HOSPITAL OF OAKLAND, was a hospital in Oakland, California, which held itself out as a specialist in caring for and treating children with the highest standards of care.

5. At all times relevant hereto, all of the defendants were the agents, servants and employees or joint venturers of all the other defendants, and at said times were acting in the course and scope of such agency, service, employment and joint venture.

6. Plaintiff is ignorant of the true names and capacities of defendants sued herein as DOES 1 through 100, inclusive, and therefore sues these defendants by fictitious names. Plaintiff will amend this Complaint to allege their true names and capacities when ascertained. Plaintiff is informed and believes and thereon alleges that each of the fictitiously named defendants are legally responsible in some manner for the occurrences therein alleged and were legally caused by the conduct of defendants.

7. In 2013, defendant ROSEN diagnosed JAHI McMATH (hereinafter "JAHI") with sleep apnea. ROSEN recommended a complex and risky surgery for sleep apnea which included the removal of her tonsils and adenoids (an adenoidtonsillectomy); the removal of the soft pallet and uvula or an uvulopalatopharyngoplasty (UPPP) and a submucous resection of her bilateral turbinates. JAHI had never been subject to a trial of a continuous positive airway pressure (CPAP) machine to treat her sleep apnea, despite the fact that such a trial is usually recommended before such a drastic surgery, especially in children. Furthermore, before a UPPP is performed on a child, it is usually recommended that the surgeon start with removing the tonsils and the adenoids only to see if that more modest procedure would cure the sleep apnea. For example, see: www.webmd.com/sleep-disorders/sleep-apnea/uvulopalatophsryngoplasty-for-obstructive-sleep-apnea.

8. On December 9, 2013, at 15:04 hours, defendant ROSEN took JAHI to the operating room at CHO to perform this extensive surgery. In ROSEN's Operative Report of his procedure, he noted that he found a "suspicion of medialized carolid on right."This meant that JAHI probably had an anatomical anomaly and that her right carotid artery was more to the center and close to the

surgical site. Although this congenital and asymptomatic anomaly would otherwise have had no impact on JAHI's life, it raised a serious issue as to this extensive surgical procedure. According to the medical literature, this posed an increased risk factor for serious hemorrhaging during or after surgery. Despite this fact, ROSEN failed to note in any of his orders for the nurses, doctors and other health care practitioners who would be following JAHI postoperatively, including the post-anesthesia care unit (PACU) and pediatric intensive care unit (PICU) nurses, to put these health care workers on notice that JAHI had a congenital abnormality with her right carotid artery that would put her at a higher risk of postoperative bleeding.

9. After surgery, at approximately 7:00 p.m., JAHI was taken to the PACU then the PICU, but JAHI's mother, Latasha Winkfield, was initially denied permission to visit JAHI. Approximately 30 minutes later, she decided to enter the PICU to visit JAHI, and she was alarmed to find her daughter coughing up blood into a plastic emesis container.

10. Latasha Winkfield expressed her concern to the nursing staff about the amount of blood JAHI was coughing up. The nurses assured Latasha Winkfield that the bleeding was "normal." A nurse then gave a suction want to Latasha Winkfield and instructed her as to how to suction blood out of her daughter's mouth. The nurses also gave her paper towels to help catch all of the blood. At that time, although JAHI was bleeding from the mouth, the packing and bandages in her nose were dry.

11. Latasha Winkfield complied with the directions and instructions of the CHO nurse as to suctioning the blood from the front of her daughter's mouth for approximately 60 minutes. At that time, another CHO nurse admonished Latasha Winkfield for suctioning JAHI, claiming that it could remove blood clots that are vital for her healing. Latasha Winkfield stopped suctioning, but her daughter continued coughing blood, and by this point, the bandages and packing in JAHI's nose were also becoming bloody. Latasha Winkfield pleaded with the nurses to call a doctor to JAHI's bedside, to no avail.

12. Later, the nurse that had originally instructed Latasha Winkfield to suction the blood from her daughter's mouth returned and admonished her for not suctioning the blood from her

daughter's mouth. This nurse then picked up the suctioning wand and began suctioning the blood from JAHI's mouth.

13. Latasha Winkfield again began requesting that a doctor be called to address her daughter's ongoing and significant bleeding. As far as Latasha Winkfield was concerned, the nursing staff at CHO did not appear to be contacting a physician since no doctors was coming to her daughter's assistance. Latasha Winkfield estimated that JAHI had lost 3 pints of blood or more. At that time, one nurse said the bleeding was normal, and another nurse said she did not know if it was normal or not.

14. Concerned about the amount of bleeding that she witnessed her daughter suffering, Latasha Winkfield contacted her mother, Sandra Chatman who she knew to be a nurse with many years of experience working in a hospital. Sandra Chatman arrived at bedside late in the evening of December 9, 2013, as the nursing staff was changing at approximately 10:00 p.m. Sandra Chatman immediately became alarmed with the amount she saw in the emesis tray, all over JAHI's clothing and bedding and in the receptacle that collected the blood from the suctioning device. Sandra Chatman immediately confirmed with the nurses that the blood in the suctioning receptacle was all JAHI's, and she advised the nurses that this was an excessive amount of bleeding for the procedure. Sandra Chatman then insisted that the nurses contact the doctors to come to her granddaughter's aid.

15. Sandra Chatman advised her daughter Latasha Winkfield that JAHI was bleeding excessively and was at risk of having serious medical complications from the loss of blood and the lack of medical care she was receiving from the nurses and the refusal of doctors to attend to JAHI. After that point, Latasha Winkfield and Sandra Chatman contemporaneously witnessed JAHI continue to bleed as her medical condition deteriorated from the medical neglect and the failure of the CHO medical staff to respond to the declining condition of JAHI.

16. At approximately 12:30 a.m., or 00:30 hours, on the morning of December 10, 2013, Sandra Chatman was watching the monitors and noted that there was a serious and significant desaturation of JAHI's oxygenation level of her blood. She also watched her heart rate drop precipitously. Sandra Chatman then called out for the nursing and medical staff to institute a Code. At 00:35 hours on December 10, 2013, the Code was called. At that time Sandra Chatman observed

a doctor finally come to the bedside of JAHI and state, "Shit, her heart stopped." The cardiopulmonary arrest and Code was documented to last until 3:08 hours, or for 2 hours and 33 minutes, an extremely long period of time. During this time, the doctors and nurses failed to timely establish an airway for JAHI and no consideration was apparently given to perform an emergency tracheotomy when it was apparent after endotracheal intubation attempts were not resulting in prompt and adequate oxygenation of JAHI in a timely manner.

17. During the resuscitation efforts in the morning of December 10, 2013, approximately two liters of blood was pumped out of JAHI's lungs.

18. During the Code, a nurse who had been caring for another child in the PICU approached Sandra Chatman to console her. This nurse told Sandra Chatman, "I knew this would happen."

19. In nursing notes added to the chart on December 15, 2013, by the night shift registered nurse responsible for JAHI who charted JAHI's postoperative hemorrhaging and that her vital signs and symptoms were critical noted that she had repeatedly advised the doctors in the PICU of JAHI's deteriorating condition and blood loss. She charted: "**This writer was informed there would be no immediate intervention from ENT or Surgery**." The Registered Nurse who took over for the night shift nurse and was responsible for JAHI, also added an addendum to her nurse charting for December 9 and 10, which chart note was added on December 16, 2013. This nurse also noted that despite her repeated notification and documentation of JAHI's post surgical hemorrhaging and critical vital signs to the doctors in the PICU, no physicians would respond to intervene on behalf of JAHI.

20. On December 11, 2013 Latasha Winkfield was advised that EEG brain testing indicated that JAHI sustained significant brain damage. On December 12, 2013 Latasha Winkfield and Marvin Winkfield were advised that a repeat EEG also revealed that JAHI had suffered severe brain damage. They were advised that JAHI had been put on the donor list and that they would be terminating her life support the next morning. Upset that the hospital administration was pushing them to donate JAHI's organs and terminate life support without explaining what had happened to JAHI, Latasha Winkfield made inquiries as to what happened. Nobody with the hospital administration explained what happened.

21. Rather than provide an explanation as to what happened to JAHI, the administration of CHO continued pressuring the JAHI's family to agree to donate JAHI's organs and disconnect JAHI from life support. At one point, David J. Duran, M.D., the Chief of Pediatrics, began slamming his fist on the table and said, "What is it you don't understand? She is dead, dead, dead, dead!" Unknown to the family at the time, medical facilities were contacting CHO offering to accept the transfer of JAHI. These offers were given to Dr. Duran on his orders and he did not share those with the family.

22. The administration at CHO then instructed visitors of JAHI to be given different and distinctive visitor badges so they would be identifiable by the CHO staff and administration. Security guards were instructed to follow the family. CHO employees were tasked with getting JAHI's mother to sign the organ donation forms. At one point, she was confronted in the chapel while praying for JAHI to sign the forms.

23. Latasha Winkfield then obtained a restraining order preventing CHO from terminating JAHI's life support. Eventually, an agreement was reached whereby JAHI was released to Latasha Winkfield. As part of this court-supervised negotiated agreement, CHO was insisting on being provided a disposition permit from the Coroner. The Coroner's Office did not know what to do and was reluctant to issue a disposition permit without issuing a death certificate.

24. On January 3, 2014. Deputy Coroner for the County of Alameda Jessica D. Horn issued a death certificate for JAHI noting a date of death of December 12, 2013 at 15:00 hrs. However, the Certificate of Death did not state a cause of death and instead notes under the immediate Cause of Death "pending investigation." The death certificate, therefore, was invalid and violated California Health & Safety Code § 102875. The Certificate of Death also failed to include a physician's certification and contains no signature of a physician certifying to the death, as required by California Health & Safety Code § 102825.

25. On May 29, 2015, the State of California Department of Vital Records, the Chief of the Death and Fetal Death Registration Section and the Center for Health Statistics and information were petitioned to rescind, cancel, void or amend JAHI's death certificate. These departments wrote back that they lacked standing to take such action and that the request should be directed to the coroner who issued the Certificate of Death.

1 26. On June 18, 2015, Muntu Davis, M.D., Health Officer for the Alameda County Health
2 Care Service Agency and the local Registrar of Births and Deaths, was petitioned to rescind, cancel,
3 void or amend JAHI's death certificate. Dr. Davis had previously indicated that the request should be
4 directed to the state agencies. To date, Muntu Davis, M.D., has not acted on the request.

5 27. Since the Certificate of Death was issued, JAHI has been examined by a physician
6 duly licensed to practice in the State of California who is an experienced pediatric neurologist with
7 triple Board Certifications in Pediatrics Neurology (with special competence in Child Neurology),
8 and Electroencephalography. The physician has a subspecialty in brain death and has published and
9 lectured extensively on the topic, both nationally and internationally. This physician has personally
10 examined JAHI and has reviewed a number of her medical records and studies performed, including
11 an MRI/MRA done at Rutgers University Medical Center on September 26, 2014. This doctor has
12 also examined 22 videotapes of JAHI responding to specific requests to respond and move.

13 28. The MRI scan on September 26, 2014, is not consistent with chronic brain death MRI
14 scans. Instead, JAHI's MRI demonstrates vast areas of structurally and relatively preserved brain,
15 particularly in the cerebral cortex, basal ganglia and cerebellum.

16 29. The MRA or MR angiogram performed on September 26, 2014, nearly 10 months
17 after JAHI's anoxic-ischemic event, demonstrates intracranial blood flow, which is consistent the
18 integrity of the MRI and inconsistent with brain death.

19 30. JAHI's medical records also document that approximately eight months after the
20 anoxic- ischemic event, JAHI underwent menarche (her first ovulation cycle) with her first menstrual
21 period beginning August 6, 2014. JAHI also began breast development after the diagnosis of brain
22 death. There is no report in JAHI's medical records from CHO that JAHI had begun pubertal
23 development. Over the course of the subsequent year since her anoxic-ischemic event at CHO, JAHI
24 had gradually developed breasts and as of early December 2014, the physician found her to have a
25 Tanner Stage 3 breast development.

26 31. The female menstrual cycle involves hormonal interaction between the hypothalamus
27 (part of the brain), the pituitary gland, and the ovaries. Other aspects of pubertal development also
28 require hypothalamic function. Corpses do not menstruate. Neither do corpses undergo sexual

maturation. There is no precedent in the medical literature of a brain dead body developing the onset of menarche and the larche.

32. Based upon the pediatric neurologist's evaluation of JAHI, JAHI no longer fulfills standard brain death criteria on account of her ability to specifically respond to stimuli. The distinction between random cord-originating movements and true responses to command is extremely important for the diagnosis of brain death. JAHI is capable of intermittently responding intentionally to a verbal command.

33. In the opinion of the pediatric neurologist who has examined JAHI, having spent hours with her and reviewed numerous videotapes of her, that time has proven that JAHI has not followed the trajectory of imminent total body deterioration and collapsed that was predicted back in December of 2013, based on the diagnosis of brain death. Her brain is alive in the neuropathological sense and it is not necrotic. At this time, JAHI does not fulfill California's statutory definition of death, which requires the irreversible absence of all brain function, because she exhibits hypothalamic function and intermittent responsiveness to verbal commands.

DEFENDANTS ROSEN, CHO AND DOES 1-100

BREACHED THE APPLICABLE STANDARDS OF CARE

34. Plaintiff incorporates herein by reference paragraphs 1 through 33 above as though fully set forth herein.

35. Defendant ROSEN was negligent and fell below the applicable standard of care in not recommending that JAHI be provided with a CPAP machine and monitored to see if her sleep apnea improved.

36. In the event that the CPAP machine was tried and did not prove successful in addressing JAHI's sleep apnea, then defendant ROSEN fell below the standard of care in not recommending that he first operate and only remove JAHI's tonsils and adenoids to see if her sleep apnea improved.

37. During the subject surgery, defendant ROSEN discovered that JAHI might have a medialized right cartoid artery. Defendant ROSEN fell below the standard of care when he failed to mention this condition in any of his postoperative orders which he knew would have been read and

relied upon by the nurses and doctors who would have been responsible to care for JAHI postoperatively in the PACU and in the PICU. By failing to note JAHI's possible medialized right cartoid artery and the significance of that condition that she was at a higher risk of life-threatening bleeding, the medical staff at CHO was not provided the important medical information which ROSEN should have provided them.

38. Defendant ROSEN fell below the applicable standard of care in failing to follow up on his patient who he suspected of having a possible medialized right cartoid artery, especially given the fact that he failed to document this condition in his postoperative orders and, therefore, no one else would have had this special and important information which he, alone, possessed.

39. The nurses and medical doctors at CHO, including the fellows, residents and attending physicians, fell below the applicable standard of care by allowing JAHI to bleed for hours without insisting that the surgeon, ROSEN, return to the bedside and address the source of the bleeding. In the event that ROSEN was not available or refused to respond, medical staff at CHO had the duty to get another surgeon involved with JAHI's care in order to identify and address the source of the significant blood loss which was getting worse and worse over time.

40. JAHI's nurses violated the Standards of Competent Performance as set forth in the directives of the Nurse Practice Act. JAHI's nurses were responsible to act as JAHI's patient advocates by initiating action to improve health care or to change decisions or activities which are against the interest of the patient. If the nurses charting on December 15 and 16 was accurate and they were continually advising the doctors of JAHI's significant blood loss and the doctors refused to respond, JAHI's nurses had the responsibility to challenge the physician's lack of action and to activate the hospitals nursing hierarchy chain of command reporting system in order to get the medical care and attention which the nurses knew JAHI needed. The nurses' failure to so act resulted in JAHI's decline until she finally arrested.

FIRST CAUSE OF ACTION
FOR WRONGFUL DEATH ON BEHALF OF PLAINTIFF
MILTON MCMATH
(Against Defendants ROSEN, CHO, and DOES 1 THROUGH 100)

41. Plaintiff incorporates herein by reference paragraphs 1 through 40 above as though fully set forth herein.

42. In the event that it is determined JAHI succumbed to the injuries caused by the negligence of the defendants, plaintiff MILTON McMATH has lost the love, companionship, comfort, care, affection, society and moral and financial support of his daughter, according to proof at the time of trial.

SECOND CAUSE OF ACTION
FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS
ON BEHALF OF PLAINTIFF
MILTON MCMATH
(Against Defendants ROSEN, CHO, and DOES 1 THROUGH 100)

43. Plaintiff incorporates herein by reference paragraphs 1 through 42 above as though fully set forth herein.

44. MILTON McMATH witnessed his daughter JAHI suffering from postoperative complications. MILTON McMATH witnessed JAHI suffering from continuous postoperative bleeding that continued to get worse. Mr. McMATH was aware that JAHI was being harmed by the inadequate and substandard nursing care she was receiving at CHO, by her surgeon who had not checked on the status of his patient or by the other medical staff at CHO.

45. As a result of the contemporaneous observation of JAHI losing significant amounts of blood while the cause of the bleeding was not addressed by the medical staff at CHO, plaintiff MILTON McMATH suffered serious emotional distress caused by the defendants in an amount to be established according to proof at the time of trial.

JURY DEMAND

46. Plaintiff hereby demands a jury trial in this action.

PRAYER

WHEREFORE, Plaintiff prays for relief, as follows:

1. For general damages in a sum according to proof;
2. For special damages in a sum according to proof;
3. For cost of suit herein incurred; and
4. For such other and further relief as the Court deems just and proper.

Dated: December 9, 2015

Law Offices of John L. Burris

Ben Nisenbaum, Esq.
Attorney for Plaintiff