IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Estate Of Aphaeus Ohakweh	§	
et al	§	
Plaintiffs & Realtors	§	
v.	§	CIVIL ACTION NO.
		_____
Harris Health System, Baylor	§	
College of Medicine, et al,	§	
	§	
Defendants	§	

PLAINTIFFS ORIGINAL COMPLAINT
&
REALTORS ORIGINAL COMPLAINT

TO THE HONORABLE COURT:

NOTICE: This Complaint/Pleading shall be construed as a whole with contents of each section and subsection incorporated by reference into all preceding and subsequent sections and subsections, and made a part thereof.

I. The Parties to This Complaint

A. The Plaintiff(s)

Plaintiffs:

Plaintiff, Estate of Dr. Aphaeus Ohakweh, is the Estate of Decedent Aphaeus Ohakweh; duly formed in Harris County Probate Court 1, and existing pursuant to the laws of the State of Texas. The Estate brings the civil rights claims pursuant to 42 U.S.C. §1983, §1985, & §1395dd on behalf of itself and on behalf of each of the following 7 co-plaintiff: Bethrand Ohakweh, Philomia Ohakweh, Emily-Jean Aguocha-Ohakweh, Cynthia Chizoba Ohakweh, Obinna Ohakweh, and two minors; altogether herein referred to as "Plaintiffs."

Plaintiff reserves the right to amend petition/complaint to include additional Plaintiffs.

B. The Realtor(s)

Realtors:
Realtor, Estate of Dr. Aphaeus Ohakweh, is the Estate of Decedent Aphaeus Ohakweh; duly formed in Harris County Probate Court 1, and existing pursuant to the laws of the State of Texas. The Estate brings the *qui tam* claims on behalf of itself and the two following co-realtors: Philomia Ohakweh & Emily-Jean Aguocha-Ohakweh; altogether herein referred to as "Realtors;" who bring the *qui tam* claims on behalf of The United States of America, for civil money penalties allowed under 42 U.S.C. §1395dd(d)(1)(A), §1395dd(d)(1)(B), §1320a-7a(f), and for claims allowed during the preceding 6 years per the 6 year statute of limitations in §1320a-7a(C).

C. The Defendant(s)

Defendant Nos. 1-16:

Defendants Martha P. Mims, Santiago Lopez, Anisha Gupta, William Robert Graham, Lydia Jane Sharp, Xiaoming Jia, Sudha Yarlagadda, Anita V. Kusnoor, Veronica Vittone, Jared Jung-Taek Lee, Wayne X. Shandera, Holly J. Bentz, Doris Lin, Elizabeth S. Guy, Van Vi Hoang, Christina C. Kao, Pralay Kumar Sarkar are all individuals who reside, maintain minimum contacts via employment, or do business in Houston, TX. During the incident complained of they were all employees of Baylor College of Medicine working as Texas State government agent employees at Ben Taub Hospital in Houston, TX. They have all responded to the original lawsuit with cause 4:16-CV-903. Location for any additional necessary service of process, if not via Counsel Jeff McClure of Andrews Kurth, is pending confirmation.

Defendant No. 17:

Defendant Joslyn Fisher is an individual who resides, maintain minimum contacts via employment, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX, and as a member of Harris Health System's Texas Health and Safety Code 166.046 Ethics Board. She has responded to the original lawsuit with cause 4:16-CV-903. Location for any additional necessary service of process, if not via Counsel Jeff McClure of Andrews Kurth, is pending confirmation

Defendant No. 18:

Defendant Baylor College of Medicine is a duly registered Texas Non-Profit Corporation doing business in Houston, TX. During the events complained of, it is classified as a Texas State agency pursuant to a Texas Health and Safety Code § 312.004 agreements. It has responded to the lawsuit

with cause number 4:16-CV-903. It may be served process via Counsel Jeff McClure of Andrews Kurth as subscribed below.

Defendant No. 19:

Defendant Diana M. Guerra is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation at her business address located at 6620 Main St Ste 1225, Houston, TX 77030. She may also be found at 1504 Taub Loop, 6th Floor, Houston, TX 77030, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 20:

Defendant David John Hyman is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his listed primary practice address Ben Taub Hospital/Baylor Department of Medicine, 1504 Taub Loop, Houston, TX 77030 or wherever he may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 21:

Defendant Deborah Riley Citron is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at her listed One Baylor Plaza, Dept of Pathology,

Houston, TX 77030 or wherever she may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 22:

Defendant Dina Winograd is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation at his listed address 2455 Dunstan Rd, Apt. 455, Houston, TX 77005 or wherever she may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 23:

Defendant Stephen R. Bujarski is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of he employed by Baylor College of Medicine in Houston, TX and working at Ben Taub Hospital in Houston, TX as a Texas State government agent employee. He may be served with citation at his business address located at 1 Baylor Plaza, Internal Medicine, Houston, TX 77030, or at 1504 Taub Loop, 6th Floor, Houston, TX 77030, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever he may be found.

Defendant No. 24:

Defendant Vinny Oommen is an individual who reside, maintain minimum contacts via employment, or does business in Houston, TX. During the incident complained of, she/he was a social worker for Harris Health System at Ben Taub Hospital in Houston, TX. She/he may be served with citation at business address: 1504 Taub Loop, Houston, TX 77030 or wherever she/he may be found, or via Harris Health System counsel, Ebon Swofford, Harris County Attorney

Office of Vince Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 25:

Defendant Joseph Shimon Kass (MD/JD) is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of, he was a health care provider at Ben Taub Hospital in Houston, TX, and a member of the Harris Health System Ethics Board. He may be served with citation at his business address located at 1504 Taub Loop, Neurology Department, Houston, TX 77030. He may also be found at Baylor College of Medicine, Neurology Department, 6501 Fannin St, Houston, TX 77030, or served via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 26:

Defendant Susan Amelia Eicher is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation at her business address located at 6550 Fannin St., Suite 1727, Smith Tower, Houston, TX 77030, or served via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 27:

Defendant Paul Edward Kwak is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation through Jeffrey McClure at Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 28:

Defendant Suman Rajagopalan is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation through, Jeffrey McClure at Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 29:

Defendant Veeral Mehta is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his residence address located at 2300 Old Spanish Trial, Apt 1015, Houston, TX 77045, or wherever he may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 30:

Defendant Mimi Phan an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his residence address located at 2300 Old Spanish Trial, Apt 1015, Houston, TX 77045, or wherever she/he may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 31:

Defendant Thankamma Macadin is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he/she was an

employee of Harris Health System at Ben Taub Hospital in Houston, TX. He/she may be served with citation at business address located at 1504 Taub Loop, Houston, TX 77030, or wherever she/he may be found, or via counsel, Ebon Swofford, Harris County Attorney Office of Vince Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 32:

Defendant Sean Reilly is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she/he was an employee of Harris Health System at Ben Taub Hospital in Houston, TX. He/she may be served with citation at business address located at 1504 Taub Loop, Houston, TX 77030, or wherever she/he may be found, or via counsel, Ebon Swofford, Harris County Attorney Office of Vince Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 33:

Defendant Lamaya Blair is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she/he was an employee of Harris Health System at Ben Taub Hospital in Houston, TX. He/she may be served with citation at business address located at 1504 Taub Loop, Houston, TX 77030, or wherever she/he may be found, or via counsel, Ebon Swofford, Harris County Attorney Office of Vince Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 34:

Defendant James Banfield is an individual who resides, maintains minimum contacts, or does business in Houston, TX. During the incident complained of he was working as a Director of Risk Management at Baylor College of Medicine in Houston, TX. He may be served with citation at his office One Baylor Plaza, MC No. BCM 208, Houston, TX 77030 or wherever he may be

found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 35:

Defendant Greg Broering is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. On or about 11/02/2015, he became a Texas Medical Board licensed physician with license number Q6396. He may be served with citation through his attorney, Jeffrey McClure at Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever he may be found.

Defendant No. 36:

Defendant Sarah Moorhead Palmquist is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation through her attorney, Jeffrey McClure at Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever she may be found.

Defendant No. 37:

Defendant David Mathew Wynne is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation through his attorney, Jeffrey McClure at Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever

she/he may be found.

Defendant No. 38:

Defendant Cliff J. Whigham is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his business address located at Baylor College of Medicine, Radiology, 1504 Taub Loop, Ste 1E05, Houston, TX 77030. He may also be served via certified mail at One Baylor Plaza Mail Stop 360, Department of Radiology, Houston, TX 77030, or via counsel Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever she/he may be found.

Defendant No. 39:

Defendant Herbert Ortiz is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she/he was an employee of Harris Health System at Ben Taub Hospital in Houston, TX. He/she may be served with citation at business address located at 1504 Taub Loop, Houston, TX 77030, or wherever she/he may be found, or via counsel Ebon Swofford, Harris County Attorney Office of Vince Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 40:

Defendant Raichel Elan Hailey is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of she/he was an employee of Harris Health System at Ben Taub Hospital in Houston, TX. He/she may be served with citation at business address located at 1504 Taub Loop, Houston, TX 77030, or wherever she/he may be found, or via counsel Ebon Swofford, Harris County Attorney Office of Vince

Ryan, 2525 Holly Hall St Ste 190, Houston, TX 77054-4124.

Defendant No. 41:

Defendant Ghana Kang is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. She may be served with citation at her address located at 744 BRICK ROW #2360 RICHARDSON, TX 75081, or served via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever she/he may be found.

Defendant No. 42:

Defendant James Parker Gregg is an individual who resides, maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his business address located at Baylor College of Medicine, Radiology, One Baylor Plaza Mail Suite 165B, Houston, TX 77030, or served via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002, or wherever he or she may be found.

Defendant No. 43:

Defendant John Michael Halphen (MD/JD) is an individual who resides in Harris County, TX and is a health care provider for Harris Health System in Harris County, TX via UT Health Science Center Houston. During the incident complained of he was Chair of Harris Health System Ethics Board. He may be served process at 5656 Kelly St. Houston, TX 77026, or wherever he may be found, or via John R. Strawn Jr., Strawn Pickens LLP, Pennzoil Place, South

Tower, 711 Louisiana, Suite 1850, Houston, Texas 77002. He has responded to the original lawsuit with cause 4:19-CV-903.

Defendant No. 44:

Defendant Nasser M. Lakkis is an individual who maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his business address located at Ben Taub Hospital,1504 Taub Loop, Houston, TX 77030, or wherever he may be found, or via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 45:

Defendant Nicola A. Hanania is an individual who maintains minimum contacts via employment, or does business in Houston, TX. During the incident complained of he was an employee of Baylor College of Medicine working as a Texas State government agent employee at Ben Taub Hospital in Houston, TX. He may be served with citation at his business address located at Baylor College of Medicine, 7200 Cambridge St. Ste 8A, Houston, TX 77030, or wherever he may be found, or served via Jeffrey McClure, Hunton Andrews Kurth, LLP, 600 Travis, Suite 4200, Houston, TX 77002.

Defendant No. 46:

Defendant Harris Health System d/b/a Harris County Hospital District d/b/a Ben Taub Hospital is a duly registered Texas non-profit entity, headquartered in Houston, TX, and is a local government entity. It has responded to the original lawsuit with cause 4:19-CV-903. It may be served process via its Counsel, Ebon Swofford, Harris County Attorney's Office, 2525 Holly Hall, Suite 190, Houston, Texas 77054, or via Vince Ryan, Harris County Attorney, 1019

Congress, 15th Floor, Houston, TX 77002.

Plaintiffs & Realtors reserve the right to amend pleading to join and/or include additional claims, Plaintiffs, and/or Defendants as necessary in the course of this litigation and/or purusant to discovery on both the claims for damages, and claims for civil money penalties.

II. Basis for Jurisdiction & Venue

A. Federal Question Basis for Jurisdiction

(a) 28 U.S. Code § 1331 because it is a civil action with claims arising under the Constitution, laws, or treaties of the United States.

- Plaintiff(s) have civil rights claims protected by U.S. Constitution Amendment XIV, and actionable under 42 U.S.C. §1983, 42 U.S. Code §1985(2), & 42 U.S. Code §1985(3).
- Plaintiff(s) also have claims under 42 U.S. Code § 1395dd.

(b) Realtor(s) also have and bring forth Federal *Qui Tam* claims for civil money penalties under 42 U.S. Code §1395dd, and §1320a–7a.

B. Additional Jurisdiction & Venue Basis

This Court has jurisdiction over Defendants, and is proper venue for this case because (a) Defendants are residents of Harris County and the State of Texas; (b) the events or incidents that are the basis of Plaintiff(s) & Realtor(s) claims occurred in Harris County Texas, and the U.S. District Court, Southern District of Texas, Houston Division is located within Harris County; (c) Plaintiff(s) & Realtor(s) have claims that arise under the U.S. Constitution and Federal Laws of the United States per 28 U.S.C. Section § 1331 *et al*; and (d) *if necessary for pleading purposes*, the damages and civil money penalties sought are within the jurisdictional limits of this Court.

III. JURY TRIAL REQUEST

Plaintiff(s) & Realtors(s) have requested a jury trial. Fee for said jury trial was paid when the civil rights claim was in Harris County Judicial District Court prior to removal, and prior to consolidation of the original qui tam case with cause 4:16-CV-1704 into 4:16-CV-903, and while in U.S. District Court, Southern District of Texas, Houston Division.

Post consolidation of the original civil rights case and qui tam cases into cause 4:16-CV-903, the cases are to be, if necessary, tried together. Hence no further jury trial request is necessary.

IV. STATEMENT OF CLAIM

FACTS

1. Ben Taub Hosptial is wholly owned and operated by Defendant, Harris County Hospital District d/b/a Harris Health System.
2. Harris Health System is a governmental entity with taxing authority that owns and operates Ben Taub Hospital. Baylor College of Medicine ("Baylor"), University of Texas Health Sciences Houston ("UT"), and Affiliated Medical Services ("AMS"), in partnership with Harris Health System ("Harris Health") & Texas Higher Education Coordinating Board ("THECB"), staff Ben Taub Hospital ("Ben Taub") with licensed faculty physicians, licensed physicians, resident physicians, and health care providers to provide health care services to the public. (Exhibit R from Baylor College Of Medicine Website: https://www.bcm.edu/about-us/affiliates/education-affiliates/harris-health, obtained 6/7/2016.)
3. Baylor & UT's physicians and Harris Health house staff provide care for patients in Ben Taub's busy Level I trauma center, which serves patients from greater Houston needing emergency care with ailments and injuries involving all the specialties and subspecialties of surgery, medicine, obstetrics and gynecology, pediatrics, and psychiatry. (Exhibit R)
4. Ben Taub Hospital is a Medicare and Medicaid participating hospital that receives subsidized funding from the U.S. Federal and Texas State government; and is therefore subject to claim

violations under 42 U.S.C. §1395dd. (Exhibit T)

5. Pursuant Section 9C of the current Health & Safety Code 312.004 agreement between Texas Higher Education Coordinating Board and Baylor College of Medicine, "Nothing in this Agreement shall be construed to violate any provision of the laws and/or regulations of the United States of America or the State of Texas, and all acts done hereunder shall be done in such manner as may conform thereto…" (Exhibit A, pg. 14)
6. Pursuant Section 9F of the current Health & Safety Code 312.004 agreement between Texas Higher Education Coordinating Board and Baylor College of Medicine, "Medical school shall comply with all federal, state, and local laws, statutes, ordinances, rules and regulations and the orders and decrees of any court or administrative bodies or tribunals in any matter affecting the performance of [the] Agreement…" (Exhibit A, pg. 21)
7. Similar language as Sections C & F above are also in the original version of the agreement between Texas Higher Education Coordinating Board and Baylor College of Medicine that was effective September 1, 2013 and terminated on August 31, 2015. (Exhibit A, pg. 12- 13)
8. Pursuant Section 2.1.4 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services (the contracting entity for Baylor and University of Texas Health Sciences Houston for the medical services at Harris County District Medical Facilities – e.g. Ben Taub Hosptial), "AMS will ensure that the Subcontractors perform the obligations and responsibilities set forth in this Agreement by entering into Service Subcontracts with Subcontractors that incorporate the terms and provisions of this Agreement." (Exhibit A, pg. 32)
9. Pursuant Section 3.1.5 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services "AMS, through the

Subcontractors, shall supply Providers to the Hospital on a **daily 24-hour basis** and to the Community Health Center and Hospital Based Clinics, consistent with their operating hours...” (Exhibit A, pg. 33)

10. Hospitals are defined as: “… hospital facilities operated by the District known as Ben Taub General Hospital, the Lyndon B. Johnson General Hospital,…” (Exhibit A, pg. 30)
11. Providers are defined as: “Physicians, House Staff, Allied Health Professionals and other health care professionals affiliated with Subcontractors and assigned by AMS to provide patient care services to the patients in the District Facilities – each of which Providers must, to the extent required and as appropriate, apply for, be awarded, and maintain in good standing (a) any applicable state licensure required of such Provider and (b) membership privileges in the Medical Staff as provided for by the Medical Staff Bylaws of the District…” will ensure that the Subcontractors perform the obligations and responsibilities set forth in this Agreement by entering into Service Subcontracts with Subcontractors that incorporate the terms and provisions of this Agreement.” *Id.*
12. Pursuant Section 3.8 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services “AMS, recognizes that the District participates in various third-party payment programs including, without limitation, government-funded programs (e.g. Medicaid, Medicare, CHIP…), health maintenance organizations, and various insured and self-insured health benefit plans…. AMS agrees to promptly record for it or the District all information that is necessary in order for the District to comply with the requirements of the Medicare Conditions of Participation and the Medicaid State Plan…” (*Id.* at pg. 38)
13. Pursuant Section 5.1 of the current Health & Safety Code 312.004 agreement between Harris

County Clinical Services and Affiliated Medical Services "…AMS, through the Subcontractors, agrees to provide health care services in District Facilities in a manner consistent with quality patient care **and in accordance with State and Federal law** and the standards established by appropriate accrediting agencies…" (*Id*. at pg. 42)

14. Pursuant Section 5.2 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services "AMS," through the Subcontractors, must provide health care services in a manner consistent with the rules, regulations, statutes, or standards of appropriate accrediting agencies…" (*Id*. at pg. 42)
15. Pursuant Section 3.8.4 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services "AMS," all contractors are required to maintain proper documentation due to Harris Health System's participation in Medicare and Medicaid funding programs. (*Id*. at pg. 38)
16. Pursuant Section 3.5.2 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services, "AMS shall require its subcontractors to comply with all District Bylaws, policies, and procedures…" (*Id*. at pg. 34)
17. Pursuant Section 3.2 of the current Health & Safety Code 312.004 agreement between Harris County Clinical Services and Affiliated Medical Services "AMS," AMS will provide HCCS with qualified physicians of the Subcontractors to supervise and direct House Staff and other Providers… on a 24 hr per day basis. (*Id*. at pg. 34)
18. Pursuant to Ben Taub General Medicine Services Policies and Procedures (pg. 1, Exhibit 49), the Senior (Physician) Staff are responsible for staff physicians with responsibilities including direct patient care, recording an attending note on admitted patients, supervision of house staff and medical students, participation in patient care and teaching conferences, membership on

committees of the hospital and medical staff, service… and specific responsibilities in subspecialty areas.

19. House Staff's (i.e. First year, upper level residents, and Chief Resident) responsibilities include at most, preliminary physical and history examination of patients, ordering laboratory and radiographic studies, documentation of activities, obtaining consultations from senior staff or other services or subspecialties and informing the Chief Resident or Senior Staff about problem cases on services, and participating in rounds. The Chief Resident responsibilities include seeking out and being available for supervision of the resident teams, diagnosis and management of problems on his service. (pgs. 1 & 2, Exhibit 49)
20. For neurology services, the Ward Attending physician (i.e. Baylor Full-Time Neurology faculty members) amongst others, reassesses patients who are clinically unstable, who have deteriorated since previously seen, or who have remained on the Neurology Service **for more than seven (7) days**, as documented by Attending note. They also provide documentation on patient charts of all functions performed by other Ward Attending physicians, and are in charge of supervising the evaluation and treatment of all patients admitted for Neurological services, and assessments of all patients seen in consultation by the Neurological Service. (pg. 2, Exhibit 50).
21. Neurology Senior Residents amongst others, evaluate and document their physical examination results, diagnostic impressions, and management plan or consultations assigned to them for each patient before the evaluation of the Ward Attending. (pg. 3, Exhibit 50.)
22. Neurology Junior Residents They also act as primary care physicians for the patients admitted for Neurology services, and act as agents for the attending (Ward) staff. Finally, they perform examinations and post evaluation of documented histories of the patient, and evaluate the

patients at intervals appropriate to their condition **(at least once per day)**… (pg. 4, Exhibit 50.)

23. Pursuant to Harris Health System's Regulation on Patient's Rights and Responsibilities Policies and Procedures, copies of Harris Health's Rights and Responsibilities are made available to patients or the primary legal representative by (a) including a written copy in the Patient Information Guide provided to all admitted patients, (b) delivered to patient or their legal representative in language or manner they can understand, *and* (c) post a printable version on Harris Health's public internet site and intranet site. (Exhibit 54)
24. Plaintiffs can confirm that a copy of Harris Health System's Regulation on Patient's Rights and Responsibilities Policies and Procedures exists on Harris Health System's website. Plaintiffs have no evidence that Harris Health System nor Defendants complied with the Patient's Rights and Responsibilities in regards to Plaintiffs. Defendants have not provided evidence of such.
25. Pursuant to Ben Taub General Hospital's Policies and Procedures for Surgical Services in the Operating Room, prior to beginning anesthesia or an operation for elective surgery, the patient record must be complete including history and physical examination, and amongst others, **operative permit signed and preparation of operative site**. Dictation of the operative report will occur **immediately following** the operation. And a **Progress Note** must be entered as soon after surgery as possible containing the following information: **operation performed, name of surgeon and assistants, name of responsible staff and whether staff was present or available to be present, anesthesia used**, brief description of findings, condition of patient at end of procedure, and other pertinent information. (Exhibit 51, pg. 3)
26. Pursuant to the Individual Services Rules and Regulations for Anesthesiology Services at Ben

Taub Hospital, the Department of Anesthesiology provides patient services 24hrs/day. Patients are expected to be given (1) preanesthetic evaluations, (2) prescription of the anesthesia plan by an anesthesiologist, (3) personal participation by an anesthesiologist in the most demanding procedures in this plan, especially those of induction and emergence, (4) an anesthesiologist remaining physically available for the immediate diagnosis and treatment of emergencies; and (5) an anesthesiologist providing indicated post anesthesia care. Anesthesia service personnel including a staff anesthesiologist, are required to be on staff in the hospital 24hrs/day, 7 days/week. (Exhibit 52, pgs. 1-2)

27. Pursuant to Harris Health System's Policies and Procedures for Advanced Directives, Harris Health Staff is required to ask patients or their legal representatives if the patient has an Advanced Directive (i.e. an appropriately witnessed document or statement that expresses a patient's wishes with regard to care when he or she is no longer able to communicate with care providers). If the patient does not have an Advanced Directive, Harris Health shall provide the patient or if competent, their (a) legal guardian, (b) a person responsible for the health care decisions of the patient, (c) their spouse, (d) any adult child, (e) the patient's parent, or (f) the person admitting the patient with a form regarding information about Harris Health's Advanced Directives Policy. (Exhibit 53, pgs. 3-5)

28. Under Harris Health System's Policies and Procedures for Advanced Directives, "surrogate decision-makers (i.e. individuals with decision-making capacity who is identified as the person who has authority to consent to medical treatment on behalf of an incapacitated patient in need of medical treatment) do not have the authority to consent to withhold or withdraw life-sustaining treatment." (Exhibit 53, pgs. 3-4)

29. The Harris Health System's Policies and Procedures for Advanced Directives defines

"terminal condition" as an incurable condition caused by injury, disease, or illness that, according to reasonable medical judgment, will produce death within six (6) months, even with available life-sustaining treatment provided in accordance with prevailing standard of medical care. (Exhibit 53, pg. 4) *This is an interesting fact because while Decedent- Plaintiff was fighting for his life and his family asking for due care and due process, Defendants were meanwhile conspiring and acting in furtherance to accelerate Plaintiffs' death, and ultimately killed him exactly on September 7, 2015: six months and 1 day after the March 6, 2015 botched, undisclosed, and improperly documented bronchoscopy with consent obtained under criminal fraud in violation of Texas Penal Code §32.21 and/or §32.46. This fact is to be later addressed in this petition.*

30. Exhibit 53 pgs, 9-22, hereby incorporated by reference, contains the facts and details of Harris Health System's Policies and Procedures for Advanced Directives in regards to communication resolution or conflict when the physician refuses to honor the patient's advanced directives or a treatment or health care decision made by or on behalf of a patient. This is Harris Health's policies and procedures for Texas Health & Safety Code §166.046. It also includes summarized specific roles of the physicians, the pavilion ethics advisory committee, district ethics advisory committee, nursing staff, and other players at each step of the process. (Exhibit 53, pgs. 9-22).

31. Per HHS' Medical Administration policies and procedures, Procedure II(A), "All medications must have a written order by a QMP." QMP, or "qualified medical personnel" is defined as "Individuals that are determined qualified by Harris County Hospital District (HCHD) Medical Staff to provide appropriate medical screening and who may be able to provide necessary stabilizing treatment in the event of an emergency. The QMP must be credentialed

and must perform within the scope of their licensure as designated by the HCHD Medical Staff Rules and Regulations."

32. Per Harris Health System policies and procedures on "Incident Reporting," Amongst others, all adverse events, incidents, near misses, and sentinel events, involving a patient, visitor, or workforce member, must be objectively documented, including in the medical record by both the medical and nursing staff, and reported in the eIRS system. The complete HHS policy and procedure are included in the appendix section of this pleading.

33. Harris Health System Policy & Procedure on Abuse, Neglect, and Exploitation of Patients; Harris Health System Policy & Procedure on Chain of Command; Harris Health System Policy & Procedure on Medical Record Documentation; Harris Health System Policy & Procedure on Incident Reporting; Harris Health System Policy & Procedure on Abuse, Neglect, and Exploitation of Patients; and Harris Health System Policy & Procedure on Disclosure of Adverse Events, are also included in the appendix section of this pleading, with all contents hereby incorporated by reference.

34. All of Appendixes 1 – 10 included in this pleading, are hereby incorporated by reference.

First Hospital Visit

1. On December 12, 2013, Decedent, a 64yr old man from Nigeria arrived at Ben Taub Hospital complaining of shortness of breath. Decedent had no health insurance (Exhibit C), but had financial capacity to pay for treatment.
2. Decedent is not a medically trained professional.
3. On 12/13/2013 as of 9:06AM, he was diagnosed with Acute Myeloid Leukemia ("AML") and Neutropenia, by Baylor physicians working under the oversight of a Dr. George R. Parkerson III.

Patient History

	Past Medical History	Date	Comments	Source
Medical as of 12/13/2013	GERD (gastroesophageal reflux disease) [530.81 (ICD-9-CM)]			Provider
	Type 2 diabetes mellitus [250.00 (ICD-9-CM)]			Provider
	Obesity [278.00 (ICD-9-CM)]			Provider
	AML [205.00 (ICD-9-CM)]	12/2013		Provider

4. Per the medical records, Decedent's AML was considered "medium priority," and the Neutropenia considered "high priority." (Exhibit D, pg. 2)
5. As of 9:56am on 12/13/2013, Decedent's diagnosed problems included Pancytopenia. Pancytopenia is a condition in which a person's body has too few red blood cells[1], white blood cells[2], and platelets.[3]

Patient and Visit Information

Visit Information

	Provider	Department	Encounter #
12/13/2013 9:58 AM	Khannan K Athreya, Resident (MD	Bt Emergency Center	67478099

Problem List

Problem List as of 12/13/2013

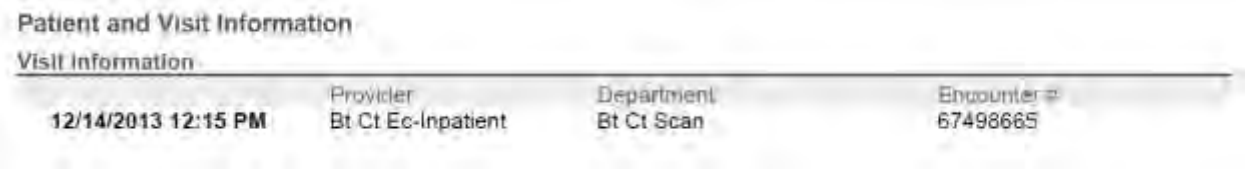
Problem	Noted	Resolved
Shortness of breath	12/13/2013	
PANCYTOPENIA	12/13/2013	
H/O malaria	12/13/2013	
DM (diabetes mellitus)	12/13/2013	
GERD (gastroesophageal reflux disease)	12/13/2013	
Dry cough	12/13/2013	
Fatigue	12/13/2013	

6. On the same 12/13/2013 and at 10:44AM, a Dr. Athreya Khannan of the internal medicine department examined Decedent and determined that Decedent need platelet and red blood cells transfusion. (Exhibit E, pg. 2)
7. On the same 12/13/2013, a Dr. Vishal Delman MD's determined that Decedent tested positive for only fever, chills, fatigue, facial swelling, cough, shortness of breath, and

[1] Red blood cells carry oxygen throughout the body
[2] White blood cells are party of the immune system and help fight off infections
[3] Platelets allow the body to form blood clots, hence protect against non-stop bleeding of cuts or wounds.

headaches; but tested negative for any eye, respiratory, cardiovascular, gastrointestinal, endocrine, genitourinary, musculoskeletal, skin, allergic/immunologic, or psychiatric/behavioral issues. He disregarded treating the AML, and executed a paracentesis (invasive) procedure instead.

8. By 12/14/2013 at 12:15pm, after the AML diagnosis, Decedent was an admitted inpatient at Ben Taub.

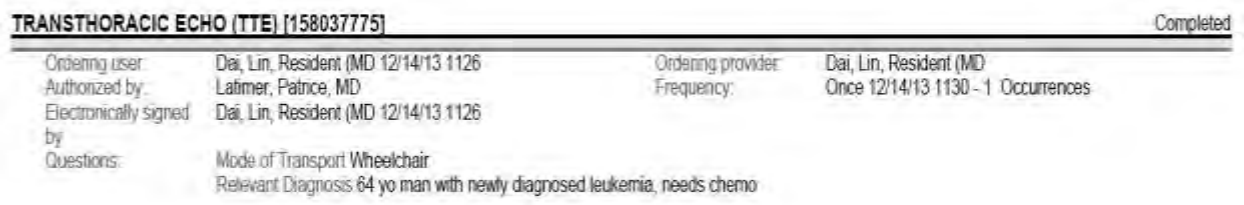


Patient and Visit Information

Visit Information

	Provider	Department	Encounter #
12/14/2013 12:15 PM	Bt Ct Ec-Inpatient	Bt Ct Scan	67498665

9. On 12/14/2013 around 11:26am, Dr. Lin Dai this time **working under the oversight and authorization** of a Dr. Patrice Latimer, noted in his records that he was being transported by wheelchair, and **needed chemotherapy**.



TRANSTHORACIC ECHO (TTE) [158037775] Completed

Ordering user:	Dai, Lin, Resident (MD 12/14/13 1126	Ordering provider:	Dai, Lin, Resident (MD
Authorized by:	Latimer, Patrice, MD	Frequency:	Once 12/14/13 1130 - 1 Occurrences
Electronically signed by:	Dai, Lin, Resident (MD 12/14/13 1126		
Questions:	Mode of Transport Wheelchair Relevant Diagnosis 64 yo man with newly diagnosed leukemia, needs chemo		

10. According to (Exhibit G, pg. 6), from the American Cancer Society, chemotherapy is to be started within days of diagnosis for leukemia as it quickly spreads through the bloodstream. *See also* *Typical treatment of most types of acute myeloid leukemia (except acute promyelocytic M3)*.[4]

11. No treatment for chemotherapy was done nor chemo procedures instituted on 12/14/2013.

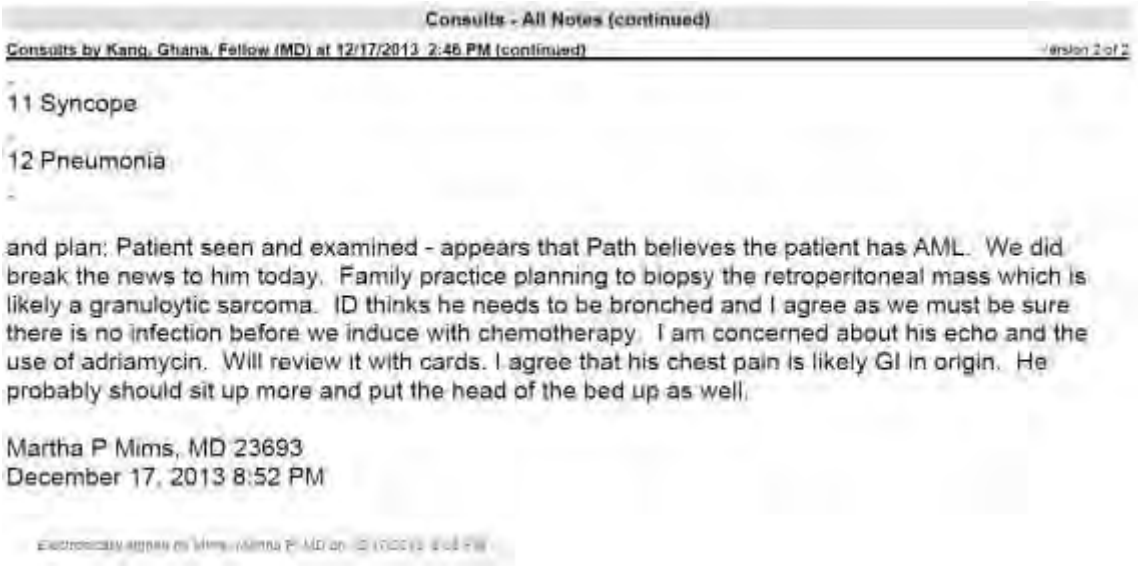
12. During the week following 12/14/2013, Bethrand frequently visited his father and watched

[4] http://www.cancer.org/cancer/leukemia-acutemyeloidaml/detailedguide/leukemia-acute-myeloid-myelogenous-treating-typical- treatment-of-aml

him physically deteriorate at Ben Taub Hospital without chemo treatment. During his visits, Bethrand frequently inquired as to the lack of induction of chemo for his father, but was rather met with responses regarding payment from the physicians.

13. Decedent received a bone marrow biopsy on 12/16/2013.

14. On 12/17/2013, Decedent finally saw a hematology & oncology specialist/staff physician, a Dr. Mims, BCM's Chief of Internal Medicine. She suggested and/or approved a bronchoscopy to rule out infection.



Consults - All Notes (continued)

Consults by Kang, Ghana, Fellow (MD) at 12/17/2013 2:46 PM (continued)

11 Syncope

12 Pneumonia

and plan: Patient seen and examined - appears that Path believes the patient has AML. We did break the news to him today. Family practice planning to biopsy the retroperitoneal mass which is likely a granuloytic sarcoma. ID thinks he needs to be bronched and I agree as we must be sure there is no infection before we induce with chemotherapy. I am concerned about his echo and the use of adriamycin. Will review it with cards. I agree that his chest pain is likely GI in origin. He probably should sit up more and put the head of the bed up as well.

Martha P Mims, MD 23693
December 17, 2013 8:52 PM

15. On early morning/midnight hr of 12/18/2013, Decedent underwent left pelvic mass biopsy in which samples of the mass from his left pelvis were collected and analyzed, and results issued in a cytopathology report received by a Dr. David Wynne.

16. Per the pelvic mass biopsy report, Decedent was found to have a low-grade retroperitoneal sarcoma: a rare form of abdominal or pelvic cancer that normally spreads to the lungs and liver; usually occurs on adults in their 50s and 60s. Percutaneous core needle biopsy is the most accurate means of diagnosing this form of cancer.[5] It is also treated with either or a

[5] "Diagnostic accuracy of percutaneous biopsy in retroperitoneal sarcoma." Almond, L.M., et al. (2019), Br J Surg

combination of (a) surgery to remove the tumor if malignant, (b) radiotherapy, and/or (c) chemotherapy.

17. The physicians did not mention this additional retroperitoneal sarcoma cancer diagnosis to Decedent nor his family until 03/24/2015.

18. On 12/19/2013 around 6:35AM, a family medicine resident physician intern – Dr. Erika Spuhler, ordered a bronchoscopy on Decedent. According to her progress notes, the physicians "need biopsy for certainty of ruling out infectious etiology prior to initiation of chemotherapy." (Exhibit B)

19. A Resident Fellow physician, Dr. Christopher Howard, did a flexible bronchoscopy ("BAL") on Decedent on 12/19/2013, **under the oversight** of a pulmonologist, Dr. Amit Parulekar. Informed consent was obtained in writing signed by Decedent. Anesthesia was also properly administered; the procedure went well and there were no complications. (Exhibit J)

20. There was "nonspecific abnormal findings on radiological and other examination of lung field." Dr. Amit recommended waiting lab results on specimens for microbiology and cytology. (Exhibit J, pg. 2)

21. The next morning, 12/20/2013, a Dr. Deborah Citron received the bronchoscopy cell tissue samples of Decedent's "lung, right middle lobe, bronchoalveolar lavage" collected on 12/19/2013, and concluded that the specimen received was satisfactory for evaluation and negative for malignancy. Yet still no chemo for Decedent. (Exhibit L)

22. On 12/14/2013 at 11:53am, 12/15/2013 at 12:22pm, 12/16/2013 at 11:18am, 12/17/2013 at 2:46pm, 12/18/2013 at 1:22pm, and at 12/19/2013 at 10:01am, Dr. Ghana Kang wrote in Decedent's medical records:

"…please consult social worker (citizenship, gold card, and etc.) to assess if he's a

106(4): 395 – 403.

candidate for BMT later on." (Exhibit M1)

14. BMT means bone marrow transplant.

15. On 12/15/2013 at 12:22pm and 12/20/2013 at 1:57pm, Dr. Daniel Y. Wang also wrote in Dr. Ohakweh's medical records:

> "…please consult social worker (citizenship, gold card, and etc…) to assess if he's a candidate for BMT later on." (Exhibit N2)

16. On 12/22/2013 at 1:08pm, Dr. Daniel Y. Wang wrote in Decedent's his medical records:

> "Also addressed his current residency status (on Visa) and lack of coverage (not eligible for Gold Card as he is living in Brazoria County)" (Exhibit N3)

17. Dr. Wang also indicated that Decedent showed no bacteria in his blood as of said 12/22/2013 report, but they were to wait for the BAL's final report before starting chemotherapy.

18. Subsequently, on said 12/22/2013 afternoon, Dr. Martha Mims, Baylor's Chief of Hematology & Oncology, examined Decedent, and met with Decedent and his son-Bethrand. Decedent supposedly had lung lesions that the physicians were unable to understand the source; but his AML was the most life-threatening matter. She then noted a challenging "social situation" regarding Decedent's visa immigrant status, the need for likely prolonged hospital retention and treatment, and payment issues. She also noted the gravity and importance of treating the AML, and per her report, "The son reports that the father can pay for his treatment. They asked me how much money it would be and I said that it would run into the thousands, probably tens of thousands of dollars. I think case management needs to be involved immediately." (Exhibit O)

14. Bethrand would not have asked about the cost of the treatment had Dr. Mims had not inquired as to payment. Yet, Bethrand informed her that Decedent had money to pay.

15. On 12/23/2013, Dr. Spuhler noted to plan chemo induction pending final study of patient for

disease.

16. The BAL report arrived on 12/23/2013 and the lung specimen samples collected were negative for malignancy, his cell count was within normal limits, negative for fungus, etc.[6]

BRONCHIAL STAIN / CULTURE [158421370] Resulted: 12/19/13 1716, Result Status: Final result

Ordering provider: Howard, Christopher, Fellow (MD) 12/19/13 1525 Resulting Lab: MISYS

Specimen Information

Type	Source	Collected On
Other	BRONCHIAL LAVAGE	12/19/13 1530

Component	Value	Ref Range	Flag	Comment	Lab
Spec Description	Bronchial lavage			-	BMC1
Order Comments	None			-	BMC1
Gram Stain	[illegible]			-	BMC1
Result	[illegible] WBC's seen. No organisms seen.				
Culture	1+ Normal flora			-	BMC1
Result					
Report Status	Final 12/22/2013			-	BMC1

17. On 12/24/2013, 5 days after the 12/19/2013 bronchoscopy, per Dr. Erika Spuhler, "Patient anxious to start treatment." (Exhibit Y)

18. As of 12/26/2013, at 7:34 am, according to Dr. Spuhler, Decedent was "to start chemotherapy soon, possibly today. Will need to stay inpatient for now as he is requiring products to maintain adequate levels." (Exhibit W)

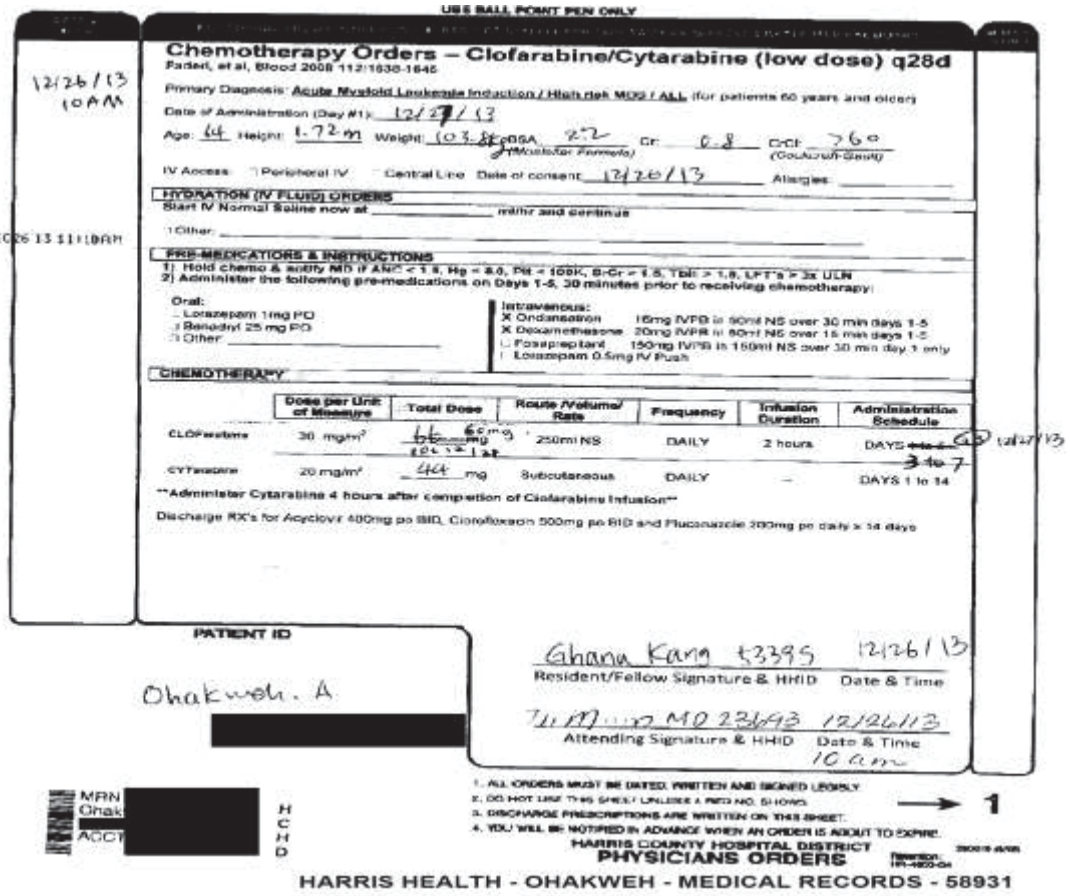
19. Decedent signed the consent form for the AML chemo treatment at 10am on 12/26/2013. Approval for the chemo was given at 11:10am, and Decedent was already to be administered clofarabine chemo on said 12/26/2013 – daily for 5 days, and cytarabine chemo 4 hours after completion of clofarabine. Ghana Khan changed the induction date to 12/27/2013 for clofarabine, and 12/29/2013 for the cytarabine.

[6] Also on 12/29/2013 at 7:34am, per a Dr. Laura Adams & Prof. Dr. Fareed M. Khan assessment, the results of the BAL lung nodule samples collected from Decedent were disclosed to be negative to date for bacteria in his blood, "s/p Bronchoscopy (12/19) NGTD on cultures;" and "no blasts identified on pathology report."

Harris County Hospital District
Department of Pharmaceutical Services
REQUEST FOR NON-FORMULARY MEDICATIONS

* Due to the fact that non-formulary drugs are not stocked in the pharmacy, 48-72 hours may be required to initiate therapy.
* Must be signed by the service/section chief.
* Patient will be charged for the smallest entire package required to fill this medication.

Date: 12/27/13 Time: 900am Patient's Name: Ohakweh Location: GA 12 Room No.: 1
Dose: 30mg/m² I.V. Frequency: days 1-5 Route: I.V.
Anticipated Duration of Therapy: 5 days. Desired First Dose Administration: 12/29/13 Date: Time:
Reason for Request: not available @ Harris health pharmacy.
Pharmacist Handling Request: Formulary alternatives discussed with physicians (write physician's name):
Resolution:
Requesting Physician's Signature: Lulua M ID Number: 43813 Service/Pager Number: 7132009510 Print Name: REMAL LULUA
Service/Section Chief's Signature: MMMMMO MD ID Number: 231693 Service/Pager Number: 7132850824 Print Name: Marilia Mimo
Patient ID: Ohakweh
REPORTING FACILITY: Please Check One [ ] Ben Taub General Hospital



USE BALL POINT PEN ONLY

Chemotherapy Orders – Clofarabine/Cytarabine (low dose) q28d

Patient, et al, Blood 2008 112:1630-1645

12/26/13 10AM

Primary Diagnosis: Acute Myeloid Leukemia Induction / High risk MDS / ALL (for patients 60 years and older)

Date of Administration (Day #1): 12/27/13

Age: 64 Height: 1.72m Weight: 103.8kg BSA: 2.2 Cr: 0.8 CrCl: 76 (Cockcroft-Gault)

IV Access: Peripheral IV Central Line Date of consent: 12/26/13 Allergies:

HYDRATION (IV FLUID) ORDERS
Start IV Normal Saline now at ____ ml/hr and continue
Other:

DEC 26 13 11:18AM

PRE-MEDICATIONS & INSTRUCTIONS
1) Hold chemo & notify MD if ANC < 1.5, Hg < 8.0, Plt < 100K, S-Cr > 1.5, Tbil > 1.8, LFT's > 3x ULN
2) Administer the following pre-medications on Days 1-5, 30 minutes prior to receiving chemotherapy:

Oral:
- Lorazepam 1mg PO
- Benadryl 25 mg PO
- Other:

Intravenous:
X Ondansetron 16mg IVPB in 50ml NS over 30 min days 1-5
X Dexamethasone 20mg IVPB in 50ml NS over 15 min days 1-5
Fosaprepitant 150mg IVPB in 150ml NS over 30 min day 1 only
Lorazepam 0.5mg IV Push

CHEMOTHERAPY

	Dose per Unit of Measure	Total Dose	Route /Volume/ Rate	Frequency	Infusion Duration	Administration Schedule
CLOFarabine	30 mg/m²	~~66~~ 60mg (60 x 1.72)	250ml NS	DAILY	2 hours	DAYS ~~1 to 5~~ 3 to 7 (5) 12/27/13
CYTarabine	20 mg/m²	44 mg	Subcutaneous	DAILY	–	DAYS 1 to 14

Administer Cytarabine 4 hours after completion of Clofarabine Infusion

Discharge RX's for Acyclovir 400mg po BID, Ciprofloxacin 500mg po BID and Fluconazole 200mg po daily x 14 days

PATIENT ID
Ohakweh, A
[redacted]

Ghana Kang 53395 12/26/13
Resident/Fellow Signature & HHID Date & Time

MD 231693 12/26/13
Attending Signature & HHID Date & Time
10 am

MRN Ohak [redacted] ACCT HCHD

1. ALL ORDERS MUST BE DATED, WRITTEN AND SIGNED LEGIBLY
2. DO NOT USE THIS SHEET UNLESS A RED NO. SHOWS
3. DISCHARGE PRESCRIPTIONS ARE WRITTEN ON THIS SHEET.
4. YOU WILL BE NOTIFIED IN ADVANCE WHEN AN ORDER IS ABOUT TO EXPIRE.

→ 1

HARRIS COUNTY HOSPITAL DISTRICT
PHYSICIANS ORDERS

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 58931

20. On 12/27/2013, at 7:29am, per Dr. Spuhler, "… will need to stay inpatient for now as he is requiring blood products to maintain adequate levels." (Exhibit X)

21. Decedent was given his first chemo treatment for his AML, first of fourteen cytarabine daily injections, on 12/27/2013 at 5:14pm, on the 14th day after the AML diagnosis of Decedent. On 12/29/2013, he was also started on his first of five clofarabine daily infusions.

22. On 12/29/2013, Dr. Laura Adams noted in Decedent's records of the payment issue, stating that Decedent was a "candidate for a Gold Card as cousin with whom he stays lives in Harris County. If is not unable to obtain, he is eligible for emergent Medicaid. Will need to stay inpatient for now as he is requiring blood products to maintain adequate erythrocyte and platelet levels."

23. On 12/30/2013, Dr. Spuhler noted in the records of the payment issue stating, "Patient is applying for permanent resident status. If not able to obtain, he is eligible for emergent Medicaid. Will need to stay inpatient for now as he is requiring blood products to maintain adequate erythrocyte and platelet levels."

24. On 1/26/2014 at 3:38pm, Dr. Courtney N Miller-Chism wrote in his medical records:

> "I discussed the case with the resident and agree with the diagnosis of:…Spoke to patient, son, and primary team. It is doubtful that patient will get gold card. He is awaiting Emergency medicaid. His ANC remains above 500. We will discharge him and arrange for BM biopsy to assess for remission on 2/4 and heme f/u appt on 2/12. This will give us time for the BM to recover and hopefully for the medicaid to kick in. He also has f/u with family medicine on 2/7." (Exhibit I)

25. On 2/11/2014, Dr. William Y. Huang you wrote in Dr. Ohakweh's medical records:

> "Patient currently without gold card, awaiting visa status change, asked him to call me if visa status changes so we can proceed with CXR and other tests." (Exhibit K)

26. Ultimately, Decedent was discharged and left the hospital on or around 1/26/2014. He later returned for outpatient follow-ups and subsequent inpatient chemo treatments from February through June 2014. E.g. He had another bone marrow biopsy on 05/5/2014, his second chemo treatment on 05/15/2014, during a 05/14/2014 – 5/21/2014 in patient admission, and

an outpatient 06/11/2014 visit with Dr. Mims, the Chief of hematology and oncology.

27. Before discharge on 05/21/2014, Decedent underwent a successful follow-up examination and physical that indicated his AML was in remission post chemo treatment.

HARRISHEALTH SYSTEM

BEN TAUB GENERAL HOSPITAL
1504 TAUB LOOP
HOUSTON TX 77030
Inpatient Record

OHAKWEH,APHAEUS
MRN: [redacted]
DOB: [redacted]1949, Sex: M
Adm 5/14/2014, D/C 5/21/2014

Progress Notes - All Notes (continued)

Progress Notes by Parkerson, George R III, MD at 5/17/2014 1:35 PM

Author: Parkerson, George R III, MD | Service: (none) | Author Type: Physician
Filed: 5/17/2014 7:23 PM | Note Time: 5/17/2014 1:35 PM | Status: Signed
Editor: Parkerson, George R III, MD (Physician)
Related Notes: Related Note by Spuhler, Erika, Resident (Resident) filed at 5/17/2014 1:55 PM

FAMILY MEDICINE ATTENDING

Teaching Physician Note
On 5/17/2014 as faculty in Family Medicine, I have seen and examined Aphaeus Ohakweh with the family medicine resident.

I agree with the findings and plan as documented in the resident physician's note.

A/P
1. **PICC (peripherally inserted central catheter) in place**
2. AML (acute myeloblastic leukemia)
3. Retroperitoneal sarcoma
4. CHEMOTHERAPY
5. DM (diabetes mellitus)
6. HTN (hypertension)
7. Abnormal chest x-ray

64y.o. male with DM, HTN, AML(diagnosed 11/2013) s/p induction therapy (12/2013), admitted 5/14/14 for consolidation chemotherapy. Tolerating chemotherapy well. Also has low grade retroperitoneal sarcoma; will get follow up staging CTs for same. Patient doing well clinically.

RParkerson, MD 23644
Faculty, Family and Community Medicine

Electronically signed by Parkerson, George R III, MD on 5/17/2014 7:23 PM

Progress Notes by Spuhler, Erika, Resident at 5/17/2014 1:35 PM

Author: Spuhler, Erika, Resident | Service: BT Family Practice | Author Type: Resident
Filed: 5/17/2014 1:55 PM | Note Time: 5/17/2014 1:35 PM | Status: Addendum
Editor: Spuhler, Erika, Resident (Resident)
Related Notes: Cosigned by Parkerson, George R III, MD (Physician) filed at 5/17/2014 7:23 PM
Original Note by Spuhler, Erika, Resident (Resident) filed at 5/17/2014 1:43 PM

Medicine Team: Family Practice; Intern Progress Note

Assessment and Plan:
Principal Problem:
CHEMOTHERAPY
Active Problems:
Neutropenia
AML (acute myeloblastic leukemia)
DM (diabetes mellitus)
Diastolic dysfunction
Retroperitoneal sarcoma
HTN (hypertension)
H/O malaria

Printed by 83811 at 11/5/15 11:30 AM

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 58054

Tinea cruris

Patient is a 64y.o. male with h/o DM2, HTN, AML(diagnosed 11/2013) s/p induction therapy (12/2013) who was admitted 5/14/14 for consolidation chemotherapy. Tolerating chemotherapy well.

AML: in remission per bone marrow biopsy 5/5/14
Hematology following, appreciate recs
- Cytarabine day 3/7, Clofarabine day 3/3.
- wbc 5.9, ANC 5590, Hgb 12, plts 172

DM:
- A1c 9.4
- on steriods, BGs 200-470s last 24 hrs
- adjusted NPH to 40 units bid + regular 5 units qac
- SSI
- hold metformin
- gabapentin for neuropathy

HTN:
- amlodipine 10 mg daily
- lisinopril 5 mg daily

Tenia Cruris
- miconazole topical prn

Low-grade sarcoma (retroperitoneal mass):
- appears to be a low grade tumor and unsure if this is the cause for the lung nodules
- treating AML first as this is more aggressive pathology
- per heme/onc, pan CT for restaging pending

Insomnia
- zolpidem prn

Prophylaxis:
DVT: lovenox daily (active cancer)
GI: on omeprazole (GERD)

Case and plan discussed with Dr. Parkerson.

Erika Spuhler, MD
Family Medicine, PGY-1
HCHD #53305
Pager: 281-952-5376

Subjective: Tolerating chemo well. Good appetite. No headaches. No complaints.

Objective:
VITALS:

Patient Vitals for the past 24 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2
05/17/14 0700	135/81 mmHg	97.9 °F (36.6 °C)	Oral	86	18	98 %
05/17/14 0405	141/90 mmHg	98.2 °F (36.8 °C)	Oral	88	21	97 %
05/16/14 2338	136/95 mmHg	98.7 °F (37.1 °C)	Oral	99	21	98 %
05/16/14 1910	143/95 mmHg	97.5 °F (36.4 °C)	Oral	91	21	99 %
05/16/14 1500	139/61 mmHg	98.2 °F (36.8 °C)	Oral	90	20	100 %

Physical Exam
General Appearance: Awake, alert, no apparent distress
Skin: No bruises, rashes, lesions
Eyes: Conjunctivae/corneas/sclerae clear. Pupils are equally round and reactive to light. Extraocular movements are intact.
Oropharynx: Lips, mucosa, and tongue normal. Teeth and gums normal. Oropharynx normal. No tonsillar enlargement.
Lungs: Lungs clear to auscultation with no wheezing, rales, or rhonchi
Heart: Regular rate and rhythm without murmur, gallop, or rubs.
Abdomen: Abdomen soft, non-tender & symmetric. Bowel sounds normal. No masses, organomegaly. No rebound or guarding.
Vascular Pulses: Equal and strong peripheral pulses in all extremities
Musculoskeletal: There is no redness, warmth, or swelling of the joints. Full range of motion noted. Motor strength is 5 out of 5 all extremities bilaterally.

Data:
Recent Results (from the past 24 hour(s))
GLUCOSE POC
Collection Time
05/16/14 4:58 PM

Result	Value	Range
Glucose POC	305 (*)	74 - 106 mg/dL

GLUCOSE POC
Collection Time
05/16/14 9:15 PM

Result	Value	Range
Glucose POC	342 (*)	74 - 106 mg/dL

CBC/DIFF
Collection Time

28. Dr. George Parkerson's "Final Diagnosis/Diagnoses" before Decedent's discharge was "AML, Retroperitoneal Sarcoma, DM (diabetes mellitus), HTN (hypertension)." Dr. Paterson's team noted the spread of the Retroperitoneal Sarcoma tumor from his left pelvis to the right pelvis as of 05/21/2014.

HARRISHEALTH SYSTEM

BEN TAUB GENERAL HOSPITAL
1504 TAUB LOOP
HOUSTON TX 77030
Inpatient Record

OHAKWEH,APHAEUS
MRN: [redacted]
DOB: [redacted]/1949, Sex: M
Adm:5/14/2014, D/C:5/21/2014

Discharge Summaries - All Notes

Discharge Summaries by Parkerson, George R III, MD at 5/21/2014 6:27 PM Version 2 of 2

Author: Parkerson, George R III, MD | Service: (none) | Author Type: Physician
Filed: 5/21/2014 7:16 PM | Note Time: 5/21/2014 6:27 PM | Status: Addendum
Editor: Parkerson, George R III, MD (Physician)
Related Notes: Related Note by Spuhler, Erika, Resident (Resident) filed at 5/21/2014 6:50 PM
Original Note by Parkerson, George R III, MD (Physician) filed at 5/21/2014 7:16 PM

FAMILY MEDICINE ATTENDING

Teaching Physician Note

On 5/21/2014 as faculty in Family Medicine, I have seen and examined Aphaeus Ohakweh with the family medicine resident.

I agree with the findings and plan as documented in the resident physician's note.

A/P

1. PICC (peripherally inserted central catheter) in place

2. AML (acute myeloblastic leukemia)

3. Retroperitoneal sarcoma

4. CHEMOTHERAPY

5. DM (diabetes mellitus)

6. HTN (hypertension)

7. Abnormal chest x-ray

64y.o. male with DM, HTN, AML(diagnosed 11/2013) s/p induction therapy (12/2013), admitted 5/14/14 for consolidation chemotherapy. Tolerated chemotherapy well.

Also has pelvic tumor- smooth muscle neoplasm with uncertain malignant potential, that hasn't changed in past 5 mos; follow up CTs showed no change in size of tumor, but now in right pelvis; previously in left pelvis. Oncology plans to follow him in Oncology clinic for pelvic tumor, and will f/u with Hematolgy clinic for AML.

RParkerson, MD 23644

Faculty, Family and Community Medicine

Electronically signed by Parkerson, George R III, MD on 5/21/2014 7:16 PM

Discharge Summaries by Parkerson, George R III, MD at 5/21/2014 6:27 PM Version 1 of 2

Author: Parkerson, George R III, MD | Service: (none) | Author Type: Physician
Filed: 5/21/2014 7:16 PM | Note Time: 5/21/2014 6:27 PM | Status: Signed
Editor: Parkerson, George R III, MD (Physician)
Related Notes: Related Note by Spuhler, Erika, Resident (Resident) filed at 5/21/2014 6:50 PM
Addendum by Parkerson, George R III, MD (Physician) filed at 5/21/2014 7:18 PM

FAMILY MEDICINE ATTENDING

Printed by 83811 at 11/5/15 11:30 AM

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 57966

HARRISHEALTH SYSTEM

BEN TAUB GENERAL HOSPITAL
1504 TAUB LOOP
HOUSTON TX 77030
Inpatient Record

OHAKWEH,APHAEUS
MRN: [redacted]
DOB: [redacted]/1949, Sex: M
Adm:5/14/2014, D/C:5/21/2014

Discharge Summaries - All Notes (continued)

Discharge Summaries by Parkerson, George R III, MD at 5/21/2014 6:27 PM (continued) Version 1 of 2

Teaching Physician Note

On 5/21/2014 as faculty in Family Medicine, I have seen and examined Aphaeus Ohakweh with the family medicine resident.

I agree with the findings and plan as documented in the resident physician's note.

A/P

1. PICC (peripherally inserted central catheter) in place

2. AML (acute myeloblastic leukemia)

3. Retroperitoneal sarcoma

4. CHEMOTHERAPY

5. DM (diabetes mellitus)

6. HTN (hypertension)

7. Abnormal chest x-ray

64y.o. male with DM, HTN, AML(diagnosed 11/2013) s/p induction therapy (12/2013), admitted 5/14/14 for consolidation chemotherapy. Tolerated chemotherapy well.

Also has pelvic tumor- smooth muscle tumor with uncertain malignant potential that hasn't changed in past 5 mos; follow up CTs showed no change in size of tumor, but now in right pelvis; previously in left pelvis. Oncology plans to follow him in Oncology clinic for pelvic tumor and will f/u with Hematolgy clinic for AML.

RParkerson, MD 23644
Faculty, Family and Community Medicine

Electronically signed by Parkerson, George R III, MD on 5/21/2014 7:16 PM

Discharge Summaries by Spuhler, Erika, Resident at 5/21/2014 6:27 PM Version 1 of 1

Author: Spuhler, Erika, Resident | Service: BT Family Practice | Author Type: Resident
Filed: 5/21/2014 6:50 PM | Note Time: 5/21/2014 6:27 PM | Status: Signed
Editor: Spuhler, Erika, Resident (Resident)
Related Notes: Cosigned by Parkerson, George R III, MD (Physician) filed at 5/21/2014 7:18 PM

Department of Medicine
Team: Family Practice
Adult Discharge Summary

Name: Aphaeus Ohakweh
DOB: [redacted]/1949

Printed by 83811 at 11/5/15 11:30 AM

HARRISHEALTH SYSTEM

BEN TAUB GENERAL HOSPITAL
1504 TAUB LOOP
HOUSTON TX 77030
Inpatient Record

OHAKWEH,APHAEUS
MRN: [redacted]
DOB: [redacted]1949, Sex: M
Adm:5/14/2014, D/C:5/21/2014

Discharge Summaries - All Notes (continued)

Discharge Summaries by Spuhler, Erika, Resident at 5/21/2014 6:27 PM (continued) Version 1 of 1

MRN: [redacted]
Admission Date: 5/14/2014
Discharge Date: 5/21/2014
Admit Attending: Mehta, Niraj
Discharge Attending: Parkerson, George R III,*
Service: BT Family Practice
Admission Diagnosis/Diagnoses: AML
Final Diagnosis/Diagnoses: AML, Retroperitoneal Sarcoma, DM, HTN

Consults: Hematology, Oncololgy

Procedures: Chemotherapy

History:
Past Medical History

Diagnosis	Date
• GERD (gastroesophageal reflux disease)	
• Type 2 diabetes mellitus	
• Obesity	
• AML	12/2013
• Heart failure with preserved left ventricular function (HFpEF)	12/2013
ECHO	
• Anemia	
• Clotting disorder	
• HTN (hypertension)	

Past Surgical History

Procedure	Laterality	Date
• Hx umbilical hernia repair		
• Picc placement by picc team	Right	12/16/2013
40cm basilic vein		

No Known Allergies

Hospital Course:
The patient is a 64y.o. male with h/o DM (A1c 9.4 --05/2014), HTN, AML(diagnosed 11/2013) s/p induction therapy (12/2013), Retroperitoneal Sarcoma (incidental finding during diagnosis of AML) who was admitted to BTGH on 5/14/14 for consolidation chemotherapy. Patient completed 7 days of Cytarabine and 3 days of Clofarabine. Patient tolerated chemotherapy well without side effects. Pan CT was done for re-staging of his sarcoma. CT showed stable well-circumscribed pelvic mass now in right pelvis previously in left pelvis, likely mobile stromal tumor. Other findings included interval resolution of pulmonary airspace disease, decreased mediastinal lymphadenopathy, and prostate

Printed by 83811 at 11/5/15 11:30 AM

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 57968

29. At the 06/11/2014 hematology-oncology follow-up visit with Dr. Mims, focused on the AML. The Problem Lists in Decedent's records during the 06/11/2014 visit included the Retroperitoneal Sarcoma, and all physicians were on official notice of the Retroperitoneal Sarcoma.[7]

[7] Contrary to the Problem List, the Sarcoma was first noted on 12/18/2013 after the pelvic biopsy per the medical records, and Decedent was first diagnosed with AML at Ben Taub on 12/13/2013.

Mims, Martha P, MD at 6/11/2014 5:33 PM
Author Type: Physician Status: Signed
TEACHING PHYSICIAN NOTE

I personally examined Aphaeus Ohakweh, performed the key portions of the history and physical examination and was directly involved in his care.

I reviewed the past medical records, laboratory results and resident's note and agree with the findings as documented in the resident's note..

I discussed the case with the resident and agree with the diagnosis of: AML who received Clofara/Cytara and consolidation in May with Clofara/Cytara. Plan to admit for next cycle of Clofara/Cytara on Tuesday coming up.

Martha P Mims, MD 23693
June 11, 2014 5:34 PM
Printed by 83811 at 11/5/15 11:30 AM

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 58584

30. On the 06/11/2014 visit with Dr. Mims, Gold Card funding for payment was still a discussed concern. Decedent paid out of pocket for the medical services.

Ohakweh, Aphaeus (MR # [redacted]) Page 4834

Medications (continued)
Medication Comments (continued)

Orders
All Orders
No orders found

Result Summary
All Results
No results found

Progress Notes
Sam, Mildred at 6/11/2014 2:33 PM
Author Type: Clinical Case Manager Status: Signed
Met with patient today about his eligibility. Explained to Mr Ohakweh that all Oncology patient have either valid gold/cd or some type of funding.Without any type of funding in place he is a 100% full pay patient . Mr Ohakweh said his son was working on his gold/cd. I gave him my card should they have any questions or concerns. Patient said he understood and paid $76.00 today for his appt.

Mildred Sam, Oncology Referral Coordinator
713 566-3314
Pgr: 281 952 5517

31. Plaintiffs received the medical records regarding the first hospital visit on or about October 2015 from Harris Health System (Exhibit V).

32. There were no other admissions or cycles of chemo treatments (i.e. the clofara or the cytara[8])

[8] Clofara means "Clofarabine;" Cytara means "Cytarabine." These are chemotherapy drugs.

given Decedent. The "Tuesday coming up" after Wednesday 06/11/2014, was 06/17/2014. Per the medical records, nothing occurred on said 06/17/2014, nor for the remainder of 2014. There are no office or hospital visits for treatments scheduled, ordered or executed. There are also no medication orders, nor physician entries showing any office or hospital visits.

33. Decedent received a total of 2 out of 3 necessary chemo treatments. The first was from 12/27/2013 to 1/10/2014, and the second was on 05/15/2014. The third that was to occur on 06/17/2014, per Dr. Mims' visit on 06/11/2014 was not scheduled nor carried out.

34. Decedent and his family arranged for payment with the hospital claims department, and paid their required co-pay and/or payments for the medical services provided Decedent.

35. Decedent returned to his routine active lifestyle, which included playing tennis.

Second Hospital Visit

36. On or about March 4, 2015 a 66yr old Decedent again arrived from Nigeria. Upon arrival his son Bethrand drove him directly to the hospital for evaluation.

37. Decedent walked into Ben Taub Hospital with his son for treatment complaining of fatigue, shortness of breath (SOB), cough, and chest pain (CP).

38. A physician- Dr. Tolu Olade at Ben Taub Hosptial attended to him. Decedent was tired but yet coherent while answering the doctor's questions.

39. A chest x-ray and electrocardiogram were done while Decedent was in the ER. By 11:57am, the ER physicians (Dr. Olade and resident Dr. Winograd) noted that Decedent had hypoxia[9], respiratory distress, and "volume overload.[10]"

[9] Condition in which the body or a region of the body is deprived of adequate oxygen supply, not complete oxygen supply at the tissue level. This has serious injury effects on the body, body region, or body organ deprived oxygen.
[10] There was too large a volume of blood in one of the chambers of Decedent's heart for the heart to function efficiently, not infections of his lungs.

40. Decedent had no allergies to any medication. Dr. Tolu Olade relayed to Decedent's son that based upon her team's assessment, Decedent had an acute renal injury, low blood counts indicative of a possible Acute Myeloid Leukemia (AML) relapse, and that his chest x-rays showed dispersed infiltrates in his lungs uncharacteristic of pneumonia. Decedent's son expressed to Dr. Tolu Olade that he had been treated for leukemia in 2014, and that those infiltrates were present then, and were negative for any type of bacterial or fungal infection.
41. Also upon evaluation in the emergency department ("ED") at Ben Taub hospital Decedent's initial vital signs showed an elevated heart rate at 110 beats per minute (normal is 60 to 100), and oxygen saturation (measure of how much oxygen is dissolved in one's blood) of 91% (normal is >95%).
42. While in the ED, it is documented that Decedent's oxygen saturation would occasionally drop to the 80's requiring them to place an oxygen mask around his mouth and nose for intermittent respiratory support.
43. With the mask on, his saturation quickly improved to normal levels. As documented in the initial intake notes by the doctors, Decedent was responsive, able to give a full history about his condition and answer all their questions. The only positive finding on physical examination by the doctors was that Decedent had "decreased breath sounds in the right and left lower lung fields." This led to a work-up, as would any Decedent presenting to the ED in Decedent's state, that included blood work, non-invasive imaging of the lungs, and non-invasive evaluation of his heart.
44. Ben Taub Hospital's team of Emergency Department physicians made a decision to admit Decedent to a unit on the 4th floor for further evaluation.
45. However, the physicians in the hospital did not want to admit and properly treat Decedent.

46. The ER the physicians knew of his AML condition and past prior treatments at Ben Taub. They tried to have him admitted as Decedent needed to be admitted. Resident Dr. Dina Winograd, working with and under the supervision of Dr. Tolulope Olade, contacted the admission department hospital physician, a Family Medicine physician named Dr. Varughese, to inform them of Decedent's presence and his necessary admission. But the response she received from the admitting physician, Dr. Varughese, was that he wanted the MICU team to first see and consult with Decedent before they admit him from the ER. Decedent's health issues also included thrombocytopenia, i.e. a condition of abnormal low levels of platelets.

47. Regardless, after about an hour, the non-ER physicians informed the ER physicians that they were going to send a resident physician, Dr. Elaine Chang, to evaluate Decedent in the ER.

Interval Progress: Patient on non-rebreather and sating well, stable. Labs significant for AKI with Cr up to 4.1 from 1.3 in June, 2014. CXR with diffuse infiltrates bilaterally likely due to volume overload but infection cannot rule out. Will order CT pon contrast to further evaluate. WBC is 7.4, platelets 15.

The patient's condition is guarded

Current clinical impressions include:
1. **Chest pain**
2. AKI (acute kidney injury)
3. Thrombocytopenia
4. Shortness of breath

Plan: Hospitalize with the following plan of care: Evaluation for SOB, AKI, untreated AML, thrombocytopenia.

Dina Winograd, Resident (MD
March 4, 2015 10:08 AM

EC PROVIDER COMMUNICATION NOTE

I was contacted by Dr. Varughese from the Family Medicine service at 10:10am hr and I made a request for hospitalization. The patient was accepted for hospitalization by the service. The admitting provider will enter the hospitalization order.

Dina Winograd, Resident (MD
March 4, 2015 10:10 AM
Printed by 83811 at 7/24/15 12:37 PM

ED Provider Notes - All Notes (continued)

ED Provider Notes by Winograd, Dina, Resident (MD at 3/4/2015 8:04 AM (continued))

EC PROVIDER COMMUNICATION NOTE

I paged the Hematology service at 10:40am hr to notify them that this patient is here and being admitted (as has AML and followed by them). Still awaiting call. I was contacted by admitting team (Dr. Varughese) and they would like MICU consult prior to admission. Will consult MICU.

Dina Winograd, Resident (MD
March 4, 2015 10:50 AM

EC PROVIDER COMMUNICATION NOTE

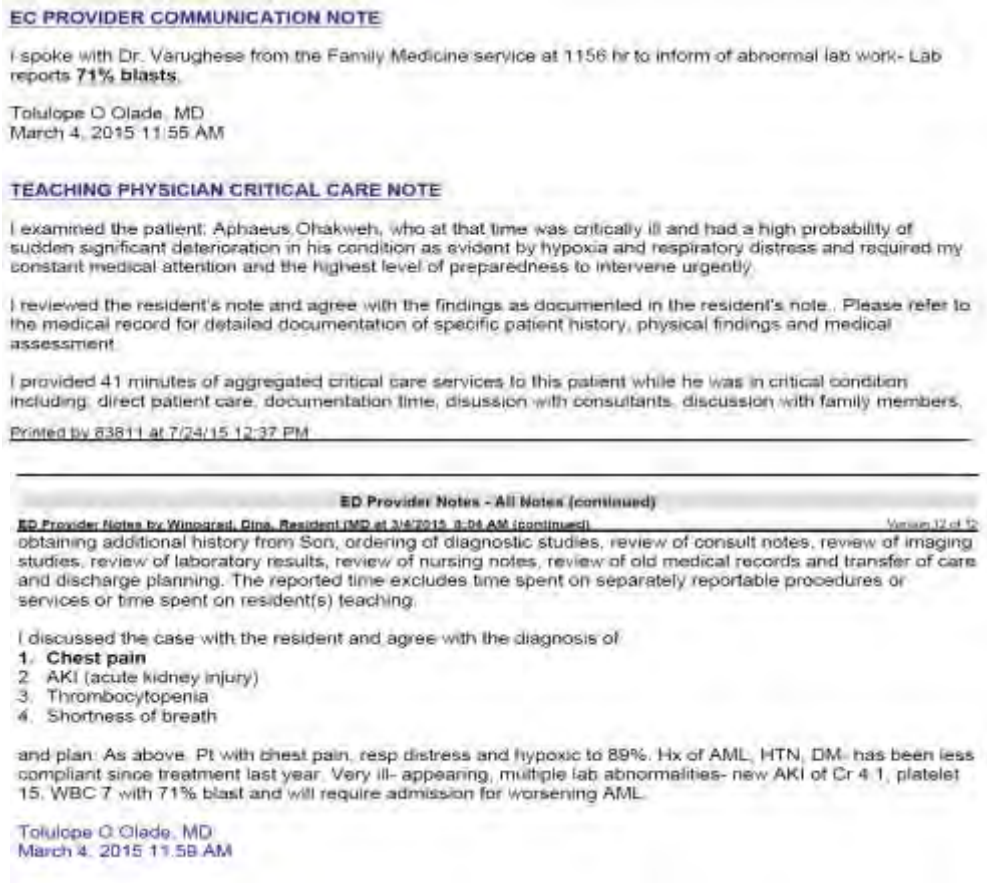
I was contacted by Hematology fellow at 10:58am. Given patient MRN, she will review chart, admitting team to contact hematology again once patient admitted.

Dina Winograd, Resident (MD
March 4, 2015 10:58 AM

EC PROVIDER COMMUNICATION NOTE

I called the MICU resident to consult regarding possible ICU care for patient at 11:07am. Dr. Chang will come evaluate patient.

Dina Winograd, Resident (MD
March 4, 2015 11:04 AM



EC PROVIDER COMMUNICATION NOTE

I spoke with Dr. Varughese from the Family Medicine service at 1156 hr to inform of abnormal lab work- Lab reports **71% blasts**.

Tolulope O Olade, MD
March 4, 2015 11:55 AM

TEACHING PHYSICIAN CRITICAL CARE NOTE

I examined the patient: Aphaeus Ohakweh, who at that time was critically ill and had a high probability of sudden significant deterioration in his condition as evident by hypoxia and respiratory distress and required my constant medical attention and the highest level of preparedness to intervene urgently.

I reviewed the resident's note and agree with the findings as documented in the resident's note. Please refer to the medical record for detailed documentation of specific patient history, physical findings and medical assessment.

I provided 41 minutes of aggregated critical care services to this patient while he was in critical condition including: direct patient care, documentation time, discussion with consultants, discussion with family members.

Printed by 83811 at 7/24/15 12:37 PM

ED Provider Notes - All Notes (continued)

ED Provider Notes by Winograd, Dina, Resident (MD at 3/4/2015 8:04 AM (continued)) Version 12 of 12

obtaining additional history from Son, ordering of diagnostic studies, review of consult notes, review of imaging studies, review of laboratory results, review of nursing notes, review of old medical records and transfer of care and discharge planning. The reported time excludes time spent on separately reportable procedures or services or time spent on resident(s) teaching.

I discussed the case with the resident and agree with the diagnosis of
1. **Chest pain**
2. AKI (acute kidney injury)
3. Thrombocytopenia
4. Shortness of breath

and plan: As above. Pt with chest pain, resp distress and hypoxic to 89%. Hx of AML, HTN, DM- has been less compliant since treatment last year. Very ill- appearing, multiple lab abnormalities- new AKI of Cr 4.1, platelet 15, WBC 7 with 71% blast and will require admission for worsening AML.

Tolulope O Olade, MD
March 4, 2015 11:59 AM

14. Dr. Tolulope Olade was clearly concerned at the delay and lack of admission considering Decedent's condition, and detailed his notes in the medical records.

15. While in the ER, Decedent encountered the same fellow, Dr. Ghana Kang.

SAVE SMEAR/ NOT FOR PATH REVIEW [190435092] Active

Ordering user:	Kang, Ghana, Fellow (MD) 03/04/15 1108	Ordering provider:	Kang, Ghana, Fellow (MD)
Authorized by:	Kang, Ghana, Fellow (MD)	Frequency:	Once 03/04/15 1109 - 1 Occurrences
Electronically signed by:	Kang, Ghana, Fellow (MD) 03/04/15 1108		

16. At 12:51pm, per the ER Nurse Tindall, the MICU resident was at his bedside and stated that Decedent was not going to be admitted to the MICU.

17. At 12:08pm, a resident physician Dr. Sophia Kumbanattel, ordered a renal (kidney) ultrasound of Decedent. It was done at 2:48pm by another resident, Dr. Arya Rishi. An attending/staff radiologist, a Dr. Kaplan, was supposed to be present, authorize, and electronically sign off on the renal ultrasound, as well as "review the images and agree with

the resident's interpretation." This did not occur. The unfinalized report's interpretation became effect for the course of Decedent's treatment. The resident's "impression" was "unremarkable renal ultrasound. No sonographic findings to suggest medical renal disease."

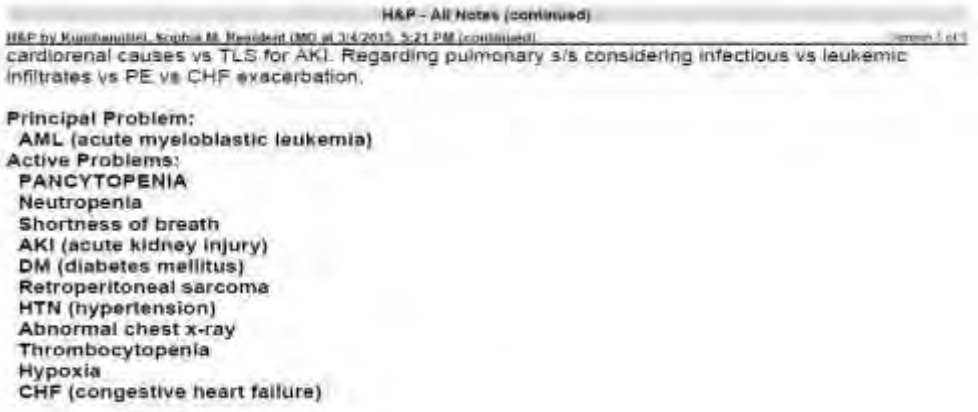
18. The MICU consult with Resident MD, Dr. Elaine Chang, occurred in the ER in the late afternoon of 03/04/2015.

19. Decedent disclosed his history of AML and chemo to her and told her, "I think my illness is coming back" (Exhibit 2) Dr. Chang noted of Decedent's leukemia history in the medical records, reviewed his CT chest imaging with the Hematology/Oncology Fellow, a Dr. Jatinder P Hothi, and concluded that the results were "suggestive of infection or leukemic infiltration."

20. Dr. Chang noted that Decedent's oxygen requirements were not excessive, but suggested the need for a "bronchoscopy to distinguish between infection vs. leukemic pulmonary infiltrates." (Exhibit 2) She discussed her diagnosis and treatment suggestion with the Fellow, and no attending physician. To address the possibility of pneumonia, antibiotics were started empirically. However, to address the possibility of AML relapse, a hematology/oncology specialist needed to weigh in their input and ultimately start chemotherapy as soon as possible, without delay.

21. Decedent was then later admitted to the intermediate care unit.

22. While in the intermediate care unit, Decedent saw a licensed but Family Practice physician and his resident for a history and physical at 5:21pm, who noted the following problems:



H&P – All Notes (continued)

H&P by Kyeibaniibi, Sophia M, Resident (MD at 3/4/2015, 5:21 PM (continued)) Version 1 of 1

cardiorenal causes vs TLS for AKI. Regarding pulmonary s/s considering infectious vs leukemic infiltrates vs PE vs CHF exacerbation.

Principal Problem:
AML (acute myeloblastic leukemia)
Active Problems:
PANCYTOPENIA
Neutropenia
Shortness of breath
AKI (acute kidney injury)
DM (diabetes mellitus)
Retroperitoneal sarcoma
HTN (hypertension)
Abnormal chest x-ray
Thrombocytopenia
Hypoxia
CHF (congestive heart failure)

23. Also, amongst others, she anticipated discharging Decedent in 4 – 5 days.

24. Overall, upon Decedent's admission to the hospital, Decedent's primary care was then immediately under that of inexperienced Family Medicine resident physicians, with consulting services from inexperienced Hematology/Oncology resident and fellow physicians or pharmacy personnel, and inexperienced and unqualified Medicine Intensive Care Unit (MICU) physicians and personnel; all without proper oversight. It was the overall impression of the team of doctors overseeing Decedent at that time, that Decedent's respiratory status was a result of 1) pneumonia or 2) leukemic infiltrates due to a relapse of his AML.

25. In the late night of 03/04/2015, within ~12 hours of Decedent's admission and while in the intermediate care unit, a rapid response was called on Decedent. It is documented by the nurse Decedent's oxygen saturation reached to 80% while on the oxygen mask. Decedent was assessed by the team of inexperienced and unsupervised physicians, and the decision was made to escalate his care and transfer him to the MICU and place him on Bilevel Positive Airway Pressure (BiPAP), a form on non-invasive mechanical ventilator (respiratory) support; a ventilator device that helps with breathing.

26. Around 10:58pm, post the rapid response, a resident physician viewed Decedent's chest x-

rays and noted that he had hypoxia and "volume overload," not infections of his lungs.

27. A cardiologist was never consulted for examination and treatment of Decedent.

28. An electrocardiogram was done on 03/04/2015. Then a BCM cardiology specialist, a Dr. Nasser M. Lakkis, only reviewed the electrocardiogram report the following early morning on 03/05/2015, and interpreted the report as "sinus tachycardia[11], arm leads reversed[12], and abnormal rhythm ecg[13]." He never went and saw or examined Decedent, nor reviewed Decedent's medical records. The staff physician at this time, Dr. Guerra, did not request a cardiologist consult. No physician or staff ever requested a cardiologist consult to see and examine Decedent.

29. Decedent habitually played recreational tennis.

30. Regardless, around 2:53am, per the intermediate care unit resident, an MICU team member, a resident Dr. Atur Sheth, came to the intermediate care unit and assessed Decedent. He informed the intermediate care resident that Decedent was going to be transferred to MICU, intubated, and put on mechanical ventilation; but there were currently no beds available in MICU. However, they planned to intubate Decedent (for the ventilation purposes only and not for examination – e.g. bronchoscopy –purposes) in his current room 5E if there is a delay in a bed becoming available in MICU.

31. The MICU consult was by resident Dr. Atur Sheth, at 3/5/2015 at 12:32AM. Decedent was able to communicate and give consent for the intubation for the ventilation. Dr. Sheth stated, "Patient was ok with intubation and chest compressions/CPR – patient wants both if needed, full code. Attempted several times to get in touch with family and finally successful."

[11] Heart rate faster than 100 beats per minute, and could be an indication of heart problem.
[12] Limb lead reversal usually occurs due to the technical error of reversing the right and left arm electrodes and is more common when non-experienced personnel replace ECG technicians.
[13] Signal of medical emergency such as heart problem.

Consults by Sheth, Atur T, Resident (MD) at 3/5/2015 12:32 AM

Author: Sheth, Atur T, Resident (MD) Service: BT MICU Author Type: Resident
Filed: 3/5/2015 4:15 AM Note Time: 3/5/2015 12:32 AM Status: Signed
Editor: Sheth, Atur T, Resident (MD (Resident))
Related Notes: Addendum by Sheth, Atur T, Resident (MD (Resident)) filed at 3/5/2015 4:17 AM

R3 MICU Consult Note

RFC:
Tachypnea, hypoxia

HPI:
Please see MICU consult note from earlier today by Dr. Chang for full history.

Since prior evaluation, patient with worsening hypoxia and tachypnea that has not improved with bipap that was placed after RRT called for hypoxia. See RRT note for interventions. Patient current complains of SOB, improved with bipap, but still present. Seems mildly altered per nursing compared to earlier. However, he is still answering questions appropriately. Denies any chest pain. Asked if ok with intubation and chest compressions/CPR - patient wants both if needed, full code. Attempted several times to get in touch with family and finally successful.

Consults - All Notes (continued)

GEN: moderate resp distress, increased WOB, AAOx3, cooperative
HEENT: anicteric sclerae, PERRL, dry MM
CV: tachy, no murmurs, no JVD
RESP: diffuse coarse BS, +increased WOB
ABD: Soft, NT, ND, Bowel sounds present
EXT: trace lower ext edema
SKIN: No rashes/lesions, no jaundice
NEURO: AAOx3, no focal deficits

Labs and Imaging Reviewed

A/P:
Patient also with worsening CXR concerning for early ARDS vs leukemic pulm infiltrates vs worsening multifocal pneumonia. Also with possible early TLS given significant burden from untreated AML (70% blasts on smear) Given patient's declining clinical status and development of acidosis, concerning for respiratory fatigue and signifying hypercapnic (and possible hypoxemic) respiratory failure, will admit to MICU and intubate. Patient ok with intubation and is full code. Have informed sister-in-law of likely intubation.
-continue abx, add clindamycin for anaerobic coverage.
-will consult heme in AM; may need to be started on treatment for AML
-possible early TLS: will not give fluids at this time given possible ARDS, but will not diurese either - repeat labs in AM and will re-assess after that

See R1 H&P for additional details.

Case d/w MICU on-call fellow, Dr. Manickavel.

Atur Sheth, MD, PGY-3
HCHD# 050029
Baylor College of Medicine
MICU On-Call Resident
x39128

32. Resident physician, Dr. Sheth, even stated to "consult heme in the AM; may need to be started on treatment for AML." In other words, there was a need to consult the hematology department staff in the morning of 03/05/2015, and to start treatment for the AML.

33. As of 5:29am on 03/05/2015, Decedent's was transferred to MICU team; with unsupervised and inexperienced MICU team now the primary team, and thus responsible for making decisions about his care.

34. Overall, the medical team overseeing Decedent from admission until the afternoon of

3/5/2015, mostly consisted of Family Medicine, Hematology/Oncology, MICU residents and fellows that included Dr. Elain Chang (Resident- Hematology/Oncology), Ghana Kang (Hematology/Oncology Fellow), Jatinder Hothi (Nephrology Fellow), Mahsa Yazdan Bakhsh (Resident – Family medicine), Allison Uyemura (Resident - Obstetrics & Gynecology), Jianbo Wang (Hematology/Oncology fellow), and Dr. Masha Yazdan (Resident – Family Practice).

35. This is the same Ghana Kang that was in the first hospital visit and participated in the Gold Card inquisition in the first hospital visit. Per history with Decedent, per Decedent's medical records from the emergency room, she was aware, or should have been aware, of Decedent's AML and his necessary care, i.e. that Decedent simply needed further chemo treatment. Said Ghana Kang was involved in Decedent's care from 03/04/2015 until about 03/24/2014, after Decedent had sustained severe injuries, and was denied chemo after Dr. Mims got involved.

36. While on the BiPAP, Decedent showed stable improvement in his respiratory status, however was overall still suffering from hypoxemia (i.e. low blood oxygen) and as a result in critical condition according to the inexperienced and unsupervised MICU team.

37. The two health care personnel consulted for treatment recommendations by the inexperienced and unsupervised physicians (e.g. Dr. Uyemura, Hoti, *et al*), were two clinical pharmacists, Sean Reilly and Ngo Hoa Le. There were no qualified physicians or specialists present or involved at this time, as required.

38. Ms. Ngo Le, the first clinical pharmacist, came in on 3/5/2015 at 10:47am and tried to execute the task of a hematology/oncology staff physician should be doing. She noted the obvious AML issue in Decedent's medical records, noted his hypertension issue, and noted

his heart issue as "diastolic heart failure.[14]" She recommended to "Monitor Renal Function."[15]

39. The second clinical pharmacist, Sean Reilly, subsequently arrived at 12:14pm on 3/5/2015, and also tried to execute the duties of a specialized staff physician. He examined Decedent, noted that Decedent was not anxious or depressed, noted mildly enlarged lymph nodes, noted that his kidneys were "unremarkably" fine, and noted a right ventricle (heart) pressure overload.

40. Decedent's kidneys were "unremarkable" per Mr. Reilly's review of Decedent's renal (kidney) ultrasound report. He stated that there was "No sonographic findings to suggest medical renal disease." Yet, he made a drug-related high-dosage (300mg) recommendation for Allopurinol, and instructed the physicians in writing, "**Please do NOT dose reduce the Allopurinol for renal impairment. We need to be aggressive… will only be using a couple of days.**" Consequently, Decedent was put on allopurinol 300mg twice a day.

41. Decedent saw an MICU Pulmonary & Critical Care physician – Dr. Diana Guerra – on 03/05/2015 at 3:31pm for a history and physical evaluation. Dr. Guerra never mentioned nor personally and individually authorized a bronchoscopy or BAL procedure.

42. On 03/05/2015 at 3:00pm, Decedent then saw a Nephrology physician, Dr. Jingyin Yan. Mr. Yan, in his progress notes noted the need to consult Hematology/oncology specialist to determine the best course of treatment. (Exhibit 3) He noted Decedent's problems including the diastolic heart failure.

43. The following day on 3/6/2015 at 12:03pm, a Dr. Jingyin Yan wrote,

[14] This diastolic heart failure was later suggested to be from "findings suggestive of right ventricle pressure overload," per the 03/05/2015 electrocardiogram. However, Decedent *never* saw a cardiologist.
[15] Ms. Ngo Hoa Le checked in on Decedent the following morning on 03/06/2015 at 9:09am, and noted that his "Renal improved."

and plan: s/p rasburicase yesterday. Uric acid level is improving. We saw a lot of uric acid crystal yesterday in urine sediment, which is absent in the urine sediment today, indicating that he has uric acid nephropathy. Please adjust allopurinol dose per renal function. Agree with intubation for respiratory failure. He needs hypotonic fluid for hypernatremia. Lasix as needed for pulmonary edema. Discussed with hemonc team, no schistocytes were seen in peripheral smear, so this is not HUS-TTP.

Jingyin Yan, MD
March 6, 2015 12:03 PM

44. Hence per Dr. Yan, Decedent had acute renal/kidney issues from his AML. Furthermore, the high dose of Allopurinol was improperly ordered and administrated. The allopurinol dosage was reduced from 300mg twice a day to 100mg daily on or about 03/09/2015.

45. There is evidence that an experienced hematology/oncology fellow physician, a Dr. Jianbo Wang, who supposedly was consulted, saw Decedent on 03/05/2015 at 9:56pm. According to Dr. Wang,

> "This morning (before he was intubated), we spent quite sometime to communicate with him. While the communication was difficult due to his BiPAP and respiratory distress, we also suggest to discuss with his son, he insisted to converse with us without deferring to his son (since his son is still in Nigeria and will come to Houston next week), **and he expressed his interest in seeking further chemotherapy for AML relapse**..." (Exhibit 5 – pg. 2)

46. Dr. Wang's statement and assessments was signed off on by the staff physician, Dr. Weei-Chi Lin, a Hematology staff, on 3/6/2015 at 4:16 PM. Neither Dr. Wang nor Dr. Lin's entries state any authorization for a BAL.

47. Regardless, it's clear that Decedent was asking for chemotherapy and never consented to a BAL, nor provided an advanced directive for consent to DNR. The man wanted necessary chemotherapy. Furthermore, he had heart issues that required a cardiologist.

48. No reasonably qualified physicians such as a Pulmonary (lung) specialist, an Ear, Nose, and throat specialist, or even the suggested Hematology/Oncology that focuses on blood/cancer, was involved to confirm the need for a bronchoscopy to treat the AML or respiratory matter.

49. Nonetheless, on the morning of 3/6/15 the MICU team decided to proceed with the bronchoscopy (i.e. the BAL). The clinical judgment was based on the fact that the MICU

team felt that Decedent was under severe respiratory compromise.

50. Decedent did not need a BAL procedure. A bronchoscopy is an invasive procedure that visualizes a person's trachea or windpipe. It can be used for both diagnosing and treating respiratory conditions. In the case of Decedent, performing a bronchoscopy was of no therapeutic value and would NOT have changed his diagnosis.

51. To reiterate, the medical team was charged to determine what was causing Decedent's respiratory difficulties. The two leading causes were either 1) a lung infection, which he was already being treated with antibiotics or 2) his leukemia. The evidence gathered earlier in Decedent's work-up already pointed to a relapse in Decedent's AML, a fact that the medical team was well aware of. Since the team was keen enough to start Decedent on antibiotics for presumed lung infections, he also should have been started on chemotherapy right away for his AML instead of being subject to unnecessary ELECTIVE procedures.

52. Moreover, any lung specialist would agree that the number one contraindication to performing a NONEMERGENT, ELECTIVE bronchoscopy are certain lung and heart conditions including severe respiratory failure. Now as the medical team may have it, if their clinical impression was that Decedent was suffering from hypoxemia and severe respiratory compromise, why even think to perform a bronchoscopy if it was NOT going to change the overall management of the patient? Again, these physicians did not want to give him chemotherapy mainly because of the color of his skin, his once foreigner/alien status, and due to their own personal vendetta against him.

53. It should also be noted that as part of the bronchoscopy procedure, a patient would have to be adequately sedated with anesthetics as to not feel pain and discomfort from the procedure. In the first bronchoscopy conducted by Dr. Amit on December 19, 2013, Decedent was

properly sedated with anesthesia. In the March 6, 2015 bronchoscopy procedure, there is evidence that Decedent was not sedated. Anesthesia was not ordered for the March 6, 2015 incident.

54. Sedation itself naturally causes one's respiratory drive to decrease. So again, why did the medical team agree and decide for a bronchoscopy to be done on a patient that they stated to be in respiratory failure? Decedent needed prompt evaluation by a cancer specialist and initiation of chemotherapy, and NOT to be experimented on by inexperienced health professionals. But again, after his first treatment at the hospital in December 2013, the medical staff already felt he did not have any money. So, they were not willing to provide experienced professionals to attend to Decedent.

55. Factually speaking, Dr. Sarkar, Pulmonary Care, Critical Care, and Sleep Medicine physician stated on 3/24/2015 that he had "intermittent hypotension," and that Decedent was found to have acute renal failure at admission. Ngo Le, the pharmacist, also stated that he had hypertension, and said to monitor the kidneys. Meanwhile Sean Reilly claimed that his kidneys were "unremarkably" fine. There is no record of Dr. Sarkar ever seeing, attending to, or being involved with Decedent until after the botched tracheostomy.

56. On the evening of 03/05/2015, Decedent saw a Hematology and Oncology physician, a Dr. Weei-Chin, Lin, who stated as follows:

TEACHING PHYSICIAN NOTE

I personally examined Aphaeus Ohakweh, performed the key portions of the history and physical examination and was directly involved in his care.

I reviewed the past medical records, laboratory results and resident's note and agree with the findings as documented in the resident's note..

I discussed the case with the resident and agree with the diagnosis of:
1. **Chest pain**
2. AKI (acute kidney injury)
3. Thrombocytopenia
4. Shortness of breath
5. Hypoxia
6. Abnormal chest x-ray
7. AML (acute myeloblastic leukemia)
8. CHF (congestive heart failure)
9. DM (diabetes mellitus)
10 HTN (hypertension)

11 Acute respiratory failure

12 PANCYTOPENIA

13 Acute and chronic respiratory failure

14 Other pulmonary insufficiency, not elsewhere classified

Printed by 83811 at 7/24/15 12:37 PM

Consults - All Notes (continued)

Consults by Wang, Jianbo, Fellow (MD) at 3/5/2015 9:56 PM (continued) Version 2 of 2

and plan: 64 y/o Nigerian AML with trisomy 8 received two cycles of Cloforabine/Ara-C (first in 12/2013 and second in 5/2014). He lost follow-up after the first cycle and second cycle of chemotherapy. Recently he came to US again and now presented with anemia/thrombocytopenia and 70% blast in the peripheral blood. We had sent out flow cytometry. This morning (before he was intubated), we spent quite sometime to communicate with him. While the communication was difficult due to his BiPAP and respiratory distress, we also suggest to discuss with his son, he insisted to converse with us without deferring to his son (since his son is still in Nigeria and will come to Houston next week), and he expressed his interest in seeking further chemotherapy for AML relapse. With his comorbidity at the moment and pending intubation, I hesitate to initiate standard salvage induction chemotherapy, but will consider Decitabine 20 mg/m2 iv for five days.

Weei-Chin Lin, MD
March 6, 2015 4:05 PM

57. Decitabine is chemotherapy drug.

58. Neither Decedent nor his family never consented to a BAL. Per the medical records, there is no evidence that Decedent nor his family were ever informed of nor consented to a BAL. Decedent also has no sister-in-law.

59. Per the medical records, Defendants had the names and telephone numbers of Decedent's family members and representatives at all relevant times.

60. There is no valid copy of said consent in the medical records. The signatures alleged to be

that of Decedent are in "Exhibit M" are disputed and unrecognized by his family members who know and can recognize Decedent's signature. The signature is also alleged to be fraudulent per forgery expert report, after comparison of the 03/06/2015 BAL consent form to other undisputed consent forms. The undisputed consent forms bear Decedent's signatures provided confirmed by Decedent's son as authentic, and also contain witness signatures as required by Harris Health System policy.

61. Decedent has no sister in law, but has a daughter-in-law who is mentioned in the records. Said daughter-in-law did not receive a call regarding an anticipated bronchoscopy nor did she consent to such treatment for Decedent. Decedent's son did not consent to any 2015 bronchoscopy or BAL on behalf of Decedent. Neither Decedent nor his family member gave consent to any BAL procedures on behalf of Decedent in 2015.

62. Assuming that Decedent consented to an endotracheal intubation, such intubation is for oral insertion of a breathing pipe in his trachea for him to breathe. The consent was not for a bronchoscopy/BAL.

63. There was no emergency situation that led to the need for an emergency BAL intubation, especially without consent, nor without first giving Decedent platelets.

64. Decedent signed a consent form for a blood transfusion the morning of 03/06/2015, per a signed and witnessed 8:00am consent form. The blood transfusion was withheld.

65. The medical records show that the physicians and health care providers were aware of, amongst others, Decedent's thrombocytopenia and low platelet issue, and that Decedent needed platelets. Platelets infusion that was to be given Decedent on 03/06/2015, were also withheld.

Hothi, Jatinder P, Fellow (MD) at 3/6/2015 8:18 AM (continued)

Vasculitus given the pulmonary and renal renal failure.
TLS is a possibility, but phos, potassium not significantly elevated.
-UA with proteinuria, FeNa 0.5%, UPC 1gm, **SPEP, UPEP pend**. Urine sediment showed uric acid crystals.
-Secondary w/u - HIV(neg), ANA, C3 wnl,C4 wnl, ANCA, DSdna neg, hep panel neg, HbA1c -8.0.
Kappa/lambda, Anti GBM pending
-RUS with normal sized kdineys and normal echogenicity
-TTE showed findings suggestive of RV pressure overload. LVEF is 65-69%
-Thrombocytopenia with 70%blasts, indicative of relapse, LFTs wnl , getting platelet transfusion today
-ELevated uric acid, Heme/onc treating as TLS- on high dose allopurinol and rasburicase x1 dose
Cr downtrending, Good uop
Electrolytes/Acid/base :hypernatremia, FWD ~3lts, however given tenous resp status, be cautious with IVFs. Ok **to give D5W @50. Repeat BMP in afternoon**
Blood pressure : controlled.
Volume status : overloaded, received IV lasix x 2 doses yesterday. Witheld today but can use if resp status worsens.
Hematology: Hb stable
Bone mineral disease :Calcium, Phosphorus ok , **PTH, vitamin D 25-OH pending**
Renal dosing of meds
Avoid nephrotoxins, NSAIDS
Accurate ins/outs
No emergent need for dialysis

Jatinder Hothi
Renal Fellow
53387

	3/4	3/5	3/6
WBC	6.3	6.6	7.3
Hemoglobin	8.6 (L)	8.1 (L)	7.6
Platelet	12 (LL)	9 (LL)	5

66. Per Decedent's lab report table included in pharmacist Ngo Lee's 9:09am 03/06/2015 assessment of Decedent, the physicians knew of Decedent's daily decline in platelet and hemoglobin[16] count.

67. Most importantly, there is no evidence that a specialized, qualified, or competent fully licensed physician, signed off on a 03/06/2015 BAL.

68. The 03/06/2015 BAL document was secured in violation of Texas Penal Code 32.21 and/or 32.46. Its execution was secured through deception with intent to defraud and/or harm

[16] Hemoglobin is in the red-blood cells, and functions to transport oxygen from lungs throughout the body and returns carbon dioxide to the lungs.

Plaintiffs including Decedent. Its proof lies in the "bronchoscopy w/ bronchial alveolar lavage" (i.e. BAL) procedure report dated 3/9/2015, done three days after the 3/6/2015 bronchoscopy and tracheostomy traumatic incident. It states "Informed consent was obtained from the patient after explaining the procedure, its risks, benefits, and alternatives." But there is no informed consent form for the 03/09/2015 BAL. The only informed consent form that exists was the fraudulent 03/06/2015 informed consent form secured after Decedent was already bleeding and sedated, per Dr. Suman's report of the 03/06/2015 incident. Decedent was not a capacity to give informed consent to the 03/09/2015 BAL. Decedent's family did not give consent to the 03/09/2015 BAL.

69. Said 03/09/2019 report describes a bronchoscopy w/ bronchial alveolar lavage procedure ("BAL") done on 3/9/2015 at 9:45am, with the physician as Dr. Elizabeth Guy, and with Van Hoang as the Assisting MD/Fellow. It was to examine Decedent's lungs.

70. Basically, after the 3/6/2015 failed BAL and tracheostomy incident, and with Decedent in such much more severe injured and immunocompromised state, on 03/09/2015 Dr. V. Hoang executed another unnecessary and unconscionable BAL on Decedent without consent nor proper supervision, as a cover-up to the unnecessary and failed 3/6/2015 BAL. The unsigned 3/9/2015 document supports that Dr. Guy was not present as required for the unnecessary and unconscionable 03/09/2015 BAL.

71. The 03/06/2015 consent form indicates that it was signed at 10:10am for consent to an "endotracheal intubation, bronchoscopy with bronchial alveolar lavage, biopsy, and other interventions." The respiratory failure event occurred about two hours after around 12:04pm on said 03/06/2015. Yet, Decedent was sedated around 9:00am with fentanyl.

72. The 03/06/2015 consent form in Exhibit M also says that Dr. Guy was to do a tracheotomy.

Meanwhile Dr. Guy statement in the medical records states that Dr. Hoang did the bronchoscopy (i.e. the alleged 03/06/2015 bronchoscopy w/ bronchial alveolar lavage procedure), and Dr. Kwak confirmed that he did the tracheotomy (emergency tracheotomy).

73. Exhibit N is a fraudulent document, as supported by Exhibit Bethrand's "Affidavit."

74. Per the medical records, the bronchoscopy (i.e. bronchoscopy w/ bronchial alveolar lavage procedure) and intubation for respiratory failure were the only mentioned procedures before the March 6, 2015 respiratory failure that occurred about two hours after around 12:20pm.

75. *Per the medical records, Dr. Kwak, Nurse Railey, Mimi Phan, etc., the decision for the tracheostomy was made as an emergency decision after Decedent already experienced severe oxygen loss as a result of the undisclosed failed bronchoscopy w/ bronchial alveolar lavage attempt.*

76. Evidence of an alleged consent for the 03/06/2015 bronchoscopy with bronchial alveolar lavage decision or procedure only appears in the forged or fraudulent 3/6/2015 document, and in the handwritten and criminally fraudulent code sheet regarding the tracheostomy.

77. At the time stamp of alleged consent form for the 03/06/2015 and the code sheet, Decedent was already incapacitated. Decedent would not have been able to consent to a bronchoscopy with bronchoscopy w/ bronchial alveolar lavage, nor the subsequent endotracheal intubation, even if Defendants had him execute the document while sedated and right before the emergency tracheostomy.

78. Moreover, it was documented that pre-procedure, Decedent was alert and orientated, answering and asking appropriate questions by the doctors and nurses. Given these facts, does this coincide with someone who the doctors claim to be in respiratory failure and in dire need of intubation and a BAL? The answer is NO.

79. The BAL was unnecessary for Decedent's alleged acute respiratory failure.

80. Regardless, on page 507 of the medical records, it is documented that Decedent's oxygen saturation was 92% at the start on the intubation procedure which is an acceptable level. However as mentioned above with the steps in a bronchoscopy procedure, prior to intubation Decedent would also require moderate sedation with drugs known to cause further respiratory depression and compromise.

81. The medical records show that the staff was with full knowledge that Decedent had money to pay, and that he was "African American" as decedent became a permanent U.S. resident (Green Card holder) in later 2014 before the 2015 hospital visit.

82. All this occurred in Medical Intensive Care Unit of a Level I trauma teaching hospital – the highest possible level designation and which means that Patients have access to specialist medical and nursing care including emergency medicine, trauma surgery, critical care, neurosurgery, orthopedic surgery, anesthesiology and radiology, as well as highly sophisticated surgical and diagnostic equipment – where there are TONS of physicians and medical staff for each specialized area present, or required to be present at all times. Rather, it was incompetent physicians and/or unqualified and/or criminal minded physicians and staff assigned to conduct unnecessary high-risk procedures on Decedent without consent.

83. An inexperienced, unqualified, unstaffed, and unsupervised medical team seeking professional experience and cost savings, forged a consent document for an unnecessary bronchoscopy, and executed an unnecessary high-risk and mortally wounding invasion of Decedent's body.

84. Amongst others, Decedent had *low platelet levels*, was diagnosed with thrombocytopenia and pancytopenia, and had received *no platelet transfusion* since he arrived at Ben Taub on

03/04/2015. Yet the inexperienced, unsupervised, and unqualified physicians did an *invasive procedure with a high risk of bleeding*, and several other internal and external bodily injuries.

85. Decedent lost oxygen during the failed 03/06/2015 BAL. Thereafter, an emergency tracheostomy was done during which per the records, Decedent's oxygen saturation deteriorated to the 80's, then the 70's, then the 50's, ultimately leading to the code, i.e. a comatose patient (i.e. not breathing and had no pulse), and multi-organ failure.

86. The evidence shows that Decedent did not need the BAL. Decedent needed and asked for chemotherapy.

87. A flexible bronchoscopy is a procedure in which a 2-inch diameter and about 4 in length device is inserted into a person, then a fiber optic tube with a camera in the end is then inserted into the device, and passed through the patient's insides to view the internal organs (e.g. lungs).

88. This is a high-risk procedure that should never be done without proper precautions, preparations, trained staff, and most of all, without written and signed consent from patient or authorized persons (e.g. family) as per Exhibit P.

89. Another point documented in the medical records, is that even after putting Decedent in the worst shape possible, the medical team (including Dr. Guy and Dr. Hoang; with Dr. Hoang being the same person that participated in the botched bronchoscopy) still proceeded with a bronchoalveolar lavage/flexible bronchoscopy.

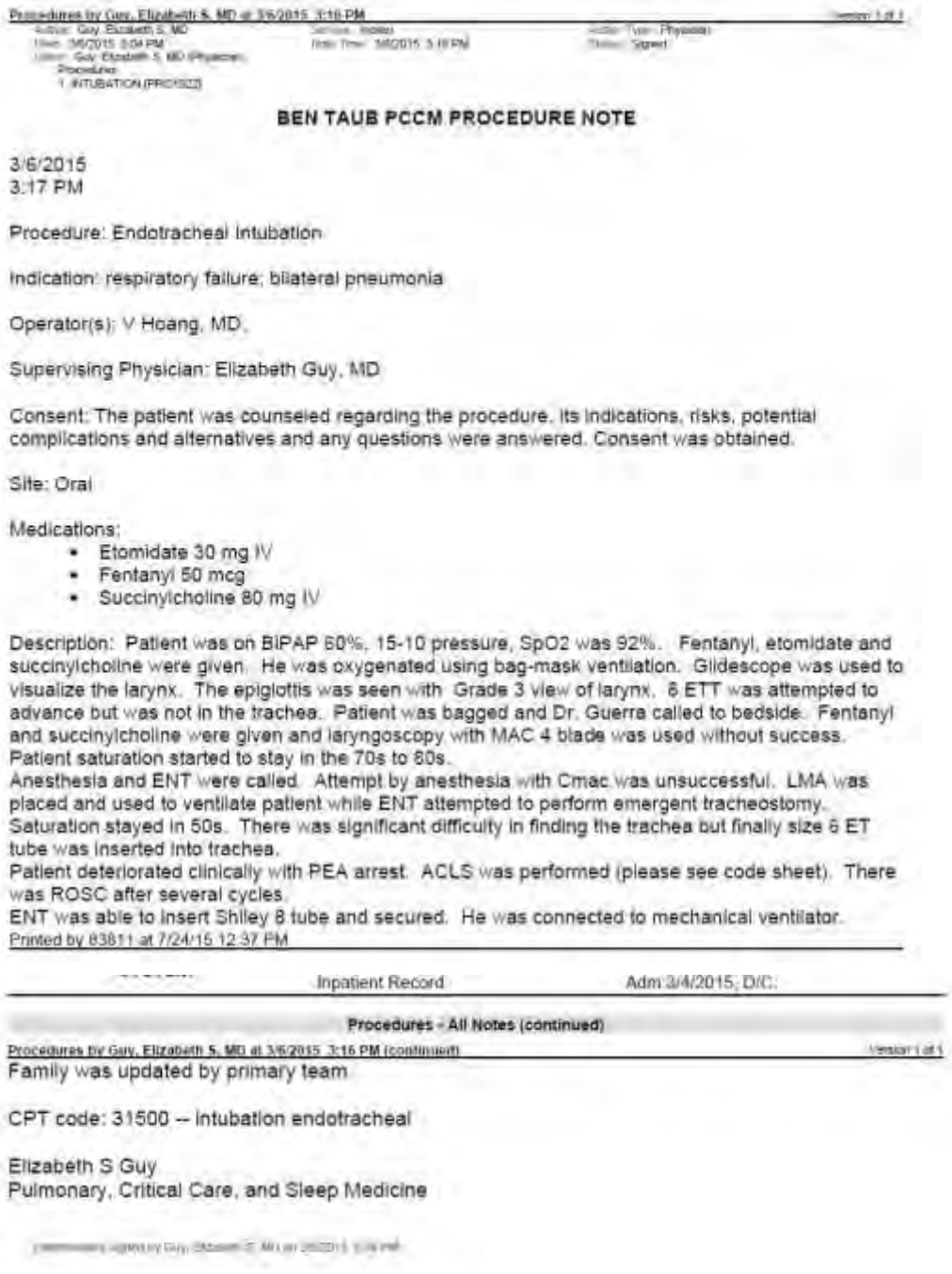
90. In other words, Defendants (Dr. Elizabeth Guy and Van Hoang) still performed a high-risk invasive procedure on the same day and again within three days after the terrible event (on 3/9/2015), on a critically ill and mortally wounded patient. There are many things unethically wrong with this.

91. First of all, pursuant to the attached (Exhibit 8) published medical research report from the United States National Library of Medicine, National Institute of Health, titled: Is BAL useful in patients with acute myeloid leukemia admitted in ICU for severe respiratory complications?" the BAL was unnecessary for ICU patients with AML and even hematological malignancy, developing acute respiratory failure. Decedent had no hematological malignancy.

92. Per the cytology report, the results of the cell specimens obtained from Decedent's after the 3/9/2015 flexible bronchoscopy (i.e. the 03/09/2015 BAL) were negative for malignant cells, just as before in this 2013 hospital visit.

Dr. Elizabeth Guy's version

14. A Dr. Elizabeth S. Guy, MD authored the primary care case management procedure note for the intubation/bronchoscopy **post** the tracheostomy and multiple organ failure. (Exhibit 10) She indicates that the operator of the endotracheal intubation was Dr. V. Hoang, MD (i.e. Dr. Van VI. Hoang, Resident MD in Pulmonary/Critical Care PGY-4), while she, i.e. Dr. Elizabeth Guy, was the supervising physician.



Procedures by Guy, Elizabeth S, MD at 3/6/2015 3:16 PM

Author: Guy, Elizabeth S, MD
Time: 3/6/2015 3:04 PM
Editor: Guy, Elizabeth S, MD (Physician)
Procedures:
1. INTUBATION (PROC502)

Service: Inpatient
Note Time: 3/6/2015 3:16 PM

Author Type: Physician
Status: Signed

Version 1 of 1

BEN TAUB PCCM PROCEDURE NOTE

3/6/2015
3:17 PM

Procedure: Endotracheal Intubation

Indication: respiratory failure; bilateral pneumonia

Operator(s): V Hoang, MD.

Supervising Physician: Elizabeth Guy, MD

Consent: The patient was counseled regarding the procedure, its indications, risks, potential complications and alternatives and any questions were answered. Consent was obtained.

Site: Oral

Medications:

- Etomidate 30 mg IV
- Fentanyl 50 mcg
- Succinylcholine 80 mg IV

Description: Patient was on BIPAP 60%, 15-10 pressure, SpO2 was 92%. Fentanyl, etomidate and succinylcholine were given. He was oxygenated using bag-mask ventilation. Glidescope was used to visualize the larynx. The epiglottis was seen with Grade 3 view of larynx. 6 ETT was attempted to advance but was not in the trachea. Patient was bagged and Dr. Guerra called to bedside. Fentanyl and succinylcholine were given and laryngoscopy with MAC 4 blade was used without success. Patient saturation started to stay in the 70s to 80s.
Anesthesia and ENT were called. Attempt by anesthesia with Cmac was unsuccessful. LMA was placed and used to ventilate patient while ENT attempted to perform emergent tracheostomy. Saturation stayed in 50s. There was significant difficulty in finding the trachea but finally size 6 ET tube was inserted into trachea.
Patient deteriorated clinically with PEA arrest. ACLS was performed (please see code sheet). There was ROSC after several cycles.
ENT was able to insert Shiley 8 tube and secured. He was connected to mechanical ventilator.

Printed by 83811 at 7/24/15 12:37 PM

Inpatient Record Adm: 3/4/2015, D/C:

Procedures - All Notes (continued)

Procedures by Guy, Elizabeth S, MD at 3/6/2015 3:16 PM (continued) Version 1 of 1

Family was updated by primary team

CPT code: 31500 -- Intubation endotracheal

Elizabeth S Guy
Pulmonary, Critical Care, and Sleep Medicine

15. Dr. Guy also stated that Decedent had respiratory failure and bilateral pneumonia.

16. Dr. Guy's statement is inconsistent as to all that occurred, and leaves out many material information. She claims that informed consent was obtained. She does not indicate that it

was an emergency situation – like the anesthesiologist Dr. Suman's version below. Per Dr. Guy's version, Decedent was given fentanyl, etomidate and succinylcholine. He was then oxygenated via a bag-mask ventilation (BMV). Then a glidescope used to visualize his larynx… Then a size 8 endotracheal tube ("8 ETT") was attempted be advanced – i.e. inserted – but unsuccessful in getting it in Decedent's trachea. Decedent was then bagged, Dr. Guerra called to beside. Then fentanyl and succinylcholine were given, and laryngoscopy[17] attempted with Mac 4 blade equipment but was without success. Thereafter, Decedent's oxygen level was then in the 70s – 80s. Then anesthesia and ENT were called in. She then states that the anesthesia team unsuccessfully attempted with the Cmac[18]. A laryngeal mask ("LMA") was then used to ventilate Decedent while the ENT tried to perform an emergency tracheostomy. Decedent's saturation stayed in the 50s. There was difficulty finding the trachea, but finally a size 6 endotracheal tube was inserted into the trachea. Decedent thereafter deteriorated clinically, with cardiac arrest result. Advanced Cardiac Life Support ("ACLS") was performed – per the code sheet. After several cycles of ACLS, they achieved restoration of spontaneous circulation ("ROSC"). ENT was then able to insert a Shelly 8 tube and secured it in his trachea. Decedent was then connected to the mechanical ventilator.

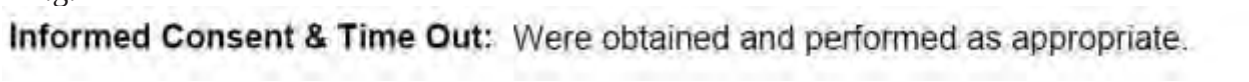
17. Dr. Guy provides an inconsistent cover-up story. Amongst others, she never states that oxygen saturation was in the 40s – 50s, nor that it ever went below 50, as indicated by Dr. Kwak and Dr. Suman. She also states that Decedent was given succinylcholine twice; the first time was with fentanyl and etomidate, and the second time with only fentanyl after Dr. Guerra was called in. Dr. Guerra never gave a statement. Most of all, she never states that

[17] Laryngoscopy looks at the throat, larynx, or vocal cords.
[18] Device used for laryngoscopy.

a bronchoscopy[19] was ordered, done, nor attempted, contrary to the Van Hoang's order at 11:53am, Paul Kwak's statement, and Dr. Suman's statement.

18. It's worth noting that Dr. Guy's entry in the records was written at 3:16pm on 3/6/2015 and signed on 5:04pm, after the emergency tracheostomy. The tracheostomy procedure and Decedent's cardiac arrest and resuscitation occurred around 12:20 – 12:40pm on 3/6/2015. Dr. Guy has been a fully licensed physician practicing since 1999. Furthermore, she never states that a "time out" was performed. "Time out" is a necessary procedure in which all necessary participants and equipment necessary for the procedure are confirmed to be present and functioning, before the procedure begins.

E.g.



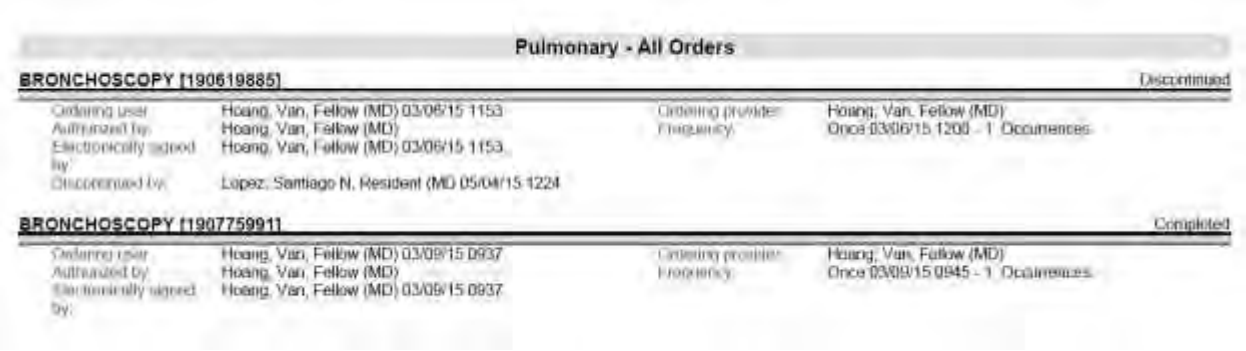
19. There should have been a time out performed for any endotracheal intubation, including for the unconsented BALs. There should have also been a pre-op procedure note.
20. Dr. Guy claims, "Consent was obtained." Yet there is no consent for a bronchoscopy. There is a *forged* consent Van Hoang signed for a 3/6/2015 bronchoscopy, which states that Dr. Guy was allegedly the bronchoscopy physician. There are no pertinent details of the bronchoscopy that occurred on 3/6/2015 as per the dated fraudulent or forged consent **allegedly signed at 10:10am**, but after Decedent already sustained injuries.
21. According to a Nurse Eke, Decedent was "chatting it up" with the staff until he was wheeled into the room for the alleged 3/6/2015 bronchoscopy procedure.
22. According to Dr. Guy, "a size 8 ETT (endotracheal tube) was attempted to advance but was not in the trachea." Here Dr. Guy is discussing the emergency tracheostomy, not a

[19] Bronchoscopy loos at the trachea, bronchi, and bronchioles. The bronchi and bronchioles are in the lungs.

bronchoscopy or BAL.

23. There is no entry statement in the medical records from Van Hoang in Decedent's medical records about her involvement in the 3/6/2015 bronchoscopy that led to the emergency tracheostomy.

24. Yet Van Hoang ordered and authorized two bronchoscopies, one on 03/06/2015 at 11:53am, and another on 03/09/2015 at 9:37am. Even though the 03/06/2015 BAL was ***fraudulently*** discontinued on 05/04/2015 by a resident Dr. Lopez, a fully licensed and qualified staff physician ***must*** authorize the orders and activities of the residents and fellows.



Pulmonary - All Orders

BRONCHOSCOPY [190619885] — Discontinued

Ordering user	Hoang, Van, Fellow (MD) 03/06/15 1153	Ordering provider	Hoang, Van, Fellow (MD)
Authorized by	Hoang, Van, Fellow (MD)	Frequency	Once 03/06/15 1200 - 1 Occurrences
Electronically signed by	Hoang, Van, Fellow (MD) 03/06/15 1153		
Discontinued by	Lopez, Santiago N, Resident (MD 05/04/15 1224		

BRONCHOSCOPY [1907759911] — Completed

Ordering user	Hoang, Van, Fellow (MD) 03/09/15 0937	Ordering provider	Hoang, Van, Fellow (MD)
Authorized by	Hoang, Van, Fellow (MD)	Frequency	Once 03/09/15 0945 - 1 Occurrences
Electronically signed by	Hoang, Van, Fellow (MD) 03/09/15 0937		

25. There is no entry statement in the medical records from any reasonably qualified and licensed physician about authorizing, prepping for, or executing the 3/6/2015 bronchoscopy that is time stamped before the 3/6/2015 emergency tracheostomy.

26. Many of the statements in the medical records regarding the March 6, 2015 incident (BAL and tracheostomy) are hours after the fact, with conflicting and missing statements from important individuals that were or should have been present to authorize, supervise, or participate in the BAL attempt and tracheostomy.

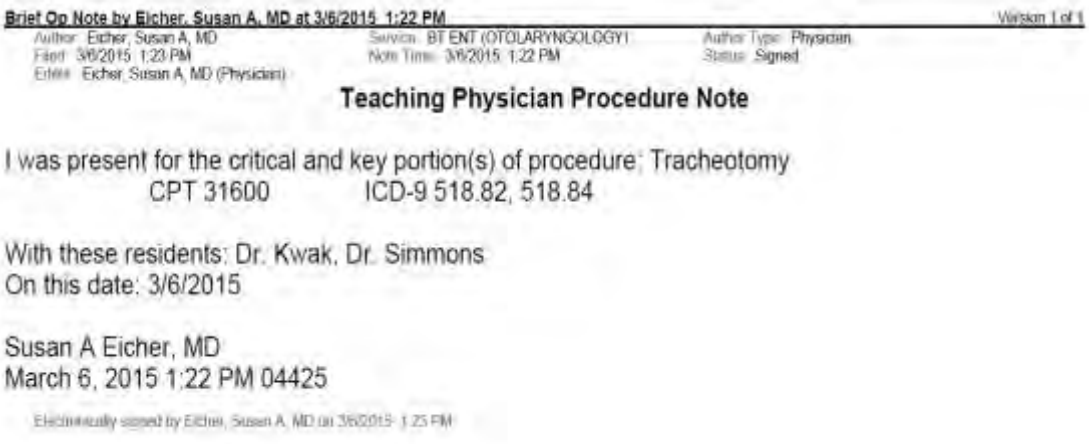
27. There is clear proof of a cover up, lack of experience, lack of supervision, and knowingly violating the law, amongst others.

<u>Resident ENT Paul Edward Kwak's involvement in the 3/6/2015 incident</u>

28. Dr. Veronica Vittone, Resident MD's notes indicated that Dr. Guy was the bronchoscopy/intubation physician on 3/6/2015 (Exhibit 11). Dr. Veronica Vittone, on 7/8/2015, cites to Dr. Guy's update note at 5:04pm on 3/6/2015 stating, "a size 8 ETT (endotracheal tube) was attempted to advance but was not in the trachea."
29. The misplacement of the endotracheal tube during the wrongful and non-consented bronchoscopy attempt, led to Decedent's loss of oxygen with "oxygen saturations hovered in the 40s-50s" (a deadly rate). It the led to further emergency procedures done by unsupervised and unqualified staff.
30. Furthermore, Dr. Vittone's Progress Notes cites the 3/6/2015 ENT note by Dr. Paul Kwak, who stated, "A direct laryngoscopy and oral endotracheal intubation were attempted by the anesthesia team but the airway could not be established. Oxygen saturations hovered in the 40s-50s. A vertical incision was made in the skin of the anterior neck with a #11-blade scapel. Significant amounts of soft tissue and fat were incised with the 11-blade to the presumed level of the trachea, but no lumen was found despite attempts to use the Bougie and flexible bronchoscope. The trachea was again palpated and medialzed, then incised horizontally with the 11-blade."
31. Decedent lost an extreme amount of oxygen, while the physicians were unable to locate his trachea lumen and unable to place the tube in Decedent' trachea to oxygenate him. Eventually, someone palpated, medialized and stabilized the trachea tube, in order to pass the tracheotomy tube that was connected to oxygen source. The physicians finally were able to connect the Decedent to oxygen.
32. Prior to and during the "presuming and guessing" period of the tracheostomy, Decedent was already deprived of oxygen. During the tracheostomy, Decedent was starved of oxygen, and

experienced severe brain injury, cardiac arrest, and multiple organ failure (including lung and kidney failure).

33. Per Resident Otolaryngology (ENT) physician Dr. Kwak's notes, he performed the tracheotomy and presumed the level of the trachea. Dr. Susan A. Eicher, MD, signed off on his presumptions and activities, per her "Teaching Physician Addendum."



Brief Op Note by Eicher, Susan A, MD at 3/6/2015 1:22 PM — Version 1 of 1
Author: Eicher, Susan A, MD | Service: BT ENT (OTOLARYNGOLOGY) | Author Type: Physician
Filed: 3/6/2015 1:23 PM | Note Time: 3/6/2015 1:22 PM | Status: Signed
Editor: Eicher, Susan A, MD (Physician)

Teaching Physician Procedure Note

I was present for the critical and key portion(s) of procedure: Tracheotomy
CPT 31600 ICD-9 518.82, 518.84

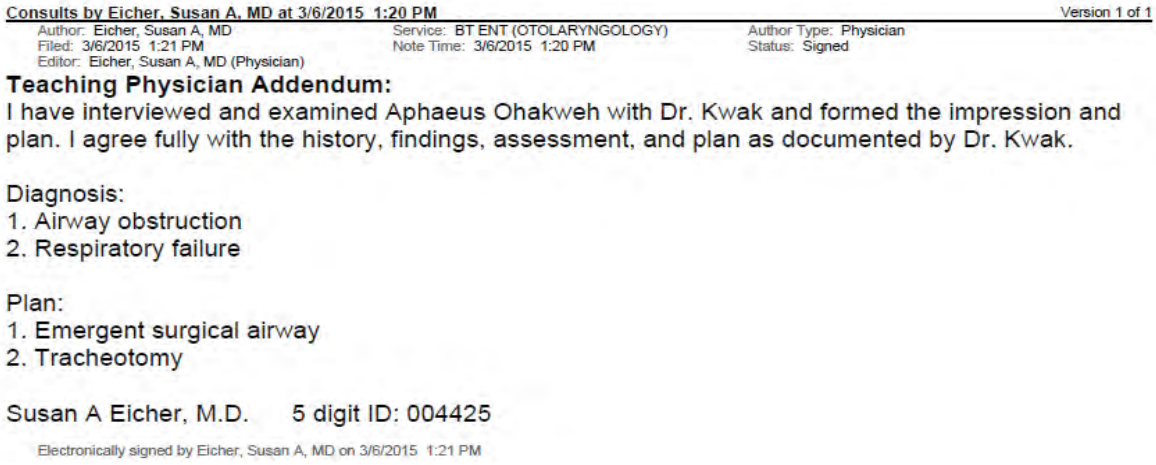
With these residents: Dr. Kwak, Dr. Simmons
On this date: 3/6/2015

Susan A Eicher, MD
March 6, 2015 1:22 PM 04425

Electronically signed by Eicher, Susan A, MD on 3/6/2015 1:23 PM

34. Dr. Eicher lied. Evidence shows that Dr. Eicher was not present as she claims. Dr. John C. Simmons, a resident ENT physician, was not present per the Code Sheet. His first medical records entry is on 03/08/2015.

35. At 1:20pm she indicated she interviewed Decedent for the tracheotomy yet to occur.



Consults by Eicher, Susan A, MD at 3/6/2015 1:20 PM — Version 1 of 1
Author: Eicher, Susan A, MD | Service: BT ENT (OTOLARYNGOLOGY) | Author Type: Physician
Filed: 3/6/2015 1:21 PM | Note Time: 3/6/2015 1:20 PM | Status: Signed
Editor: Eicher, Susan A, MD (Physician)

Teaching Physician Addendum:
I have interviewed and examined Aphaeus Ohakweh with Dr. Kwak and formed the impression and plan. I agree fully with the history, findings, assessment, and plan as documented by Dr. Kwak.

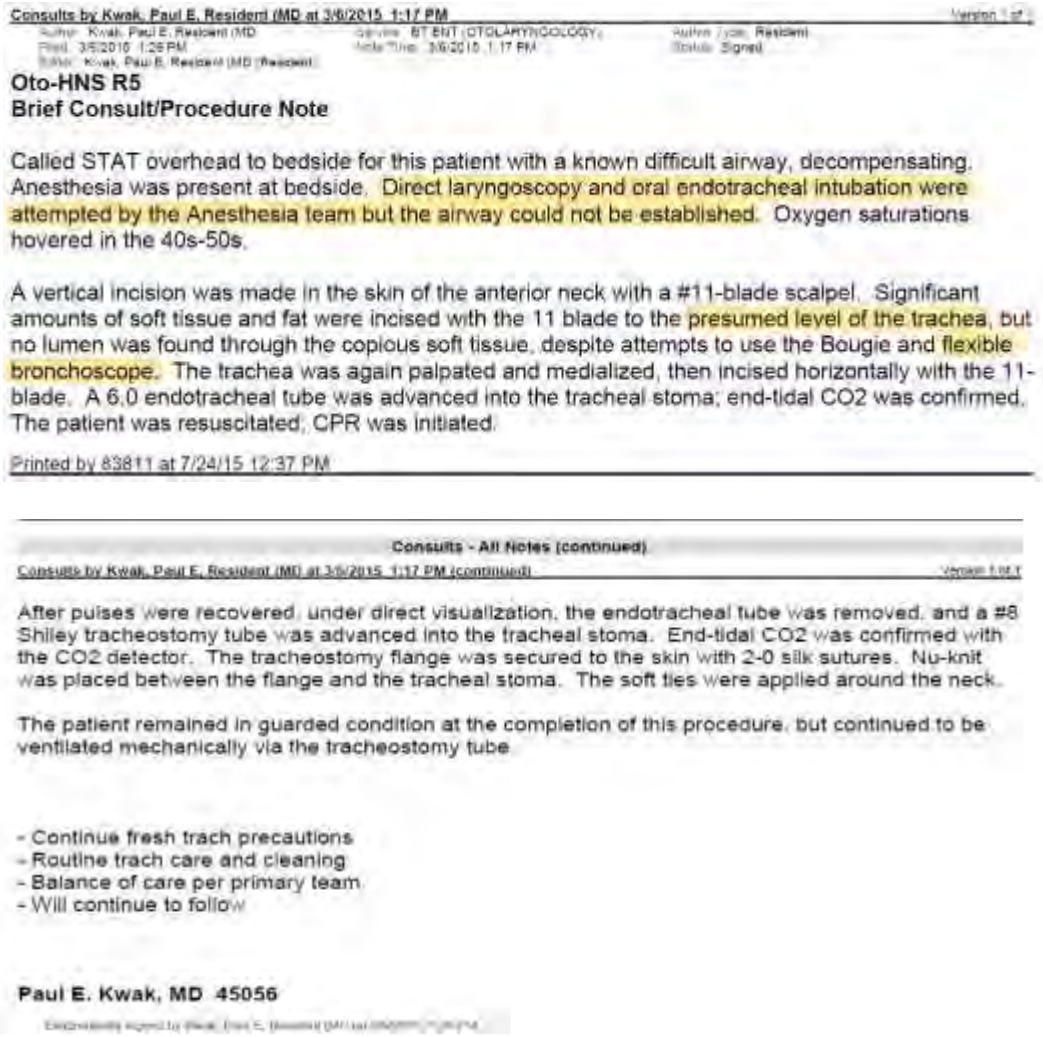
Diagnosis:
1. Airway obstruction
2. Respiratory failure

Plan:
1. Emergent surgical airway
2. Tracheotomy

Susan A Eicher, M.D. 5 digit ID: 004425

Electronically signed by Eicher, Susan A, MD on 3/6/2015 1:21 PM

36. As of 1:17pm, Dr. Kwak had already described the past tracheostomy activities.



Consults by Kwak, Paul E, Resident (MD at 3/6/2015 1:17 PM

Oto-HNS R5
Brief Consult/Procedure Note

Called STAT overhead to bedside for this patient with a known difficult airway, decompensating. Anesthesia was present at bedside. Direct laryngoscopy and oral endotracheal intubation were attempted by the Anesthesia team but the airway could not be established. Oxygen saturations hovered in the 40s-50s.

A vertical incision was made in the skin of the anterior neck with a #11-blade scalpel. Significant amounts of soft tissue and fat were incised with the 11 blade to the presumed level of the trachea, but no lumen was found through the copious soft tissue, despite attempts to use the Bougie and flexible bronchoscope. The trachea was again palpated and medialized, then incised horizontally with the 11-blade. A 6.0 endotracheal tube was advanced into the tracheal stoma; end-tidal CO2 was confirmed. The patient was resuscitated. CPR was initiated.

Printed by 83811 at 7/24/15 12:37 PM

Consults - All Notes (continued)

Consults by Kwak, Paul E, Resident (MD) at 3/6/2015 1:17 PM (continued)

After pulses were recovered, under direct visualization, the endotracheal tube was removed, and a #8 Shiley tracheostomy tube was advanced into the tracheal stoma. End-tidal CO2 was confirmed with the CO2 detector. The tracheostomy flange was secured to the skin with 2-0 silk sutures. Nu-knit was placed between the flange and the tracheal stoma. The soft ties were applied around the neck.

The patient remained in guarded condition at the completion of this procedure, but continued to be ventilated mechanically via the tracheostomy tube.

- Continue fresh trach precautions
- Routine trach care and cleaning
- Balance of care per primary team
- Will continue to follow

Paul E. Kwak, MD 45056

37. Per Dr. Kwak's version, amongst others, the anesthesia team attempted a direct laryngoscopy and oral endotracheal intubation that failed. Furthermore, he admits he tried to do a bronchoscopy – i.e. "use Bougie and flexible bronchoscope" to view Decedent's windpipe and lungs, after he presumed the level of the trachea and failed in his original incision. He leaves out Decedent's cardiac arrest. However, he indicates such when he states that after he advanced the size 6 endotracheal tube into Decedent's trachea, after his second attempt at the incision with the #11 blade scalpel – since the first attempt failed – "end-tidal CO2 was confirmed. The patient was resuscitated. CPR was initiated." After Decedent's pulse

was recovered, he was able to achieve direct visualization, then the endotracheal tube was then removed, and a tracheostomy tube inserted into the tracheal incision he made. Then end-tidal CO2 was confirmed (again?) Then the tracheostomy flange – i.e. part of the tracheostomy tube – was secured to Decedent's skin with silk sutures…

38. Aside of the conflicts or non-disclosures in Dr. Kwak's statements, including that Eichler was not present to supervise the tracheostomy, Dr. Kwak also leaves out the pneumothorax event in the forged consent form and in Dr. Suman's details below. He also states that Decedent's oxygen was already saturating in the 40s – 50s post the anesthesiologist failed laryngoscopy attempt and endotracheal intubation event; which per his statement, indicates that he observed it occur. His statement indicates that the 40s – 50s oxygen saturation was not a result of his actions. He blames the anesthesiologist team for that. Per anesthesiologist Dr. Suman's statement, she blames the MICU team for that. Per Dr. Guy's statement, anesthesia and ENT team were called in after the Decedent was already sedated twice, and the laryngoscopy equipment used, and never states that Decedent's oxygen saturation was below 50.

Dr. Mimi Phan's version per Code Sheet

39. The 1pm Code Sheet, Exhibit Code, describes the 03/06/2015 events after the failed BAL, and after Decedent already experienced lost of oxygen, i.e. hypoxia and went into cardiac arrest. She arrived in an emergency situation for the emergency tracheostomy.

40. Her summary on the Code sheet states that after several attempts at intubation, and inability to secure an airway by pulmonary/critical care and anesthesia staff, the ENT (i.e. ear, nose, and throat) staff attempted an emergency tracheostomy. The first attempt was unsuccessful, but the second attempt was successful. Throughout the event, Decedent lost oxygen, then

bradycardia (i.e. abnormally slow heart action/rate[20] - lower than 60 beats per minute), then loss of pulse.

41. The code sheet shows that Decedent went into cardiac arrest and had no pulse at 12:26pm, and it lasted for about 10 minutes, during which he required chest compressions.

42. The code sheet signed by Dr. Mimi Phan, states that Dr. Diana Guerra was the physician in charge of the code, that Dr. Kwak did the intubation for the emergency tracheostomy, and that the anesthesiologists, Dr. Mehta & Rajagopalan arrived to the emergency situation at 12:05pm.

43. There exists a handwritten "code sheet" signed by Elan Hailey RN and Thankamma

[20] In other words, the heart which its function is to pump blood to throughout the body organs, including the brain and kidneys, was not pumping at the rate enough (i.e. not enough blood pressure) to supply enough blood (Note: Regular breathing of oxygen is the means the blood is oxygenated. Blood then feeds oxygen to the brain via Vitamin E in red blood cells. Blood pressure regulates the force, volume per unit of time, and flow of blood in brain – aka cerebral perfusion pressure. Cerebral prefusion pressure ("CPP") must be controlled/maintained at a narrow level. Too little CPP means inadequate blood flow. Too much leads to too much brain pressure.) to major organs including the brain, kidneys, etc. The low blood pressure also leads to a type of kidney injury called "acute tubular necrosis" or ATN, which is when the small tube-shaped structures in the kidneys that remove salt, excess fluids, and waste products from your blood are damaged or destroyed. ATN results in acute kidney failure.

Imagine the brain as the control room of the human body. The brain's "medulla oblongata" area, controls the heart's rate of blood pressure via blood flow throughout out the body, including the brain. The brain needs this blood pressure to be oxygenated, and maintain CPP at a narrow level, so it – i.e. the brain – can function. Hence, if the brain tells the heart to increase blood flow to oxygenate the brain, and the heart is unable to, the brain injury called hypoxic ischemic encephalopathy (HIE) occurs, and brain cells are injured. Some brain cells may recover, and some may die. The extent of the injury depends on the level of deprivation of oxygen via deprivation of blood flow and oxygen to the brain.

Vasopressors are medication that constrict blood vessels, and increase blood pressure.

The heart can function and pump blood without the brain. However, the heart needs the oxygen carried in the blood to survive. When your heart muscle isn't getting enough oxygen, it causes a condition called ischemia.

Low levels of oxygen in blood is called hypoxemia.

Ischemia is a condition in which there is (a) inadequate blood flow and oxygen, (b) reduced availability of nutrients, or (c) inadequate removal of waste, from a specific part of body. The inadequate blood flow and oxygen aspect, is generally caused by narrow or blocking of an artery. Ischemia can lead to tissue or organ damage.

Uremia is a condition where there is abnormally high levels of waste products in the blood due to kidney failure. Kidneys filter and remove waste from the body via urine, remove drugs from the body, balance bodily fluids, release hormones that regulate blood pressure, control the production of red blood cells, and produce a form of Vitamin D that promotes healthy bones.

Macadden, RN at 7pm on 3/6/2015 (Exhibit Y). It states an "emergency tracheostomy by ENT surgeon after an unsuccessful intubation…" It lists everyone that was present, as well as their activities. It does not list Dr. Eicher, the required ENT physician, as present.

44. It states that Paul Kwak was the physician who performed the tracheostomy intubation. It states that a Dr. Guerra was the attending physician in charge. It also states that Herbert Ortiz, RN, Elan Hailey, RN, Thankamma Macaden, RN, Elizabeth Guy MD, Diana Guerra MD, Mimi Phan MD, Veeral Mehta MD, Rajagopalan MD, Suresh Manickvel MD, and Lamaya Blair RT were there for the tracheostomy.

45. None of these physicians, except for Dr. Guerra, appear in the medical records before the 03/06/2015 incidents.

A. PLEASE CHECK ONE: ☒ BTH ☐ LBJ ☐ QMCH ☐ CHP (specify): remains as of 5/19

DATE: 03/06/15 UNIT: 10E SERVICE: MICU CPR Event (circle event #): (1) 2 3 4 5

WITNESSED: ☒ Yes ☐ No TYPE OF ARREST: ☒ Cardiac ☒ Respiratory ☐ Full ☐ Other

INITIAL RHYTHM: ☐ V Fib ☐ V Tach ☐ Asystole ☒ PEA ☐ Bradycardia ☐ Other:

BRIEF DESCRIPTION OF INCIDENT:

During unsuccessful intubation anesthesia at bedside MICU team at bedside, emergency tracheostomy by ENT surgeon, patient bradycardia followed by PEA.

B. INTERVENTIONS (Facility Policy)

	TIME		TIME
Approximate time of code:	1220	Peripheral IV by: Site:	I
Code Blue Team called by:	I	Central IV by: MD Suresh Manickavel Site: R femoral	1350
CPR initiated by:	1220	Central IV Type:	
Intubation by: MD Paul Kwak		Presence of backboard: ☒ Yes ☐ No ☐ N/A	
☐ Nasal ☐ Oral ☒ Trach		Bed in CPR mode: ☒ Yes ☐ No ☐ N/A	
Size: #8 SHILEY Depth:		External Pacing applied: ☐ Yes Rate: MAs	
Position documented by:		Defibrillator: Type: ☐ AED ☒ Manual	
☒ Breath sounds ☒ ETCO2		Waveform: ☐ Monophasic ☒ Biphasic	

C. MEMBERS OF CODE TEAM

	Name	Arrival Time
☒ Anesthesia	MD Vencat Mehta, MD Rajagopalan	12:05 I
☐ EKG Technician		
☒ Medication Nurse	Thankamma Macadden RN	I
☒ Recording Nurse	Glan Hailey, RN	I
☒ Nurse Supervisor	Herbert Ortiz, RN	I
☐ Pharmacy		
☒ Respiratory	Lavanya Bhatt RT	I
☐ Radiology		
☑ Physician	MD Elizabeth Gary	I
☑ Physician	MD Diana Lucero	I
☑ Physician	MD Mimi Pham	I
☒ Other	Herbert Ortiz, RN	I

D. NURSE SUMMARY

Emergent tracheostomy by ENT Surgeon after unsuccessful intubation attempts by both MICU team and anesthesia team at bedside, patient bradycardic, initially followed by PEA. Chest compressions started and ACLS protocol followed.

E. LIST PROCEDURES

	TIME:
1. tracheostomy	1220 I
2.	
3.	
4.	
5	

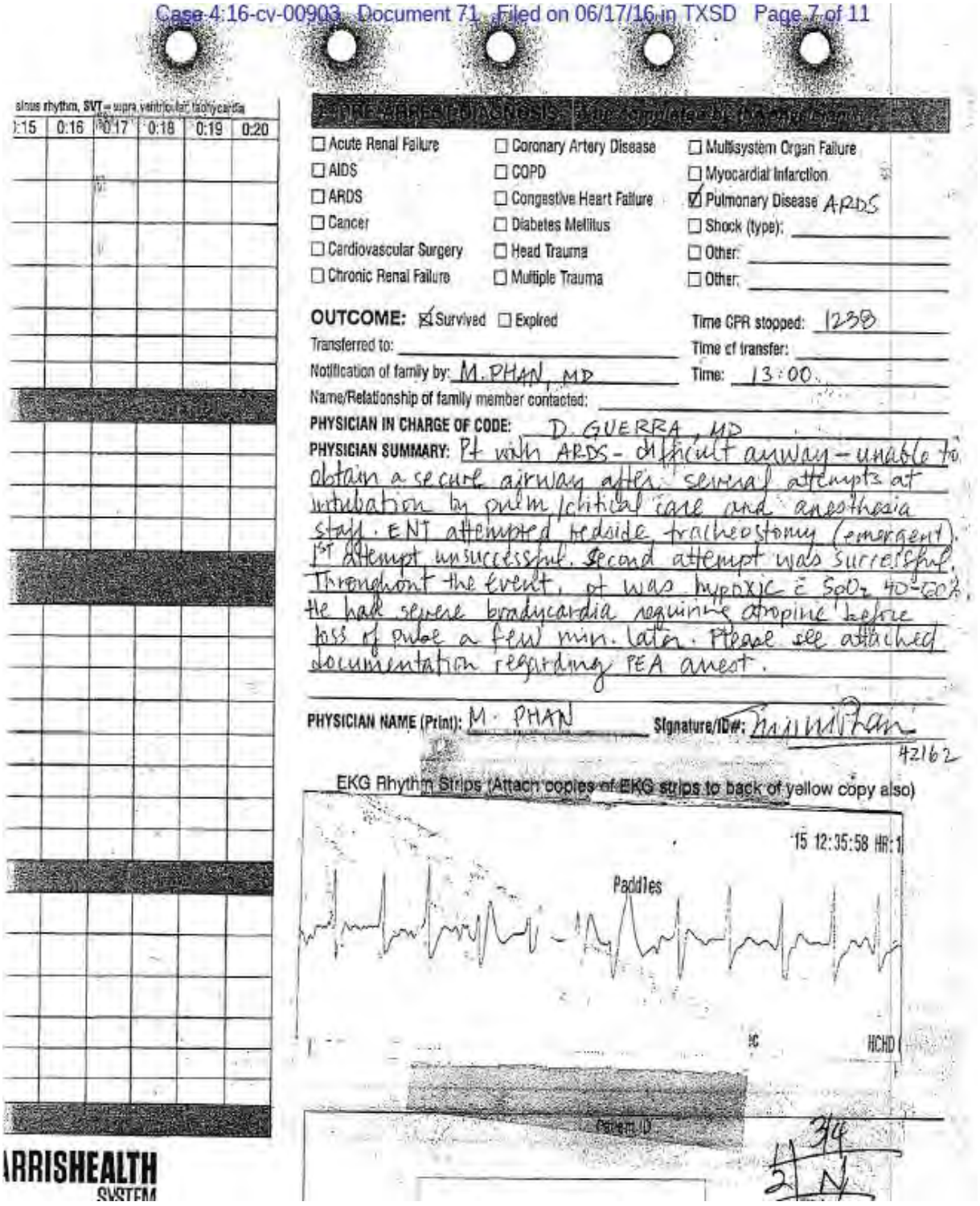
F. NAME, SIGNATURE, ID#, INITIALS

Recording Nurse Name (Print): Glan Hailey, RN Signature/ID#: RN 178193 Initials:

Medication Nurse Name (Print): Thankamma Macadden RN Signature/ID#: RN 76192 Initials: TM

Other Name (Print): Signature/ID#: Initials:

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 58880



46. The code sheet evidences that there was no specialized, qualified, or fully licensed Otolaryngology (ENT) physician present during the tracheostomy; only Resident ENT physician Paul Edward Kwak was present. Dr. Susan A. Eicher was NOT present. And

neither was the Dr. Simmons she alleges in her teaching notes.

47. The code sheet physician's summary does not state that Decedent was ever sedated, nor does it state a bronchoscopy or laryngoscopy ever occurred.

Nurse Raichel Elan Hailey, RN's version

48. Nurse Raichel Elan Hailey, RN, disclosed her report made at 3/6/2015 at 7:39pm – pg. 25952 of Decedent' Ben Taub medical records – that "patient received anxious on BIPAP 60% FiO2… Intubation and bronchoscopy unsuccessfully attempted this shift by MICU team, MD Guy and MD Guerra, and anesthesia, ultimately emergent tracheotomy at bedside by ENT performed. Patient bradycardic and atropine administered. Patient PEA following tracheotomy at 12:26, CPR initiated and ACLS protocol followed. Patient ROSC achieved at 12:38. Right radial arterial line and right femoral CVC placed by team. Currently patient not responsive… no movement to pain… fighting vent." (Exhibit 12)

49. Nurse Hailey's statement was given at 7:39pm. The main traumatic events of the tracheostomy, which she was present for and signed the code sheet, occurred around 12:04pm to 12:38pm.

50. Regardless, Decedent was so far gone/near death due to loss of oxygen because of the failed presumption of his trachea, Dr. Guy, Guerra, and the anesthesiologists, and without these physicians assuring the proper location and stabilizing the trachea before passing the endotracheal tube (ET) into Decedent's trachea.

51. Decedent was reflexively and involuntarily fighting the vent under frustration, hopelessness, and helplessness (i.e. he pulled out the tube unconsciously "fighting vent:" a reflex/instinctive reaction). Again, the fighting vent shows that he was not well sedated or oxygenated.

52. Furthermore it is no surprise that Decedent, while not sedated with anesthesia during the

trauma encountered in the unnecessary high-risk invasive bronchoscopy procedure that normally would require significant anesthesia, and while undergoing a procedure by medical personnel who were presuming the position of his trachea instead of verifying the anatomical position of Decedent's trachea as required, was under unbearable pain and endured cardiac arrest, brain anoxia, etc. His lack of oxygen was partly due to the multiple wrongfully placement of the ET tube outside the trachea and the extended period he went without oxygen.

53. A Dr. Suman Rajagopalan, MD of Ben Taub's Bt 6emi Mdcl ICU department was the care provider on 3/6/2015 per the medical records, and oversees the anesthesiology department. (Exhibit 13). Dr. Suman did not order anesthesia for the 3/6/2015 incident. (Exhibit 13) She also disclosed that "**verbal consent was not obtained**," nor "**written consent obtained**" as it was an "emergent situation." According to Dr. Suman, the failed intubation for the 03/06/2015 BAL occurred before 12:04pm. She disclosed that she was called to Decedent's bedside, into an emergency situation, and Decedent was already unconscious. She also discloses that the emergency intubation she was involved in began at 12:04pm, which corresponds with the code sheet for the emergency tracheostomy intubation. And at **2:12**pm she ordered the emergent intubation for the 12:04pm emergency intubation.

Anesthesia Procedure Notes - All Notes

Anesthesia Procedure Notes by Rajagopalan, Suman, MD at 3/6/2015 2:12 PM — Version 6 of 8

Author: Rajagopalan, Suman, MD Service: (none) Author Type: Physician
Filed: 3/6/2015 6:24 PM Note Time: 3/6/2015 2:12 PM Status: Addendum
Editor: Rajagopalan, Suman, MD (Physician)
Related Notes: Original Note by Rajagopalan, Suman, MD (Physician) filed at 3/6/2015 3:24 PM

Procedure Orders:
1. EMERGENT INTUBATION [190632508] ordered by Rajagopalan, Suman, MD at 03/06/15 1412
2. HCHD ANESTHESIA BLOCK ARTERIAL CATHETER [190635648] ordered by Mehta, Veeral D, Resident at 03/06/15 1443

Intubation (out of the OR)
Date/Time: 3/6/2015 12:04 PM
Universal Protocol
Consent: Verbal consent not obtained, written consent not obtained. The procedure was performed in an emergent situation.
Indications
Respiratory distress, respiratory failure and hypercapnia (ARDS)
Procedure Details
Intubation method: intubating LMA
Patient status: unconscious
Preoxygenation: bag valve mask
Sedatives: etomidate
Paralytic: succinylcholine
Laryngoscope size: C-MacD blade (attempted intubation with a CMAC but the cords were anterior and unable to pass the ETT, intubation aborted and plan for bed side tracheostomy while continuing mask ventilation)
LMA: LMA 5
Number of attempts: 1
Ventilation between attempts: BVM
Comments
Called to the beside along with ENT for stat intubation in MICU. Patient with history of ARDS, leukemia. MICU team reported attempts at intubation but were unsuccessful. On arrival at the bedside, oxygen saturation in the 50s, moderately difficult bag mask ventilation as reported by MICU but was able to ventilate with 2 hands and oral airway. Etomidate 20 mg and succinylcholine 100 mg was given. NO improvement in saturation was seen but the decision was made to attempt intubation given the ARDS situation. CMAC used, grade 2b view with cricoid pressure, copious secretions suctioned, unable to pass the ETT as the cords were anterior.
Desaturation noted to the 30s and hence intubation aborted and BMV continued. Decision was made by the primary team to proceed with the tracheostomy. LMA was inserted at this point, color change noted on CO2 detector along with chest rise, oxygen saturation still in the 40-50s range. ENT proceeded with the tracheostomy and airway secured with 6.0 ETT. Patient became bradycardic, hypotensive for which atropine was given. He then went into PEA arrest for which chest compression with epinephrine and vasopressin were used per ACLS protocol. His saturation did not go over 60-70%. Bronchoscopy was done and the ETT positioned to 3 cms above the carina. Due to difficulty in BMVand poor saturation, a decision was made to switch over to a cuffed shiley 8.0. Arterial line placed to better monitor the blood pressure.The ambu bag ventilation continued while the ENT sutured the trach in place. Saturation reached upto a 100%. bronchoscopy done by MICU team. Care transferred to them and RT.
Arterial Catheter (A-line)
Laterality: right
Site: radial
Prep: ChloraPrep
Catheter
Gauge: 20 G
Procedures

Anesthesia Procedure Notes - All Notes (continued)

Anesthesia Procedure Notes by Rajagopalan, Suman, MD at 3/6/2015 2:12 PM (continued) — Version 8 of 8

guide wire used and guide wire removed
Sterile barrier used: antiseptic used during arterial catheter insertion, hand hygiene performed prior to central venous catheter insertion and mask used during central venous catheter insertion.
Narrative
Start Time: 3/6/2015 1:02 PM
Anesthesiologist: Rajagopalan, MD
Resident/CRNA: Mehta, MD

I was present for the entire procedure and available at the bedside throughout.

Suman Rajagopalan, MD

Electronically signed by Rajagopalan, Suman, MD on 3/6/2015 6:24 PM

54. In lay terms, Dr. Suman states that "MICU team reported attempts at intubation but were unsuccessful." Hence, she arrived after the unsuccessful intubation attempt by the inexperienced and unsupervised MICU team. She then states that Decedent was already

experiencing low oxygen levels – "oxygen saturation in the 50s" – upon her arrival, and that the MICU team reported had difficulty in ventilating Decedent with a bag valve mask, but they were able to do so orally and manually with two hands. **Decedent was then sedated for the first time with etomidate and succinylcholine.** There was no improvement in in his oxygen levels, then they decided to intubate Decedent given his acute respiratory distress syndrome situation. An attempt was made with the Cmac, pressure applied right below his Adam's apple, a lot of secretions were suctioned, and there was no success in passing the endotracheal tube. The intubation was unsuccessful and they aborted the attempt, and used the bag valve mask. Thereafter, "the decision was made to attempt intubation given his acute respiratory distress situation." A laryngeal mask ("LMA") was then used, they then **noted a color change in the carbon dioxide detector along with Decedent's chest rising[21],** and Decedent's blood oxygen levels were still severely low. ENT team then proceeded with a tracheostomy and airway secured with a size 6 endotracheal tube. Thereafter, Decedent's heat slowed and had low blood pressure, and he was medicated for it. Decedent then went into cardia arrest, and chest compressions were given. Decedent's blood oxygen never got better to normal conditions. A bronchoscopy was then done and it was still hard to give Decedent oxygen via the bag valve mask, so they switched to a tube. The bag valve mask oxygenation attempt continued while they ENT sutured the tube in place. Decedent's oxygen then got better and reached 100% levels. Bronchoscopy was then done by the MICU team, and care transferred to them.

55. Unfortunately, Dr. Suman's version is helpful but partly inconsistent or untruthful as to all that occurred as it does not include, amongst others, the MICU team's BAL intubation events

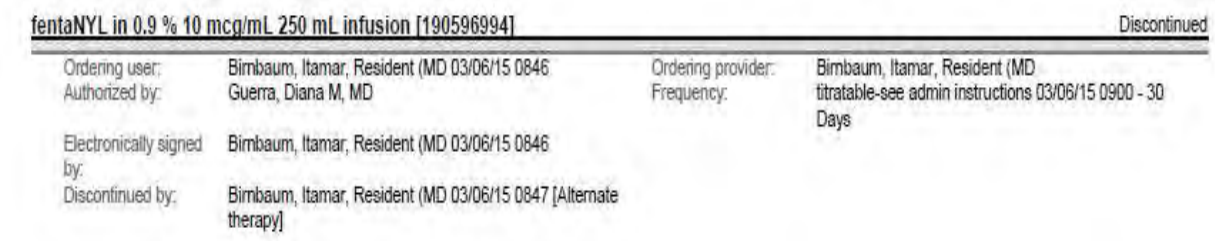
[21] This is the "pneumothorax" last listed in the second page of Decedent's alleged consent form in this pleading.

that occurred before she arrived; nor does it mention a laryngoscopy.

56. Dr. Kwak blames the anesthesiology team for doing a laryngoscopy and endotracheal intubation that led to oxygen saturation in the 40s – 50s, and his statement indicates he was present for it. Contrary to resident Dr. Kwak, Dr. Suman does not mention a laryngoscopy being done nor her participation in such. She also mentions that the MICU team already attempted an intubation before she arrived, and that Decedent's oxygen saturations was already in the 50s. She also states that the MICU team, not the ENT team – i.e. resident Dr. Kwak, did the bronchoscopy. She also fails to mention that fentanyl was given Decedent, and fails to state that she attempted a laryngoscopy per Dr. Kwak. Dr. Guy's version states that the anesthesia team were called in after all sedations were given. Dr. Suman's version states that Decedent was given etomidate and succinylcholine sedations after she arrived, not fentanyl and succinylcholine, or all three of etomidate, fentanyl and succinylcholine.

57. The records show that no one ordered a laryngoscopy, nor ordered and administered any sedation on Decedent before the for the wrongful BAL, and the laryngoscopy **as required**. No sedation was ordered and administered before the emergency events during which fentanyl, etomidate and/or succinylcholine were then ordered and given… if they were ever given. The medication orders do not state when they were administered. Just that they were ordered. It doesn't say who ordered them, electronically signed for them, or administered them.

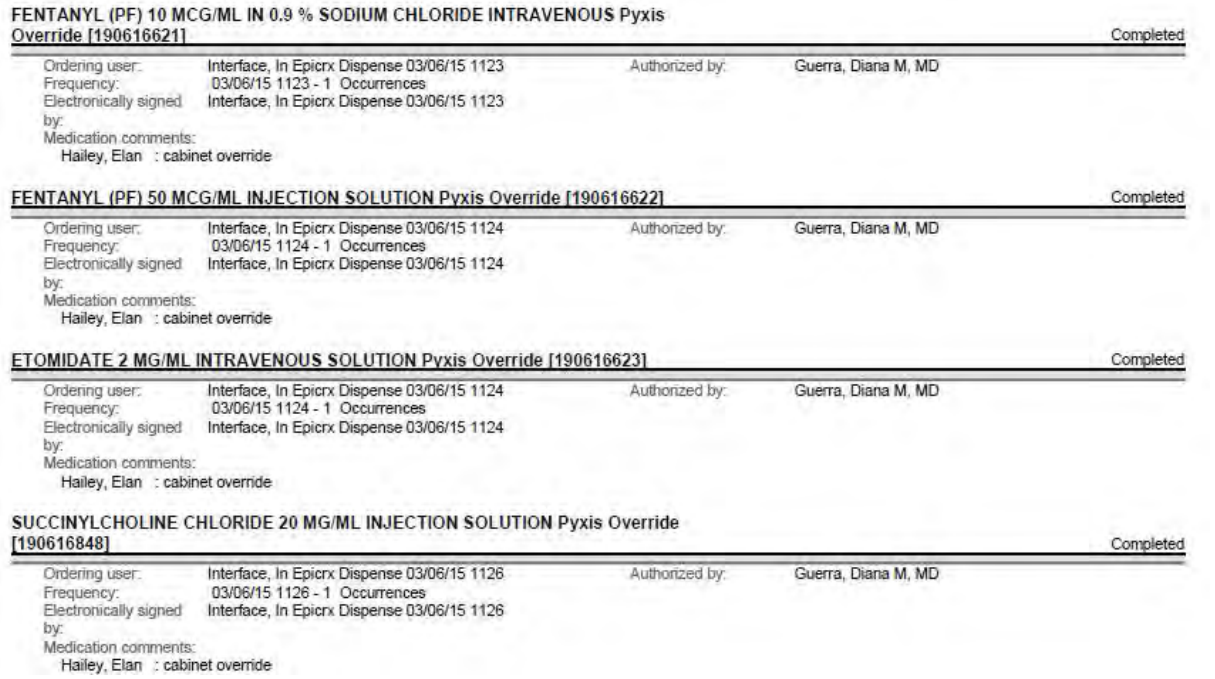
58. Per Dr. Suman's report and disclosures, and per the records, Decedent was not sedated at all prior to the emergency event. A resident physician, a Dr. Ramar Bimbaum ordered and discontinued fentanyl for Decedent at 8:46am and at 8:47am.



fentaNYL in 0.9 % 10 mcg/mL 250 mL infusion [190596994] — Discontinued

Ordering user:	Birnbaum, Itamar, Resident (MD 03/06/15 0846	Ordering provider:	Birnbaum, Itamar, Resident (MD
Authorized by:	Guerra, Diana M, MD	Frequency:	titratable-see admin instructions 03/06/15 0900 - 30 Days
Electronically signed by:	Birnbaum, Itamar, Resident (MD 03/06/15 0846		
Discontinued by:	Birnbaum, Itamar, Resident (MD 03/06/15 0847 [Alternate therapy]		

59. Per the below, that was the only sedation order for Decedent before 11:23am. The 11:24am order of Etomidate and succinylcholine corroborates with Dr. Suman's report.



FENTANYL (PF) 10 MCG/ML IN 0.9 % SODIUM CHLORIDE INTRAVENOUS Pyxis Override [190616621] — Completed

Ordering user:	Interface, In Epicrx Dispense 03/06/15 1123	Authorized by:	Guerra, Diana M, MD
Frequency:	03/06/15 1123 - 1 Occurrences		
Electronically signed by:	Interface, In Epicrx Dispense 03/06/15 1123		
Medication comments:	Hailey, Elan : cabinet override		

FENTANYL (PF) 50 MCG/ML INJECTION SOLUTION Pyxis Override [190616622] — Completed

Ordering user:	Interface, In Epicrx Dispense 03/06/15 1124	Authorized by:	Guerra, Diana M, MD
Frequency:	03/06/15 1124 - 1 Occurrences		
Electronically signed by:	Interface, In Epicrx Dispense 03/06/15 1124		
Medication comments:	Hailey, Elan : cabinet override		

ETOMIDATE 2 MG/ML INTRAVENOUS SOLUTION Pyxis Override [190616623] — Completed

Ordering user:	Interface, In Epicrx Dispense 03/06/15 1124	Authorized by:	Guerra, Diana M, MD
Frequency:	03/06/15 1124 - 1 Occurrences		
Electronically signed by:	Interface, In Epicrx Dispense 03/06/15 1124		
Medication comments:	Hailey, Elan : cabinet override		

SUCCINYLCHOLINE CHLORIDE 20 MG/ML INJECTION SOLUTION Pyxis Override [190616848] — Completed

Ordering user:	Interface, In Epicrx Dispense 03/06/15 1126	Authorized by:	Guerra, Diana M, MD
Frequency:	03/06/15 1126 - 1 Occurrences		
Electronically signed by:	Interface, In Epicrx Dispense 03/06/15 1126		
Medication comments:	Hailey, Elan : cabinet override		

60. Dr. Suman does not mention the fact that the first attempt at the emergency tracheostomy failed. However, she does disclose that a bronchoscopy was done.

61. However, it is clear that attempt for an intubation, an intubation for the BAL that was ordered and authorized by only MICU team member Van Hoang at 11:53am, already occurred and failed when Dr. Suman arrived.

62. However, Dr. Suman's report states that she arrived bedside for an intubation that began at 12:04pm, in an emergency situation; and the MICU team already attempted intubating Decedent for the unconsented 03/06/2015 BAL.

63. The record entries disconnect as to the timeline and detail of events corresponding with that of other statements including who was present and hat time they arrived, what procedure was to be done and what was eventually done, who authorized and oversaw which the procedure, etc. The record entries evidence that an intubation attempt for an unconsented bronchoscopy was done and failed. The inexperienced and unsupervised physicians were unable to orally intubate Decedent, and harmed him. Decedent was also not originally sedated for said oral intubation attempts. After the intubation attempts for the unconsented BAL failed, they then tried to intubate him for the sake of this respiratory distress. Decedent loss of oxygen, resulting from the wrongful BAL intubation attempt, created an emergency situation and need for a tracheostomy (i.e. to create an hole in his trachea to oxygenate him). The intubation for the emergency tracheostomy was executed without proper supervision of Dr. Eicher. The intubation attempt was unsuccessful with the C-MacD blade, and Dr. Kwak passed the ET blindly into Decedent, while MICU had difficulty providing oxygen to Decedent with the "bag mask." After Decedent had endured severe pain and suffering, cardiac arrest, multiple organ failure, and was revived, the tracheostomy was eventually executed resulting in a breathing tube via Decedent's trachea, and Decedent ventilator dependent. Then the unconsented bronchoscopy, that was to be a BAL per the forged consent form, was then still done – as a justification cover-up of the lack of consent. The unconsented BAL, was then done later on 03/09/2015, also as a justification cover-up of lack of consent.

64. It is clear that no consent – oral or written, was obtained from Decedent or his family for any bronchoscopy or BAL procedures, nor did any fully licensed staff physician approve of such before the 03/06/2015 events. The Code Sheet says Dr. Guerra was in charge. Yet the

BAL consent form says Dr. Guy. Dr. Guy's report does not mention a 03/06/2015 BAL. It is also clear that the 03/09/2015 BAL lacked consent.

65. Per the medical records, the personnel involved prior to the emergency tracheostomy were Itamar Birnbaum (resident), William B Lemaster (resident), Dr. Chang (resident), Dr. Gilmore (resident), Dr. Hoang (fellow), *et al*. (Exhibit 7) That's the MICU team.

66. Exhibit 7 shows undisputable evidence that Dr. Guerra was the attending physician, but had a reputation of allowing the residents and other third parties to order medications and electronically sign-off on said medications and procedures, on her behalf. Just as the staff/supervising physician must electronically sign-off on the documented work of the residents and fellows, the staff/supervising physician that authorizes the medication and procedure **must** be the person to electronically sign-off on it.

67. Furthermore, on said 03/06/2015 before and after traumatic event, Decedent still had the *volume overload* issue. A cardiologist was still not consulted, nor did the himself cardiologist go and see Decedent, whom he knew was a patient that needed his services.

68. Finally, Dr. Guy and Paul Kwak's disclosures are the first mention of a laryngoscopy. There is no mention of a laryngoscopy prior to 03/06/2015, nor did Decedent consent to such.

<u>Addition to the 3/6/2015 incident</u>

69. Decedent sustained severe wounds from the BAL and tracheostomy tube placement. As of 3/28/2015, per Dr. Kao, the trachea site developed ulcers. Per Dr. Winograd's physical exam notes on 3/28/2015, Decedent had dry blood in his mouth.

70. There is evidence that there was additional issues and damages caused with the tracheostomy tube as it subsequently had to be constantly replaced (Exhibit 14); meanwhile Decedent was without proper oxygen, bleeding internally, and getting multiple catheters recklessly inserted

into his left and right jugular without proper oversight, and being put through DNR procedures.

71. Furthermore, why list Herbert Ortiz RN again in "Other" category in the same page of the documents just lines after writing his name as the "Nurse Supervisor" category? This shows the state of mind of the nurses attempting to cover up for the physicians and themselves.

72. Also, included in the code sheet is a statement from Mimi Phan. Mimi stated that there was difficult airway in several attempts to intubate Decedent. There was then a bedside emergency tracheostomy attempted. The first was unsuccessful, the second was successful. Throughout the event, patient was hypoxic. Dr. Guerra was in charge.

73. Dr. Guerra, as the Pulmonary, Critical Care, and Sleep Medicine physician in charge, should have been present before any procedure began. Yet, she was called into an emergency situation after the original intubation, per Dr. Guy's version. Everyone on the Code Sheet were allegedly there for the emergency situation.

74. Simply put, the failed intubation for the 03/06/2015 BAL done without consent, failed, and created an emergency situation. Dr. Guy was not present for the BAL, as she was supposed to be, but she was present for the emergency tracheostomy. She and BCM staff, allowed to the residents and fellows to acting alone and without supervision in regards to Decedent's health care services. She was called into an emergency situation when the intubation attempts for the non-consented BAL failed. Dr. Guerra was not present for the unconsented BAL's intubation, as required for supervising physicians. She, the person in charge, was not present because she authorized and acquiesced to the residents and fellows to acting alone and without supervision in regards to Decedent's treatment. Therefore, she was called into an emergency situation when the intubation for the non-consented BAL failed, and was

present for the emergency tracheostomy. Van Hoang ordered and attempted a BAL alone without proper supervision of Dr. Guerra or Guy, and failed.

75. Simply put, Dr. Eicher was not present for the any intubation or emergency tracheostomy. She is the ENT physician, and her present required for at least the emergency tracheostomy. Resident Dr. Kwak did the emergency tracheostomy alone without proper supervision of Dr. Eicher, and failed.

76. There exists a modern and sophisticated video monitoring camera on the wall of the room where the event occurred. Plaintiffs requested for the recording of the camera. According to Dr. Fisher at the ethics board meeting in July 2015, the recording does not exist. According to Harris Health, the **modern and sophisticated** surveillance camera does not work.

<u>Pertinent details as to the second hospital visit</u>

77. Immediately after the 03/06/2015 event, before the physicians and nurse wrote, signed, and filed their disclosure statements on Decedent's trauma event, the physicians and staff already planned and acted to discharge Decedent.

Flowsheet Note by Peterson, Willie at 3/6/2015 4:24 PM

	03/06/15 1621
Charting Type	
Charting Type	Initial
Hospital Stay Greater than 30 Days	
Hospitalization >30 Days?	No
Advance Directives (For Healthcare)	
Do you have any Advance Directives for Healthcare?	Unknown
Is the Code Status current?	Yes
Patient Information	
Source of Information	Medical Record
Behavior	Sedated
Military Experience	No
Discharge Plan Screen	
Current Residence	Apartment

Printed by 83811 at 7/24/15 12:38 PM

Flowsheet Note - All Notes (continued)

Flowsheet Note by Peterson, Willie at 3/6/2015 4:24 PM (continued)

Current Household Composition	Family members
Current Support System	Immediate family
Patient Expects to be Discharged to:	Apartment
Anticipated Discharge Support System	Immediate family
Anticipated Discharge Date	03/10/15
General Family Information	
Patient Marital Status	Married
Primary Contact Person	Ibe Ohakweh(son)
Income Information	
Income Source	Parental/family support
Income/Expense Information	No income
Financial Resources	
Insurance/Benefits	None
Basic Needs	Met with difficulty
Legal Information	
Legal Concerns	No unmet needs
Mental Health	
Mental Health Concerns	No past / current concerns
Substance Abuse	
Substance Abuse	No past/current concerns
Acuity Level	
Medical Acuity	Category 5

H/P-65 yo male with AML diagnosed in 2013,s/p chemotherapy with no follow,diastolic heart failure, DM2, and hypertension who presents with worsening SOB for the last 2 weeks.Developed worsening respiratory function's and intubated
Problem-Discharge Planning

Intervention-Continue ongoing assessment of patient clinical status through multidisciplinary and observation of patient to identify clinical status/criteria for a plan of post acute care or transition to lower level of care
Evaluation-Continuing MICU treatment-intubated and sedated
-Continue to establish family contact-no answer at 651-278-4393
-Patient non funded for alternative placement or care
-No valid HHS benefit's

Printed by 83811 at 7/24/15 12:38 PM

Flowsheet Note - All Notes (continued)

Flowsheet Note by Peterson, Willie at 3/6/2015 4:24 PM (continued) Version 1 of 1

-Discharge Option's: Will be based on clinical status
-Home with family
Contact clinical case management for all discharge needs
W.Peterson RN/CCM-98889
281-952-0406

Electronically signed by Peterson, Willie on 3/6/2015 4:36 PM

78. On 03/11/2015, per Dr. Lakkis' interpretation of the report of an electrocardiogram done the same day, only the sinus tachycardia still existed. Still, no cardiologist was sent to see Decedent, nor did the himself cardiologist go and see Decedent, whom he knew was a patient

that needed his services.

79. When Decedent's son arrived at Ben Taub from a trip to Nigeria on 3/12/2015, he headed straight to his hospital bedside from the airport only to find that the alert and oriented individual he left in the hands of the physicians, was now on life support; with tubes all over him; bloodied up in his nose, ears, and mouth, and in the intensive care unit (6E room 11). He took pictures and began to question the staff as to what had happened.

80. Dr. Sarkar, the attending physician at this time, explained to him that his father was placed on BIPAP (oxygen mask) for two days shortly after he was admitted; that his father's sputum cultures were negative and so they decided to further assess his lungs by performing a bronchoscopy on 03/06 which required that he'd be intubated first. Dr. Sarkar stated that they obtained written consent from Decedent. (Note again: no valid written consent has been provided.)

81. Per Dr. Sarkar, attempts were made to resuscitate Dr. for 30 minutes. Due to the length of time taken to bring him back he suffered extensive anoxic brain injury, kidney failure, respiratory failure, and digestive failure.

82. According to Dr. Sarkar, two "respiratory/anesthesiology" trained medical personnel and/or physicians conducted the intubation on March 6, 2015 unsuccessfully, during which Decedent' heart stopped, he sustained cardiopulmonary arrest, incurred multiple organ failure, lost total consciousness, and had to be resuscitated.

83. A Nurse Eke on staff informed Decedent's son that on the day of the bronchoscopy, Decedent was "chatting it up" with them until the bronchoscopy procedure begun on March 6. Hence, Decedent was not properly sedated prior to the botched bronchoscopy.

84. The multiple organ failure directly resulted in Decedent dependence on ventilator support

(following an emergency tracheotomy performed by ENT), dialysis support and GI tube feeding.

85. Decedent later regained organ functions but suffered severe brain injury due to the loss of oxygen. However, following the March 6, 2015 events, as well as the March 9, 2015 bronchoalveolar lavage, decedent was not in a vegetative state. He was just severely or mortally injured.

Vegetative State Issues and Additional Events after the March 6. 2015 incident

86. Mimi Phan and Van Hoang did a Quentin Catheter placement on Decedent on or about 3/10/2015 "**in anticipation of HD"** (i.e. Hemodialysis) (Exhibit 15 – pg. 5). It was inserted into his "right internal jugular vein." Dr. Sarkar was supposed to be present to oversee this procedure. Rather, he was "available during the procedure." (Exhibit 15 – pg. 4).

87. Per Robert De Silva, RN at 4:35pm on 3/10/2015 after the catheter placement, Nurse De Silva was "Unable to dialyze patient, **HD catheter not working**, unable to aspirate both ports. Dr Hothi and ICU MD team notified." (Exhibit 16)

88. Per Dr. Xiaoming Jia's entry in the medical records- pg 24331 – Decedent was bleeding from his trachea as of the night of 3/11/2015. (Exhibit 18)

89. Bethrand will testify that when he arrived at Ben Taub Hospital on 3/12/2015 and saw his father, he met Dr. Sarkar in the hospital. After Dr. Sarkar told Bethrand his version of the 3/6/2015 event, which was that a bronchoscopy on March 6th went wrong, and that there were two anesthesia trained personnel present, Dr. Sarkar told Bethrand to "just forget about him" (i.e. forget about his father, Decedent) and told Bethrand that Decedent was going to be DNR'd. To which Bethrand got fumed and replied that his father (i.e. Decedent) was not going to die, Decedent needs to receive full treatment, and that a lot of people both here and

in Nigeria were depending on Decedent being alive.

90. On 3/16/2015 at 1:22pm, in the Teaching Physician note, Dr. Martha P Mims wrote "the family - I know the son from the last hospitalization. I don't think there is much we are going to be able to do for his AML" in her first visit and examination of Decedent after 06/11/2014.

91. Hence, Defendants created a situation in which they would not provide chemotherapy to Decedent for his AML before Dr. Mims finally saw and evaluated him, and disqualified him for chemo.

92. Other catheter placement issues:

a) R Fem Central line 3/9/15. Suresh Kumar Manikavel (fellow MD) was the physician who did the procedure. Dr. Elizabeth Guy claimed that she was partly present (i.e. there for insertion and left. Later returned.) This catheter placement was removed/discontinued on 3/18. (Exhibit 19)

b) R Quentin catheter on 3/10/15 done by Mimi Phan & Van Hoang on Decedent's right internal jugular vein (neck area). Sarkar was supposed to be the overseeing attending physicians. He was not present but stated that he was "available." The catheter was later found to be improperly placed and had to be redone/revised on 3/11/15 as it was causing further sever injury to Decedent. It was discontinued on 3/16. (Exhibit 19)

c) L Quentin catheter insertion in Decedent's left internal jugular vein (neck area) by Dr. Christina Kao on 3/16/15; found to be clogged on 3/25; and discontinued 3/26. (Exhibit 19)

d) R Internal Jugular vein central line catheter placement done on 3/18/15 by Van Hoang. According to Van Hoang, Sarkar was present. Only 1 of 3 ports working as of 3/25/15; removed on 4/10. (Exhibit 19)

e) R femoral Quentin Catheter placement on 3/26/15 by Dr. Venkata Bandi; clogged as of 3/30/15. (Exhibit 19)

f) L Internal jugular vein Quentin catheter placement again on 3/31/15 Van Hoang. Sarkar alleged to be Present. Dr. Sarkar only co-signed Van Hoang's notes regarding this procedure. (Exhibit 19)

93. After the 3/6/2015 incident, Decedent regained some function but still had kidney/renal issues, had bowel movements on tube feeds, and respiratory function with ventilator support. The medical record reported that Decedent was either (a) fully awake or (b) his brain

function was still minimal, or (c) his kidneys were worsening. The medical records also stated that he had pain reflexes on occasions and eye movement, but sometime Decedent was unresponsive to commands, and other times it stated that he was fully awake or communicating and giving consent to treatment.

94. As of 3/8/2015, per MICU resident, Dr. Gilmore, and OBGYN resident, Dr. Uyemura, Decedent was taken off sedation and pressors (vasopressors being a life-sustaining treatment needed for remediation and possible recovery from his 03/06/2015 cardiac arrest and brain injury), while his kidneys were worsening from, amongst others, the AML effects including on his bone marrow and the multiple organ failure from the 03/06/2015 event. (Exhibit 18)

95. It was the attending physician, Dr. Sarkar's, decision to stop vasopressors on 03/08/2015; but for the following weeks their efforts to take Decedent of vasopressor support, led to episodes of hypotension of Decedent; i.e. episodes of low blood pressure.

96. From 03/08/2015 to 05/31/2015, Decedent was to be on a plan of care that its goals included optimizing his brain oxygen, blood flow and pressure; his cerebral functions.

97. Yet, on 03/09/2015, Van Hoang executed an unnecessary 03/09/2015 BAL, done without supervision or consent; and thereafter, Decedent was bleeding from his trach area – the area of the source of his oxygen. Hence Decedent's source of oxygen at that time was also seriously compromised.

98. Per the medical records, Decedent was not in a persistent vegetative state until 7/10/2015. (Exhibit 21) Yet Baylor physicians and Harris Health System health care providers leveraged coercion and undue influence on the family in an effort to obtain authorization to withhold life-sustaining treatment from Decedent as of March 2015.

99. After Decedent was in a severely injured state, it became a goal by the physicians to get him

out of the hospital at his and his family's expense, or otherwise DNR Decedent – i.e. withhold and/or withdraw necessary/essential care from Decedent including withholding or withdrawing of life-sustaining treatment.

100. Overnight into the morning of 03/12/2015, Decedent was bleeding from his trachea. The Nephrology attempted dialysis, but were unsuccessful as the catheter was not functioning well.

101. On the morning of 03/12/2015, Dr. Sarkar contacted Decedent's son on the telephone. Decedent's son stated his desire that Decedent be given full and all necessary treatment/supportive care until he has the opportunity to speak with other family members.

102. On the morning of 03/13/2015, Decedent was given platelets, packs of red blood cells, and was given hemodialysis (i.e. dialysis) treatment.

103. On the evening of 03/13/2015, Dr. Sarkar and another physician spoke with Decedent's son and daughter to discuss hospital course and prognosis given Decedent's acute respiratory failure, renal failure, and AML recurrence. The family desired that the hospital continues all measures of support.

104. On 03/14/2015, Decedent was bleeding from his nose and trachea site. Per the hematology team, they had no plan to give him chemotherapy given his multiple organ failure. On this 03/14/2015, the Nephrology team – headed by a Dr. Thomas – determined that he was in "ESRD"[22] and gave him dialysis, which he tolerated well. Also, as of this 03/14/2015, Decedent's problem list included "hypoxia," not "anoxic brain injury[23]." The volume overload and the clear failure to consult a cardiologist, was still evident in

[22] "End-Stage Real Disease" – a condition where the kidneys cease functioning on a permanent basis; leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
[23] When the brain is completely deprived of oxygen due to sudden cardiac arrest, choking, strangulation, etc.

Decedent's the medical records he allegedly reviewed.

105. On 03/15/2015, a brain CT scan was ordered and done on Decedent, which showed that Decedent had anoxic brain injury.

106. As of 03/16/2015, Decedent was experiencing mild spreading of excess accumulation of fluid in spaces of his brain.

107. As of 03/17/2015, the spread was slowing, but he was showing signs of the results of severe brain trauma, but no seizures noticed.

108. As of 03/21/2015, per the staff Nephrologist, Dr. Thomas, Decedent's acute kidney injury subsequently developed after damage to his kidneys from excess uric acid in his body, and the low blood pressure and resulting inadequate blood flow and oxygen to his kidneys 03/06/2015 events. She further disclosed Decedent's issues to include *volume overload."* A cardiologist was still not consulted.

109. As of late March 2015, the physicians already concluded and agreed to execute the withholding or withdrawal of life-sustaining treatment from Decedent, and acted accordingly.

110. Also, aside of the fact that Decedent never saw a cardiologist, Decedent did not see a neurologist after the 03/06/2015 events until 03/26/2015; when the physicians were working to institute the DNR of Decedent. Prior to that, Decedent's care was in the hands of Pulmonary (i.e. respiratory), Critical Care, and Sleep Medicine physicians until 03/18/2015 when Dr. Mims began to participate in his care. Sometimes, they were uncertain of Decedent's brain condition or the cause of his condition.

111. Effective on 03/18/2015, the medical team assigned Decedent at Ben Taub included cardiology.

Team Assigned Ben Taub

Effective: 03/18/12

Hospitalist
Medicine
Obstetrics
Surgery
Cardiology
Critical Care Med
Emergency Medicine
ENT (Otolaryngology)
Family Medicine OB
Family Practice
GI Medicine
Gyn A
Gyn B
Gyn Oncology
Interventional Radiology
Medicine Oncology
MICU
Neonatal ICU

112. But Decedent, again, never saw a cardiologist while at Ben Taub.

113. On 03/24/2015, the primary care team (Dr. Sarkar & Dr. Chang) and Chief of hematology team, Dr. Mims, met and discussed with Decedent's family, including Decedent's son and Decedent's father-in-law, regarding status of Decedent's current medical condition. The physicians felt that Decedent was not improving, contrary to the observations of the family.

18 Goals of care, counseling/discussion

and plan: Patient seen and examined. Remains intubated and on pressors. Having HD about every other day. On my exam he does not arouse to voice or follow commands. I have intermittently seen him with his eyes open, but he does not track or focus on me when I speak to him. I do not feel there has been any neurologic improvement.

We had a long discussion with the son, ex-wife and the father-in-law of the son who is a CT surgeon in Maryland. Dr. Chang's note accurately describes the conversation. The family feels that the patient is blinking in response to their questions and squeezing their hand. I did not witness this when I was in the room with the patient, the son and the patient's ex-wife. The father-in-law seems to be the family spokesperson and he relayed to us that the family expects us to continue full support in the ICU, but they do not favor giving chemotherapy while the patient is this ill.

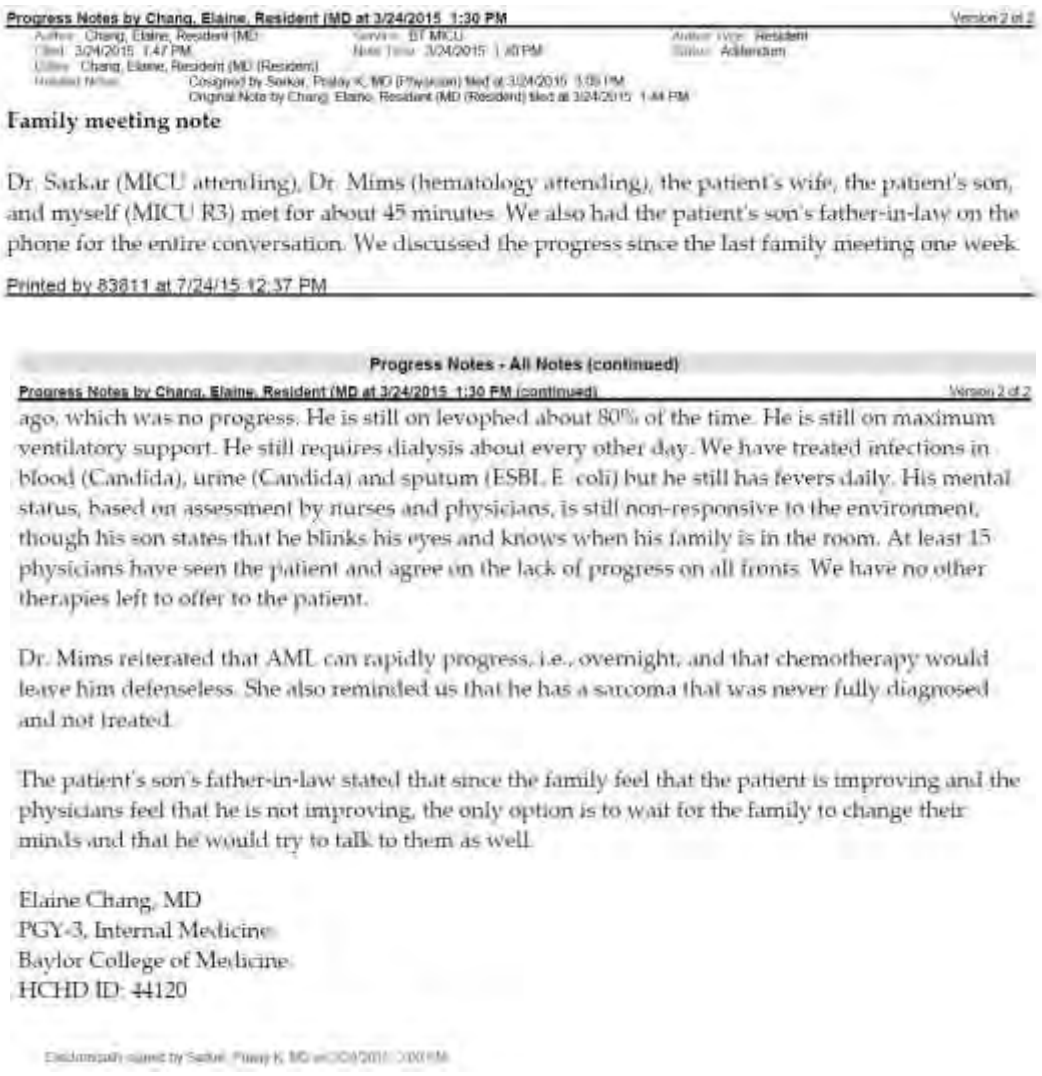
Martha P Mims, MD 23693
March 24, 2015 6:58 PM

Electronically signed by Mims, Martha P, MD on 3/24/2015 7:04 PM

Consults by Kang, Ghana, Fellow (MD) at 3/24/2015 10:06 AM

Version 1 of 2

114. Per Resident MD, Dr. Chang, Dr. Mims stated "that AML can rapidly progress, i.e. overnight, and that chemo would leave him defenseless. She also reminded us that he has a sarcoma that was never fully diagnosed and not treated." The family requested more time as they believed that Decedent was recovering in terms of mental function.



Progress Notes by Chang, Elaine, Resident (MD at 3/24/2015 1:30 PM — Version 2 of 2

Author: Chang, Elaine, Resident (MD) Service: BT MICU Author Type: Resident
Filed: 3/24/2015 1:47 PM Note Time: 3/24/2015 1:30 PM Status: Addendum
Editor: Chang, Elaine, Resident (MD (Resident))
Related Notes: Cosigned by Sarkar, Pralay K, MD (Physician) filed at 3/24/2015 3:05 PM
Original Note by Chang, Elaine, Resident (MD (Resident)) filed at 3/24/2015 1:44 PM

Family meeting note

Dr. Sarkar (MICU attending), Dr. Mims (hematology attending), the patient's wife, the patient's son, and myself (MICU R3) met for about 45 minutes. We also had the patient's son's father-in-law on the phone for the entire conversation. We discussed the progress since the last family meeting one week

Printed by 83811 at 7/24/15 12:37 PM

Progress Notes - All Notes (continued)

Progress Notes by Chang, Elaine, Resident (MD at 3/24/2015 1:30 PM (continued)) — Version 2 of 2

ago, which was no progress. He is still on levophed about 80% of the time. He is still on maximum ventilatory support. He still requires dialysis about every other day. We have treated infections in blood (Candida), urine (Candida) and sputum (ESBL E. coli) but he still has fevers daily. His mental status, based on assessment by nurses and physicians, is still non-responsive to the environment, though his son states that he blinks his eyes and knows when his family is in the room. At least 15 physicians have seen the patient and agree on the lack of progress on all fronts. We have no other therapies left to offer to the patient.

Dr. Mims reiterated that AML can rapidly progress, i.e., overnight, and that chemotherapy would leave him defenseless. She also reminded us that he has a sarcoma that was never fully diagnosed and not treated.

The patient's son's father-in-law stated that since the family feel that the patient is improving and the physicians feel that he is not improving, the only option is to wait for the family to change their minds and that he would try to talk to them as well.

Elaine Chang, MD
PGY-3, Internal Medicine
Baylor College of Medicine
HCHD ID: 44120

Electronically signed by Sarkar, Pralay K, MD on [illegible]

115. According to Dr. Brian M. Zwecker (Nephrology fellow), as of 3/25/2015, Decedent's catheter was not functioning well. (Exhibit 17)

116. On said 3/25/2015, while Decedent's catheter was not functioning and he was losing oxygen, Dr. Joslyn Fisher was already executing the plan of withholding life sustaining treatment from Decedent. At 4:06pm, in her Ben Taub Ethics Consult notes, she wrote "…Medically appropriate treatment option(s) for end of life care - consider offering several options -including withdrawal of all life-sustaining care, withdrawal of some life-sustaining/prolonging care, or limiting escalation of care." She also wrote that Dr. Sarkar

must document this (Exhibit F). She even went as far as writing into Decedent's medical records, "Excerpt from Harris Health System Advance Directives Policy 4128," which includes Harris Health's procedures for decision regarding life-sustaining treatment, and which somewhat mirrors Texas Health & Safety Code 166.046. However, Decedent at this time was not yet a qualified patient – i.e. deemed terminal or irreversible.

117. Evening of 03/25/2015, Bethrand visited his father, who was able to respond to blink command even in his state.

Progress Notes - All Notes (continued)

Progress Notes by Chang, Elaine, Resident (MD at 3/26/2015 12:40 AM (continued)

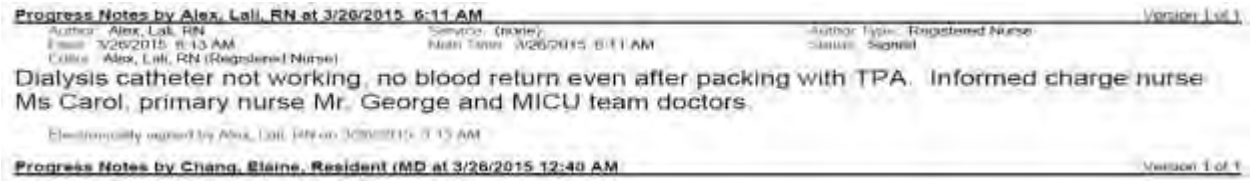
I was unable to contact Mr. Ibe by phone to ask to come for family meeting on Thursday, 3/26. However, he came to the hospital to visit this evening around 11:30 pm. I asked him to come to a meeting but he did not want to come because he felt like one meeting was enough in one week and that we needed to wait longer for a clinical change to occur before another meeting would be useful. He then went on to say
- he cannot withdraw care because the decompensation in his father's clinical status was "too sudden"
- he feels pressured by us and then started saying that he when goes to work he does all he can for the benefit of patients and we should be doing everything for the sake of the patient
- the patient is making clinical improvements and can blink on command

In response to the last point, I asked the son to demonstrate. He asked the patient to blink, waited 10 seconds, and said, "See, he blinked!" I hadn't seen any movement, so he tried again. He waited 10 seconds, and the patient blinked, but did not make any other movement or eye contact. He then said that we have been doing a great job of treating the patient which had resulted in his clinical improvement, and to please continue with full support.

A/P Mr. Ibe seemed to feel threatened by my request for a family meeting, so I did not offer counter arguments that he and his family have had two weeks to adjust to his decompensation.
- non-purposeful blinking
- will consult neurology formally to document neurologic status
- continue full care for now (will need new dialysis catheter)
- discuss with ethics committee again whether we should wait until next week for family meeting

Elaine Chang, MD
PGY-3, Internal Medicine
Baylor College of Medicine
HCHD ID: 44120

118. On early morning of 03/26/2015, amongst others, Decedent's dialysis catheter was not working early in the morning.


Progress Notes by Alex, Lali, RN at 3/26/2015 6:11 AM

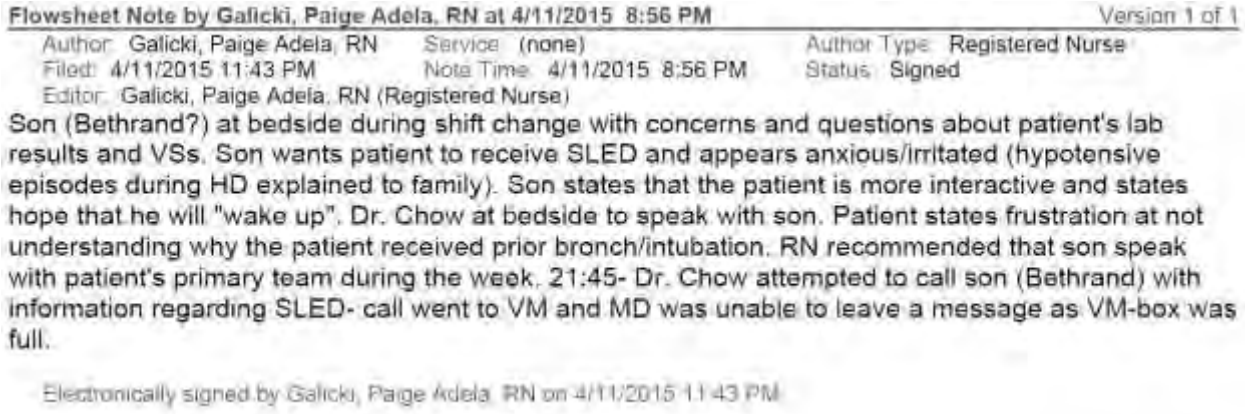
Dialysis catheter not working, no blood return even after packing with TPA. Informed charge nurse Ms Carol, primary nurse Mr. George and MICU team doctors.

Progress Notes by Chang, Elaine, Resident (MD at 3/26/2015 12:40 AM

119. Per Dr. Sarkar's progress notes on 3/27/2015, "This patient has relapsed AML that cannot be treated given his current condition and as untreated has very poor prognosis… In my view, the patient's condition is terminal, given the number of organ injury and lack of any improvement in nearly 3 weeks of full medical care. Life expectancy in a case of untreated AML is also poor (from days to few months) … We have suggested that at this time our medical recommendation will be to withdraw life sustaining measures e.g. Hemodialysis and mechanical ventilation." (Exhibit 46)

120. On 3/31/2015 and as a result of the injury sustained at the hand of Ben Taub Hospital physicians since his admission to the hospital, Dr. Jianbo Wang, MD, a Hematology Fellow, disclosed in Decedent' Ben Taub medical records, "Neurology staff indicates patient has no chance of meaningful neurological recovery and that he is going to enter vegetative and minimal conscious state." (Exhibit 23)

121. On 04/11/2015, Bethrand visit his father, inquired about his care, and was frustrated about the unconsented bronchoscopy and lack of dialysis per the RN and fellow on staff.


Flowsheet Note by Galicki, Paige Adela, RN at 4/11/2015 8:56 PM

Version 1 of 1

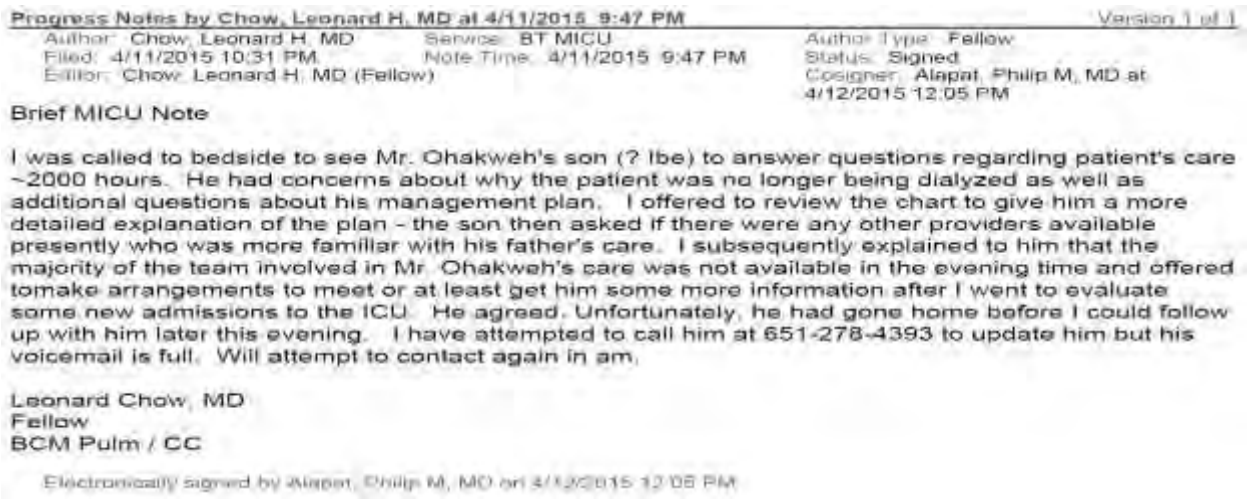
Author: Galicki, Paige Adela, RN Service: (none) Author Type: Registered Nurse

Filed: 4/11/2015 11:43 PM Note Time: 4/11/2015 8:56 PM Status: Signed

Editor: Galicki, Paige Adela, RN (Registered Nurse)

Son (Bethrand?) at bedside during shift change with concerns and questions about patient's lab results and VSs. Son wants patient to receive SLED and appears anxious/irritated (hypotensive episodes during HD explained to family). Son states that the patient is more interactive and states hope that he will "wake up". Dr. Chow at bedside to speak with son. Patient states frustration at not understanding why the patient received prior bronch/intubation. RN recommended that son speak with patient's primary team during the week. 21:45- Dr. Chow attempted to call son (Bethrand) with information regarding SLED- call went to VM and MD was unable to leave a message as VM-box was full.

Electronically signed by Galicki, Paige Adela, RN on 4/11/2015 11:43 PM



Progress Notes by Chow, Leonard H, MD at 4/11/2015 9:47 PM — Version 1 of 1

Author: Chow, Leonard H, MD | Service: BT MICU | Author Type: Fellow
Filed: 4/11/2015 10:31 PM | Note Time: 4/11/2015 9:47 PM | Status: Signed
Editor: Chow, Leonard H, MD (Fellow) | Cosigner: Alapat, Philip M, MD at 4/12/2015 12:05 PM

Brief MICU Note

I was called to bedside to see Mr. Ohakweh's son (? Ibe) to answer questions regarding patient's care ~2000 hours. He had concerns about why the patient was no longer being dialyzed as well as additional questions about his management plan. I offered to review the chart to give him a more detailed explanation of the plan - the son then asked if there were any other providers available presently who was more familiar with his father's care. I subsequently explained to him that the majority of the team involved in Mr. Ohakweh's care was not available in the evening time and offered tomake arrangements to meet or at least get him some more information after I went to evaluate some new admissions to the ICU. He agreed. Unfortunately, he had gone home before I could follow up with him later this evening. I have attempted to call him at 651-278-4393 to update him but his voicemail is full. Will attempt to contact again in am.

Leonard Chow, MD
Fellow
BCM Pulm / CC

Electronically signed by Alapat, Philip M, MD on 4/12/2015 12:05 PM

122. On 4/14/2015, there was a Moderate Sedation Pre-Procedure Form completed by a Dr. Gregory H. Broering, Resident MD. In the Sedation Risk Assessment, Dr. Broering states that Decedent was an appropriate candidate for moderate sedation, and that he was "a patient with severe systemic disease that is not immediately life threatening." (Exhibit 43) Dr. Broering also stated that Decedent had regular heart rate, strong pulses, and that his lungs were clear bilaterally. Dr. Broering also stated in the Focused Patient Interview and Physical Examination, that Decedent was fully awake as of that day. He wrote in his Assessment and Plan for a hemodialysis catheter placement on Decedent that his recommended sedation plan was "discussed with patient who communicated understanding." (Exhibit 43) According to Dr. Broering, Decedent was in "no respiratory distress" as of his physical examination for the hemodialysis catheter placement on 4/14/2015. Dr. Broering thereafter recommended a few sedation drugs, Versed and Fentanyl, to be used if required. David M. Wynne MD agreed and signed off on Dr. Broering's 4/14/2015 Pre-op treatment plan for the hemodialysis catheter placement. Therefore, as of 4/14/2015, Decedent was able to communicate and was in no respiratory distress.

123. On 4/16/2015, Decedent's son Bethrand visited his father and video recorded Decedent

crying and moving his shoulders in response to Bethrand's communications to him about his injury (Exhibit Video). However, Decedent was unable to verbally communicate back likely due to the brain injury sustained.

124. On 4/18/2015 at 2:46pm, Nurse Tochukwu B Onyekwelu wrote that "Air detector in the line, attempted to flush but not able, called dialysis nurse Robert who told me to stop the dialysis and blood was returned back. Patient was stable, no apparent respiratory distress. (Exhibit 20)

125. As of the morning of 4/18/2015, per Dr. Kalpalatha Guntupalli he was "weaned … off pressors." (Exhibit 22) Pressors is one of the necessary life-sustaining treatment later suggested to be withheld from Decedent by the Harris Health System ethics board consisting of Baylor College of Medicine and UT Health Science Center physicians.

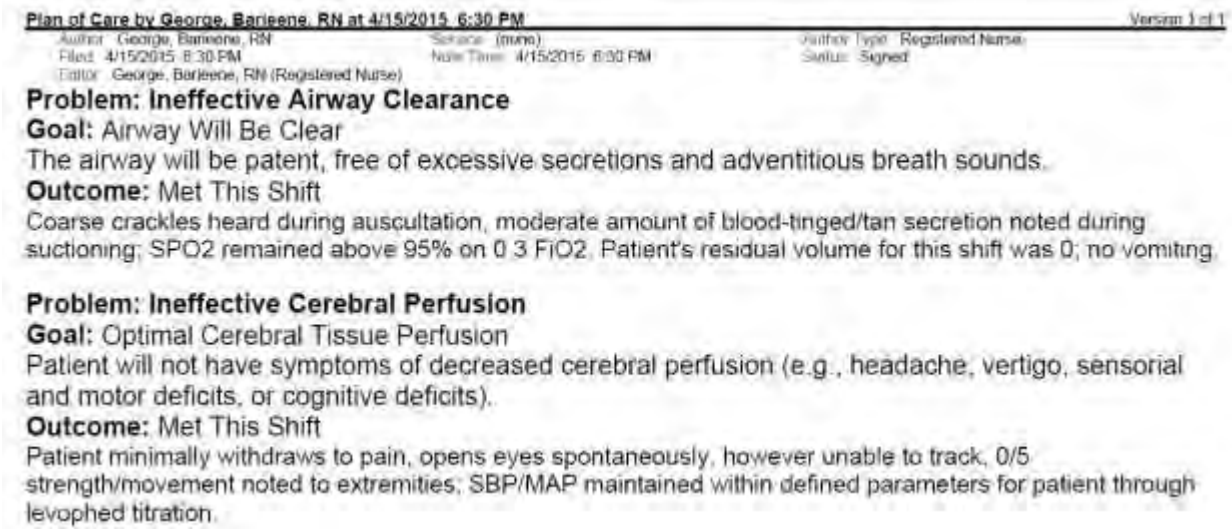
126. As of 04/16/2015 & 04/19/2015, per his brain optimization evaluation and exercises report, Decedent was "responsive to painful stimuli," and able to "minimally withdraws to pain..."

Plan of Care by Babu, Susamma, RN at 4/6/2015 6:29 PM Version 1 of 1

Author: Babu, Susamma, RN Service: (none) Author Type: Registered Nurse
Filed: 4/6/2015 6:29 PM Note Time: 4/6/2015 6:29 PM Status: Signed
Editor: Babu, Susamma, RN (Registered Nurse)

Problem: Altered Gas Exchange - Ventilator
Goal: Optimal Gas Exchange
Patient will maintain regular respiratory rate and rhythm.
ABGs will be within normal limits, and PIP's less than 50 cm/H2O.
Outcome: Met This Shift
Intervention: Assess Respiratory Rate, Rhythm, And Character
Patient on vent AC mode, Tracheal suction done large amount of secretions noted, maintained spo2 >90%. Trach care done , wound present tracheal site and ozing large amount of secretions.

Problem: Ineffective Cerebral Perfusion
Goal: Optimal Cerebral Tissue Perfusion
Patient will not have symptoms of decreased cerebral perfusion (e.g., headache, vertigo, sensorial and motor deficits, or cognitive deficits).
Outcome: Met This Shift
Response to painful stimuli, opens eyes spontaneously not interactive.



Plan of Care by George, Barieene, RN at 4/15/2015 6:30 PM — Version 1 of 1

Author: George, Barieene, RN | Service: (none) | Author Type: Registered Nurse
Filed: 4/15/2015 6:30 PM | Note Time: 4/15/2015 6:30 PM | Status: Signed
Editor: George, Barieene, RN (Registered Nurse)

Problem: Ineffective Airway Clearance
Goal: Airway Will Be Clear
The airway will be patent, free of excessive secretions and adventitious breath sounds.
Outcome: Met This Shift
Coarse crackles heard during auscultation, moderate amount of blood-tinged/tan secretion noted during suctioning; SPO2 remained above 95% on 0.3 FiO2. Patient's residual volume for this shift was 0; no vomiting.

Problem: Ineffective Cerebral Perfusion
Goal: Optimal Cerebral Tissue Perfusion
Patient will not have symptoms of decreased cerebral perfusion (e.g., headache, vertigo, sensorial and motor deficits, or cognitive deficits).
Outcome: Met This Shift
Patient minimally withdraws to pain, opens eyes spontaneously, however unable to track, 0/5 strength/movement noted to extremities; SBP/MAP maintained within defined parameters for patient through levophed titration.

127. 04/27/2015 was the last day a fellow level staff was involved in Decedent's care. Thereafter, it was only residents, and the staff or teaching physicians. Sometimes, it was just the residents without the staff or teaching physicians.[24]

128. On 04/27/2015, Decedent was transferred from MICU to the general medicine floor. At this time, the goal of care was DNR. Within the next day, by 04/28/2015, Decedent was back in MICU. He was oozing secretions out of his trachea.

129. On 05/04/2015, per Dr. Lakkis' interpretation of an electrocardiogram report done on 05/01/2015, the sinus tachycardia did not exist, the abnormal rhythm leg existed, as well as (a) artrial fibrillation with rapid ventricular response, and (b) non-specific T-wave abnormality. Still, no full cardiologist consult was requested, and Decedent saw no cardiologist. The cardiologist involvement was only to review and interpret the electrocardiogram reports. He did not go and see Decedent, whom he knew was a patient that needed his services.

130. On 5/10/2015 and 5/13/2015, Resident Dr. Santiago N. Lopez under the authorization

[24] E.g., Dr. Xandera left Decedent's care in the hands of only his residents from 06/30/2015 to 07/01/2015, and from 07/02/2015 to 07/06/2015. He was not present.

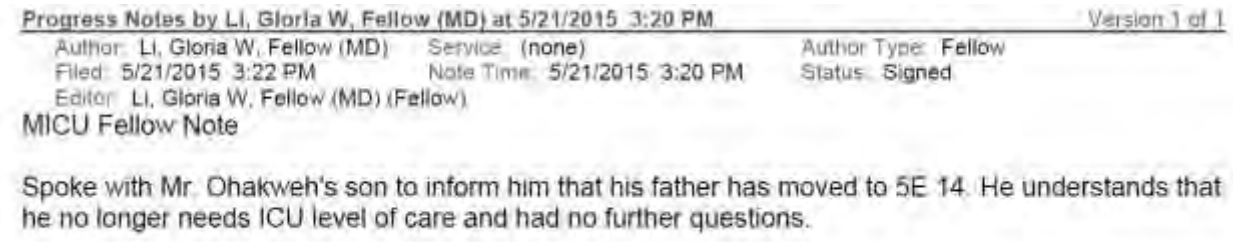
of Dr. Elizabeth Guy wrote that Decedent was in a persistent vegetative state due to anoxic brain injury. (Exhibit 24)

131. On 5/11/2015 at 5:24pm, Dr. Sarah M. Palmquist, Resident MD, completed a similar physical, assessment and plan for pre-op, for a percutaneous gastrostomy tube placement (Exhibit 55). She also stated that Decedent was in "no respiratory distress" and "the plan was discussed with the patient who communicated understanding." Dr. Palmquist also thereafter recommended a few sedation drugs, Versed and Fentanyl, to be used if required. Dr. Cliff Whigham, DO signed off on Dr. Palmquist's 5/11/2015 treatment plan on 5/12/2015 at 9:01am, and wrote "See Pre-op notes completed by Dr. Palmquist on 5/11/2015."

132. On 5/18/2015 at 4:35pm, Dr. Sarah M. Palmquist, Resident MD, completed another Pre Procedure Form. (Exhibit 56) In the physical examination and assessment and plan section, she wrote "no respiratory distress" and "the plan was discussed with the patient who communicated understanding." *Id*. Dr. James Gregg, reviewed her work at 9:26am the following day, 5/20/2015, and approved her diagnosis and planned procedure. *Id*.

133. On 5/21/2015, Dr. Diana M. Guerra, Assistant Professor Pulmonary and Critical Care at Baylor College of Medicine stated that Decedent was in vegetative status, at 12:11pm in Decedent' Ben Taub medical records. (Exhibit 25) However, Decedent was not ruled/deemed to be in a persistent vegetative state until 7/10/2015. (Exhibit 27)

134. On 05/21/2015, after the physicians wrongfully stated that Decedent was in a vegetative state, Decedent was transferred out of the MICU to unit 5E at Ben Taub hospital.



Progress Notes by Li, Gloria W, Fellow (MD) at 5/21/2015 3:20 PM — Version 1 of 1

Author: Li, Gloria W, Fellow (MD) Service: (none) Author Type: Fellow
Filed: 5/21/2015 3:22 PM Note Time: 5/21/2015 3:20 PM Status: Signed
Editor: Li, Gloria W, Fellow (MD) (Fellow)

MICU Fellow Note

Spoke with Mr. Ohakweh's son to inform him that his father has moved to 5E 14. He understands that he no longer needs ICU level of care and had no further questions.

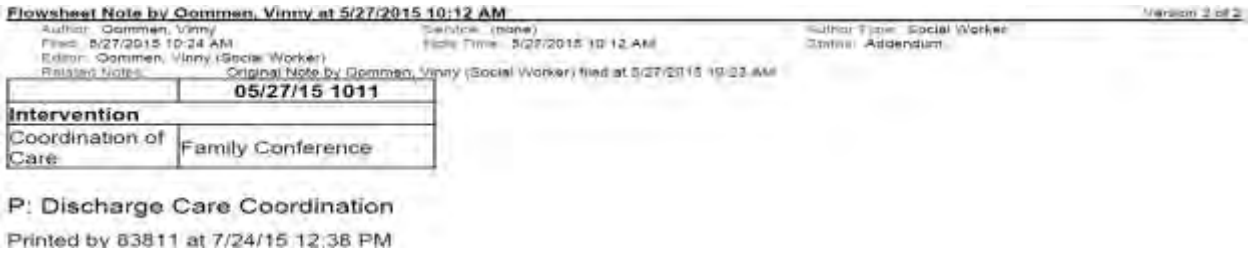
135. Thereafter, the physicians in Ben Taub's unit 5E began efforts to get him either moved to Long-Term Acute Care within the hospital, or have him discharged home. Per their notes, the option to be exercised depended on funding. Hence, they consulted the social workers.

136. On 5/22/2015 at 8:15am, Dr. Elizabeth Guy wrote in the Pulmonary Attending Physician Note, "A/P… persistent vegetative state." (Exhibit 28) Again, this was false because Decedent was alleged to be in a persistent vegetative state until 7/10/2015 per the medical records.

137. On 5/22/2015, 5/23/2015, and 5/26/2015, Dr. Stephen R. Bujarski, Fellow, Pulmonary Attending Physician, wrote, "…anoxic brain injury, vegetative status." (Exhibit 29) Decedent was not in a persistent vegetative state until 7/10/2015. Prior to 7/10/2015 Decedent was at worst in a minimally conscious state, or at best in a state of awareness.

138. On 5/26/2015 at 10:15am, Dr. Elizabeth Guy wrote that Dr. Ohawkeh was in a "persistent vegetative state" in her pulmonary attending physician notes. (Exhibit 30)

139. On 05/28/2015, per Vinny Oommen, they BCM physicians and hospital staff were trying to discharge Decedent, while executing the DNR procedures on him against his wishes.



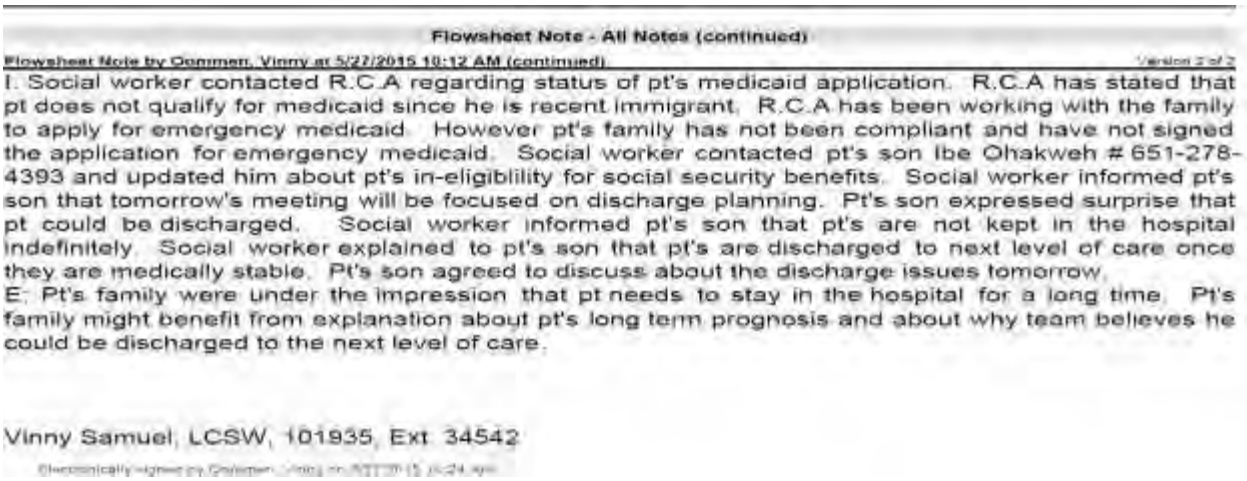
Flowsheet Note by Oommen, Vinny at 5/27/2015 10:12 AM — Version 2 of 2

Author: Oommen, Vinny Service: (none) Author Type: Social Worker
Filed: 5/27/2015 10:24 AM Note Time: 5/27/2015 10:12 AM Status: Addendum
Editor: Oommen, Vinny (Social Worker)
Related Notes: Original Note by Oommen, Vinny (Social Worker) filed at 5/27/2015 10:23 AM

	05/27/15 1011
Intervention	
Coordination of Care	Family Conference

P: Discharge Care Coordination

Printed by 83811 at 7/24/15 12:38 PM



Flowsheet Note - All Notes (continued)

Flowsheet Note by Oommen, Vinny at 5/27/2015 10:12 AM (continued)

I. Social worker contacted R.C.A regarding status of pt's medicaid application. R.C.A has stated that pt does not qualify for medicaid since he is recent immigrant. R.C.A has been working with the family to apply for emergency medicaid. However pt's family has not been compliant and have not signed the application for emergency medicaid. Social worker contacted pt's son Ibe Ohakweh # 651-278-4393 and updated him about pt's in-eligiblility for social security benefits. Social worker informed pt's son that tomorrow's meeting will be focused on discharge planning. Pt's son expressed surprise that pt could be discharged. Social worker informed pt's son that pt's are not kept in the hospital indefinitely. Social worker explained to pt's son that pt's are discharged to next level of care once they are medically stable. Pt's son agreed to discuss about the discharge issues tomorrow.

E: Pt's family were under the impression that pt needs to stay in the hospital for a long time. Pt's family might benefit from explanation about pt's long term prognosis and about why team believes he could be discharged to the next level of care.

Vinny Samuel, LCSW, 101935, Ext 34542

140. On 6/1/2015 at 1:18pm, a social worker by the name Vinny Oommen wrote in his discharge care coordination plan, "…primary team is also consulting ethics committee for futility of care in a pt with persistent vegetative state." (Exhibit 31) Pt. means "patient."

141. According to Vinny Oommen's medical records entry, the family was not willing to pay for Decedent's transfer nor did they want Decedent transferred.[25] Also per Vinny Oommen's entry, Decedent did not qualify for insurance. Meanwhile Decedent, a U.S. resident, suffered kidney failure and was above 65yrs old. Per His 06/01/2015 entry, even the Ben Taub CEO was aware of Decedent's situation.

[25] During the months of April, May, and/or June, Bethrand received numerous harassing telephone calls and voice mails from the Hosptial social worker, Ms. Vinny Ommenn and her team. Ms. Ommenn wanted Bethrand to sign documents that would enable Decedent's hospital bills to be covered by Medicaid. When Bethrand arrived read the fine print in the documents, the fine print said that Texas Medicaid Recovery Act allowed the Hospital to go after the responsible party's estate. The document also had no indication of the amount of the hospital bill in question.

Bethrand inquired as to the meaning and effect of the clause allowing the Hospital to pursue claims against Decedent's estate. According to Bethrand, Vinny Ommenn and her staff kept "dogging the question."

Bethrand then felt suspicious and did not sign the document because the physicians and staff were still misrepresenting the facts regarding the cause of Decedent's injuries, his condition, etc.; and Vinny Ommenn and her staff were not answering the Texas Medicaid Recovery Act questions he asked, and Bethrand did not want to accepted liability for hospital's wrongful activities.

Flowsheet Note by Oommen, Vinny at 6/1/2015 1:18 PM Version 2 of 2

Author: Oommen, Vinny Service: (none) Author Type: Social Worker
Filed: 6/1/2015 1:56 PM Note Time: 6/1/2015 1:19 PM Status: Addendum
Editor: Oommen, Vinny (Social Worker)
Related Notes: Original Note by Oommen, Vinny (Social Worker) filed at 6/1/2015 1:53 PM

Printed by 83811 at 7/24/15 12:38 PM

Flowsheet Note - All Notes (continued)

Flowsheet Note by Oommen, Vinny at 6/1/2015 1:18 PM (continued) Version 2 of 2

	06/01/15 1318
Intervention	
Current Support System	Immediate family

P: Discharge Care Coordination
I: Social worker took part in an multidisciplinary meeting with pt's family(son Mr. Ibe, daughter in law Chinyere and pt's ex wife/mother of pt's son Ms. Philomina, son's father in law and two other family via telephone conference) primary team, MICU, case management supervisor, palliative care team, chaplin services, unit supervisor and unit director on 05/28/15. Pt's primary team educated pt's family about pt's prognosis and stability for discharge. Pt's son has stated that pt came to the hospital alert and able to communicate and he is in a vegetative state due to bronchoscopy that was done in the hospital. MICU doctor explained to pt's son and family that pt suffered a cardiac arrest and had to be coded for a long time and also intubated. Pt's family is still insistent that pt's current condition is due to hospital's fault. Pt's family want hospital to incur the cost of pt's post discharge placement and care. CCM supervisor informed pt's family that the hospital could assist with DME and home services for pt. Pt's family declined stating that they cannot care of pt at home nor pay for pt to go to a facility. CCM supervisor educated pt's family that it is the family's responsibility to make arrangements for the post discharge care of the loved ones. Pt's family disagreed with the same and are also insisting on keeping pt full code. Pt's son's father in law asked the team to arrange a meeting with the hospital administration. It was decided to consult ethics committee for futility of care and also arrange a meeting of the family with the hospital CEO. CCM supervisor has talked to the hospital CEO and found that he is available on June 2 between 11am and 2pm. Social worker notified pt's son about the same. Pt's son told social worker he cannot make a decision on whether he will be available to come on June 2 and need to consult with other family members. Pt's son agreed to contact social worker with his decision later. Social worker has not heard a response from pt's son. Social worker contacted pt's son and left him several voice mails. Social worker contacted pt's daughter in law # Chinyere Cell: 301-873-9834 and Work: 713-873-9331 and updated her about the CEO's availability for meeting with family tomorrow. Pt's daughter in law has stated that pt's son is not available tomorrow. Pt's daughter in law agreed to communicate with pt's son and contact social worker once they have a date when they will be available. Social worker informed pt's daughter in law that the meeting needs to happen soon since pt is medically stable for the next level of care. Pt's daughter in law verbalized understanding.
E: Pt's family's lack of acceptance of pt's poor prognosis and terminal state, and unwillingness to take responsibility for pt's post discharge care expenses is a barrier to pt's discharge. Social worker will continue her efforts to facilitate a meeting with hospital administration so they can voice their concerns but also make a decision on how they will provide care to pt post discharge. Meanwhile primary team is also consulting ethics committee for futility of care in a pt with persistent vegetative state.

Vinny Samuel, LCSW, 101935, Ext. 34542

Printed by 83811 at 7/24/15 12:38 PM

Additional Facts

142. On *6/11/2015*, Tigist Mehari, Resident MD, wrote a progress note that exists on page 24621 of Decedent's Ben Taub medical records, "… brain injury from prolonged cardiac arrest with resuscitation. Cat Scan Impression Report on *4/15/2015* confirms changes consistent with global hypoxic ischemic injury… Currently on exam, he continues to maintain brain stem reflexes…" (Exhibit 32)

143. On 06/2/2015, an internal medicine physician[26] wrote in Decedent's medical records that he was irreversible. A Dr. Cynthia Peacock did so by writing in his medical records at 9:41pm, "… No corneal reflex… **Patient's prognosis is poor and condition is irreversible**."

144. Dr. Peacock oversaw the care of Decedent from 06/01/2015 to about 06/13/2015. However, her last teaching physicians note was on 06/12/2015. Thereafter, Decedent's care was left to her resident, a resident Dr. Aradhna Seth. Said Dr. Seth even authored and signed the "Teaching Physician's Note" in Decedent's medical records on 06/12/2015 and 06/13/2015.

145. On 6/23/2015, at 1:37pm, Dr. Joslyn Fisher also later wrote in his medical records, "…patient's terminal (and essentially irreversible) neurologic condition…" (Exhibit 33)

146. On 6/30/2015 at 8:03am, Dr. Jared Lee wrote in the medical records, "…recent neuro exam with possible facial grimacing to painful stimuli in few areas of body, may reflect minimally conscious state rather than persistent vegetative state but this does not change expected overall outcome (no hope for meaningful recovery); still with brain stem reflexes..." (Exhibit 34)

---

[26] I.e., A physician outside of Dr. Sarkar and a Nicola A. Hanania two compromised physicians with conflict of interest with Decedent, and both from from BCM's Pulmonary Critical Care and Sleep Medicine and MICU team.

Drs. Hanania, Sarkar, Guerra, Peacock, and more, all had a habit or established a custom of allowing or authorizing even the residents to order and electronically sign for medications.

On many occasions from 03/05/2015, Dr. Hanania was not the supervising staff physician over Decedent, but his name or account appears to authorize Decedent's medications. When he was overseeing Decedent on 04/29/2015, the allowed the resident to order and sign for sedatives, and approved the write-up of the resident 4 days later on 05/03/2015. Per the medical records, on many occasions, he may not have even seen or supervised the care of Decedent, but his name simply appears in the authorization of medication only.

147. Dr. Sudha Yarlagadda wrote the same in the medical records on 7/1/2015 at 1:46pm, on 7/2/2015 at 2:40pm, 7/3/2015 at 11:32am, 7/4/2015 at 8:53am, and 7/6/2015. (Exhibit 35) Holly J. Bentz wrote the same on 6/27/2015 at 7:05am, and on 6/28/2015 at 7:21am. (Exhibit 36) Veronica Vittone wrote the same on 6/26/2015 at 2:54pm. (Exhibit 37)

148. On 7/6/2015 at 5:47pm, Dr. Sudha Yarlagadda wrote in the medical records, "…recent neuro exam with possible facial grimacing to painful stimuli in few areas of body, may reflect minimally conscious state rather than persistent vegetative state but this does not significantly change expected overall outcomes (no hope for meaningful neurologic recovery); still with brainstem reflexes." (Exhibit 38)

149. In the same notes under the Goals of Care/Placement, Dr. Sudha wrote, "…now patient is stable albeit still with poor prognosis from a neurological and heme/onc[27] standpoint. No funding for LTAC." Dr. Xandera signed off on Dr. Sudha's work on 7/7/2015 at 12:59am. (Exhibit 39)

150. On 7/7/2015, Dr. Veronica Vittone at 7:05am wrote, "… now in persistent vegetative state vs. minimally conscious state." Yet in the same records she wrote "…Still with minimal conscious state vs persistent vegetative state." Dr. Wayne Shandera signed off on Vittone's assessment notes and findings at 10:34am.

151. On 07/07/2015, a Dr. Justin A. Chetta, Resident MD, completed the a Moderate Sedation Pre Procedure Form and stated that Decedent was "a patient with mild systemic disease" and was a candidate for moderate sedation, and recommended the same "plan of sedation drugs to be used" on Decedent as Dr(s) Broering and Palmquist had done for Decedent in their prior encounters. Dr. Chetta stated that Decedent had a regular heart rate, and strong peripheral

[27] i.e. Hemotology/oncology

pulses. (Exhibit 58)

152. On the same 7/7/2015 at 11:48am (Exhibit 59) Dr. Chetta also stated that Decedent was in vegetative state and needing replacement of feeding tube, recommended the same sedation plan as before, yet stated that "the plan was discussed with patient who communicated understanding" Dr. David Wynne agreed with Dr. Chetta's treatment plan on 7/8/2015 at 11:18am (Exhibit 59)

153. On 7/8/2015 at 2:09pm, Dr. Sudha Yarlagadda wrote in the progress notes, "In past few weeks, patient has had minimal facial grimacing to painful stimuli in few areas of body, may reflect minimally conscious state rather than persistent vegetative state…" and "…Still with minimal conscious state vs persistent vegetative state." Yet in the same progress notes Dr. Sudha also wote in the assessment plan, "… now in persistent vegetative state vs. minimally conscious state." He also wrote "… overall outcome and prognosis does not change with PVS vs MCS." PVS means persistent vegetative state, while MCS means minimally conscious state.

154. On the same 7/8/2015 at 5:33pm, social worker by the name Vinny Oommen wrote a "Discharge Care Coordination" in the records and also wrote, "now in persistent vegetative state vs minimally conscious state… Patient does not have eligibility for funding." (Exhibit 40)

155. Per Dr. Xandera writing on 7/8/2015 at 2:23pm, Dr. James Banfield at Baylor College of Medicine's Risk Management office was notified of Decedent's case. (Exhibit 41)

156. On 7/8/2015 at 3:39pm, Nurse Rebecca Williams Clinical Case Manager wrote in her Flowsheet notes, "… now in persistent vegetative state vs. minimally conscious state… Disposition: Home when medically stable." (Exhibit 42)

157. On 7/9/2015 at 8:10am, Dr. Sudha and Xandera authorized and requested a neurological consult for a "need for attending noted conscious vs. persistent vegetative state." On that same 7/9/2015 at 3:16pm, contrary to Dr. Sudha and other physicians' findings, Dr. Lydia J. Sharp, MD, Neurologist, wrote in Decedent' Ben Taub medical records, "…3/6/2015 and has been unresponsive since. No improvement for past three months. No grimace… consistent with vegetative state."

158. Per Dr. Lydia Sharp's 7/9/2015 consult notes, on 3/26/2015, Neurology physicians were consulted on Decedent's case and "he was found to have persistent brainstem reflexes but extensor responses to noxious stimuli…severely disabled state with only fragments of understanding, requiring long lasting or indefinite nursing care." (Exhibit 62)

159. Hence as of 3/26/2015, Decedent still had brainstem reflexes, but will require long lasting or indefinite nursing care.[28]

160. Per Dr. Sharp's 7/9/2015 notes, "Neurology has also seen the patient on 6/15 and 6/23, no change in exam was seen."[29]

161. So as of 6/23/2015, Decedent still had brainstem reflexes *et al*, but will require long lasting or indefinite nursing care. Decedent also did have responses to stimuli as of 6/30/2015 per Dr. Jared Lee and Wayne Shandera.

162. Dr. Sharp's notes describing Decedent on 7/9/2015 at 1:37pm went as follows: "Currently

[28] This is another evidence of the cost Defendants would have to bear. But rather, the physicians and health care service provider Defendants decided to plot to DNR or kill him. For example, he had brain reflexes on 3/26/2015, but on 3/27/2015, Dr. Sarkar, Dr. Fisher, and the physicians suggested and concluded withholding life-sustaining treatment. Decedent was not ruled as terminal or irreversible at this time.

[29] Since 03/28/2015, the only Ben Taub neurology team personnel that saw Decedent was a resident, Dr. Margaret J. Brock, on 05/07/2015. She was unsupervised. No fully licensed neurologist signed off on her evaluations. The physicians thereafter used the resident's evaluations and decisions basis for their ongoing decisions.

the patient is afebrile with stable vital signs within normal limits. Labs show normal white count[30] and no major metabolic abnormalities… Intact cough." (Exhibit 63)

163. On 7/22/2015, according to Dr. Jesus H. Hermosillo, Fellow, "respiratory failure with difficult intubation, underwent emergent tracheotomy, had PEA (pulseless electrical activity) arrest and multi organ failure… anoxic brain injury… ventilator-dependent on tube feeding."

Gold Card and Funding Issues

164. After Decedent was transferred from the MICU to unit 5E on 05/21/2015, and stabilized, the focus shifted to his placement. The resident and staff physician, noted that the family was not interested in their de-escalation of care but since Decedent was ventilator dependent[31], was not requiring vasopressors, and without active infection, they wanted to consider placing Decedent in LTAC;[32] and immediately consulted the social worker.

165. From 05/23/2015 to 06/22/2015, Decedent's daily "goals of care/placement" medical records included, "Patient is currently medicaid pending; according to social work does not have option of LTAC. Will explore possibility of obtaining a ventilator for home and d/cing[33] home with family/wraparound services for supportive care while conveying to family that patient will be total care for the rest of his life."

[30] White blood cells fight infections.
[31] Multiple attempts to take Decedent off the ventilator had failed, hence Decedent was ventilator dependent at this time.
[32] LTAC (aka Long-Term Acute Care) is a division within the hospital for ventilated patients, patients requiring extended intravenous antibiotic therapy, and medically complex patients. The division provides specialized actue care for medically complex patients who are critically ill, and require extended stay in the hospital within the acute care setting. Decedent would be a typical patient for long-term acute care.
[33] I.e. "Discharging"

#Goals of Care/Placement
- ethics consulted
- s/p multiple family meetings with MICU team, palliative care, and ethics team. Previous discussions w/ family were with the intent of changing code status/transitioning to comfort measures as patient was critically ill with poor prognosis. However, now patient is stable albeit still with poor prognosis from a neurological and heme/onc standpoint. Focus of discussions going forward will be on placement rather than code status. Patient is currently medicaid pending; according to social work does not have option of LTAC. Will explore possibility of obtaining a ventilator for home and d/cing home with family/wraparound services for supportive care while conveying to family that patient will be total care for the rest of his life.
- from a heme follow-up standpoint, patient is not a candidate for chemotherapy. His counts have been stable and he has not required transfusion for weeks. Plan for heme follow-up as discussed with heme fellow would be periodic CBC checks and if transfusion is needed patient would need to be transported by ambulance for transfusion.

166. The ethics consulted is the 166.046 ethics team.

167. Also, on 05/24/2015, per the standing physician,

ATTENDING ATTESTATION

I have personally interviewed and examined the patient at bedside and I have reviewed the medical record. I have discussed the plan with the housestaff, Dr. Huang, and I agree with the history, physical, assessment and plan as outlined in their note.
- at this point, pt seems to be stable on IMV and at goal tube feeds
- will try to discuss with family whether they have the resources for LTAC/nursing facility or home if we can arrange ventalator and tube feeds

Doris Lin, MD, MS, FACP

168. On 06/01/2015, Decedent's "goals of care/placement" mirrored that since 05/23/2015, but also included that the physicians will reconsult ethics to address futility of care; which was allegedly done on said 06/01/2015.

169. On 06/23/2017, Decedent's "goals of care/placement" changed to the following:

Goals of Care/Placement
- ethics consulted; will reconsult to set up meeting
- s/p multiple family meetings with MICU team, palliative care, and ethics team. Previous discussions w/ family were with the intent of changing code status/transitioning to comfort measures as patient was critically ill with poor prognosis. However, now patient is stable albeit still with poor prognosis from a neurological and heme/onc standpoint. No funding for LTAC
- from a heme follow-up standpoint, patient is not a candidate for chemotherapy. His counts have been stable and he has not required transfusion for weeks. Transfusions PRN per heme
- discussions with family detailed at bottom of note (hospital course)
- ethics reconsulted 6/1
- last update at bedside 6/20; family inquired as to updates, informed them there has been no

170. Starting with resident Dr. Vittone on 7/7/2015, until 9/1/2015, every day, each resident wrote in Decedent's medical records, "No gold card or funding for LTAC at this time." And the standing physician approved of their entries.

Withholding of Life Sustaining Treatment

171. Starting on March 12, 2015 with Dr. Sarkar, the hospital physicians began to pressure or coerce Decedent's family to make him a DNR patient. On 3/24, 3/25, 3/29, 4/1, 4/27, 5/28, 6/23, & 7/11, the hospital physicians discussed and attempted to convince the family to approve withholding of life-sustaining treatment or to discharge him. (Exhibit 65) The family members continuously refused and kept searching for alternative transfer venues.

172. On 03/25/2015, Defendant, Joslyn Fisher, entered the recommendation to withhold life-sustaining treatment in her "Initial Summary of Recommendations" in Decedent's medical records.

173. On 4/1/2015, Defendant, Dr. Christina Kao, the MICU attending physician, Dr. Joslyn Fisher, and others met with the Decedent's family. Per Dr. Kao's entry in the medical records, she suggested that the hospital and family agree to make Decedent a DNR patient, and recommended withholding of life-sustaining treatment such as dialysis, vasopressors[34], and transfusions. Pertinent parts of her writing in the medical records of Decedent on 4/1/2015 at 7:47am reads as follows:

> "A status of DNR in case of cardiac arrest was suggested as well as the recommendation by myself to withhold dialysis, vasopressors, and transfusions. The family wishes patient to remain at current status." (Exhibit 66)

174. The family refused to allow the withholding of life-sustaining treatments and informed the physicians that Decedent would have wanted any fighting chance to stay alive.

175. As of 4/16/2015, Decedent was in a conscious state per a video of him crying and responding to Bethrand's apologetic communication for the harm he sustained at the hands

[34] Vasopressors (aka "pressors") are necessary for Decedent's cerebral perfusion optimization – i.e. the optimization of his brain's oxygen, blood flow, and pressure; necessary for his brain injury stabilization and possible recovery.

of Decedent while Bethrand was away. Decedent was not yet in a persistent vegetative state nor ruled irreversible at that time. He had only been deemed terminal, ***not irreversible***, by Dr. Sarkar on 03/27/2015, based on his multiple organ injuries and in anticipating that Decedent would die without AML.

176. On 04/26/2015 and 04/27/2015, per Nephrologist Dr. Jingyin Yan, Decedent still had acute kidney injury, but his renal function continues to improve and were recovering.

177. On 05/08/2015, a resident Dr. Lopez removed hypokalemia[35], acute kidney injury, pancytopenia, and thrombocytopenia on the medical records problem list. Decedent's medical problem list was thereafter, incomplete while under Dr. Guy's oversight as of said 05/08/2015. The problem list eliminations were later rightfully re-instated/re-entered in Decedent's problem list on 06/01/2015, by Dr. Cynthia Peacock when she took over as the staff physician. However, by that time, the physicians already gave up on Decedent, and were more focused on either DNRing Decedent or his placement out of the hospital at home because "patient is currently Medicaid pending; according to social work does not have option of LTAC" and he "will be total care for the rest of his life."

#Goals of Care/Placement
- ethics consulted
- s/p multiple family meetings with MICU team, palliative care, and ethics team. Previous discussions w/ family were with the intent of changing code status/transitioning to comfort measures as patient was critically ill with poor prognosis. However, now patient is stable albeit still with poor prognosis from a neurological and heme/onc standpoint. Focus of discussions going forward will be on placement. Patient is currently medicaid pending; according to social work does not have option of LTAC. Will explore possibility of obtaining a ventilator for home and d/cing home with family/wraparound services for supportive care while conveying to family that patient will be total care for the rest of his life
- from a heme follow-up standpoint, patient is not a candidate for chemotherapy. His counts have been stable and he has not required transfusion for weeks. Plan for heme follow-up as discussed with heme fellow would be periodic CBC checks and if transfusion is needed patient would need to be transported by ambulance for transfusion
- s/p family meeting 5/28, discussions documented above
- will reconsult ethics to address futility of care

178. In Dr. Joslyn Fisher's consult notes on 5/18/2015 at 2:10pm, at the 4/1/2015 meeting

[35] Per the problem list, Decedent developed hypokalemia (i.e. low levels of potassium in his blood that increases the risk for abnormally low heart rhythm, and can cause cardiac arrest.) on 04/25/2015.

with the family, “Family-Plaintiffs describe Mr. Ohakweh as a "fighter" who would want "everything done to save his life.” She also wrote “Since the family discussion on 4/1/15, the patient no longer requires dialysis.” (Exhibit 67)

179. Decedent’s family gave Defendants as of 4/1/2015, knowledge of what Decedent would desire. Per Dr. Fisher’s 5/18/2015 consult notes, she even wrote that “He was a fighter that would have wanted everything done to save his life.”

180. Per the notes of the resident physician involved in Decedent’s care on 04/01/2015,

4/1 plan for family meeting with **ethics today. Addendum:** MICU team, ethics team and family met today (son-Ibe, patient's daughter in law, ex-wife were present and his daughter and daughter in law's father were on the phone). Family feels that patient continues to improve from a neurologic stand point so they would like to continue with his care at current level and still feel that they need more time before they make any decisions, such as withdrawing or de-escalating care

181. On 04/02/2015, per the Nephrology team, Decedent was unable to be taken off dialysis, and there was no evidence of renal (kidney) recovery. Per the staff Nephrology physician:

Progress Notes (continued)
Raghavan, Rajeev, MD at 4/2/2015 6:13 AM (continued)

1. AKI in patient with critical illness including AML, CHF, and PEA arrest. At this time, he is not arousable to verbal stimulation despite being off sedation. He remains critically ill on vasopressor support and full ventilatory support.

We will continue to support with dialysis, as tolerated by patient. If his vasopressor requirements increase to 2 pressors, then the risk of an event related to the dialysis procedure becomes very high and we would not be able to continue.
Rajeev Raghavan, MD
April 2, 2015 2:12 PM

Faculty, BCM division of Nephrology

182. The physicians, unsuccessful in obtaining approval to withhold life-sustaining treatment from Decedent or his family, decided to further create a dire or futile or irreversible condition of Decedent, while Decedent fought for his life. They did so by withholding necessary and essential medical care/treatment from Decedent – i.e. to create a futile situation or irreversible condition in which the ethics board would agree to withhold or withdraw life-sustaining treatment (“DNR”) from Decedent. They also misrepresented Decedent’s condition and information about their obligations to Decedent and his family all over

Decedent's medical records and orally, including about their DNR recommendations; in anticipation of the Harris Health Ethics Board's 166.046 review of the records and decision making of whether to withhold life sustaining treatment.

183. On May 28, 2015, Ben Taub Hospital personnel and defendants recommended for Decedent to be discharged to another facility (Exhibit 64), gave them a list of locations, and told them that the facilities on the list will cost them $1000 per day, and that the family would incur such cost. The family disagreed to such a discharge because neither Decedent nor any Family-Plaintiffs can afford such an expense. Moreover, given that Ben Taub Hospital, its personnel, and its affiliates (i.e. Baylor College of Medicine physicians) caused the harm to Decedent and his family, it was inconceivable that Decedent's family was being asked to accept financial responsibility for the injury caused to Decedent while on admission at Ben Taub Hospital.

184. Decedent went to the hospital with neurological functioning to get treated for his pre-existing health problems. However, Ben Taub Hospital personnel and their affiliates caused him multiple organ failure, irreversible injuries, continues bodily injury, as well as continuous grief to Family-Plaintiffs. The hospital's planning or attempts to discharge him with the extensive brain and various other injuries he sustained at the hands of Ben Taub Hospital, its personnel, and its affiliates, in addition to the untreated disease he was admitted for, merely shocked the family's and really any reasonable mind's conscience; not to mention that they are suggesting that his family bear their estimated $1000 per day cost to care for him in his incapacitated state, with multiple bedsores, with proof of aggravated assault on him during the 3/6/2015 procedure, and his swollen arm and body.

185. Even after months of search, the family was even unable to find an alternative venue on

the list provided by the hospital staff that would accept Decedent under such circumstances (e.g. $1000/day and provide life-sustaining treatment according to Texas Health & Safety Code 155.046(g)'s terms).

186. On 6/23 & 6/30, Jared Jung-Taek Lee wrote the same 4/1 DNR statement as Dr. Christina Kao in Decedent's medical records which reads as the following:

> "4/1 family meeting with Ethics with Dr. Kao (MICU attending), Dr. Jabuonski (MICU fellow), Dr. Winograd, Dr. Fisher (ethics), Dr. Citron (palliative care) and multiple representatives from case management and chaplain; recommended status of DNR, family wished for patient to continue max medical support" (Exhibit 68)

187. On 6/24 & 6/27 of 2015 Holly J. Bentz copied and pasted the same 4/1 DNR statement from Jared Jung-Taek Lee's medical entry in Decedent's medical records. (Exhibit 69) Dr. Doris Lin signed off on Holly Bentz's writings on 6/24/2015. (Exhibit 70)

188. Dr. Wayne Shandera, attending physician and Associate Professor at Baylor College of Medicine, signed off on the 6/23 & 6/30 statements by Jared Lee, (Exhibit 71) and also wrote in Decedent's medical records on 6/29 at 10:16am:

> "65-yo with AML, dx 2013, CHF, DM, herpes, admitted for respiratory failure, PEA, anoxic brain injury, ventilator assd pneumonia, minimally conscious but leaning toward a PVS, *no funding with his being Nigerian*, family is trying to decide on goals of care, a meeting tomorrow with them will take place with Ethics committee." (Exhibit 72)

189. Dr. Sudha Yarlagadda copied and pasted the same 4/1 DNR statement from Jared Jung-Taek Lee's medical entry in Decedent's medical records on 7/1, 7/9, 7/10, 7/11, 7/18, 7/16 (Exhibit 73) Dr. Anita V. Kusnoor Signed off on Sudha Yarlagadda's writings on 7/17/2015 as attending physician (Exhibit 73).

190. Dr. Veronica Vittone copied and pasted the same 4/1 DNR statement from Jared Jung-Taek Lee's medical entry in Decedent's medical records on 7/8/ & 7/12. (Exhibit 75)

191. On 7/21, 7/22, 7/23, Xiaoming Jia's medical notes in Decedent's medical records

included another copy and paste of the same 4/1 DNR statement from Jared Jung-Taek Lee's medical entry. (Exhibit 76)

192. By the Harris County Ethics Board meeting under Texas Health & Safety Code Rule 166.046, which occurred on 7/24/2015, it was basically obvious that the Ethics Board, including Dr. John Michael Halphen, was ready to make Decedent a DNR patient.

193. Plaintiffs were also not given proper 48hrs advanced notice prior to the meeting (Exhibit 80), nor were they given Decedent's medical records 10 days before as required by Harris Health Hospital Policy and Texas Health and Safety Code 166.046(b)(4)(c). Bethrand was blind-sighted with a letter in the mail less than 48hrs before the meeting; and out of concern that the physicians were going to succeed in killing his father/Decedent against his fathers' and the family's wishes, waived the short notice matter and immediately retained counsel.

194. At the meeting, Dr. John Michael Halphen stated that the ultimate decision was on the ethics board team, with his decision as supreme; that the family were merely there to give their input, and that if the family did not agree with the decision, they had 10 days to appeal the decision to the probate court.

195. In regards to procedure, the Ethics Board personnel stated that they were not involved in the treatment of Decedent; that their job was merely to review the records, listen to input, and make their decision on whether to withhold life-sustaining treatment which in this case consists of withholding CPR, dialysis, pressors, and ICU treatment. This was a lie.

196. Joslyn Fisher, and Joseph Kass were involved in the treatment of Decedent while executing their 166.046 consult.

197. For example, Dr. Kass was the licensed neurologist – and actually BCM's head of neurology department at that time – involved in the treatment of Decedent on 3/27/2015. He

signed a consult and wrote "I personally examined Aphaeus Ohakweh with the resident on 3/27/15. I have discussed his case with the resident and agree… as per resident note… Physical exam and history suggests that patient has essential no chance of meaningful neurological recovery and that he is going to enter a vegetative or minimally conscious state." (Exhibit 78) This is during the period in which the physicians were acting to DNR Decedent as they already agreed to do per Dr. Sarkar. However, Dr. Kass never qualified Decedent's brain condition as terminal or irreversible, nor did he ever state that Decedent's brain could to handle chemo treatment for his AML. Also, he diagnosed Decedent with, amongst others, "hypoxia, acute kidney injury, renal failure, pancytopenia, AML, thrombocytopenia."

198. The neurology resident that evaluated Decedent with Dr. Kass and that Dr. Kass agreed with her findings, stated that even though Decedent had "persistent brain stem reflexes… with likelihood of meaningful recovery very poor (e.g. severely cognitively disabled/fully dependent state or minimally conscious state/ vegetative state.)" She recommended that the health care providers continue to address the goals of care.

199. On 03/27/2015, the Dr. Workeneh and his Nephrology fellow also evaluated Decedent. He still had end-stage renal disease, and was in a severe stage of kidney failure.

200. On 03/28/2015, Dr. Mims and her hematology/oncology fellow, Dr. Wang saw Decedent. Per Dr. Mims at 12:34pm, "Patient seen and examined – continues on ventilator and back on pressors this am. Continues in renal failure. Low grade fevers (highest 100.3). Hb and platelets remain low due to AML in marrow. Very poor prognosis – not responding to voice or requests."

201. As of 03/30/2015, Decedent was requiring dialysis every other day, and was to be given

dialysis on said 03/30/2015, but the catheter was clogged and malfunctioned. On the morning of 03/31/2015, Decedent's breathing became very abnormally rapid per the standing physician.

202. Ms. Fisher was an attending physician overseeing Decedent on or about 4/30/2015 and 5/1/2015, and ordering treatment medications to be administered to Decedent. (Exhibit 78)

203. On 07/22/2015, Dr. Fisher again conducted an Ethics Consult Follow Up in which per her notes, (a) she was informed that Decedent's condition had further deteriorated, to the stage that they would not offer him chemo, (b) Decedent's physician at that time, Dr. Kusnoor, agreed to proceed with HHS Ethics committee, (c) there was a call with Bethrand, herself – i.e. Dr. Fisher, and Dr. David Hyman – Professor and Chief of General Medicine at BCM, in which they set the time for the ethics board meeting for 07/24/2015 at 12:00pm, and (d) the 07/24/2015 Ethics Board meeting will be led by Dr. John Halphen.

204. Dr. Anita Kusnoor was the attending physician overseeing decedent during the period of the ethics board meeting, and was present at the ethics board meeting on July 24, 2015. One of the topics discussed at the Ethics board meeting, aside from withholding life-sustaining treatment, was that the physicians were "weaning [Decedent] off the breathing ventilator" – a process by which a patient's dependence on mechanical ventilation is reduced and eventually terminated, implying that Decedent was breathing on his own without mechanical assistance -- and that Decedent could be transferred to a hospice care facility. Dr. Kusnoor claimed that she stopped attempting to wean Decedent off the ventilator because she did not want to "rock the boat" and suggested that the family take him to a hospice care.[36]

[36] There is no certification from any physician for an appropriate transfer (e.g. that the risks of being at the hospital outweighs the benefits of being moved out of the facility to a third place) in the medical records. There was also no medical facility willing to take on Decedent and provide the necessary care he needed. Plaintiffs could not find one.

205. At the ethics board meeting, it was communicated to Plaintiffs that Decedent was "brain-dead." This was not the case as per the medical records, Decedent was in a "persistent vegetative state." There's a huge difference between the two. Brain-dead means no brain activity and complete dependence on mechanical life-support (e.g. ventilation-oxygen machines to breathe, etc). Such is not a requirement for persistent vegetative state patients. It depends on the level of their brain injury.

206. Family-Plaintiffs asked whether the periods in which Decedent was able to breathe on his own without a ventilator was increasing or decreasing- to better assess for signs of cognitive and respiratory improvement, and to make a better-informed decision on withholding life-sustaining treatment. None the BCM, UT, and HHS physicians and executives in the meeting room could answer this question**.** Hence, the family asked the physicians to go back and try to record-time the intervals in which Decedent was breathing on his own before the ventilator takes effect to assist again, to see if the time margins are increasing or decreasing before such a decision would be made. They agreed ethics board staff agreed to do so.

207. Yet, throughout the July 24, 2015 ethics board meeting, the CEO of the Harris County Ethics Board - Dr. Halphen of UT Health Science Center, and the ethics board physicians (i.e. Dr. Fisher, Dr. Kass, and a gentleman by the name of Dr. Sutton) attempted to coerce or bully the family into succumbing to their demands of Harris County Ethics Board, Ben Taub and Baylor health care providers to be allowed to withhold life-sustaining treatment from him. Decedent had been in ICU for months.

208. The issue at the Ethics Board meeting was whether the family would authorize the physicians to withhold CPR, dialysis, pressors, and ICU[37] treatment. If not, they stated that

[37] Intensive Care Unit

Decedent be discharged at the expense of his family.

209. Decedent was in ICU at that time. To the family, authorization to withhold ICU treatment from Decedent, coupled with withholding pressors, CPR, and dialysis, meant a bad faith authorization not to treat Decedent anymore (and Decedent would die); even though Defendant were the ones to put him in his condition.

210. Dr. Joslyn Fisher was at this meeting as a strong proponent to the withholding life-sustaining treatment. Dr. Josheph Kass was at also at the meeting and a proponent of withholding life-sustaining treatment.

211. Family-Plaintiffs were being deceived into making a blind decision to DNR Decedent based on the inconsistent and false reasons from the physicians. These physicians could not even tell the family the truth as to what happened to Decedent and his current condition/state. According to Halphen and the ethics board meeting physicians, "…With treatment, he's going to die anyway. Without treatment, he was going to die anyway."

212. Family-Plaintiffs present at the meeting requested for the specific life-sustaining treatment recommendations in writing, to which the Ethics Board refused to provide.

213. Under the circumstances, Family-Plaintiffs refused to give such authorization and stated that they needed some time to speak with other family members in United States and abroad. Dr. Halphen granted the family a week to decide, but still make it clear that the decision was up to the Ethics board, and ultimately his decision. He also stated that if the family did not agree with his decision, they can file a suit in probate court.

214. Decedent and his family were never provided with Decedent's medical records in compliance with THSC §166.046(b)(4)(c) – i.e. before or after the ethics board meeting and decision.

215. After the ethics board meeting, Decedent's family requested Decedent's medical records. They received over 26,003 pages of medical records from Harris Health System that were Decedent's medical records from 03/04/2015 until about July 28, 2015, signed under penalty of perjury by Harris Health's custodian of records. Said medical records were incomplete or manipulated in both form and substance, and did not comply with THSC §166.046(b)(4)(c) nor HIPPA.

216. The medical records provided Decedent's family, printed on 07/24/2015 at 12:37pm, were from 03/04/2015 – 07/24/2015, and contained wrongful/deceptive changes and were all altered to affect their verity; e.g. below.

Problem List (continued)				Date Reviewed: 3/4/2015
	ICD-9-CM	Priority	Class	Noted - Resolved
Increased oropharyngeal secretions	528.9			6/4/2015 - Present
PAIN	780.99			5/28/2015 - Present
Air hunger	786.09			5/28/2015 - Present
At risk for spiritual distress	V49.89			5/28/2015 - Present
Sacral decubitus ulcer, stage II	707.03 707.22			5/22/2015 - Present
Feeding by G-tube	V44.1			5/14/2015 - Present
Nosocomial pneumonia	486			5/9/2015 - Present
Bacteremia due to Enterococcus	790.7 041.04			5/9/2015 - Present
On mechanically assisted ventilation	V46.11			5/9/2015 - Present
Hypoxic ischemic encephalopathy (HIE)	768.70			3/28/2015 - Present
HERPES LABIALIS	054.2			3/27/2015 - Present
Candidemia	112.5 995.91			3/27/2015 - Present
Colonization with multidrug-resistant bacteria	V09.91			3/27/2015 - Present
Goals of care, counseling/discussion	V65.49			3/12/2015 - Present
Acute and chronic respiratory failure	518.84			3/6/2015 - Present
Hypoxia	799.02			3/4/2015 - Present
CHF (congestive heart failure)	428.0			3/4/2015 - Present
Abnormal chest x-ray	793.2			2/11/2014 - Present
HTN (hypertension)	401.9			1/25/2014 - Present
Retroperitoneal sarcoma	158.0			12/25/2013 - Present
DM (diabetes mellitus)	250.00			12/13/2013 - Present
RESOLVED: AKI (acute kidney injury)	584.9	High		3/4/2015 - 5/7/2015
RESOLVED: ALL (acute lymphoblastic leukemia of infant)	204.00	High		3/4/2015 - 3/4/2015
RESOLVED: Neutropenia	288.00	High		12/20/2013 - 5/7/2015
RESOLVED: PANCYTOPENIA	284.8	High		12/13/2013 - 5/7/2015
RESOLVED: Hypernatremia	276.0			4/25/2015 - 5/7/2015
RESOLVED: Hypokalemia	276.8			4/25/2015 - 5/7/2015
RESOLVED: Renal failure	586			3/26/2015 - 5/7/2015
RESOLVED: Chest pain	786.50			3/4/2015 - 3/4/2015
RESOLVED: Thrombocytopenia	287.5			3/4/2015 - 5/7/2015
RESOLVED: CHEMOTHERAPY	V58.11			5/15/2014 - 3/4/2015
RESOLVED: Tinea cruris	110.3			5/15/2014 - 3/4/2015
RESOLVED: H/O malaria	V12.03			5/14/2014 - 3/4/2015
RESOLVED: S/P chemotherapy, time since less than 4 weeks	V66.2			1/25/2014 - 3/4/2015
RESOLVED: Neutropenic fever	288.00 780.61			1/18/2014 - 1/25/2014
RESOLVED: Scrotal mass	608.89			1/18/2014 - 3/4/2015
RESOLVED: Tooth pain	525.9			1/18/2014 - 3/4/2015
RESOLVED: Mucositis	528.00			1/16/2014 - 3/4/2015
RESOLVED: Ulcer mouth	528.9			1/14/2014 - 3/4/2015
RESOLVED: Groin rash	782.1			1/11/2014 - 3/4/2015
RESOLVED: CHEMOTHERAPY	V58.11			12/27/2013 - 1/14/2014
RESOLVED: Adjustment disorder	309.9			12/25/2013 - 12/25/2013
RESOLVED: Emotional stress	308.9			12/25/2013 - 1/25/2014
RESOLVED: Counseling and coordination of care	V65.49			12/22/2013 - 1/14/2014
RESOLVED: Diastolic dysfunction	429.9			12/21/2013 - 3/4/2015
RESOLVED: Abnormal chest CT	793.2			12/19/2013 - 12/20/2013
RESOLVED: Abdominal mass	789.30			12/14/2013 - 12/25/2013
RESOLVED: Pulmonary infiltrate	793.19			12/14/2013 - 1/25/2014
RESOLVED: Neutropenic fever	288.00 780.61			12/14/2013 - 12/20/2013
RESOLVED: Shortness of breath	786.05			12/13/2013 - 12/20/2013
RESOLVED: H/O malaria	V12.03			12/13/2013 - 12/20/2013
RESOLVED: GERD (gastroesophageal reflux disease)	530.81			12/13/2013 - 3/4/2015
RESOLVED: Dry cough	786.2			12/13/2013 - 12/20/2013
RESOLVED: Fatigue	780.79			12/13/2013 - 1/25/2014
RESOLVED: Insurance coverage problems	V60.69	Low		1/25/2014 - 3/4/2015

217. They also lacked the below entry.

Consults by Halphen, John M, MD at 7/24/2015 8:41 PM Version 1 of 1

Author: Halphen, John M, MD | Service: (none) | Author Type: Physician
Filed: 7/24/2015 9:29 PM | Note Time: 7/24/2015 8:41 PM | Status: Signed
Editor: Halphen, John M, MD (Physician)

District Level Ethics Committee Note

The district level ethics committee met today at noon with the treatment teams and the son of the patient. The patient lacks decision-making capacity. Ibe Ohakweh is the son, and he represents the family. He indicates that he and the current wife of the The wife of the son was present, the prior wife of the patient, Mr. Nweke who is a lawyer for the family, and two others invited by the family participated via phone. The primary team was represented by the Dr.; Kusnoor. Dr. Kass represented neurology who had been following the patient. Dr. Fisher who has been involved in the BTGH Ethics subcommittee meeting was also present to discuss the case with the family.

The condition of the patient was discussed, questions from the family were answered, and the recommendations of the treatment team were conveyed to the family. The family representatives were instructed to try to make a decision for the patient that they believe the patient would make for himself given his current circumstances. The opinion of the treatment team is that the patient has suffered extensive and permanent brain injury, is unable to interact with his environment voluntarily, is not alert, will not be able to improve with time. Also related to the family was that the patient has AML and the patient is unable to receive chemotherapy because of his poor performance status. The treatment team recommended that the care of the patient not be escalated by withholding CPR, ICU level care, further dialysis, or pressors if the blood pressure falls. The family representative Mr. Ibe Ohakweh expressed the desire to have more time to consider accepting or rejecting the recommendations.

The district level Ethics Committee deliberated and decided to postpone their final decision until after giving the patient's family one week from the time of this meeting. Mr. Ibe Ohakweh has been called by me at 651-278-4393 and this decision was related to him. He was asked to convey the family decision to the treatment team before next Friday at 12 noon. If there is still disagreement between the treatment team and the family, the Ethics Committee will continue it's deliberations.
John Halphen, MD 38129 Cell- 713-515-2716

Electronically signed by Halphen, John M, MD on 7/24/2015 9:29 PM

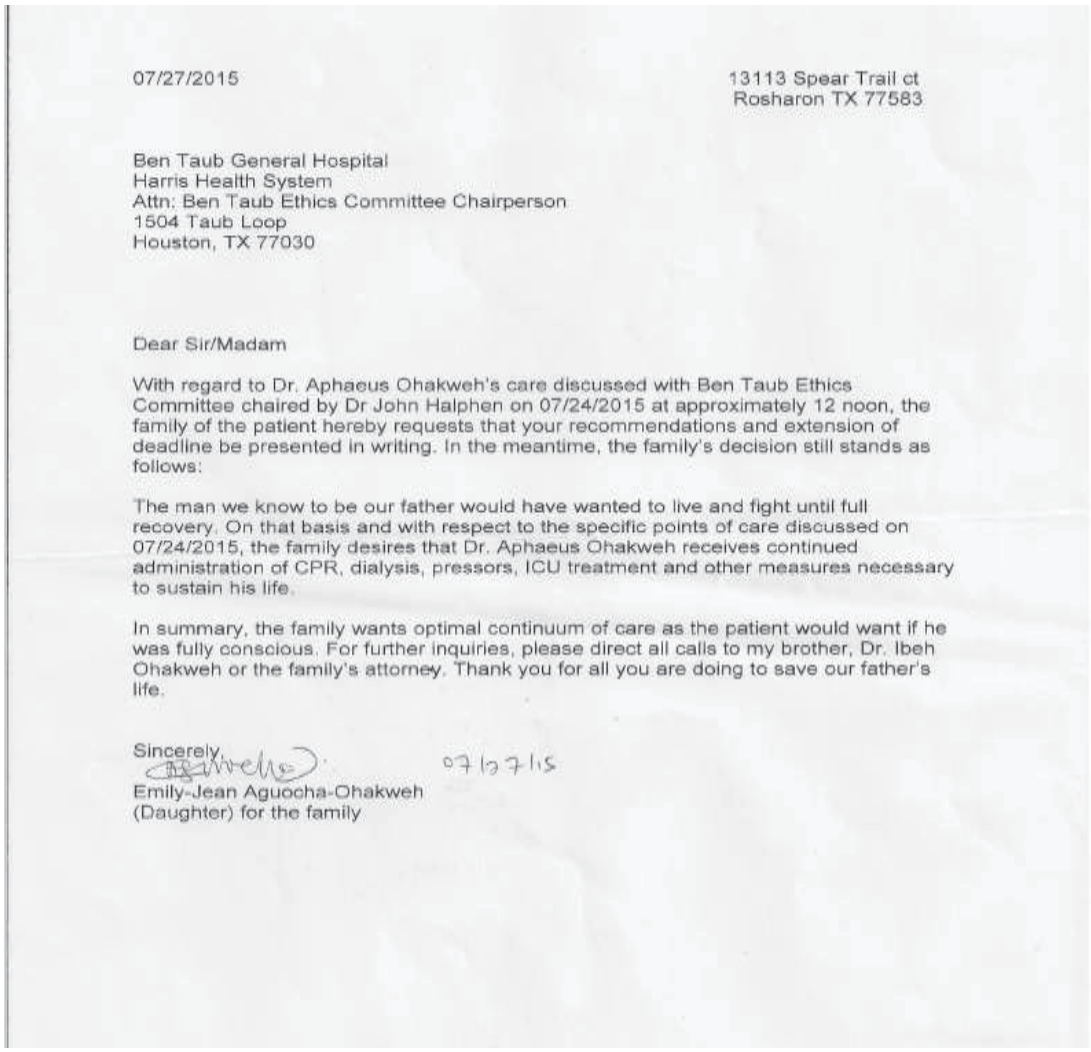
218. There exists a recorded telephone call voice mail from Dr. Halphen, left on Bethrand's voice mail within minutes after the 12:00pm Harris County Ethics Board THSC §166.046 meeting seeking the family's response from Bethrand, mentioning the DNR suggestions again, and asking Bethrand to contact the hospital staff with their response.

219. Throughout the week of 7/26/2015, Dr. Halphen personally contacted Bethrand on Bethrand's his cell phone eight (8) times in an attempt to elicit a response from Bethrand to act on behalf of Decedent and Decedent's family, and to authorize the Harris Health Ethics Board to withholding of life- sustaining treatment from Decedent.

220. After seeing 8 missed calls and receiving the voicemail from Dr. Halphen, Bethrand called Dr. Halphen back, told Dr. Halphen that the family needed time to decide, and ultimately asked Dr. Halphen to put the recommendations in writing; to which Dr. Halphen refused and stated "this conversation is over," then hung up the phone on Bethrand.

221. Immediately after the telephone call, Bethrand and Family-plaintiffs immediately drafted

and sent a response letter, as requested by Halphen in the prior mentioned voice mail message, to Harris Health & Ben Taub stating their position in writing not to withhold life-sustaining treatment, and that Decedent would have wanted every chance to be alive. Defendant Halphen confirms that Harris Health Ethics Committee received the letter.



07/27/2015

13113 Spear Trail ct
Rosharon TX 77583

Ben Taub General Hospital
Harris Health System
Attn: Ben Taub Ethics Committee Chairperson
1504 Taub Loop
Houston, TX 77030

Dear Sir/Madam

With regard to Dr. Aphaeus Ohakweh's care discussed with Ben Taub Ethics Committee chaired by Dr John Halphen on 07/24/2015 at approximately 12 noon, the family of the patient hereby requests that your recommendations and extension of deadline be presented in writing. In the meantime, the family's decision still stands as follows:

The man we know to be our father would have wanted to live and fight until full recovery. On that basis and with respect to the specific points of care discussed on 07/24/2015, the family desires that Dr. Aphaeus Ohakweh receives continued administration of CPR, dialysis, pressors, ICU treatment and other measures necessary to sustain his life.

In summary, the family wants optimal continuum of care as the patient would want if he was fully conscious. For further inquiries, please direct all calls to my brother, Dr. Ibeh Ohakweh or the family's attorney. Thank you for all you are doing to save our father's life.

Sincerely,
07/27/15
Emily-Jean Aguocha-Ohakweh
(Daughter) for the family

222. On 8/10/2015, Decedent's family received the decision letter below from Dr. Halphen on behalf of the Harris Health Ethics Board, stating that Harris Health System have decided to withhold life-sustaining (i.e. CPR, dialysis, pressors, and ICU treatment).

HARRISHEALTH SYSTEM

Harris Health System
P.O. Box 66769, Houston, Texas 77266-6769

7/31/2015

Bethrand Ohakweh
13113 Spear Trail Court
Rosharon, Texas 77583

Dear Dr. Bethrand Ohakweh:

Because you are serving as the family representative and surrogate for your father Aphaeus Ohakweh, I am informing you of the decision of the Harris Health System ethics committee regarding your father's care. It is noted that your father is unable to make medical decisions for himself.

This ethics committee was convened at 12 noon on July 24, 2015 with you present, your wife present, and your attorney present. Other family arrived via phone and in person. At this meeting, the medical treatment team involved in the care of your father presented his condition, their recommendations, and answered your questions. Because you wanted to have time to discuss with your family the recommendations of the medical team, we agreed to resume deliberations after a delay of one week. This was explained to you by phone that same day. The week passed with no notification of a decision from you, and so we resumed the discussion at 12 noon today July 31, 2015.

Today, the ethics committee agreed with the recommendations of the medical team taking care of your father. These recommendations, which were discussed with you at the July 24th meeting, were that your father not have (1) further dialysis, (2) cardiopulmonary resuscitation (CPR), (3) medications to bring the blood pressure up (pressors), or (4) admission into the intensive care unit. We agree with the medical treatment team that these measures are and will not be in the future, beneficial and appropriate care for your father due to his condition and prognosis.

A letter from the Ethics committee was delivered and signed by you on July 22, 2015. The letter explained the next steps in this process. The current level of care will be continued for ten (10) days during which time you have the opportunity to transfer your father to a facility listed in the letter. At the end of this period, the medical team's four recommendations will be put into effect. Please refer to this letter and the ethics committee will be happy to answer the questions you have.

Sincerely,
John M. Halphen, MD Chair of the Ethics Committee
John M. Halphen, MD

Author: John M Halphen 7/31/2015 6:28 PM

223. The family immediately responded with the below letter stating that they disagree with the Ethics Board's decision, and that they the family desires that Decedent continue to receive administration of CPR, dialysis, pressors, ICU treatment, and other necessary measures to sustain his life. Defendant Halphen confirms that he received this letter.

08/13/2015

13113 Spear Trail ct
Rosharon TX 77583

Ben Taub General Hospital
Harris Health System
Attn: Ben Taub Ethics Committee Chairperson (John Halphen, MD)
1504 Taub Loop
Houston TX 77030

Dr. Halphen/ Medical team

In response to your decision letter received on the 08/10/2015 in the matter of Dr. Aphaeus Ohakweh's care, we the family wishes to inform you that we disagree with your decision to stop all life-sustaining treatment. Given the circumstances surrounding the events that led to his present condition and your refusal over the phone on 07/27/2015 @10:19am to present your recommendations in writing as requested by the family, the family does not believe that all facts are being presented to them as you failed to show any reproducible and justifiable evidence (such as records) for your recommendations during the 07/24/2015 meeting.

We have evidence to show that Dr. Aphaeus Ohakweh's health has tremendously improved and that he is regaining some brain function, a fact which was misrepresented at the meeting on 07/24/2015. On that basis, we do not agree with your recommendations to stop CPR, dialysis pressors, ICU treatment if and when he needs these. Please be reminded that he has not needed any of the aforementioned treatments for some months since he was last removed from the intensive care unit.

The man we know to be our father would have wanted to live and is fighting for full recovery. On that basis and with respect to the specific points of care discussed on 07/24/2015, the family desires that Dr. Aphaeus Ohakweh receives continued administration of CPR, dialysis, pressors, ICU treatment and other measures necessary to sustain his life.

Please be informed that we hold you and the institution responsible for any breach in the continuity medical care to our father whose health is improving as evidenced by his records.

In summary, the family wants optimal continuum of care as the patient would want if he was fully conscious. For further inquiries, please direct all communications to my brother, Dr. Ibeh Ohakweh or/and the family's attorney. Thank you for all you are doing to save our father's life.

Sincerely,

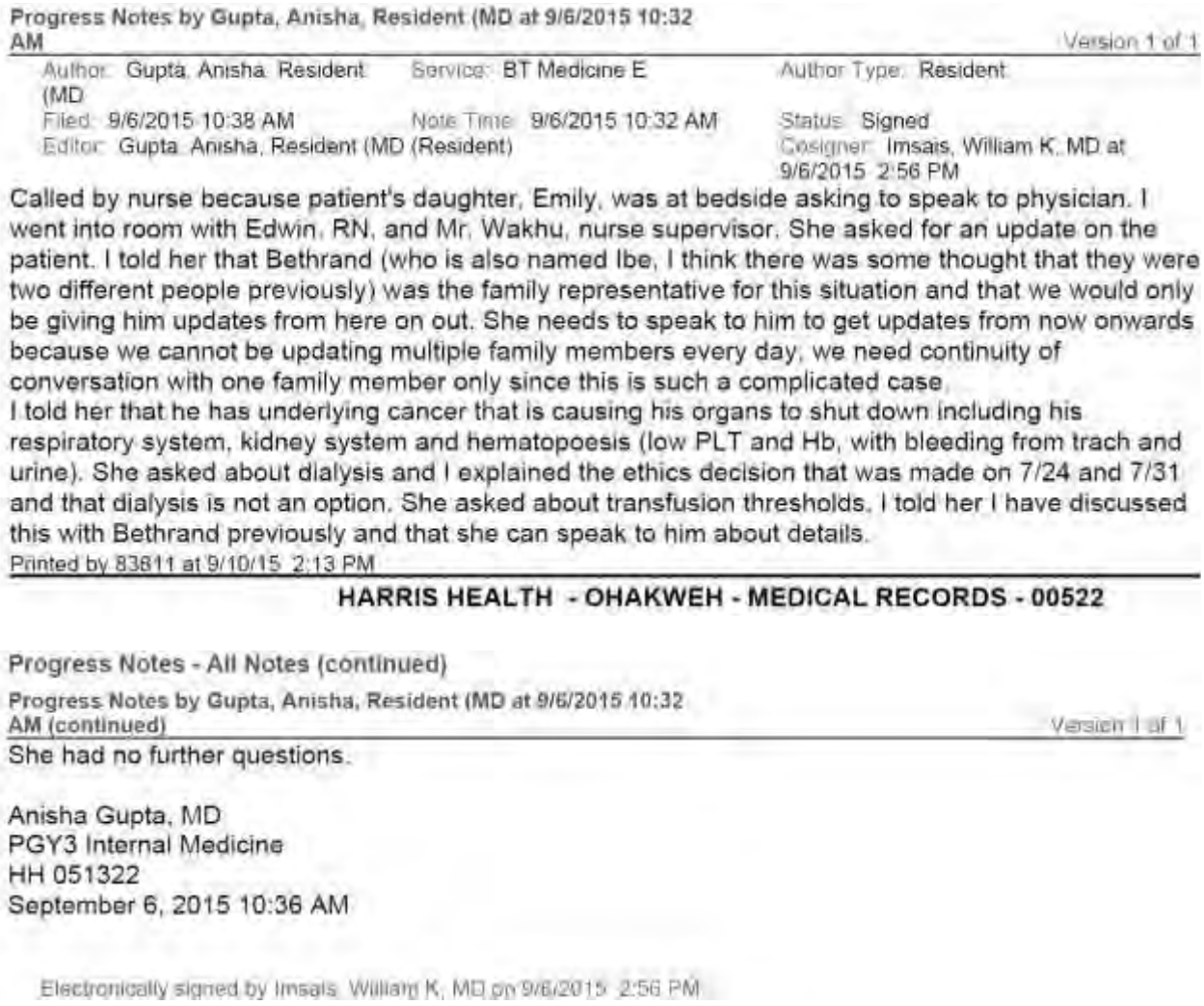
08/13/2015

Emily-Jean Aguocha-Ohakweh
(Daughter) for the family

224. On a subsequent visit to the hospital and after the Ethics Board Meeting, Bethrand spoke to the nurse on staff who claimed that the physicians attempted to wean Decedent off the ventilator, and that decent was breathing on his own for about a 3-day period. Thereafter, the nurse returned after a shift, and to his disappointment, saw Decedent was put back on the ventilator at the request of hospital executives.

225. Defendants were also aware of the existence of Decedent's daughter Emily-Jean who was

present at the Ethics Board meeting; and who also visited Decedent in the hospital. Upon her visit to see her father in the hospital, Dr. Gupta denied her pertinent details and explanation about Decedent's care. (Exhibit 79) She asked Dr. Gupta why her father was not being provided with dialysis, and was told to it was being withheld, and to communicate directly with Bethrand as he was the family representative going forward.[38]



Progress Notes by Gupta, Anisha, Resident (MD at 9/6/2015 10:32 AM) — Version 1 of 1

Author: Gupta, Anisha, Resident (MD) | Service: BT Medicine E | Author Type: Resident
Filed: 9/6/2015 10:38 AM | Note Time: 9/6/2015 10:32 AM | Status: Signed
Editor: Gupta, Anisha, Resident (MD (Resident)) | Cosigner: Imsais, William K, MD at 9/6/2015 2:56 PM

Called by nurse because patient's daughter, Emily, was at bedside asking to speak to physician. I went into room with Edwin, RN, and Mr. Wakhu, nurse supervisor. She asked for an update on the patient. I told her that Bethrand (who is also named Ibe, I think there was some thought that they were two different people previously) was the family representative for this situation and that we would only be giving him updates from here on out. She needs to speak to him to get updates from now onwards because we cannot be updating multiple family members every day, we need continuity of conversation with one family member only since this is such a complicated case.
I told her that he has underlying cancer that is causing his organs to shut down including his respiratory system, kidney system and hematopoesis (low PLT and Hb, with bleeding from trach and urine). She asked about dialysis and I explained the ethics decision that was made on 7/24 and 7/31 and that dialysis is not an option. She asked about transfusion thresholds. I told her I have discussed this with Bethrand previously and that she can speak to him about details.

Printed by 83811 at 9/10/15 2:13 PM

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 00522

Progress Notes - All Notes (continued)

Progress Notes by Gupta, Anisha, Resident (MD at 9/6/2015 10:32 AM (continued)) — Version 1 of 1

She had no further questions.

Anisha Gupta, MD
PGY3 Internal Medicine
HH 051322
September 6, 2015 10:36 AM

Electronically signed by Imsais, William K, MD on 9/6/2015 2:56 PM

226. Further evidence is that Decedent also did not sign any advanced directive or consent upon admission or at any time during his stay in the hospital. But Defendants were keen on accelerating decedent-plaintiff's death because *amongst others*, he was elderly, a visa holder,

[38] This was after the hospital was informed of the existence and provided contact information of the family attorney.

of Nigerian origin or African American, and/or lacked insurance.

227. Per Dr. Weei-Chin Lin's entry of Dr. Yan, Decedent "expressed his interest in seeking further chemotherapy for AML relapse." There is no evidence that Decedent or his family properly consented to the attempted BAL. The only evidence provided by Defendants has is a forged consent form.

228. Decedent clearly already had a bronchoscopy in the first treatment, withstood it and their tests, and finally started to receive the chemotherapy he needed. This time around, he was clear as to what he needed – chemotherapy treatment for his AML. The last set of treatment was withheld from him in the first hospital visit.

229. Neither Decedent nor anyone in his family ever consent to any March 2015 bronchoscopy. Even more evident, there is no pertinent details as to the failed 03/06/2015 bronchoscopy.

230. With the authorization to withhold life-sustaining treatment from Decedent from Harris Health Ethics Board and Dr. Halphen, and without being able to find any alternative venue to accept Decedent under such circumstances, the month of August 2015 was a critical month for the physician to deliver the final blow to Decedent. Dr. William Graham and Dr. Anisha Gupta were the physicians on staff during that month.

231. Decedent was not taken well care of by Dr. William Graham's medical team, which included Dr. Anisha Gupta. They withheld essential health care and life-sustaining treatment and essential health care from Decedent during their involvement in treating Decedent, and in the final weeks and days of Decedent's life.

232. When a once stable Decedent began to further deteriorate in front of the medical team's eyes due to their refusal to provide needed health care, the medical team acted to provided

rather accelerate Decedent's state to futility, and accelerated his 09/07/2015 death.

233. It is documented in the records that daily labs were performed up until August 14, 2015. These daily labs included a complete blood count (CBC) and a basic metabolic profile (BMP). On August 14, Decedent had the following labs hemoglobin (hgb) 8.4, hematocrit (hct) 27.4, and platelets (plt) 11. One should know that these numbers are way below the normal cutoff especially the platelets. To this end, the medical team did transfuse Decedent 1 unit of platelets on that day.

234. Shockingly though, the next set of labs for Decedent was not performed until August 20. Now most medical professional would agree that after transfusing one blood product, it is normal practice to perform a post-transfusion lab work; and this should hold more true to anyone in such a critical state as Decedent. However the medical team delayed this blood work until August 20th, 2015 at which point things could only be worse. August 20th was also a key day regarding the medical management of Decedent because it was the day that marked the DE-ESCALATION of Decedent's medical care.

235. In other words, on this paramount day of August 20th 2015, Decedent had the following blood work: Hgb 6.6, Hct 22.1, and Plt of 7. Again, these numbers are way below the normal ranges. In fact, it is documented throughout the doctors' daily progress notes that Decedent would receive blood product transfusions as needed if his Hgb <7 and/or his plt< 10 or shows signs of bleeding. Thus, with this in mind the medial team elected to give him ONLY 1 unit of packed red blood cells which would only affect his Hgb and not his Plt.

236. On August 24th, 2015 at 1.34pm, Dr. Anisha Gupta spoke over the phone with Decedent's son, Bethrand about his father's August 20th lab work at which time she stated that she will not transfuse any platelets until Decedent bleeds.

237. Dr. Gupta documented in the medial records that "getting Plt tx for Plt of 7 on 8/20 without bleeding episodes was not worth the risk." However, all along Decedent had been receiving Plt transfusions with values even greater than 7.

238. For example, on 8/14 he received 1 unit of plt for a value of 11, on 8/9 he received 1 unit for a value of 16, and on 8/5 he received 1 unit of plt for a value of 23. It should be known that up until 8/14, Decedent was receiving daily blood transfusion or platelet transfusion as part of his continued care.

239. After receiving the blood transfusion on 8/20/2015, the medical team made the decision not to obtain post-transfusion blood work, let alone conduct any further blood work until 8/27/2015.

240. On or about the evening of 8/25/2015, Bethrand received a call from Dr. Anish Gupta indicating that Dr. Ohawkeh was in imminent death, and that Bethrand should come to the hospital if he wanted to see his father one last time. Bethrand and family immediately left for the hospital. When they arrived at the hospital, the nurses on staff informed them that Decedent was not dying, and that Dr. Gupta was away in the ER. Bethrand and family waited for Dr. Gupta. She did not arrive.

241. On 8/27/2015, Decedent's blood work was as follows: Hgb 4.4, Hct 15.2 and Plt of 2. On this day, one would also see derailments in some of Decedent's other blood works including a creatinine (Cr) of 2.7 and blood urea nitrogen (BUN) of 78. Up until 8/27/15, as seen in the medical records, Decedent's BUN and Cr were stable. Therefore, it comes as no surprise why Decedent suffered acute kidney injury; anyone who went to medical school knows that the number one cause of acute kidney injury is anemia or blood loss, which is evident in the drop in Decedent's Hgb from 6.6 to 4.4 over the course of one week: from

8/20/2015 to 8/27/2015. All of which could have been prevented if the medical team did not amongst others, act willfully wrongful, with conscious indifference or reckless disregard for the rights, life, and safety of Plaintiffs, recklessly, maliciously, fraudulently, intentionally, and/or knowingly to administer improper and/or deadly health care to the patient as he severely deteriorated.

242. On 8/27/2015 the medical team pumped Decedent with 3 units of packed red blood cells and 1 unit of platelets. The next set of blood work was performed on August 31st and this lab work was even WORSE. Decedent had a Hgb of 4.0, Hct of 13.3, and Plt of 1. The medical team again attempted to cover-up their wrong doing by ordering to give Decedent 3 units of blood and 2 units of platelets on 8/31. On a 9/1 visit to the hospital, Edwin RN told Bethrand that Decedent made 75 milliliters of just blood on 08/31/2015 and 25 milliliters that morning of 9/1/2015.

243. By 9/2/2015, Decedent's lab work showed a Hgb of 5.8, Hct of 17.1, Plt of 28, and poor kidney function reflected in a Cr of 5.1, BUN of 170, and urine output of virtually zero.

Death of Decedent

244. On the last week of August 2015 provided many Defendants with the Texas Civil Practice and Remedies Code Chapter 101 & Chapter 74 notice of claim letters.[39] Some of the letters sent to the physicians were also sent to Barbara Johnson at Baylor College of Medicine's risk management department.

245. On September 1 and September 2, 2015, Mrs. Barbara Johnson also received the emails attached as "Exhibit K" and hereby incorporated by reference. Barbara Johnson schedule a

[39] At that time, Plaintiffs' were still yet to get the consent forms, and necessary and accurate facts and evidence to properly analyze the case. Considering the 6-month timeline, the rush to send the notice of claim letters was merely timely and precautionary measures.

call to discuss Decedent's matter. During the call on September 2 at 2pm CST, Barbara Johnson and another gentleman- Mr. James Banfield - were informed that Dr. Anisha Gupta was part of the medical team with Dr. Graham and were executing actions on Decedent that was accelerating his death. She was also informed that a new medical team was on staff treating Decedent as of September 1.

246. As BCM's risk management director, Mr. Banfield had a duty to investigate and ensure that Dr. Gupta and Dr. Graham were no longer part of the medical team treating Decedent. However, instead, Der. Gupta was kept involved in the care of Decedent. Mr. Banfield is also in charge of the relationship between BCM's contracting entity with Harris County Hospital District, i.e. Affiliated Medical Services, and Texas Higher Educational Board. He had the obligation/responsibility to report Decedent's incidents to not only Affiliated Medical Services, Texas Higher Educational Board and Department of State Health Services, and all necessary authorities.

247. Per the medical records, on or about 09/02/2015 at 9:29am, Dr. Gupta ordered a high dosage of acetaminophen (TYLENOL) for Decedent to be administered every 4 hours; a dosage level greater than the maximum limit allowed.

248. On 09/02/15 at 12:50pm, Decedent was given 500 mg of acetaminophen (TYLENOL) tablet. Per the Registered Nurse, Candelaria J. Rodriguez's comments: "Dr. Gupta notified of dosage over 4g limit. MD states okay to given medication." (Exhibit 89)

249. On 09/02/15 at 5:00pm, Decedent was given 500 mg of acetaminophen (TYLENOL) tablet. Per the Registered Nurse, Candelaria J. Rodriguez's comments: "part of barcode torn off. Medication given now. Okay to give med per MD Gupta request. Patient with T> 100." (Exhibit 89)

250. On 09/03/15 at 9:05am, Decedent was given 500 mg of acetaminophen (TYLENOL) tablet. Per the Registered Nurse, Candelaria J. Rodriguez's comments: "Per Dr. Gupta- okay to administer acetaminophen as she is okay with going over the 3 g /24 hr max limit." (Exhibit 89)

251. Also, on 09/03/15 at 1:10pm, Dr. Ohawkeh was given another 500 mg of acetaminophen (TYLENOL) tablet. Per the Registered Nurse, Candelaria J. Rodriguez's comments: "Per Dr. Gupta- okay to administer acetaminophen as she is okay with going over the 3 g /24 hr max limit." (Exhibit 89)

252. On the morning of September 7, 2015, Defendant Anisha Gupta contacted Bethrand over the telephone around 9:00am to inform him that Decedent had died. Dr. Gupta stated that Decedent developed heart complications around 6:30am, and was pronounced dead around 8:30am. The death certificate stated 8:57am.

253. In Decedent's Harris County District Death Notice signed by Dr. Gupta at 9:06am, she stated Decedent was African (Exhibit 54).

254. In Decedent's death certificate, (Exhibit Z[40]), signed by a Dr. David Hyman, the cause of death listed was AML, Renal (i.e. Kidney) Failure, Respiratory Failure, and Hypoxic Ischemic Encephalopathy.

255. Since the causes of death listed partly hailed from the March 6, 2015 incident and subsequent activities, with the March 6 2015 incident being the result of a forged document, there should have been a thorough investigation to disclose the criminal forgery that triggered the events leading to the death. Hence, the death certificate should also note that a homicide had occurred, or at least an investigation is pending, in the "manner of death"

[40] Case 4:16-CV-00903, Doc. 71, Filed on 06/17/16 in U.S. District Court Southern District of Texas, Page 9 of 11.

section. It does not. Consequently, without a homicide listed on the death certificate "manner of death" section, the Houston Police Department has no authority or jurisdiction to investigate the incidents leading to Decedent's death. This is another evidence of a cover-up attempt or obstruction of justice.

256. It is worth noting that per National Institute of Health, the average time to death for someone of Decedent's age with AML and without treatment is 3 to 4 months. Decedent lasted 6 months even with his mortal wound, and lack of treatment. On the 6th month and 1 day, Defendants killed him. Furthermore, the kidney failure was induced and caused by Defendants. They also caused the respiratory failure and the hypoxic ischemic encephalopathy (i.e. brain failure).

257. Defendants acted and killed Decedent. They withheld necessary health care services from him, severely harmed him, withheld further necessary health care services from him for the sake of advancing his condition to futility, withheld necessary life-sustaining treatment including CPR, dialysis, pressors, and ICU treatment from him, accelerated his death, and killed him 1 day and 6 months after the 03/06/2015 injuries.

258. Withholding life-sustaining treatment normally is the decision of the family per Texas Health and Safety Code (THSC) Section 166.039(b), and American Medical Association Code of Medical Ethics Rule 2.20 "Withholding or Withdrawing Life-Sustaining Medical Treatment."

259. Dr. Halphen, Joslyn Fisher, and Harris Health Ethics Board decided to withhold CPR, dialysis, pressors, and ICU treatment. Per Texas Health & Safety Code 166.046(d) and Harris Health System Advance Directives Policy 4128(8) required defendants to transfer Decedent to a physician, an alternative care setting within the facility, or another facility that

will comply with the family's wishes as part of the process. However, defendants did not do so. Decedent was kept in the same Ben Taub Hospital unit 6D room 10 where he was as of the July 24, 2015 meeting, and Defendants (e.g. Anisha Gupta, William Graham, etc), accelerated his premature death while he was under their custody and/or control.

Additional Missing and Bad Faith Activity in the Medical Records

260. Dr. Van Hoang's statement about the 3/6/2015 incident is nowhere to be seen. She signed the forged consent form with a time of 10:10am in the morning of 3/6/2015 that alleges that Decedent consented to a BAL, endotracheal intubation, biopsy, and other interventions. Yet there are no pertinent details of the bronchoscopy that was done on 3/6/2015 except for physician and staff's accounts of the 3/6/2015 traumatic incident (e.g. Mimi Phan, Nurse Elan Hailey, Dr. Suman). There are also accounts from other physicians and other individual Defendants (e.g. Sarkar *et al*), residents, and fellows, that an unsuccessful bronchoscopy was attempted on 3/6/2015.

261. Furthermore, the medical records provided per the July 24, 2015 request were only from 3/4/2015 and thereafter. There were no records from the first 2013 treatment. These records were later provided to Decedent's family, and also contain deceptive or forged documents.

262. Defendant later provided medical photos of Decedent taken on 4/16/2015 that show severe bed sores all over his body as of 3/10/2015.

263. It's worth noting that prior to the 3/6/2015 incident, whenever proper consent was obtained from Decedent for any procedures, Decedent's son was present to oversee and be explained the risks and benefits, and he would then communicate to his father to consent to the procedure. The physician on staff would then sign the consent form, and a nurse will witness the document. All occurred at the same time in front of Decedent and his son.

264. After the 3/6/2015 incident, whenever proper consent was needed for Decedent's treatment, and family member was around, the hospital physician would call Decedent's son, explain the need for consent, he would give consent over the telephone, and a nurse will take the telephone from the physician and confirm that she/he has witnessed the family's consent to the specific procedure.

265. For example, for the hemodialysis catheter procedure done on Decedent on 3/10/2015 by Van Hoang, under the oversight of Elizabeth Guy, according to Dr. Guy's notes, "verbal consent obtained from family." Yet they did not act to obtain consent for the 03/09/2015 BAL, nor the 03/06/2015 BAL.

266. The 03/06/2015 and 03/09/2015 BALs executed on Decedent were a high-risk procedure that should only occur with extreme preparation, proper and required equipment, knowledge and highly trained and experienced physicians, or under the supervision of such, and requires consent. There was no consent.

267. The tracheostomy, if an emergency procedure, required clear precautions, protocol, and administration that was disregarded by Defendants due to the evident lack of supervision, and lack of knowledge or experience by the ENT team.

268. Plaintiffs did not consent to, *amongst others*, the March 2015 BALs, or the withdrawal of life-sustaining treatment. The 03/06/2015 BAL consent for is forged and/or fraudulently secured in violation of Texas Penal Code Sections 32.21 and/or 32.46. Bethrand's affidavit (Exhibit N), the statements of the physicians, and many other evidences on record, support the 03/06/2015 BAL consent form as criminally fraudulent and/or forged.

***

269. Based on the first hospital visit, Dr. Mims and Baylor physician staff were already aware

of Decedent's AML and prior treatment.

270. There was already evidence of delay in treating Decedent due to Gold Card or payment issues. A bronchoscopy was done in the first hospital visit already. The unnecessary bronchoscopy and bronchoalveolar lavage in the second hospital visit, rather than necessary chemotherapy, was an unnecessary and unreasonable wrongful activity.

271. Nurse Hailey's comments are merely part of a cover-up because if she was there and was observing or participating in the procedure, she had a duty to make sure that written signed consent was obtained before the procedure began. It wasn't. Nurse Hailey's statement was also made or given over 6hrs after the incident occurred.

272. On or about 3/10/2015, Dr. Sarkar disregarded his oversight of Van Hoang and a Mimi Phan, and allowed them to execute an invasive catheter procedure on Decedent's jugular without his presence as the attending physician. This catheter placement, amongst other catheter placements, was wrongfully executed. There are signs of deliberate indifference, amongst others, failure to supervise the invasive activities of the residents and fellows.

273. Again, per Dr. Sarkar's progress notes on **3/27/2015** - exactly three weeks after the bronchoscopy incident, "**We have suggested that at this time our medical recommendation will be to withdraw life sustaining measures e.g. Hemodialysis and mechanical ventilation**." (Exhibit 46)

274. Chemotherapy and hemodialysis are expensive medical treatments.

275. Other Defendant physicians followed course afterwards and wrote the same recommendation in the records during their attendance of Decedent.

276. The physicians Defendants also intentionally, knowingly, fraudulently, maliciously, recklessly, or with conscious indifference or reckless disregard for the rights, life, and safety

of Plaintiffs, and disregarded their treatment of Decedent per the bed-sores that developed.

277. During the months between the March 6, 2015 incident and the life-sustaining treatment decision in late July 2015, Defendants violated various aspects of Decedent's right to proper treatment and improper discharge once admitted or while in their care. They amongst others, withheld treatment from Decedent in order for him to deteriorate, subjecting him to withhold life-sustaining treatment against his and his family's wishes and the acceleration of his death. Various defendants used Decedent during that time, equivalent to a medical experiment object, and made misrepresentations in regards to decedent plaintiff's condition, in furtherance of the conspiracy to wrongfully deprive Plaintiffs of their rights, prematurely discharge Decedent, deny him of withhold life-sustaining treatment and essential health care, and accelerate his death.

278. Even Ommenn, the social worker, and nurse Rebecca Williams were planning on wrongfully discharging him in his condition. Other defendants were falsely stating all over his records that Dr. Ohawkeh was in a persistent vegetative state when he was not. Dr. Xandera also disclosed that BCM risk management director, Mr. Banfield, was aware of Dr. Ohawkeh's situation.

279. Dr. Halphen, with medical record notice of improper THSC 166.046 procedures and on professional notice of Code of Medical Ethics Rule 2.20, attempted to coerce Decedent's son to consent to the withholding of life-sustaining treatment from Decedent. After unsuccessfully able to obtain such consent, he *still* ruled to withhold life-sustaining treatment against Decedent and his family's wishes, knowing that the family's decision was what Decedent would make for himself under the circumstances.

280. Once wrongfully obtaining the DNR authorization from Halphen & Fisher, under the

oversight of Dr. Graham, Dr. Gupta - amongst other wrongful acts or omissions - withheld platelet transfusions and dialysis from Decedent, and later caused Decedent to urinate blood.

281. Plaintiffs notified Barbara Johnson at Baylor's risk management office, of Dr. Graham and his team's actions in accelerating Decedent's death. Mr. Banfield was on the call with Barbara Johnson when Plaintiffs' counsel notified Baylor of Dr. Gupta and Graham's actions on Decedent, and that they were severely harming and trying to kill Decedent.

282. The expectation was that Barbara Johnson & James Banfield would report such activity to the medical staff managers and remove Dr. Gupta and Graham from their involvement in Decedent's care. They did not. After all, the medical staff rotated from the care of Decedent on approximately a monthly basis.

283. Rather, Dr. Gupta was wrongfully given control of Decedent's health care in the month of September, until Decedents' death was achieved.

284. Decedent was never examined or evaluated by a cardiologist throughout his period at Ben Taub hospital.

Further Injuries from Defendants discrimination via withholding essential health care services

Further issues and foreseeable injuries proximately caused by Defendants while Decedent was under Defendants' control at Ben Taub Hospital, are as follows:

285. Decedent sustained severe lacerations to, amongst others, his reproductive organs, and lower leg, while at MICU.[41] He also sustained ulcers in his ears, skin, and rear end while at the hospital.[42]

286. Height and weight discrepancies of measurements both taken on the same day, 3/4/2015,

[41] Evidence of discrimination, elderly and sexual abuse, and/or torture that was not investigated as required by policy.
[42] Evidence of malicious, knowing, intentional, bad faith, and/or deliberate indifferent discrimination in treatment and inaction to provide essential health care.

by Sophia Kumbanattel, Resident MD, indicate that as of 1pm, that day he was 5ft 10 inches in height and weighed 267lbs, yet as of 4:45pm he was 5ft 11 inches in height and weighed 229lbs. Hence within three (3) hours, he gained one inch in height, and lost 38lbs. These height and weight measurements are used to determine his vital and critical medications. Hence, this is, amongst others, evidence of preventable wrongful mismanagement that contributed to Decedent' multiple irreversible organ failures including the brain failure.

287. The medical records also show that Decedent has sustained increased oropharyngeal secretions as of 6/4/2015 (Exhibit 95), which he acquired during his time at Ben Taub Hospital, and caused by Defendants. This injury was preventable and its effects could and should have been mitigated. Defendants did not do so.

288. The records (Exhibit 95) also show that Decedent contacted Nosocomial Pneumonia – hospital acquired pneumonia – as of 5/9/2015, acquired during his time at Ben Taub Hospital, and caused by Defendants. There is nothing in the records that show that Decedent received pneumonia shots as expected upon admission due to his age (over 60yrs old) to prevent him from catching pneumonia. This injury was preventable and its effects could and should have been mitigated. Defendants did not do so.

289. Pg 5 of the records (Exhibit 95) also show that Decedent contacted bacteremia due to Enterococcus – a bacteria infection of the blood stream due to the bacterial organism "coccus" forming in his blood stream acquired during his time at Ben Taub Hospital, and caused by Defendants. This occurred as of 5/9/2015 and was present as of July 24, 2015. This infection commonly affects the elderly during hospital admissions and who underwent instrumentation (i.e. Decedent's attempted intubation and pre-op BAL). Enterococcus bacteria had been known to be resistant to antibiotic like vancomycin, penicillin products,

and others. The medical and infection control team should have considered such before selecting the treatment antibiotics for Decedent. This injury was preventable and its effects could and should have been mitigated. Defendants did not do so.

290. Decedent also incurred Hypoxic Ischemic Encephalopathy (HIE), acquired during his time at Ben Taub Hospital and a result of the 3/6/2015 failed BAL, tracheostomy, and subsequent malicious and reckless catheter placements done by Defendants. Decedent was under the care of, amongst others, Dr. Kao, Guy, Guerra, and Sarkar. This HIE was hospital acquired during his time at Ben Taub Hospital, and caused by Defendants. This injury was preventable and its effects could and should have been mitigated. Defendants did not do so.

291. The records also show that Decedent contacted Candidemia on 3/27/2015 (Exhibit 95), acquired during his time at Ben Taub Hospital and as a result of the, amongst others, reckless, malicious, intentional, knowing, bad faith, and/or treatment with conscious indifference or reckless disregard of the rights, life, and safety of Decedent and Plaintiffs at the hands of Defendants. This is a fungal blood stream infection on Decedent's blood acquired during his time at Ben Taub Hospital, and caused by Defendants. This injury was preventable and its effects could and should have been mitigated. Defendants did not do so.

292. There is also evidence of colonization with multidrug-resistant bacteria that Decedent acquired on 3/27/2015 during his time at Ben Taub Hospital (Exhibit 95), and caused by Defendants. This contributes to the any drug-resistant infections, which led to Decedent's criticalness and difficulty in treating his infections. This injury was preventable and its effects could and should have been mitigated by Defendants. Defendants did not do so.

293. IMPORTANTLY: After Decedent's death, a physician employee of BCM unrelated to Decedent, disclosed to Plaintiffs' counsel that Plaintiffs' failure to supervise issue is a

common issue at BCM's operation at Ben Taub, and that Plaintiffs' issues resulting injuries continuously occur about 3 or 4 times/yr.

DAMAGES

294. Plaintiffs hereby incorporate all facts and allegations in all sections above and below.

295. Applicable Defendants' various separate wrongful acts, including separate wrongful acts with bad faith and/or deliberate indifference to Plaintiffs' constitutional rights, health, and safety, and/or their malicious, irrational, intentional, or knowing deprivation of Plaintiffs' due process and equal protection rights during both hospital visits, were a substantial factor that caused the following resulting and separate harm/damages/injuries, to each of the eight (8) Plaintiffs, and at various separate/different times during both the first and second hospital visit:

296. Decedent's estate's damage claims are (a) severe physical/bodily injuries; (b) pain and suffering; (c) loss of earnings; (d)loss of earning capacity; (e) emotional and mental anguish; (f) loss of consortium; (g) traveling costs; (h) loss of companionship, support, comfort, advise, and guidance; (i) loss of spouse's household and domestic services; (j) medical expenses; (k) loss of care; and (l) attorney fees and costs.

297. The damages claimed for the wife are: (a) loss of consortium; (b) loss of counsel; (c) loss of advice; (d) loss of spouse's household and domestic services; (e) loss of care; (f) loss of maintenance; (g) loss of support, comfort, advice, guidance, and companionship; (h) loss of monetary contributions; (i) emotional and mental anguish; (j) traveling costs; (k) loss of inheritance; (i) pain and suffering; (j) funeral and burial expenses; and (j) attorney fees and costs.

298. The damages claimed for each of the children below 18yrs of age are: (a) loss of monetary contributions; (b) loss of earning capacity; (c) loss of counsel; (d) loss of advice; (e) loss of

services including nurture, care, comfort, education, and guidance; (f) loss of support; (g) emotional and mental anguish; (h) traveling costs; (i) loss of inheritance; (j) pain and suffering; and (i) attorney fees and costs.

299. The damages claimed for each of the children above 18yrs of age are: (a) loss of earning capacity; (b) loss of counsel; (c) loss of advice; (d) loss of services including nurture, education, and guidance; (e) loss of care and comfort; (f) emotional and mental anguish; (h) traveling costs; (i) loss of inheritance; (j) pain and suffering; (k) funeral and burial expenses; and (l) attorney fees and costs.

300. Plaintiffs, which includes Decedent's Estate, also have and hereby assert a claim for all exemplary/punitive damages allowed by law and equity, and pray for such.

CAUSES OF ACTION

42 U.S.C §1983 reads as follows:

"Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable." *42 U.S.C. §1983.*

Plaintiff(s) possess(es) the following clearly protected rights and privileges secured by the United States Constitution per the following U.S. Constitution Amendments:

U.S. Constitution Amendment XIV Sec 1 – "…**nor shall any state deprive** any person of life, liberty, and property without **due process of law**, **nor deny to any person within its jurisdiction the equal protection of the laws**." *U.S. Const. Amd. XIV.*

This Amendment guarantees Plaintiff(s) rights to (a) equal protection of all Federal and State laws; including the protection against (b) deprivation of life, liberty, and property without due

process of law, by State actors. *U.S. Const. Amd. XIV; Wideman v. Shallowford Community Hospital, Inc.*, 826 F.2d 1030, 1032 (11th Cir.1987) "The due process clause, however, has traditionally been interpreted as protecting certain 'negative liberties,' *i.e.*, an individual's right to be free from arbitrary or discriminatory action taken by a state or municipality." *Wideman*, 826 F.2d at 1033.

PLANTIFFS' RIGHTS

In this case, Plaintiffs are guaranteed the following U.S. Constitutional rights, amongst other rights that were deprived:

(a) Decedent Plaintiff's substantive due process liberty, privacy and/or bodily integrity right to give consent or informed consent on his own behalf to medical treatment or the invasion of his bodily integrity. *Harris Health System Patient's Rights & Responsibilities* policy; *U.S. Const. XIV*; *Tex. Const. Art. 1, Sec. 19; England v. Louisiana State Board of Medical Exam*, 259 F.2d 626, 627 (5th Circ. 1958) ("Under all of the cases, we think it is that the State cannot deny to any individual the right to exercise a *reasonable* choice in the method of treatment of his ills, nor the correlative right of practitioners to engage in the practice of a useful profession."); *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"); *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (Before the turn of the century, this Court observed that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific R. Co.* v. *Botsford*, 141 U.S. 250, 251 (1891). This notion of bodily integrity has been embodied in the requirement

that **informed consent** is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."); *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) ("In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights… to bodily integrity, *Rochin* v. *California*, 342 U.S. 165 (1952)")

(b) Decedent Plaintiff's equal protection right against discrimination in or arbitrary provision of medical care upon his admission to Ben Taub hospital throughout the first 12/12/2013 and second 03/04/2015 hospital visits. *U.S. Const. Amd. XIV; Tex. Const. Art. 1. Sec. 3a; Harris Health System Patient's Rights & Responsibilities* policy; *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189, 197 n. 3 (1989) (citing *Yick Wo v. Hopkins*, 118 U.S. 356 (1886)) ("[t]he State may not, of course, selectively deny its protective services to certain disfavored minorities without violating the Equal Protection Clause."); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) ("Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes."); *McKee v. City of Rockwall*, Tex. 877 F.2d 409, 418 (1989) (citing *Watson v. City of Kansas City, Kansas*, 857 F.2d. 690, 694 (10th Cir.1988) ("Although there is no general constitutional right to police protection, the state may not discriminate in providing such protection.")); *Mahone v. Addicks Utility Dist. Of Harris County*, 836 F.2d 921, 932 – 938 (5th Cir. 1988) (discussing generally equal protection claims and "class of one" equal protection claims.)

(c) Decedent Plaintiff's right to an advanced directive including in the 2015 hospital visit for withdrawal or withholding of life-sustaining treatment decisions. See *Harris Health System Patient's Rights & Responsibilities* policy; *Texas Health & Safety Code §§166.032; Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 323 (1990) (The court did not specifically define what kind of evidence it would consider clear and convincing, but its general discussion suggests that only a living will or **equivalently formal directive** from the patient when competent would meet this standard.); *U.S. Const. Amd. XIV*.

(d) Decedent Plaintiff's right to give consent or informed consent, or withhold consent or informed consent to the withholding or withdrawal of life sustaining treatment ("DNR") in the second hospital visit. *U.S. Const. Amd. XIV; Cruzan*, 497 U.S. at 269 – 274; See also, *Washington v. Glucksberg*, 521 U.S. 702, 726 (1997) (… the opinion discussed in some detail this Court's substantive-due-process tradition of interpreting Due Process Clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties 'involv[e] the most intimate and personal choices a person may make in a lifetime.'); *Harris Health System Patient's Rights & Responsibilities* policy.

(e) Decedent Plaintiff's inalienable right to life. *Washington v. Glucksberg*, 521 U.S. 702, 714 (1997) (citing *Martin* v. *Commonwealth*, 184 Va. 1009, 1018— 1019, 37 S.E.2d 43, 47 (1946) ("`The right to life and to personal security is not only sacred in the estimation of the common law, but it is inalienable' ")); *U.S. Const Amd. XIV; Tex. Const. Art. 1, Sec. 19; Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 282 (1990) (It cannot be disputed that the Due Process Clause protects an interest in life...)

(f) Decedent Plaintiff's right to proper and/or essential medical care upon, amongst others, (a)

Defendants' knowledge of his AML on 12/13/2013 and 03/04/2015, and/or post Decedent's admission to Ben Taub Hospital, and/or post the establishment of a doctor-patient relationship in each hospital visit (b) Decedent's sedation for the bronchoscopies in the 2013 and 2015 hospital visits, (c) Decedent's medication with alopurinol on 03/05/2015 hospital visit, and/or (d) Decedent's injuries sustained from the failed bronchoscopy on 03/06/2015. *U.S. Const. Amd. XIV*; *Tex. Const. Art. 1. Sec. 3a*; *Harris Health System Patient's Rights & Responsibilities* policy; *See also*, *Wideman v. Shallowford Community Hospital, Inc.*, 826 F.2d 1030, 1034 - 1036 (11th Cir.1987) ("That there exists no such general right to the provision of medical care and services by the state, however, does not end our inquiry. Both the Supreme Court and various circuit courts have indicated that the existence of a "***special custodial or other relationship***" between an individual and the state may trigger a constitutional duty on the part of the state to provide certain medical or other services. In these special circumstances, the state's failure to provide such services might implicate constitutionally protected rights… The primary thread weaving these special relationship cases together is the notion that if the state takes a person into custody or otherwise ***assumes responsibility for that person's welfare***, a special relationship may be created in respect of that person, and the fourteenth amendment imposes a concomitant duty on the state to assume some measure of responsibility for the person's safety and well-being… [A] constitutional duty [to provide essential medical care] can arise only when a state or municipality, by exercising a significant degree of custody or control over an individual, places that person in a worse situation than he would have been had the government not acted at all… The key concept is the exercise of coercion, dominion, or restraint by the state. The state must somehow significantly limit an individual's freedom or impair his ability to act on his own before it will be constitutionally required to care and provide

for that person.") (emphasis added). *See also, Whitton v. City of Houston*, 676 F.Supp. 137, 139 (1987) (citing *Wideman*). See also, *Johnson v. Dallas Indep. Sch. Dist.*, 38 F.3d. 198, 200 (5th Cir. 1994) (citing *Wideman v. Shallowford Community Hospital, Inc.*, 826 F.2d 1030, 1035 (11th Cir.1987)). *See also, Cruzan v. Missouri*, 497 U.S. 261, 341 (1990) Footnote 12 ("We have recognized that the ***special relationship*** between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause. See, *e. g.*, *Griswold* v. *Connecticut*, 381 U.S. 479, 481 (1965); *Roe* v. *Wade*, 410 U.S. 113, 152-153 (1973); *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759 (1986).")

(g) Decedent Plaintiff's right against deprivation of his life in violation of prescribed statutory procedures in the second hospital visit. *U.S. Const Amd. XIV; Tex. Const. Art. 1, Sec. 19; See also, Carey v. Piphus*, 435 U.S. 247, 259 (1978) (recognizing that the 14th Amendment procedural due process right protects against "mistaken or unjustified deprivation of life, liberty, or property"); *See also, Cruzan*, 497 U.S. at 280 (1990) (recognizing that procedural due process rights includes, in the situation of an incompetent decedent, a state established procedural safeguards "to assure that the surrogate's action conforms as best it may to the wishes expressed by the patient while competent.").

(h) Decedent Plaintiff's family members' right to consent or withhold consent on Decedent's behalf for Decedent's medical treatment while incapacitated. *Texas Health & Safety Code §313.004(a) & §313.005(b)*; *U.S. Const. Amd. XIV*; *Cruzan*, 497 U.S. at 262. *Id*. at 327 – 328;

(i) Decedent Plaintiff's family members' privacy right to consent or withhold consent to withholding or withdrawal of life-sustaining treatment on Decedent's behalf in the second hospital visit. *Cruzan*, 497 U.S. 261, 271 – 280, (recognizing that due process rights includes

family or surrogates' right to consent or withhold consent to the withholding or withdrawal of life-sustaining treatment for incompetent persons based on clear and convincing evidence of what the patient would exercise it in the circumstances); *Washington*, 521 U.S. at 726 (discussing substantive due process right of family members and intimate family decisions); *Texas Health & Safety Code §§166.004(d) & 166.039(b)*; *U.S. Const Amd. XIV.*

(j) All Plaintiffs' right to Decedent's medical records in compliance with Federal & State Statutes in the second hospital visit. *See Standards for Privacy of Individually Identifiable Health Information*, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. § 164.500 et seq.); *Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the [HITECH] Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules*, 78 Fed. Reg. 5,566 (Jan. 25, 2013); *Harris Health System Patient's Rights & Responsibilities* policy; *Texas Health & Safety Code §166.046(b)(4)(C)*; *U.S. Const. Amd. XIV; Tex. Const. Art. 1, Sec. 3a.*

(k) Decedent Plaintiff's right to life-sustaining treatment until 10 days after both (a) Defendants' written decision to DNR him on or about 08/30/2015 and (b) his medical records that are in compliance with *Texas Health & Safety Code §166.046(b)(4)(C)* are provided to his family members; in the second hospital visit. *Texas Health & Safety Code §166.046(e); U.S. Const. Amd. XIV; Tex. Const. Art. 1, Sec. 3a; Harris Health System Patient's Rights & Responsibilities* policy.

42 U.S.C. §1395dd

Decedent and family Plaintiffs' have Federal Statutory rights outlined throughout 42 U.S.C. §1395dd ("EMTALA"); including but not limited to:

a. right to the necessary stabilizing treatment for Decedent's emergency medical

conditions (e.g. AML, retroperitoneal sarcoma, pancytopenia, etc.) so that within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during (1) Decedent's discharge from the Ben Taub Hospital facility he is in, or (2) Decedent being moved outside the Ben Taub Hospital facility he is in[43]; ***or***

b. right to be discharged from the Ben Taub facility Decedent is in, or moved outside the Ben Taub facility Decedent is in to another facility if said discharge or movement outside the Ben Taub facility Decedent is in to another facility complies with the following[44]:

   i. Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian), after being informed of Ben Taub's obligations under 42 U.S.C. §1395dd and of the risk of discharge from the Ben Taub facility Decedent is in or moved outside the Ben Taub facility he Decedent in to another medical facility, in writing requests discharge from the Ben Taub facility Decedent is in or moved outside the Ben Taub facility he Decedent in to another medical facility[45];

   ii. a physician has signed a certification that includes a summary of the risks and benefits upon which the certification is based, that based on the information available at the time Decedent is (1) discharged from the Ben Taub facility he is in or (2) moved outside the Ben Taub facility he is in, that the medical benefits reasonably expected from the provision of appropriate medical treatment at

[43] *42 U.S.C. §1395dd(b)(1)(A)*
[44] *42 U.S.C. §1395dd(b)(1)(B)*
[45] *42 U.S.C. §1395dd(C)(1)(A)(i)*

another medical facility outweigh the increased risks to Decedent[46]; or

iii. if a physician is not physically present in the emergency department at the time Decedent is discharged from the Ben Taub Hospital facility Decedent is in, or moved outside the Ben Taub Hospital facility Decedent is in to another facility, a qualified medical individual or person acting on the behalf of Ben Taub Hospital, Harris Health System, or Harris County Hospital District, has signed a certification described in clause (ii) above/in the preceding paragraph after a fully licensed physician legally authorized to practice medicine and surgery by the State of Texas, in consultation with the qualified medical individual or person acting on the behalf of Ben Taub Hospital, Harris Health System, or Harris County Hospital District, has made the determination described in said clause (ii) above/in the preceding paragraph, and subsequently countersigns the certification[47]; and

iv. Decedent's movement outside the Ben Taub Hospital facility Decedent is in to another facility constitutes an appropriate transfer[48] – i.e. in compliance with Decedent's rights as dictated in the following subsequent subsection (c).

c. right to "appropriate transfer" – i.e. right to be discharged from or moved outside the Ben Taub facility Decedent is in, to another medical facility after,

i. Ben Taub and its physicians and/or staff provide the medical treatment within Ben Taub Hospitals' capacity that minimizes the risks to the Decedent's health[49];

[46] *42 U.S.C. §1395dd(C)(1)(A)(ii)*
[47] *42 U.S.C. §1395dd(C)(1)(A)(iii)*
[48] *42 U.S.C. §1395dd(C)(1)(B)*
[49] *42 U.S.C. §1395dd(C)(2)(A)*

ii. the receiving facility,

(A) has available space and qualified personnel for the treatment of Decedent[50], ***and***

(B) has agreed to accept Decedent in their facility and provide appropriate medical treatment[51];

iii. Ben Taub hospital and its physicians and/or staff sends to the receiving facility all medical records (or copies thereof) available at the time of the Decedent's movement out of Ben Taub for the sake of his assignment/handover to the other medical facility (e.g. outpatient facility) including records related to Decedent's emergency medical conditions, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, written informed consents, and/or certification that includes a summary of the risks and benefits upon which the certification is based (or copy thereof) from a Ben Taub physician that based on the information available at the time of Decedent's discharge or removal from Ben Taub and assignment/handover to the outpatient or other medical facility, that the medical benefits reasonably expected from the provision of appropriate medical treatment at the other facility or receiving facility outweighs the increased risks to Decedent, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to Decedent while at Ben Taub[52];

[50] *42 U.S.C. §1395dd(C)(2)(B)(i)*
[51] *42 U.S.C. §1395dd(C)(2)(B)(ii)*
[52] *42 U.S.C. §1395dd(C)(2)C)*

iv. the Decedent's movement outside the Ben Taub facility is in to another facility is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the movement outside of the Ben Taub facility Decedent is in to the receiving facility[53]; ***and***

v. which meets such other requirements as the U.S. Secretary of Health & Human Services may find necessary in the interest of the health and safety of individuals/patients transferred.[54]

d. Right to written informed consent to refuse examination and treatment of Decedent's emergency medical condition, after Ben Taub Hospital and its physicians and/or staff (1) offers Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) examination and treatment of his emergency medical condition, and (2) informs Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) of the risks and benefits to Decedent of such examination and treatment.[55]

e. right to written informed consent to refuse to be transferred outside the Ben Taub facility Decedent is in to another facility, if Ben Taub Hospital and its physicians and/or staff (1) offers to transfer Decedent out of the Ben Taub facility he is in and to another facility, (2) the transfer complies with *42 U.S.C. §1395dd(C)*, and (3) Ben Taub Hospital and its physicians and/or staff inform Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) of the

[53] *42 U.S.C. §1395dd(C)(D)*
[54] *42 U.S.C. §1395dd(C)(2)(E)*
[55] *42 U.S.C. §1395dd(B)(2)*

risks and benefits to Decedent of such transfer.[56]

f. right against Ben Taub Hospital and its physicians and/or staff's delay in providing appropriate medical screening examination required under *42 U.S.C. §1395dd(a)* or further medical examination and treatment required under *42 U.S.C. §1395dd(b)* in order to inquire about Decedent's method of payment (e.g. Gold Card) or insurance status.[57]

42 U.S.C. §1985

(2) "… if two or more persons conspire for the purpose of impeding, hindering, obstructing, or defeating, in any manner, the due course of justice in any State or Territory, with intent to deny to any citizen the equal protection of the laws, or to injure him or his property for lawfully enforcing, or attempting to enforce, the right of any person, or class of persons, to the equal protection of the laws; *42 U.S.C. §1985(2)*

(3) "If two or more persons in any State or Territory conspire or go in disguise on the highway or on the premises of another, for the purpose of depriving, either directly or indirectly, any person or class of persons of the equal protection of the laws, or of equal privileges and immunities under the laws; or for the purpose of preventing or hindering the constituted authorities of any State or Territory from giving or securing to all persons within such State or Territory the equal protection of the laws;… in any case of conspiracy set forth in this section, if one or more persons engaged therein do, or cause to be done, any act in furtherance of the object of such conspiracy, whereby another is injured in his person or property, or deprived of having and exercising any right or privilege of a citizen of the United States, the party so injured or deprived may have an action for the recovery of damages occasioned by such injury or deprivation, against any one or more of the conspirators." *42 U.S.C. §1985(3)*

First Hospital Visit

Deprivation of 14th Amd. U.S. Constitutional Equal Protection & Due Process Rights
Equal Protection

The governmental actor Defendants' discrimination against Decedent, by irrationally and arbitrarily withholding and delaying necessary oncology health care services in the first hospital visit, is a violation of Decedent's equal protection rights under these facts and circumstances. *See*

[56] *42 U.S.C. §1395dd(B)(3)*
[57] *42 U.S.C. §1395dd(h)*

Yick Wo v. Hopkins, 118 U.S. 356 (1886)); *Mahone v. Addicks Utility Dist. Of Harris County*, 836 F.2d 921, 932 – 938 (5th Cir. 1988).

In the first hospital visit, Decedent experienced wrongful and irrational discrimination in treatment of his ills including unnecessary delay or withholding of chemo for his diagnosed AML, and withholding of treatment for his diagnosed retroperitoneal sarcoma.

Decedent was already deemed to need chemotherapy 6 days before – i.e. as of 12/13/2013, and said chemo for his AML should have been instituted immediately due to the natural rapid advancement of AML. However, applicable Defendants deemed Decedent's AML, a serious medical condition with serious medical need for chemo treatment, a "medium priority."

Applicable Defendants were deliberately indifferent to Decedent's serious health care needs. They acted with conscious disregard to Decedent's constitutional rights to treatment, his health, and/or his safety by delaying treatment for his AML, and/or disregarding the necessary treatment for Decedent's diagnosed retroperitoneal sarcoma.

It took an unreasonable 6 days delay from the day of his AML diagnosis and notice that Decedent needed chemo for Baylor physicians to order the BAL, an unreasonable additional 4 days delay for the BAL results to return, and an unreasonable additional 4 days before Decedent was given his first chemo treatment. Overall, took an unreasonable delay of 14 days after Decedent's AML diagnosis and notice that Decedent needed chemo, for applicable Baylor Defendants to institute the first stage of chemo treatment.

Meanwhile, Decedent and his family members was anxious for him to begin chemo treatment, and applicable Defendants executed various unreasonable acts to delay or withhold necessary chemo treatment from Decedent – e.g. inquiry as to Gold Card, insurance, and/or payment means, and illegal efforts to enroll him in the Gold Card program which he would not qualify. Also,

meanwhile, the Baylor physicians provided Decedent with blood products to keep him temporarily stabilized as they acted to ensure his payment for chemo treatment.

The physicians were aware of the rapid harm that AML causes. It is documented in Decedent's medical records in both the first and second hospital visit. E.g. In the first hospital visit, Dr. Mims stated that the AML was the most concern of the two cancer treatments he needed. Baylor physicians overseeing Decedent noted both that the AML and his retroperitoneal sarcoma diagnosed on 12/18/2013, and stated "that they would treat the AML first as it was a more aggressive pathology." Hence, the physicians knew, and disregarded the danger of the delay in treatment of the AML. Yet, the arbitrarily kept it as medium priority.

Also, on 03/24/2015 in the second hospital visit, Dr. Mims also stated/admitted/confirmed to Decedent's family "that AML can rapidly progress, i.e. overnight." Considering that AML spreads rapidly, the 14-day delay in providing chemo is clearly unreasonable. Defendants, e.g. Dr. Mims and her team, were more focused on ensuring that Decedent, an African visa holder, would guarantee payment of their services before they would provide him with chemo.

Further obvious evidence of Defendant's wrongful and irrational discrimination against Decedent (i.e., withhold or delay provision of necessary health care/cancer treatments) due to Decedent's race, alienage (visa or foreigner status), origin, and/or age continued in 2014 during the first hospital visit. On 2/11/2014, Dr. William Y. Huang you wrote in Dr. Ohakweh's medical records:

> "Patient currently without gold card, awaiting visa status change, asked him to call me if visa status changes so we can proceed with CXR and other tests." (Exhibit K)

This occurred after Decedent left/was discharged from the hospital after his first set of three necessary sets of treatments. Hence Dr. Huang's position is that the Gold Card was a condition precedent to proceed with chest x-rays and other tests.

Furthermore, the physicians withheld disclosing to Decedent nor his family members of the retroperitoneal sarcoma condition and the need to treat the condition, even with knowledge of its advancement. Meanwhile, they inquired as to Gold Card funding for payment. Such further evidences their wrongful and/or irrational discriminatory actions.

Decedent was given 2 out of 3 stages of hospital inpatient chemo treatments. During his 05/14/2014 hospital admission, it was noted that his AML was in remission post the chemo. It was also noted that he would be seeing the oncology team for treatment of his retroperitoneal sarcoma condition. When he arrived at Dr. Mims' outpatient facility on 06/11/2014, the hematology and oncology specialist and decision maker for cancer treatments, he again faced irrational inquiry as to Gold Card and means of payment. Dr. Mims stated a necessary 06/17/2014 admission for his final stage of Clofarabine and Cytarabine chemo administration that was never scheduled, and that never occurred. Furthermore, Dr. Mims did not address treatment for his advancing retroperitoneal sarcoma.

Simply put, Defendants presumed that because Decedent was elderly, a visa holder (i.e. alien) and not a Harris County resident, of African/Nigeria origin, and lacked insurance, he was poor or could not afford the health care services, and/or was going to leave the country without paying their bill.

Per Sam Mildred, they wanted to be assured of "funding in place" before providing Decedent with the oncology (i.e. cancer treatment) services. In prior encounters, they were even willing to try to coerce him to commit a crime by using a family member's address in Harris County, so that he would qualify for a Gold Card, and they would be assured of funding before providing him with oncology patient services – i.e. AML and retroperitoneal sarcoma cancer treatment services.

As of 06/11/2014 and 06/17/2014, Decedent was a visa holder (an alien); not a Harris County

resident. They knew that he would not qualify for a Gold Card. Therefore, Dr. Mims and her staff never scheduled nor conducted Decedent's final 06/17/2014 admission and AML chemotherapy administration. They also never discussed the retroperitoneal sarcoma as well as treatments for the retroperitoneal sarcoma with Decedent nor his family at any time in the first hospital visit.

Dr. Mims and her staff knew of Decedent's ability to pay since the 12/22/2013 meeting. Decedent fulfilled his financial obligations for their services. Yet, they wrongfully and/or irrationally discriminated against him in the provision of health care services because he was elderly, a visa holder (foreigner/alien) and not a Harris County resident, of African/Nigeria origin, and lacked insurance. They presumed he lacked funds or was poor, and would not pay for their services.

When Decedent was diagnosed with retroperitoneal sarcoma on 12/18/2013, Defendant Dr. Mims withheld this information from Decedent and his family. It required treatment via surgery, radiotherapy, or chemotherapy during the first hospital visit. Without treatment, just as the AML would have cost Decedent his life, the retroperitoneal sarcoma would have also cost Decedent his life if untreated, or added to the injuries that cost him his life. The lack of timely treatment of the retroperitoneal sarcoma actually ended up being a reason Dr. Mims disclosed to Plaintiffs as a reason why Decedent would not qualify for chemo in the second hospital visit, after they injured him.

They physicians wrongfully delayed giving Decedent or instituting protocol or treatment for the necessary chemotherapy, and withheld knowledge of and treatment for the retroperitoneal sarcoma from Decedent and his family. Meanwhile, they provided Decedent with blood products to maintain stability, e.g. "adequate erythrocyte and platelet levels," while (1) they inquired as to means of payment, and (2) worked to assure that payment for health care services were

assured/insured via Gold Card.

The Gold Card[58] is Harris County's healthcare financial assistance for low-income Harris County residents.[59] Decedent was not a Harris County resident in 2013. He was a visa holder, and would not have qualified for the Gold Card.

Decedent would also have fallen in the category of a suspect class or a disfavored minority within the pool of patients at Ben Taub Hospital because he was an alien/foreigner (i.e. visa holder) of African or Nigerian origin/nationality and/or not of U.S. citizen nor Harris County resident. Decedent would also have fallen into a recognized "vulnerable group" that the State has interest in protecting because he was elderly, a Harris Health System hospital patient that possessed a terminal condition (e.g., Decedent's AML and/or retroperitoneal sarcoma), and was presumed poor because he lacked insurance. *Washington*, 521 U.S. at 731 ("Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes.")

Regardless, Decedent as a patient at Ben Taub was entitled to non-discriminatory medical care; even without having insurance coverage. However, applicable Defendants presumed that since he was a foreigner/alien (i.e. visa holder), of African or Nigerian origin/nationality and/or not a U.S. citizen or Harris County resident, and had a terminal condition (AML and/or retroperitoneal sarcoma), he had no money to pay for his necessary treatment or would leave the country without paying for treatment. Hence, they delayed or withheld providing him with necessary chemotherapy for AML and withheld knowledge and treatment for his sarcoma, until they were assured of Decedent's means of payment for current and future health care services. Meanwhile,

[58] pdi.rice.edu/patient-resources/health-insurance/gold-card/
[59] https://www.harrishealth.org/SiteCollectionDocuments/eligibility/policies/financial-assistance-program-policy-5.02.pdf

Decedent's health continued to deteriorate due to applicable Defendants' delay in administering necessary treatment – e.g. chemotherapy, and applicable Defendants' withholding of necessary treatment for his retroperitoneal sarcoma.

Defendants indirectly withheld the necessary chemotherapy treatment, a necessary condition precedent to stabilize his AML condition and a condition precedent to properly or legally discharge Decedent from the hospital – since per Dr. Lin Dai Decedent was diagnosed with AML on 12/14/2013 at the hospital and they knew he needed chemotherapy, until they were assured of payment for medical care. Such is also evidence of applicable Defendants' exercise of dominion, coercion, or control over Decedent's health care and well-being, while Decedent was in their custody.

From 12/14/2013 Dr(s). Ghana Kang, Daniel Wang, Laura Adams, Erika Spuhler, Courtney Chism continuously noted of his visa status and lack of Gold Card for the sake of payment for treatment, during a period that Decedent needed timely induction of chemo. Dr. Mims, Baylor's Chief of Hematology and Oncology, in 12/22/2013 also inquired as to payment for the necessary chemo during her meeting with Decedent and his son. The main topic of discussion was not the AML and the retroperitoneal sarcoma, and the course of treatment for both cancers. Rather, it was in regards to payment for the chemo for the AML only. The retroperitoneal sarcoma was not discussed, even though it was already diagnosed at that time.

Such supports that the delay or withholding of the necessary chemo for the AML, and the withholding of necessary treatment for the retroperitoneal sarcoma, were for wrongful irrational and discriminatory reasons including due to his alienage. It also shows that the physicians leveraged obstacles such as delaying ordering the BAL, delayed results for the 12/18/2013 BAL that took an unreasonable 5 days for the final report, and delaying the induction of chemo, to work

to assure that they were to be paid for the oncology services. After the BAL results arrived on 12/23/2013, it also took to an additional 4 days for Decedent to receive first treatment, while they continued to inquire as to Gold Card and Medicaid.

Defendants knew, and disregarded that Decedent was a visa holder (i.e. alien) from Nigeria, and would not qualify for Gold Card. Although not within the scope of their health care services, hence irrelevant for their physician health care service duties, they were informed that Decedent had funds to pay for the services as of the meeting with Dr. Mims. Yet they continued to delay and withhold necessary oncology/cancer treatment health care services while trying to coerce Decedent into wrongfully applying for Gold Card. Hence, even when they knew, and disregarded that Decedent would not qualify for Gold Card, and even when they were informed that he had funds to pay, they still delayed and withheld necessary health care services including oncology services (i.e. for his AML and for the retroperitoneal sarcoma) from Decedent. They wrongfully, irrationally, and arbitrarily denied treatment of Decedent's cancers until they were guaranteed payment.

Decedent paid out of pocket for the health care services. Yet Dr. Mims and her team still did not provide Decedent with the last stage of chemo for the AML, nor treatment services for the known spreading retroperitoneal sarcoma cancer. Dr. Mims, the oncology and hematology decision maker, had her referral staff inform Decedent of the need for "funding in place" for oncology services. She withheld the last stage of clofarabine and cytarabine Decedent needed, and withheld disclosing necessary cancer treatment services for the retroperitoneal sarcoma.

Dr. Mims and applicable Defendants' discrimination against Decedent was irrational. They were obligated to provide him with non-discriminatory care under Federal – e.g. 14th Amendment U.S. Constitutional Equal Protection clause, State, and local laws, including as the terms of their

co-op agreement, and Harris Health System Policies and Procedures. They irrationally discriminated against him in treatment against Decedent's equal protection rights to non-discriminatory health care services because Decedent was an elderly foreigner/alien (i.e. visa holder), of African/Nigeria origin, and lacked insurance. The discrimination against Decedent because of his national origin or alienage visa status, i.e. a suspect class, is an equal protection clause rights deprivation analyzed under strict scrutiny status. *Graham v. Richardson*, 403 U.S. 365,371-72 (1971) The discrimination against Decedent due to his age and/or race is also a deprivation of his 14th Amendment Constitutional equal protection rights.

Furthermore, the two distinct classes in this case would be (a) Harris County residents without insurance that are patients at Harris Health System health care facilities; and (b) non-Harris County residents without insurance that are patients at Harris Health System health care facilities. Decedent would fall within the second class. The discrimination against Decedent because of his alienage or non-Harris County resident status, by delaying or withholding treatment from him so that they can illegally qualify Decedent for Gold Card, is a deprivation of, amongst others, Decedent's equal protection rights. Such discrimination does not pass rational basis nor strict scrutiny test.

All Ben Taub Hospital or Harris Health System hospital patients are subject to Harris Health System's Patient's Rights and Responsibilities policy. Decedent was within similarly situated individuals – i.e. Ben Taub Hospital or Harris Health System health care facility patients, subject to the Patient's Rights and Responsibilities policy.

Harris County resident patients at Ben Taub, without insurance, and that meet Harris Health System's financial assistance program criteria, would qualify for Gold Card. Visa holders do not because they are not Harris County residents. Daniel Y. Wang and other physicians, Defendants

were aware that Decedent was not a resident of Harris County. They were aware that Decedent also temporarily stayed in Brazoria County. Hence, Decedent would not qualify for Gold Card.

The irrational and wrongful discrimination against Decedent in regards to health care services, because he was a foreigner (i.e. visa holder) or non-Harris County resident, by delaying provision of necessary health care, until they were assured of means of payment for health care services by wrongfully or illegally enrolling or trying to qualify him for the Gold Card, is also a violation of, amongst others, Harris Health System financial assistance program policy, Harris Health System's Patient's Rights & Responsibilities policy, and the 14th Amendment U.S. Constitution Equal Protection Clause.

The disqualification of Decedent from the Gold Card because he was not a resident of Harris County, shows that amongst others, applicable Defendants' discrimination in regards to Decedent's health care treatment or their health care services to Decedent (e.g., their delay or withholding the provision of necessary health care services – including oncology services or chemo – because Decedent was a foreigner/visa holder and/or lacked insurance) does not serve any legitimate state interest. *Village of Willowbrook v. Olech*, 582 U.S. 562, 564 (2000) (discussing "class of one" equal protection U.S. Constitutional rights claim).

The wrongful, irrational, capricious, and/or arbitrary discrimination[60] in treatment of Decedent due to his origin is deterred against by the U.S. Constitution's 14th Amendment equal protection clause, Texas Constitution Article 1 Section 3a equal protection clause, and Harris Health System Patient's Rights and Responsibilities policy. Furthermore, since equal protection of the law also requires that laws be equal on their face, and that they be executed so as not to deny equality, the wrongful, irrational, capricious, and/or arbitrary discrimination against Decedent, a disfavored

[60] deliberate indifference, malicious, knowing, or intentional

minority, based on amongst others, his foreign status, his Nigerian/African origin, his age, and/or his lack of insurance, is protected against by the 14th Amendment equal protection clause per *Yick Wo v. Hopkins*; and actionable under 42 U.S.C. §1983. *Mahone*, 836 F.2d at 932. See also, *Olech v. Vill. of Willowbrook*, 160 F.3d 386, 387 (7th Cir. 1998), affd, 120 S. Ct. 1073 (2000) (holding that equal protection claims also arise when a state or local government official inequitably administers a state statute or local ordinance.)

Baylor physician defendants and HHS staff were, amongst others, malicious, deliberately indifferent to Decedent and his family's constitutional rights, health, and safety. They were conscious of, or recklessly disregarded the consequences of their actions in discriminating against Decedent in regards to health care services, or depriving Decedent of his equal protection rights to essential and/or proper or timely health care services – including oncology services – without discrimination. Without necessary and/or timely examinations and treatments for Decedent's serious medical conditions, they knew that Decedent's medical condition would worsen and he would die. They clearly acted maliciously, knowingly, intentionally, in bad faith, and/or with deliberate indifference.

Baylor physician defendants and HHS staff were amongst others, malicious, deliberately indifferent to the fact that the resulting harm to Plaintiffs, were a highly predictable consequence of their wrongful actions or inactions of depriving of Decedent of his equal protection rights to health care services, including oncology services, without discrimination.

Baylor physician defendants and/or HHS staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent actions in discriminating against Decedent in provision of health care services, subjected or caused Decedent to be deprived of his equal protection rights - i.e. Decedent's right to essential and/or proper/timely health care without discrimination. The

deprivation of Decedent's equal protection rights was a substantial factor that caused the resulting harm/damages to Plaintiffs.

Decedent and his family incurred harm resulting from the Baylor physician defendants and HHS staffs' malicious, knowing, intentional, bad faith, and/or with deliberate indifferent discrimination in treatment; the deprivation of Decedent's equal protection right to non-discriminatory health care services including oncology services. Decedent and his family's resulting harm/injuries include the bodily injury sustained due to the delay or withholding of examination, and/or non-treatment of his AML, pancytopenia, and/or the retroperitoneal sarcoma, mental anguish sustained, anxiety sustained due to the delayed treatment or non-treatments, mental anguish or anxiety due to risk of illegal immigrant status from his visa term, financial harm such loss of income and/or income opportunities, additional unnecessary health care and expenses for said additional unnecessary health care (e.g. blood products needed to maintain adequate erythrocyte and platelet levels until he received chemo treatment). Decedent's and Plaintiffs' other resulting harm from the constitutional rights deprivations are dictated in the "DAMAGES" section of this pleading.

Due Process

The governmental actor Defendants' withholding and delaying necessary oncology health care services in the first hospital visit, is also a violation of Decedent's due process rights under these facts and circumstances. *See Wideman v. Shallowford Community Hospital, Inc.* 826 F.2d 1030 (11th Cir.1987).

Amongst others, upon Decedent's admission to the hospital in December 2013, there existed a special relationship between Decedent and the governmental health care providers per the terms of Harris Health System's Patient's Rights and Responsibilities policy, and the Texas Health &

Safety Code §312.004 Co-Op Agreement; which entitled Decedent to essential health care. Furthermore, since Ben Taub hospital was a medical institution/hospital that received Medicaid or Medicare funding from the Federal government, and subject to patient obligations under 42 U.S.C. §1395dd, there is a special relationship exists between Decedent and the hospital and the BCM physicians.

The special relationship between Decedent and applicable Defendants, since they took custody of Decedent or assumed responsibility for his welfare/health care upon his admission to Ben Taub Hospital and placed Decedent in a worse physical and financial situation than he would have been had Defendants not admitted him at all, executed the various invasive procedures on Decedent, and/or delayed or withheld the necessary health care services from Decedent, entitles Decedent to a due process right to necessary/essential health care. *Wideman*, 826 F.2d at 1034 – 1036. *Johnson v. Dallas Indep. Sch. Dist.*, 38 F.3d. 198, 200 (5th Cir. 1994) (citing *Wideman*, 826 F.2d at 1035) Upon his admission, they took physical custody of Decedent, as well as the duty or obligation to provide Decedent with health care services.

A physician-patient special relationship was also established, along with its required fiduciary duty. Also, Decedent had a right to non-discriminatory health care services including oncology services. Decedent had a right to pay for the services out of pocket. Decedent had a right against being forced to obtain insurance or forced to illegally qualify himself for a Gold Card before receiving oncology services from the physicians. The physicians, in acting out of the scope of their duties to insure funding for the oncology services via Gold Card, before providing necessary oncological services, is coercion as because said physician Defendants were using intimidating behavior and/or threatening reprisal (i.e. withholding or delaying necessary or further necessary health care services including oncology services until they were assured that Decedent was able to

pay – especially since they already provided some health care services) to compel Defendant to act against his will and illegally obtain Gold Card insurance, or provide up-front funding before the services are provided.

The physician defendants' exercise of dominion, coercion, or control over Decedent's health care and well-being, also supports Decedent's due process right to necessary/essential health care, including right to proper/timely induction of chemo for the AML and treatment of the retroperitoneal sarcoma. *Whitton*, 676 F.Supp. at 139.

The way things work is that the physicians provide health care services, Decedent is provided a bill, and Decedent pays the bill. Decedent does not have to provide any upfront proof of funds or assurance of funding as a condition precedent for the physicians provide him with health care services. It is not the duty or responsibility of the physicians to act in ***any manner*** to ensure collection of payment for health care services. Bill collection or securing proof of funds is not within the scope of their duties. Their scope of their duties includes protecting the sanctity of the doctor-patient fiduciary obligations owed Decedent – in compliance with all Federal, State, and local laws.

Since bill collection or ensuring funding for services is not within their scope of duties, there is no rational basis – let alone compelling state interest – to justify the physicians to leverage Gold Card, lack of proof of funds, or lack of insurance issues, (or even his visa status, his nationality, etc.) as any reason to affect the doctor-patient relationship they have with Decedent, breach the doctor-patient fiduciary obligation they owe Decedent, nor deprive Decedent of his constitutionally protected right to privacy or liberty right.[61] Otherwise, the physicians are allowed

[61] See. *Whalen v. Roe*, 429 U.S. 589, 596 - 597 (1977) (recognizing that "the doctor-patient relationship is one of the zones of privacy accorded constitutional protection" but "that individual States have broad latitude in experimenting with possible solutions to problems of vital local concern."); See also Roe v. Wade, 410 U.S. 113 (1973) (recognizing that the doctor-patient relationship is one which

to wrongfully, irrationally, capriciously, and/or arbitrarily exploit the doctor-patient fiduciary relationship, or deprive Decedent's constitutionally protected liberty or privacy right, simply because they are government physicians.

Also, contrary to the cases like *Whitton*, *Wideman*, *Jackson v. Byrne,* 738 F.2d. 1443 (7th Cir.1984), etc., firefighters, policemen, teachers, EMS, and general government employees generally are not in a recognized special relationship with individuals they interact with due to their professional service. They owe no fiduciary duty obligations to said individuals. However, physicians are different, just as lawyers. There is a universal, common-law, and U.S. constitutionally recognized special relationship (i.e. fiduciary duty) between physicians and their patients, and with lawyers and their clients.

Had applicable Defendants transferred Decedent to another health care provider, or had applicable Defendants not admitted Decedent at all, or instituted the invasive procedures on him, Decedent would have gone to another health care provider, received the necessary and non-discriminatory health care that he needed – including chemo within days of diagnosis, and would not have deteriorated to the rate which he did at Ben Taub hospital or incurred the harm that he did while at Ben Taub hospital before Defendants finally instituted chemo treatment on him.

After the invasive paracentesis procedure on 12/13/2013, Decedent was then being transported around with a wheelchair. Decedent had money to pay for the health care services. Rather, physician Defendants in the first hospital visit irrationally and wrongfully withheld necessary health care oncology services from Decedent because, amongst others, they were not assured of funding. They did not transfer Decedent to a medical facility that will provide him with the medical care he needed – e.g., chemo for his AML and treatment for his retroperitoneal sarcoma.

Furthermore, Decedent was at the hospital for months in the first hospital visit, was provided

multiple treatments in the hospital including on 05/21/2014. The physicians knew of his retroperitoneal sarcoma condition as of 12/18/2013, after they did their pelvic biopsies, and did not disclose it to Decedent nor his family. Dr. Mims and the physicians had a fiduciary duty to Decedent to disclose this material information. *Sheets v. Burman,* 322 F.2d. 277, 279-280 (5th Cir. 1963) She nor the physician Defendants acted to treat it via surgery, radiotherapy, or chemotherapy. They withheld the retroperitoneal sarcoma information, and denied Decedent of his right to necessary health care/treatment for the sarcoma, amongst other necessary treatments they denied him. They then later used the sarcoma's existence and their lack of treatment of it, as one of their reasons to arbitrarily deny Decedent of chemo or necessary health care in the second hospital visit. They knew, and disregarded the highly predictable outcome that if Decedent or his family were informed of said retroperitoneal cancer in the first hospital visit, Decedent and his family would have sought treatment for it as well as the AML.

Decedent and Plaintiffs incurred harm resulting from the Baylor physicians and/or HHS/Ben Taub staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent deprivation of Decedent's 14th Amendment due process right to health care services, including oncology services. The deprivation of Decedent and his family's 14th Amendment due process rights was a substantial factor in causing Decedent and his family's resulting injuries including bodily injury sustained due to the delay or non-treatment of his AML and/or the retroperitoneal sarcoma, mental anguish sustained, anxiety sustained due to the delayed treatment or non-treatments, mental anguish or anxiety due to risk of illegal immigrant status from his visa term, financial harm such loss of income and/or income opportunities, additional unnecessary health care and expenses for said additional unnecessary health care (e.g. blood products needed to maintain adequate erythrocyte and platelet levels until he received chemo treatment). Decedent and his family members' other

resulting harm from the U.S. constitutional due process rights deprivations are dictated in the damages section of this pleading.

***

Considering the multiple government health care providers involved, including the Chief hematologist – Dr. Mims, who participated in the delay or withholding of chemo treatment from Decedent for the sake of payment for health care services, while they knew of Decedent's serious medical need, there is evidence that all individuals acted maliciously, knowingly, intentionally, in bad faith, and/or with deliberate indifference to Decedent's serious health care needs, and to his constitutional right to necessary and timely treatment for his health care needs without discrimination, and deliberate indifference to his safety.

Dr. Mims and her physician staff knew of the AML as of 12/14/2015 and stated that he needed chemo. They also knew of the retroperitoneal sarcoma cancer upon their pelvic biopsy result as of 12/25/2015, and failed to address it nor disclose it to Decedent and his family. Even 5 months after the diagnosis of the sarcoma, they were aware of its spread, yet disregarded its disclosure or treatment.

Dr. Mims and her physician staff disregarded the known or obvious current and future consequences (e.g. (a) the worsening of the AML and the requiring of blood products to maintain adequate erythrocyte and platelet levels for Decedent, and (b) the terminal issue/complications/effects due to the lack of treatment of the retroperitoneal sarcoma cancer) of their actions or inactions of delaying the chemo treatment for the AML, and/or of withholding the disclosure and/or treatment of the retroperitoneal sarcoma cancer.

Decedent had money to pay for the health care services. However, Dr. Mims and physician Defendants acted intentionally, maliciously, knowingly, and in bad faith to harm, and/or acted with

deliberately indifferent to his constitutional rights, health, and safety. Defendants' wrongfully malicious, knowing, intentional, bad faith, and/or deliberate indifferent actions were a substantial factor in causing or subjecting Decedent to the deprivation of his due process and equal protection rights to essential and/or proper/timely health care without discrimination, and was also a substantial factor in causing the resulting harm/damages to Decedent.

Baylor physician defendants such as Dr. Mims, and/or HHS staff, were deliberately indifferent to the fact that the resulting harm to Plaintiffs were a highly predictable consequence of their wrongful actions or inactions of depriving of Decedent of his due process right to health care services, including oncology services. They clearly acted maliciously, knowingly, intentionally, in bad faith, and/or with deliberate indifference to deprive Decedent of said rights and cause Plaintiffs the highly predictable resulting harm.

Considering that there was a special relationship between the BCM, HHS, and Decedent, BCM physician defendants and/or HHS staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent actions or inactions that included delaying and/or withholding necessary health care services, including oncology services, even when aware of the highly predictable consequences of their delay or withholding of necessary health care services, subjected or caused Decedent to be deprived of his 14th Amendment U.S. Constitutional due process rights - i.e. Decedent's right to essential and/or proper/timely health care. The deprivation of Decedent's due process rights was a substantial factor that caused the resulting harm/damages to Plaintiffs.

Decedent and his family's resulting harm/injuries include the bodily injury sustained due to the delay or withholding of examination, and/or non-treatment of his AML, pancytopenia, and/or the retroperitoneal sarcoma, mental anguish sustained, anxiety sustained due to the delayed treatment or non-treatments, mental anguish or anxiety due to risk of illegal immigrant status from

his visa term, financial harm such loss of income and/or income opportunities, additional unnecessary health care and expenses for said additional unnecessary health care (e.g. blood products needed to maintain adequate erythrocyte and platelet levels until he received chemo treatment). Decedent's and Plaintiffs' other resulting harm from the constitutional rights deprivations are dictated in the "DAMAGES" section of this pleading.

Failure to Train or Inadequate Training[62]

Alternatively, and/or additionally, the various official hierarchal or staff levels of the health care providers involved, i.e. from residents to Chief physicians, and the various incidents in which they continued to delay or withhold the provision of essential and timely health care to treat Decedent's serious AML and/or his retroperitoneal sarcoma conditions, supports a wrongfully malicious, knowing, intentional, bad faith, and/or deliberate indifferent failure to train, or adequately train the staff by BCM or HHS. A pattern of similar constitutional violations by untrained employees is also ordinarily necessary to demonstrate deliberate indifference for purposes of failure to train.

The continuous violations of Decedent's due process rights to treatment without unnecessary, irrational, or undue delay in the first hospital visit is sufficient enough to demonstrate wrongfully malicious, knowing, intentional, bad faith, and/or deliberate indifferent for the purposes of failure to train. The continuous violations of Plaintiffs' equal protection rights to treatment without discrimination in both hospital visits, are also sufficient enough to demonstrate malice, knowingly wrongful, intentionally wrongful, bad faith, and/or deliberate indifference for the purposes of failure to train. BCM physicians and HHS staff should have been trained or adequately trained in regards to all the Federal, State, and local laws mentioned in this pleading including constitutional

[62] The inadequate training allegation focuses on the deficiencies in the substance of training of the individuals, and not on the format of their training.

laws, §1983, and all the applicable pled federal and state case laws. Such would have provided them with the proper and needed training and knowledge necessary to properly execute their duties.

Per the THSC §312.004 co-op agreement, BCM and/or HHS knew that Federal, State, and local laws including policies and procedures, were material elements to be complied with by applicable all Defendants including all physicians and/or health care providers, during their provision of health care services to patients at Ben Taub Hospital or HHS facilities. BCM and/or HHS decision makers knew that their staff and/or physicians would have to know all applicable laws, policies, and procedures, in order to properly execute their duties during their provision of services at HHS facilities.

The THSC §312.004 co-op agreement also imposed a contractual obligation on BCM to staff HHS facilities with physicians that will provide all health care services in the facilities, in compliance with all Federal, State, and local laws, and for 24 hours a day, 7 days a week. Hence, BCM and their applicable staff, knew that that their physicians should have been trained in regards to all the laws such as the Federal, State, and local laws mentioned in this pleading.

BCM and/or HHS decision makers disregarded the known or obvious consequences of their failure to train or adequately train their staff and/or physicians in regards to the applicable laws, policies, and procedures, and including EMTALA and U.S. constitutional rights of Decedent and other patients at HHS facilities. Amongst others, the constant (a) complaint of Bethrand to the staff and/or (b) the delay or withholding of timely and necessary medical screenings and treatment of his terminal illnesses (e.g. the AML and the retroperitoneal sarcoma) for the sake of payment assurance, provides or should have provided constructive or actual notice to the senior staff and decision makers – including Dr. Mims – of the omission in training of the applicable laws, policies,

and procedures. *See Connick v. Thompson*, 131 S.Ct. 1350, 1360 (2011)

In the second hospital visit, Dr. Mims even stated to Decedent's family "that AML can rapidly progress, i.e. overnight." Per the medical records, the AML was diagnosed on 12/14/2013, and was not promptly treated until 12/29/2013. Hence the BCM and/or HHS executive physicians, e.g. Dr. Mims, knew of the harmful effects of their wrongfully, irrational, unreasonable and/or arbitrary delay or withholding of necessary and timely provision of health care services to Decedent, including for the sake of irrational Gold Card enrollment efforts.

Per the medical records, the retroperitoneal sarcoma was diagnosed on 12/18/2013, after a pelvic biopsy, and was not untreated. Rather, the information was known but withheld from Defendant and his family members until 03/24/2015, after they severely injured him in subsequent hospital visit, then leveraged the retroperitoneal sarcoma cancer condition and their failure to treat it, coupled with the severe injuries they caused him, as reason not to provide him with later chemo treatment.

The medical records and their contents are – or should be – edited by senior staff, stored, and then reviewed by decision makers for compliance and/or risk management purposes. If the records are not reviewed and issues noted to upper management decision makers for compliance and/or risk management purposes, considering that BCM and HHS operate under an educational co-op agreement, such a deficiency in operations is a serious policy and procedure defect/issue, and a deliberate indifferent or malicious, wrongfully knowing, intentional, and/or bad faith policy of inaction that subjects BCM and/or HHS to liability under §1983 for the actions or inactions of their staff. Such policy of inaction in light of notice that the co-op program will cause constitutional violations "is the functional equivalent of a decision by BCM and/or HHS to violate the Constitution themselves." *Id*.

BCM and/or HHS's failure to train or inadequate training of their staff or physicians in regards to the applicable Federal, State, and local laws necessary to properly execute their duties under the co-op agreement, constitutes a deliberate indifference (i.e. conscious or reckless disregard of the consequences of their actions or inactions) to the rights, health, and/or safety of the patients at HHS facilities, including Decedent at Ben Taub Hospital; and evidences a policy of failure to train or inadequate training staff under which HHS and/or BCM are liable under §1983. *See Connick*, 131 S.Ct. at 1359 (citing *Canton v. Harris*, 489 U.S. 378, 388, 109 S.Ct. 1197, 103 L.Ed.2d 412 (1989)). It also evidences malicious, knowing, intentional, and bad faith failure to train.

Aside of its malicious, knowing, intentional, and bad faith nature of the failure to train, said wrongful action or inaction of BCM and/or HHS, and their necessary or applicable departments management, or executive decision makers, in their failure to train or adequately train the applicable health care provider staff – including applicable current or putative Defendants – in the applicable laws necessary to execute their duties, constitutes deliberate indifference to the fact that deprivation of Plaintiff's equal protection and due process rights to health care services including oncology services, as well as the resulting harm to Plaintiffs, are a highly predictable consequence of their wrongful actions or inactions (i.e. their failure to train or adequately train the physicians and other health care providers in regards to the Federal, State, and local laws).

Had BCM and/or HHS trained their staff or physicians in regards to the applicable Federal, State, and local laws necessary to properly execute their duties under the co-op agreement, they would not have subjected Decedent to the deprivation of this 14th Amendment equal protection and due process rights, nor caused said rights to be deprived from Decedent. Also, the resulting harm to Decedent and his family would not have occurred. Decedent would have received the necessary and timely treatment he needed for his conditions, and the hospital and its health care

providers would have been paid.

BCM and/or HHS' malicious, knowing, intentional, bad faith, and/or deliberate indifference in their failure to train or adequate train the physicians and other health care providers in regards to the Federal, State, and local laws, subjected or caused the deprivation of Decedent and his family's U.S. Constitutional equal protection and due process rights, and was a substantial factor that caused the resulting harm to Decedent and his family members. Decedent and his family members incurred harm resulting from the, amongst others, irrational discrimination in treatment – an equal protection rights deprivation, and the deprivation of Decedent's due process right to health care.

Decedent and his family members' resulting harm include bodily injuries, mental anguish, anxiety due to the delayed chemo treatment, exposure to illegal immigrant status due to the limitation of his visa, financial harm including loss of income or income opportunities, health care and expenses for said temporary/ineffective health care provided due to the delay in treatment (e.g. blood products needed to maintain adequate erythrocyte and platelet levels). Decedent and his family members' other resulting harm are dictated in the DAMAGES section of this pleading.

Failure to Supervise

Alternatively, and additionally, the supervising physicians directed the subordinates to take actions that deprived Decedent and his family of their equal protection and due process rights. The supervising physicians also had actual knowledge of their subordinate's violations of the equal protection and due process rights of Decedent and his family, and acquiesced to said violations. Furthermore, BCM and/or HHS supervisors' knowing, intentional, bad faith, and/or deliberate indifference to the highly predictable consequences of their actions and inactions, to deprive Plaintiffs and patients at HHS facilities of their constitutional rights, and/or compromise health

and safety of Plaintiffs and patients at HHS facilities, established and maintained a policy, practice, or custom in their operations at HHS facilities, which directly subjected or caused the deprivation of the equal protection and due process rights of Decedent and his family (i.e. Plaintiffs).

The lack of supervision is clearly evident in the first hospital visit. The lack of supervision subjected or caused Decedent the deprivation of his equal protection and due process rights clearly secured under the 14th Amendment of the U.S. Constitution.

As already argued in sections above, the delay in providing necessary and essential screening and treatment for Decedent's AML, including chemo was a deprivation of Decedent's due process and equal protection rights.

First of all, the lack of supervision that led to the delay in screening and treatment is evidenced by the delay of time it took before the December 2013 BAL was executed. It was executed after Decedent finally saw an oncologist, Dr. Mims, about 5 days after he was at the hospital, and she approved of the BAL screening. Considering that (a) the chief oncologist, Dr. Mims, saw the AML as the most pressing issue at the 12/22/2013 meeting, and (b) on or about 03/24/2015, said Dr. Mims stated to Decedent's family that AML rapidly progresses overnight, had there been proper supervision of the subordinates, Decedent should and would have seen an oncologist within 24 hours of his AML diagnosis. Any necessary and proper screenings would have been timely executed, and Decedent would have been put on chemo. The 12/26/2013 Chemotherapy Orders clearly state Decedent's primary diagnosis as "Acute Myeloid Leukemia / High Risk … (for patients 60 years and older)"

Second, the lack of supervision that caused further delay in the provision of essential health care, e.g. treatment for Decedent's AML via chemo induction, is evidenced by Ghana Kang's adjustment of the dosage and time of chemo induction for Decedent on 12/27/2013, after Dr. Mims

signed off on it on 12/26/2013. Dr. Mims did not initial to approve the dosage adjustment. Per the document, it "must be signed by the service/section chief." Furthermore, per the chemotherapy order sheet, Decedent was to be given the Clofarabine first on 12/26/2015, and the Cytarabine 4 hour after the Clofarabine. It is clear that Dr. Mims and the fellow, Ghana Kang, signed the document on 12/26/2013. Hence Dr. Mims, the supervising and chief of hematology and oncology, approved of the chemo induction dosages. However, per the documents and the fellow's sole initials, Ghana Kang thereafter altered the dosage, time of dosages, and sequence of dosages. Dr. Mims did not approve of the alterations in the documents via her initials. Dr. Mims should have approved of the alterations, at least the dosage and sequence of the alterations. Considering the delay in chemo induction that already occurred, any further delay for the chemo treatment, in light of the rapid advancement of AML, is a serious matter that requires her approval. Ghana Kang does not write any reason for the adjustment of the dosages, sequence, and time of induction. During said period, the Gold Card or proof of funding was still an issue that the physicians were awaiting.

The lack of supervision of BCM physicians also caused the irrational discrimination in health care services that occurred in the first hospital visit, a deprivation of Decedent's 14th Amendment equal protection rights. Had the physicians been supervised, they would or should not have irrationally discriminated against Decedent in regards to provision of health care services, including oncology services. The "funding in place" via Gold Card, Medicaid, etc., should not have been an issue or reason to delay the provision of essential screenings and treatment that Decedent needed for, amongst others, his AML, retroperitoneal sarcoma, and pancytopenia. Decedent would not also have been prematurely discharged, his final third stage of chemo treatment would have been provided, and Decedent would have been properly treated for the

retroperitoneal sarcoma, and the pancytopenia issues. Decedent's visa would also not have been at risk, and the hospital would have been paid for their services.

It is also clear that the supervisors acquiesced to or directed their subordinates' continuous deprivation of Decedent's 14th amendment due process and equal protection rights, and the conspiracy to deprive him of said rights. The continuous delay and withholding of essential health care services from Decedent was clear in the medical records of Decedent since 12/14/2015. The Gold Card issue existed per the medical records from 12/14/2015. Decedent saw various staff and/or supervising physicians since at least 12/16/2015 for a bone marry biopsy. He saw Dr. Mims for the first time on 12/17/2015. Dr. Mims reviewed his medical records and examined Decedent, and clear saw or should have seen the continuous Gold Card issues. By 12/17/2015, Decedent's son was already at the hospital many times inquiring about the delay in chemo induction for Decedent, to which he was met with payment issues responses by the physicians.

The fact that Dr. Mims also inquired as to payment for the AML on 12/22/2015, a matter out of her scope of responsibilities or that should be out of her scope of responsibilities, is also evidence of her acquiescence to the irrational discrimination in treatment due to Decedent's alienage and origin, and a custom of said discrimination via delay in treatment for the sake of payment assurances, within BCM physicians at HHS facilities.

Such custom of practice, as well as the supervisors' acquiescence for such discrimination in health care services, is further evidenced when Decedent was prematurely discharged, and on 2/11/2014, Dr. Huang depended on Decedent's change of visa status to obtain the Gold Card so that the physicians can proceed with the chest x-ray and other tests that he needed. In other words, they delayed or denied Decedent treatment because he was a foreigner and did not have a Gold Card, as he did not qualify for the Gold Card.

Such custom of practice, as well as the supervisors' acquiescence and direction of subordinates, as well as HHS' staff in their participation of the discrimination in health care services, is further evidenced when Decedent went to see Dr. Mims, the oncologist, in the HHS outpatient facility in 06/14/2014. Decedent did not yet have a Gold Card, i.e. their alleged "funding in place" requirement for oncology patients. Hence, not only did Dr. Mims did not treat him for this AML, but she did not disclose to the retroperitoneal sarcoma issue that needed treatment. She was supposed to discuss and begin treatment for said sarcoma issue per the physician's note on Decedent's May 2014 second stage chemo induction. Dr. Mims, one of BCM's chief physicians, rather had the HHS staff social worker discuss with Decedent about their unwritten policy, aka their custom, in regards to funding in place for the sake of receiving oncology services, and then discharged Decedent from the facility. She did not schedule him for the final stage of chemo induction that was to occur on 06/17/2014.

Simply put, BCM's failure to supervise their physician staff at HHS facilities, subjected or caused Decedent and his family to be deprived of their equal protection and due process rights, and was a substantial factor in the injuries they sustained in the first hospital visit. The failure to supervise allegation includes the custom or practice, continuously carried about by BCM physicians at HHS facilities, in which the Decedent was denied necessary examination and treatment for his health care needs, simply because he was from Nigeria/Africa, a visa holder, and lacked insurance. Yet, Decedent had funds to pay for the services, and they knew that (a) Decedent had funds to pay for the services – especially since he always paid out of pocket, and (b) Decedent would not qualify for the Gold Card.

The fact that HHS staff, the social worker, actually stated the need for "funding in place" for oncology services, shows that HHS also allows its staff to participate in the wrongful

discriminatory custom of irrationally denying, withholding, and/or delaying health care services, until assurance of "funding in place."

Had the BCM physicians and HHS staff been supervised, they would not have denied, delayed, and/or withheld treating Decedent for his AML, retroperitoneal sarcoma, and pancytopenia. Decedent would have been timely examined and treated, and would have been discharged after he had been properly treated for his ills.

Also, had BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants, properly screened their applicable staff health care providers prior to their hiring and/or assignment to Ben Taub Hospital and/or the medical unit where Plaintiff was treated, the applicable Defendants and/or HHS and BCM staff would not been hired and/or assigned to the unit or department that resulted in their involvement of Plaintiff's matter.

Had applicable current and/or putative Defendants been supervised and/or evaluated during their hiring and/or assignment in the unit or department that resulted in their involvement of Plaintiff's matter, BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants would have acted to mitigate or deter the violation of Federal law, State law, local law, and/or HHS policies and procedures, that evidently continuously occurred, including in Decedent's case. They would have re-assigned said current or putative applicable Defendants, provided better training and/or oversight of the Defendants, or simply not retain such staff – e.g., Dr. Ghana Kang, Dr. Mims, etc. BCM and/or HHS would or should have also acted to assure that Decedent's rights were not deprived him, and that he was timely and properly provided the examinations and complete treatments that needed for his ills, without discrimination. Decedent would not have been prematurely discharged and

kept out of the hospital.

Amongst others, BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants' their customary practice of failure to supervise the applicable health care provider staff, inclusive of William Y. Huang, Daniel Y. Wang, Martha Mims, and Ghana Kang, during their health care provider activities while at Ben Taub or in Decedent's Ben Taub unit(s), evidences malicious, knowing, intentional, bad faith, and/or deliberate indifference to the rights, health, and/or safety of the patients at HHS facilities, including Decedent at Ben Taub Hospital; and evidences a custom of failure to supervise via malicious, knowing, intentional, bad faith actions or inactions, also evidences deliberate indifference to the constitutional rights of Decedent and/or HHS facility patients by directing and/or acquiescing to their subordinates' deprivation of, or conspiring to continuously deprive the 14th Amendment equal protection and due process rights of patients such as Decedent. Hence HHS and/or BCM are liable under 42 U.S.C. Sections 1983 and 1985. The Section 1985(3) conspiracy exists because, amongst others, the BCM physicians and HHS staff conspired for the purpose of depriving Decedent of his equal protection right to essential health care services treatment without discrimination, and irrationally leveraged intimidation via Gold Car or insurance to execute such; and because Decedent was a foreigner, from Nigeria/Africa, and was vulnerable – i.e. possessed serious or terminal illnesses.

Considering that the physicians boldly wrote all over Decedent's medical records, the financial issues and financial reason for the delay or withholding of essential health care, and even noted that Decedent would not qualify for Gold Card and that they were waiting for him to get his visa so that they could continue providing necessary health care services, shows that the BCM physicians and staff, including HHS staff, are continuously given unchecked authority/lee-way to

wrongfully operate the facilities in violation of Federal, State, and local laws, as well as contrary to the terms of the THSC Chapter 312 co-op agreement. Such custom of unchecked authority also consequently allows the BCM physicians and HHS staff to not only continuously deprive Decedent and/or Ben Taub or HHS patients of his 14th Amendment U.S. Constitutional equal protection and due process rights to essential health care services without discrimination, but also conspire to deprive Decedent and/or Ben Taub or HHS facilities of said rights, especially when the patients and/or their families – like in Decedent's case – question their unchecked authority or wrongful discriminatory and unconstitutional activity.

The malicious, knowing, intentional, bad faith, and/or deliberate indifference action of BCM and/or HHS, their necessary or applicable departments management or decision makers, in their lack of supervision of the BCM physicians customary practice at HHS facilities, subjected Decedent to, or caused Decedent and his family members the deprivation of their due process and equal protection rights guaranteed them under the 14th Amendment of the U.S. Constitution. The failure to supervise issues discussed led to the conspiracy of BCM physicians and HHS staff to subject or cause Decedent to be deprived of said U.S. constitutional rights; especially the moment Bethrand intervened. Rather than fully treating Decedent, the BCM physicians delayed and withheld essential treatment from Decedent, prematurely or wrongfully discharged him, and did not complete his necessary treatments including his third stage of chemo, and disclosure and treatment for his retroperitoneal sarcoma. Rather, the consciously focused on their assurance of funding as the topic of issue.

Said malicious, knowing, intentional, bad faith, and/or deliberate indifferent actions and/or inactions of BCM and/or HHS, their necessary or applicable departments management or decision makers, in their failure to supervise customary practices at Ben Taub hospital and/or HHS

facilities, acquiescing to or participating in the wrongful and unconstitutional actions or inactions of their subordinates and colleagues, and directing the wrongful and unconstitutional actions or inactions of their subordinate health care provider staff – including applicable current or putative Defendants, constitutes a malicious, knowing, intentional, bad faith disregard of their wrongful actions or inactions, and/or deliberate indifference to the deprivation of Decedent and his family's equal protection and due process rights to health care, and the highly predictable consequence of the failing to supervise the subordinates, staff, and the activities at Ben Taub and HHS facilities.

Amongst others, also already mentioned, such irrational delay in treatment in Decedent's case and with his AML condition, constitutes amongst others, a deliberate indifference to constitutional due process and equal protection rights of Decedent – i.e. right to health care services, including oncology services, without discrimination; and subjected or caused Plaintiffs the deprivation of said constitutional rights. The unsupervised BCM physicians' deprivation of said constitutional rights, also were a substantial factor in causing Decedent and his family the injuries complained of. Said resulting injuries, originating from BCM and/or HHS' customary practice (i.e. custom or practice) in failing to supervise their physicians and staff, and its result (i.e. BCM staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent acquiescence to or directing their subordinates to deprive or conspire to directly or indirectly deprive, Decedent of his 14th Amendment U.S. Constitutional equal protection and due process rights), are further detailed throughout this pleading.[63]

Decedent and his family incurred harm resulting from the, amongst others, irrational discrimination in treatment – an equal protection rights deprivation, and the deprivation of

[63] Other 14th Amendment equal protection rights irrationally, capriciously, arbitrarily, and/or unjustly deprived Decedent and his family in the first and second hospital visit, are rights to equal protection of HHS policies and procedures; including those attached in the Appendix to this pleading.

Decedent's due process right to health care – that include bodily injuries, mental anguish, anxiety due to the delayed chemo treatment, exposure to illegal immigrant status due to the limitation of his visa, financial harm including loss of income or income opportunities, health care and expenses for said temporary/ineffective health care provided due to the delay in treatment (e.g. blood products needed to maintain adequate erythrocyte and platelet levels). Decedent and his family members' other resulting harm are dictated in the DAMAGES section of this pleading.

Second Hospital Visit
Material Timeline/Factual Summary For Second Hospital Visit

On 03/04/2015 Decedent arrived again at Ben Taub. The hospital and staff knew that they did not have the necessary or proper staff to attend to Decedent. Decedent was admitted and dumped in the hands of unsupervised, unspecialized, and unqualified health care providers – e.g. Hematology/Oncology resident and fellow, Obstetrics & Gynecology resident, Family Medicine resident, Nephrology Fellow, and fellows.

When possible, the staff physicians even noted the need for specialized physicians for Decedent.

Decedent was admitted to a hostile environment, and was in the hands of inexperienced, untrained, unstaffed, and some unlicensed personnel. At least one identified health care provider, a fellow staff, Dr. Ghana Khan, who was part of the hostile debates between Decedent and the physicians over the delay in treatment (i.e. lack of chemo treatment provided Decedent) in the December 2013 hospital visit, was again present when Decedent was admitted to MICU in 2015.

At a moment, the helpless and unsupervised resident physicians left in charge of his care, e.g. Dr. Uyemura, depended on a pharmacist, a Mr. Sean Riley, to provide Decedent with health care.

Mr. Riley, who was not a trained and fully licensed physician, nor specialist physician, conducted his medical evaluation of Decedent, prescribed, and administered an unnecessary high dosage of alopurinol for Decedent, that led to further harm.

Decedent was in an environment hostile to his safety and well-being, in the hands of inexperienced residents, unqualified health care providers, and without adequate or proper staff and/or supervision. Decedent was discriminated against in regards to the necessary or essential chemo treatment that he needed, and that was entitled to.

They physicians did not seek to stabilize his emergency medical condition (i.e. his AML and retroperitoneal sarcoma cancers, his heart issues, and his thrombocytopenia and pancytopenia conditions). Decedent even informed them of his AML sickness, and they were aware of his AML sickness.

As of the 03/04/2015 day of Decedent' arrival to the ER and his admission, Decedent also informed the resident and fellow physicians, "I think my illness is back." I.e. his AML has relapsed. Per the medical records, on 03/04/2015, the unsupervised MICU health care provider he informed, decided do a bronchoscopy ("BAL") on him. No staff physician approved of the BAL.

Decedent did not consent nor give informed consent to said BAL, Defendants did not obtain such. Decedent returned and sought chemo treatment for his AML. Plaintiffs were still ignorant of this retroperitoneal sarcoma issue and its advancement because Dr. Mims, the Chief oncologist/neurologist withheld disclosure of said information since December 2013 during the first hospital visit.

In the December 2013 hospital visit, when Decedent was diagnosed with AML, Decedent was

discriminated against in treatment, but eventually received only 2 out of 3 stages of chemo treatment after multiple requests and even heated debates for said chemo.[64] He was originally denied or delayed for the chemo. Then after heated debates and unnecessary delay, he received the first stage, and was wrongfully and prematurely discharged. He returned and received the second, was again wrongfully discharged, and was denied the third.

Regardless, rather than planning to execute chemo treatment, and provide Decedent with a cardiologist for his heart issue that was clear upon his arrival in March 2015, the inexperienced and unsupervised staff planned to execute the wrongful BAL. Decedent nor any reasonable person would clearly not have consented to an unsupervised high-risk invasive procedure that could cost him his life to be done on him under such conditions – e.g. by unsupervised residents and fellow physicians; had he been duly and properly informed. Furthermore, no staff physician authorized the BAL.

In the early morning on 3/5/15 a rapid response was called on Decedent due to low oxygen levels, even while he was on an oxygen mask. Decedent was assessed by the team of inexperienced and unsupervised physicians, and the decision was made to escalate his care and transfer him to the MICU and place him on BiPAP, a non-invasive ventilator device that helped with his breathing.

The unsupervised and inexperienced MICU team were now the primary team after Decedent was transferred and thus responsible for making decisions about his care. While on the BiPAP, Decedent showed stable improvement in his respiratory status, however was overall still suffering

[64] In the 2013 hospital visit, the hospital physicians diagnosed Decedent with AML, stated that he needed chemo, but delayed giving him chemo treatment because of his African origin, his lack of insurance, and presumption of his inability to pay. After watching Decedent deteriorate, Bethrand raised a fit for chemo in visits, and informed them that Decedent had money to pay. The hospital then gave him 2 out of 3 necessary chemo treatments. When he had the relapse and returned in 2015, Decedent was a green card holder.

from hypoxemia (i.e. low blood oxygen), and as a result in critical condition according to the inexperienced and unsupervised MICU team.

Acute hypoxemic respiratory failure is a major cause of death for patients with AML in its early stage.[65]

On said 03/05/2015, due to Decedent's respiratory issues, the physicians suggested he be intubated. Decedent agreed to be intubated for the sake of oxygenation, but never signed a consent form. He also never agreed or consented to any BAL.

On 03/06/2015, there was not emergency situations before Decedent was intubated for the BAL. The physicians knew that Decedent needed blood transfusions, and platelets, and withheld said necessary/essential medical care. Rather, the inexperienced and unsupervised BCM physicians prepared to and executed the unnecessary, unsupervised, and high-risk invasive BAL on Decedent, without consent or informed consent; and failed upon intubating him for the unnecessary, unconsented, and unsupervised BAL. They then tried to do a laryngoscopy on Decedent, and failed. Decedent was not sedated at any time before any intubation began.

The failed 03/06/2015 intubation attempt and the failed laryngoscopy, resulted in Decedent bleeding, injury to his vocal chords, loss of oxygen, and more. It also led to the need for and execution of an unsupervised emergency tracheostomy, during which Decedent sustained/endured further significant time without oxygen, suffered cardiac arrest, lung failure, kidney failure, and required resuscitation. He also sustained severe brain injury, amongst others.

Under the circumstances, a BAL was not the proper procedure for Decedent on 03/06/2015.

[65] https://www.atsjournals.org/doi/pdf/10.1164/rccm.201701-0080LE

Per the published medical report from the U.S. National Library of Medicine & National Institute of Health, a BAL for Decedent was unnecessary. The risks outweighed the benefit for an MICU patients like Decedent, who was allegedly experiencing respiratory failure, and had AML.

The 03/06/2015 intubation, which was done for the unconsented BAL, as well as the laryngoscopy and the emergency tracheostomy, occurred without any proper and required supervision, and without consent or informed consent.

In the middle of the traumatic events of 03/06/2015, and right before the unsupervised emergency tracheostomy began, Defendant Van Hoang forged a consent form for the 03/06/2015 BAL, and included endotracheal intubation, biopsy, and other interventions.

The tracheostomy was decided upon, per the unsupervised ENT resident that did the procedure, under a state of emergency created after the traumatic result of the unnecessary, unsupervised, and failed 03/06/2015 BAL attempt, and the failed laryngoscopy attempt.

The fraudulent/forged 03/06/2015 consent form for the alleged BAL, emergency intubation, and more, appears after Decedent was sedated, and lacks the required witness signature. Decedent was not at capacity to give consent or informed consent to the wrongful, unnecessary, and/or unsupervised 03/06/2015 BAL, endotracheal intubation, biopsy, or anything; at the time the document was fraudulently created.

Immediately after the traumatic events on 03/06/2015, the supervising physicians, including a Dr. Guy, then wrote cover-up stories that misrepresented the details, sequence, and activities of the 03/06/2015, in an effort to cover-up their tracks and cover-up the incident. They BCM physicians and HHS staff also quickly acted to discharge Decedent immediately from the hospital,

while everyone came up with and drafted their cover-up disclosures. Supposedly, they were unable to discharge Decedent because his family was not present.

On 03/09/2015, while Decedent was incapacitated, severely harmed, and in an immunocompromised state, the same physician that executed the failed 03/06/2015 failed intubation and BAL, executed another unsupervised BAL on Decedent without consent or informed consent – from Decedent nor his family members. Meanwhile, the physicians and staff had Decedent's family's contact information in their medical records since the first hospital visit. Nobody in their right mind would do such a high-risk invasive procedure on Decedent, nor would they so without consent or informed consent. One can only imagine what occurred in said subsequent BAL or the motive for the procedure. However, such was already a custom and pattern of practice.

The 03/09/2015 BAL report also falsely states that "informed consent was obtained from the patient after explaining the procedure, its risks, benefits, and alternatives." However, Decedent was already incapacitated per the 03/06/2015 BAL and tracheostomy traumatic events when the 03/06/2015 document was forged, and was incapable of giving consent or informed consent to the 03/09/2015 BAL. The physicians had decedent's family member's contact info, yet did not obtain consent or informed consent from them for the 03/09/2015 bronchoscopy.

The signature section of the 03/09/2015 BAL report evidences lack of proper specialized or experienced staff supervision. The signed report of the 03/09/2015 BAL with Dr. Guy as the Pulmonologist and Dr. Van Hoang as the Assisting MD/Fellow states as follows:

I was present during the entire viewing portion of the procedure. I personally reviewed the images and report prepared by the resident or fellow and agree with the findings. After the procedure was completed,
the patient was taken to the recovery in good condition.

This report is considered preliminary unless an electronic signature appears
below.
This Procedure was electronically signed of on :
3/9/2015 9:37:41 PM By Elizabeth Guy M.D.

However, for a 12/19/2013 consented and successful BAL executed by a Dr. Parulekar, and a with Dr. Chris Howard as Assisting MD/Fellow, Dr. Parulekar signed the report for said 12/19/2013 BAL as follows:

I was present during the entire procedure. I personally reviewed the images and prepared the report. Procedure completed.
-This procedure was electronically signed off on: by Amit Parulekar-

Therefore, again, Dr. Guy was not present as required for the 03/09/2015 BAL procedure, which was again wrongfully done without consent or informed consent.

Further evidence showing that the 03/06/2015 fraudulent/forged consent form was a cover-up of the failed 03/06/2015 BAL, is in Dr. Guy's entry in the medical records on 03/09/2015, signed on 03/11/2015 at 6:22am. It discusses the endotracheal intubation events involving Dr. Suresh Manikavel's insertion of the femoral central line.

Procedures by Guy, Elizabeth S, MD at 3/9/2015 10:34 AM Version 1 of 1
Author: Guy, Elizabeth S, MD Service: (none) Author Type: Physician
Filed: 3/11/2015 8:22 AM Note Time: 3/9/2015 10:34 AM Status: Signed
Editor: Guy, Elizabeth S, MD (Physician)
Related Notes: Related Note by Manickavel, Suresh Kumar, Fellow (MD) (Fellow) filed at 3/9/2015 12:13 PM

PCCM ATTENDING NOTE

Date of Service: 3/6/2015

I was present during the insertion of femoral central line, supervised critical portions and immediately available for the rest of it. I agree with the above note by Dr. Manickavel.

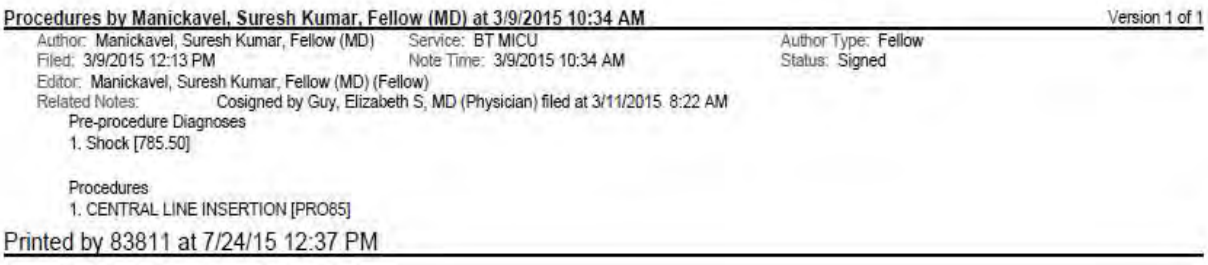
Elizabeth S Guy, MD
Pulmonary, Critical Care, and Sleep Medicine

Electronically signed by Guy, Elizabeth S, MD on 3/11/2015 8:22 AM

Per the Code Sheet created on 03/06/2015 after the traumatic events, if the code sheet is taken

as accurate as to those present during the tracheostomy, she was present for the emergency tracheostomy, and the catheter placement in Decedent's femoral vein. However, the timing of the entry in the medical records, are highly questionable.

Dr. Guy's medical entry for the catheter is on 03/09/2015, three days after the event. Dr. Manikavel's entry in the records that describes the catheter placement on Decedent's right femoral vein, as alleged in the code sheet, is also created three days later on 03/09/2015, and co-signed by Dr. Guy and filed on 03/11/2015.



Procedures by Manickavel, Suresh Kumar, Fellow (MD) at 3/9/2015 10:34 AM Version 1 of 1

Author: Manickavel, Suresh Kumar, Fellow (MD) Service: BT MICU Author Type: Fellow
Filed: 3/9/2015 12:13 PM Note Time: 3/9/2015 10:34 AM Status: Signed
Editor: Manickavel, Suresh Kumar, Fellow (MD) (Fellow)
Related Notes: Cosigned by Guy, Elizabeth S, MD (Physician) filed at 3/11/2015 8:22 AM

Pre-procedure Diagnoses
1. Shock [785.50]

Procedures
1. CENTRAL LINE INSERTION [PRO85]

Printed by 83811 at 7/24/15 12:37 PM

Inpatient Record Adm:3/4/2015, D/C:

Procedures - All Notes (continued)

Procedures by Manickavel, Suresh Kumar, Fellow (MD) at 3/9/2015 10:34 AM (continued) Version 1 of 1

Procedure performed on 3/6/2015

Procedure Performed: Central Venous Catheter Site: Right Femoral Vein

H&P Status: H&P was reviewed, the patient was examined and no change has occurred in patient's condition since H&P was completed.

Ultrasound Guidance: Yes

Primary Indication: medication infusion

Diagnostic Data Review: Non-Applicable

Informed Consent & Time Out: Were obtained and performed as appropriate.

Barrier Precautions & Sterile Technique: As documented in the Pre-Procedure Check List.

Documentation of Procedure: The right femoral area was cleaned, isolated and draped in sterile fashion. The right femoral vein was cannulated with a 7Fr triple lumen catheter under ultrasound guidance using Seldingers technique.

Local Anesthesia: Lidocaine 1% 5ml without epinephrine

Number of Kits Used: 1

Sterile Dressings: Applied

Estimated Blood Loss: Minimal

Specimens Collected: Non-applicable

Specimens Sent: Non-applicable

Follow-Up Chest X-ray: Not indicated

Complications: none

Primary Proceduralist: Suresh Manickavel MD

Supervising Physician: Dr Guy MD

Inpatient Record Adm:3/4/2015, D/C:

Procedures - All Notes (continued)

Procedures by Manickavel, Suresh Kumar, Fellow (MD) at 3/9/2015 10:34 AM (continued) Version 1 of 1

Suresh Kumar Manickavel, MD

Electronically signed by Guy, Elizabeth S, MD on 3/11/2015 8:22 AM

Aside of word of mouth to Decedent's family members, an anesthesiologist disclosure report of the 03/06/2015 events, the ENT resident's disclosure report of the 03/06/2015 event, part of Nurse Hailey's 7:39pm cover-up disclosure, subsequent statements from residents and other physicians – example below from a resident Dr. Uyemura, and a bronchoscopy order by Van Hoang, the only evidence to support that a bronchoscopy was done on 03/06/2015 is the forged consent form.

Electronically signed by Sarkar, Pralay K, MD on 3/12/2015 1:43 PM

Progress Notes by Uyemura, Alison, Resident (MD at 3/12/2015 12:59 PM Version 1 of 1

Author: Uyemura, Alison, Resident (MD | Service: (none) | Author Type: Resident
Filed: 3/12/2015 1:00 PM | Note Time: 3/12/2015 12:59 PM | Status: Signed
Editor: Uyemura, Alison, Resident (MD (Resident)
Related Notes: Cosigned by Sarkar, Pralay K, MD (Physician) filed at 3/12/2015 1:43 PM

Daily MICU Progress Note

Date of Service: 3/12/2015
Time: 12:59 PM

Hospital LOS: 8 days
ICU Day: 8 days

65y.o. male with a h/o AML diagnosed in 2013 and treated with chemotherapy but was lost to follow up, diastolic heart failure, DM2, and hypertension who presented with worsening SOB for the last 2 weeks. Per patient he recently traveled to Nigeria in late February. He stated that from the time he arrived in Nigeria he noticed he was short of breath and it continued to worsen during the 2 weeks he was there. For 2 days prior to admission, he has also noticed nonexertional chest pain that radiates to his back. CXR on arrival revealed diffuse patchy opacities concerning for volume overload and ARDS. CT chest showed mediastinal lymphadenopathy and multiple airspace and interstitial opacities. On the day of admission an RRT was called because the patient had worsening hypoxia and increased work of breathing but he improved after being placed on BiPAP. The patient subsequently became confused so the MICU was consulted for possible intubation given that patient had CO2 of 47.9 and pH of 7.19 on ABG. Patient's repeat ABG improved with a pH of 7.45 and CO2 of 33.3 on bipap. Patient had O2sats at 96% on 45% O2 with bipap.

On morning of 3/6/15, decision was made intubation/bronchoscopy. However, issues arose when patient was attempting to be intubated - very difficult airway. Patient began to decompensate. Oxygen saturations in the 40s-50s. ENT and Anesthesia were called for assistance. Patient had PEA - multiple rounds of compressions received. Patient regained pulse, tracheostomy tube was placed - and was ventilated mechanically.

On afternoon of 3/6/15, patient requiring pressure support with epinephrine and levophed. Patient was started on broad spectrum ABx (Vancomycin, cefepime, clindamycin and levaquin).

Printed by 83811 at 7/24/15 12:38 PM

Dr. Guy's disclosure never stated that a BAL occurred on 03/06/2015, even though the forged consent form bears her name, and per her statement, she was supposedly present at the time Van Hoang ordered the bronchoscopy on 03/06/2015. Subsequent residents and physicians also refer to Dr. Guy as the physician who was present during the 03/06/2015 BAL. For example, amongst others, a resident Dr. Vittone on 07/08/2015, uses Dr. Uyermura and Sarkar's summary above, yet also states that Dr. Guy did the bronchoscopy 03/06/2015.

Progress Notes by Vittone, Veronica, Resident (MD at 7/8/2015 5:41 PM) Version 1 of 1

Author: Vittone, Veronica, Resident (MD) Service: (none) Author Type: Resident
Filed: 7/9/2015 10:18 AM Note Time: 7/8/2015 5:41 PM Status: Signed
Editor: Vittone, Veronica, Resident (MD (Resident)

HOSPITAL COURSE TO DATE, CHART REVIEW

Aphaeus Ohakweh presented to BT in 12/2013 with pancytopenia and was diagnosed with AML with trisomy8 s/p induction chemotherapy with clofarabine/cytarabine in 12/2013. His post-induction marrow showed 7% trisomy 8 by FISH and plan was to give induction chemo again. Then he was lost to follow up for some time. He's now in morphologic remission by BM biopsy on 5/5/14 and admitted for consolidation chemo. Today is actually the last day of his chemo. Medical oncology was consulted for low grade sarcoma in his pelvis that was incidentally found back in 12/2013 when it was decided to focus treatment of AML which would be more life threatening. Repeat scan 5 months later shows the pelvic mass that was initially located in L pelvis is now in R pelvis, but stable in size, raising a possibility of pedunculated exophytic sigmoid gastrointestinal stromal tumor. Pt is asymptomatic.

Chemo hx
-- 12/16/13: AML with 69% blasts -cytogenetics 47,XY,+8[6]/46,XY[14]
-- 12/18/13: Left pelvic mass biopsy:Low grade sarcoma (Spindle cell lesion identified)
-- 12/29/13: He underwent induction : Regimen; Clofarabine 30mg/m2 daily for 5 days on days 1 through 5, cytarabine 20mg/m2 SC daily for 14 days on days 1 through 14. (Stefan Faderl, et al, Blood 1 Sep 2008; 112; 5).Completed clofrarabine on 1/2/14 and completed Ara-C on 1/9/14. Hospital course complicated with Neutropenic sepsis +ESBL proteus s/p ertapenem completed on 1/24/14.
-- 02/04/14: No morphologic disease, karyotype normal but FISH detects 7% trisomy 8
--5/5/14: BMBX: no morphological leukemia (hypocellular sample, no FISH done)
--5/14/14: C#2 clofarabine, ara-c

6/11/2014 Hematology Clinic Note
64 y/o man with AML with trisomy 8; s/p induction with clofa/low dose ara-c in 12/2013-----> CR per BMBx 5/2014. Received Consolidation #1 5/14/14
*__AML with trisomy 8:__
-- cts better; ANC 1000 today
-- we will give 1 more consolidation then bone marrow biopsy to look for residual trisomy 8 per FISH
-- plan to admit pt on 6/17/14. Half sheet filled and given to pt
*__Sarcoma:__
- Appears to be a low grade tumor, not sure this is the cause for the lung nodules
- Would treat AML first as that is the more aggressive pathology
D/W Dr Mims
RTC in 3 weeks with labs

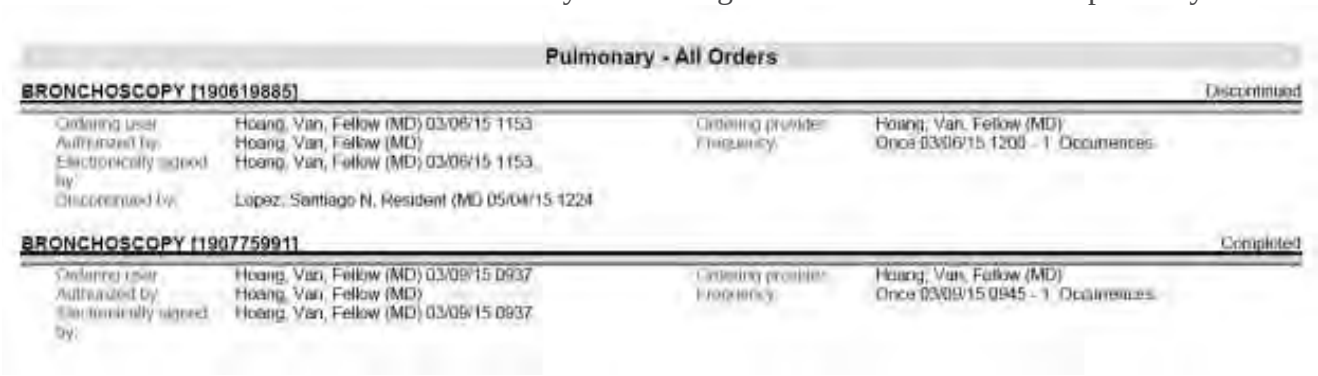
Dr Guerra MICU attending
Dr Guy bronch, intubation 3/6/2015
ENT emergent surgical airway trach 3/6/2015

Printed by 83811 at 7/24/15 12:37 PM

The material details as to e.g. (a) who was present and (b) who did the procedure, of the failed 03/06/2015 BAL does not exist. It is left out of the records, and covered up. The only evidence of the BAL is the forged/fraudulent 03/06/2015 consent form created to cover-up the failed 03/06/2015 BAL, Nurse Hailey's 7:39pm cover-up disclosure, word of mouth to Decedent's family members, the anesthesiologist disclosure report of the 03/06/2015 events, the ENT resident's disclosure report of the 03/06/2015 event, and subsequent statements in the medical

records days and months later after the 03/06/2015 events that allege that a bronchoscopy occurred on 03/06/2015. Most importantly, there is no evidence that a specialized, qualified, or competent fully licensed physician, signed off on a 03/06/2015 BAL, nor was present for it.

The order records, as below, show two total BALs were ordered; one 03/06/2015 and another on 03/09/2015. Both were also authorized by Van Hoang at 11:53am and 9:37am respectively.



Pulmonary - All Orders

BRONCHOSCOPY [190619885] — Discontinued

Ordering user	Hoang, Van, Fellow (MD) 03/06/15 1153	Ordering provider	Hoang, Van, Fellow (MD)
Authorized by	Hoang, Van, Fellow (MD)	Frequency	Once 03/06/15 1200 - 1 Occurrences
Electronically signed by	Hoang, Van, Fellow (MD) 03/06/15 1153		
Discontinued by	Lopez, Santiago N, Resident (MD 05/04/15 1224		

BRONCHOSCOPY [1907759911] — Completed

Ordering user	Hoang, Van, Fellow (MD) 03/09/15 0937	Ordering provider	Hoang, Van, Fellow (MD)
Authorized by	Hoang, Van, Fellow (MD)	Frequency	Once 03/09/15 0945 - 1 Occurrences
Electronically signed by	Hoang, Van, Fellow (MD) 03/09/15 0937		

However, the discontinuing of the 03/06/2015 BAL order by a resident Dr. Sanitago Lopez on 05/04/2015 is another cover-up attempt that was fraudulently done way too late; and an effort to cover-up for Dr. Guerra, who was also implicated by many parties – including Dr. Guy herself – to be the person in charge at that time.

Simply put, per the evidence provided, Decedent *may* have consented to an endotracheal intubation – i.e. oral insertion of a breathing tube, for the sake of his oxygen intake and management of respiratory issues. However, there is no evidence that he nor his family members consented to a 03/06/2015 or 03/09/2015 BAL procedure. There is evidence that an intubation for BAL was done or attempted on 03/06/2015, and failed, and there is evidence that the 03/06/2015 events were done without consent. There is also evidence that the 03/06/2015 procedures were attempted and done by inexperienced, unqualified, and unsupervised staff. Finally, there is clearly

evidence of both forgery and misrepresentations to cover-up the events that occurred on 03/06/2015; amongst others, one being that the wrongful 03/06/2015 intubation was rather done for the unconsented BAL, another being that there was lack of supervision and lack of sedation.

The emergency tracheostomy, which involves cutting his throat open to insert the breathing tube, occurred after the oral intubation for the wrongful BAL attempt, which Dr. Guy called the endotracheal intubation as a cover-up, was done as an emergency situation without proper supervision of Dr. Eicher, the qualified ENT physician. Hence the ENT resident Dr. Kwak, wrongfully executing the emergency tracheostomy without a qualified physician oversight or guidance, "presumed" the position of Decedent's trachea, and also failed in the emergency tracheostomy attempt. Decedent, who already endured loss of oxygen and injuries, went further period without oxygen, sustained cardiac arrest, multiple organ (kidney and lung) failure, and had to be resuscitated.

The medical records contain continuous and multiple misrepresentations of the events that occurred on 03/06/2015, and withholds details of the failed 03/06/2015 BAL. Simply put, everyone couched their stories much later, and seem to try to evade the material facts and events. Others entered cover-up short summaries stories that are not only inconsistent, but exclude details, parties, and sequences.

In general, the medical records contain continuous and multiple misrepresentations. For example, contrary to Dr. Vittone's summary MICU notes entry on 07/08/2015, the decision for the 03/06/2015 BAL was made on 03/04/2015 by resident Dr. Elaine Chang, not on 03/06/2015. The resident physicians then tried to carry it out on 03/06/2015, without getting notice nor consent

from Decedent nor his family.

In summary, the physicians attempted an intubation for a BAL. But Decedent's consent to the intubation was for the sake of respiratory management, not for examination BAL purposes. The intubation for the BAL failed, then a laryngoscopy failed, resulting in the need for a subsequent emergency tracheostomy, that also failed. All because the actors were unsupervised, inexperienced, and unqualified.

Since Decedent did not consent to the BAL, after everyone had time to review the records and get their cover-up stories, the senior absent supervisors and health care providers then wrongfully misrepresented inconsistent versions of the events via their disclosures. They withheld or removed material reports and required disclosures regarding the 03/06/2015 events from the medical records, such as the BAL done without consent.

While covering up their wrongful actions, some of the Defendant physicians and health care providers tried to manipulate or misrepresent their disclosures to paint a picture that (a) Decedent was experiencing respiratory failure with oxygen/breathing issues, and then (b) the physicians went straight to an emergency tracheostomy. The 03/06/2015 BAL procedure details are left out.

Considering that Decedent had a high priority pancytopenia and thrombocytopenia condition, given that he had a low platelet count and was not get given any platelets since his hospital admission, their sequence misrepresentations create a major disconnect by leaving out material details and the existence of the failed 03/06/2015 BAL. With Decedent's pancytopenia and thrombocytopenia issue (i.e. low platelets, hence lack of the ability to form blood clots and rendering him open to non-stop bleeding of his cuts or wounds), resorting straight to cutting

Decedent open to insert a breathing tube would be creating a dire or terminal situation.

They would have to constantly give him platelets so that he could form blood clots in order not to bleed to death from the trachea incision for the breathing tube. Hence any decision to cut him open, knowing that he had pancytopenia and thrombocytopenia, and unable to form blood clots to heal any cuts, would have been a terminal decision; unless it was a last-minute emergency decision per Dr. Suman's report. Yet, said emergency was only created when they already tried to intubate him for the wrongful 03/06/2015 BAL attempt without consent, failed, and tried the laryngoscopy and failed, and Decedent was already bleeding, lost oxygen, and sustained injuries.

On 03/12/2015, Bethrand arrived to see his father unconscious, bleeding everywhere and severely injured. A teaching staff physician is told him to just forget about his father. At this time, Decedent only had anoxic brain injury – i.e. injury due to loss of oxygen to the brain. They provided him with pain medication and minor treatment, but no brain examination nor platelets.

Decedent received platelet infusions on the morning of 03/12/2015, then the following day on 03/13/2015, three days later on 03/16/2015.

On or about 03/25/2015, the staff, after prior discussions, got together and decided to recommend DNR. They got a neuro-physician to see Decedent. The date of evaluation of Decedent postdate the recommendation of said neuro physician. Hence the medical records are inconsistent in the time and date stamps; as if material statements were altered afterwards.

As of 04/1/2015, Defendant physicians and executive staff physicians then tried to coerce or force Decedent's family to give them consent to DNR Decedent. To which they refused. Bethrand was still able to non-verbally communicate with Decedent, but Decedent just could not verbally

respond. However, he could non-verbally communicate and display emotional responses in his responses – e.g. cry. Defendants still executed withdrawal and withholding of life-sustaining treatment. They wrongfully deprived Decedent of necessary and essential health care – e.g. dialysis and pressors – as of early April 2015, without consent or informed consent.

Defendants were required to provide Decedent with a brain evaluation every 7 days at the least, and since 03/06/2015. This did not occur. The first was done on 03/25/2015 or 03/26/2015. The second was done almost three months later on 06/15/2015, the third was done 9 days after the second on 06/23/2015, and the fourth 16 days later on 07/09/2015.

Without provision of necessary and essential care, Decedent continued to deteriorate and, amongst others, accumulate bed sores. Yet he fought for his life and was not deemed irreversible, while the Defendants continued to withdraw life-sustaining treatment from him and deprived him of necessary and essential health care under which he is constitutionally obligated to receive. Also, meanwhile, Defendants were simultaneously trying to force or coerce the family members to give them consent to withdraw life-sustaining treatment from Decedent, to which they refused.

Per the medical records Decedent was not deemed irreversible in writing in his medica records by a physician until 06/23/2015. He was deemed terminal, yet not irreversible, by a hostile physician on 03/27/2015. Therefore, the physicians and Defendants could not begin instituting THSC 166.046 DNR (i.e. withdrawal of life-sustaining treatment) procedures on Decedent until by 06/23/2015.

From 03/31/2015 to about 07/9/2015, Decedent was allegedly still in a minimal conscious state. Per the medical records, Decedent was on a feeding tube but yet was still able to

communicate understanding to treatment plan as of 07/07/2015.

On 07/09/2015, after (a) multiple rejected requests for months from Defendants to the family to consent to withdrawal of life-sustaining treatment to Decedent (b) months of still withdrawing life-sustaining treatment from Decedent against THSC Chapter 166, (c) months of depriving Decedent of his right to constitutionally entitled medical care, and (4) months of perpetuating the harm on Decedent that increased the likelihood of his death, Decedent had his second neuro evaluation and the physician stated that he was then in a persistent vegetative state.

On 07/10/2015, the medical records then indicate that Decedent was the officially deemed as in a persistent vegetative state. On 07/24/2015, the THSC 166.046 Harris Health Ethics Board convened with Decedent's family and Counsel, and sought to coerce them to give consent to DNR. They informed Decedent's family and Counsel that Decedent was going to die eventually. The attending physician stated that Decedent was however breathing on his own without ventilator.

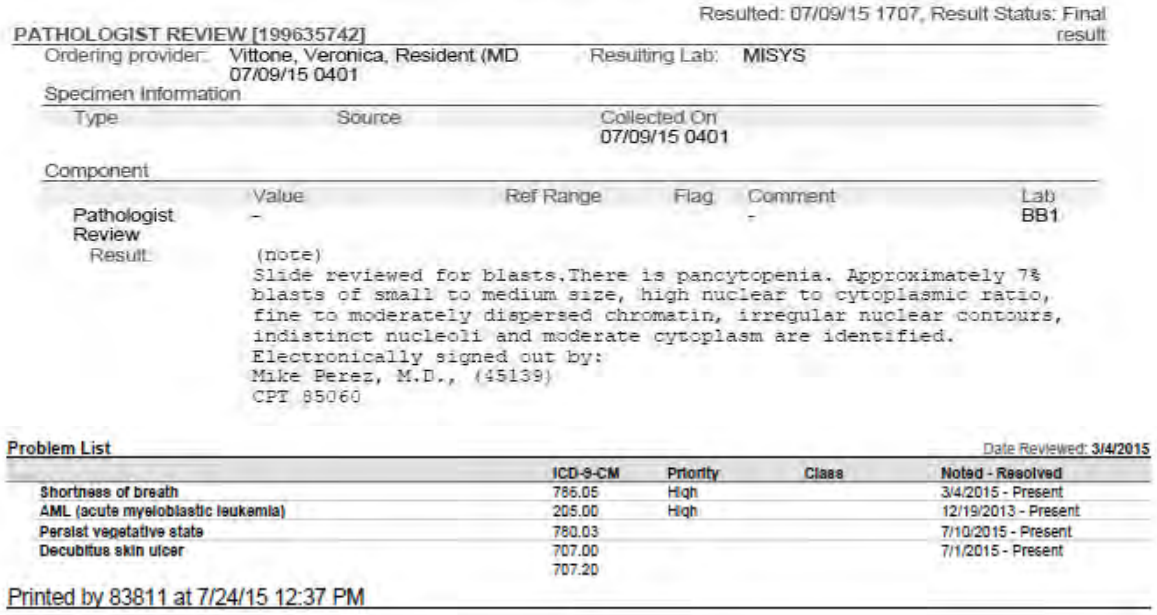
Decedent's family and Counsel refused to give consent to the DNR, and requested the medical records from them. The hospital nor physicians provided medical records in compliance with THSC 166.046(b)(4)(c) nor HIPPA. Furthermore, the 26,003 pages of medical records provided Plaintiffs per their 07/24/2015 request, showed clear evidence that they were tampered with, in violation of Texas Penal Code §37.10(a)(1) and/or §37.10(a)(3).[66] Yet the Defendants still DNR'd Decedent with multiple violations of THSC Chapter 166, multiple violations of his and his family's due process rights, etc.

Decedent suddenly expired on September 07, 2015, after Defendants' receipt of – amongst

[66] Contents were altered, and the verity of the documents were clearly impaired. An example is the 03/04/2015 Problem List below. These 26,003 pages of records were provided Plaintiffs along with a business records affidavit from a HHS records custodian that attested to their supposed authenticity.

others - notice of claim letters/communications from Counsel.

Unfortunately, the misrepresentation in Decedent's medical records continued throughout the second hospital visit until Decedent's 09/07/2015 death. For example, amongst the countless misrepresentations in the medical records, the below problem "Problem List" was reviewed on 03/04/2015. Yet many listed "RESOLVED" problems postdate 03/04/2015; e.g. 05/07/2015. Also, it states Decedent's acute kidney injury and pancytopenia were resolved on 05/07/2015[67] and the chemotherapy issue was resolved on 03/04/2015. Yet, per a pathologist review lab report dated 07/09/2015, Decedent still had pancytopenia as of 07/09/2015.



Resulted: 07/09/15 1707, Result Status: Final result

PATHOLOGIST REVIEW [199635742]

Ordering provider: Vittone, Veronica, Resident (MD 07/09/15 0401 Resulting Lab: MISYS

Specimen Information

Type	Source	Collected On
		07/09/15 0401

Component

	Value	Ref Range	Flag	Comment	Lab
Pathologist Review	-			-	BB1

Result:

(note)
Slide reviewed for blasts.There is pancytopenia. Approximately 7% blasts of small to medium size, high nuclear to cytoplasmic ratio, fine to moderately dispersed chromatin, irregular nuclear contours, indistinct nucleoli and moderate cytoplasm are identified.
Electronically signed out by:
Mike Perez, M.D., (45139)
CPT 85060

Problem List Date Reviewed: **3/4/2015**

	ICD-9-CM	Priority	Class	Noted - Resolved
Shortness of breath	786.05	High		3/4/2015 - Present
AML (acute myeloblastic leukemia)	205.00	High		12/19/2013 - Present
Persist vegetative state	780.03			7/10/2015 - Present
Decubitus skin ulcer	707.00 707.20			7/1/2015 - Present

Printed by 83811 at 7/24/15 12:37 PM

[67] Dr. Kalpalatha Guntupalli, a Pulmonary, Critical Care, and Sleep Medicine licensed physician, and his resident, a Dr. Santiago Lopez, noted the pancytopenia and acute kidney injury during their 05/07/2015 6:13AM evaluation of Decedent in the MICU. Afterwards on 05/08/2015, Dr. Elizabeth Guy took over as the staff physician with Dr. Lopez as resident. Dr. Lopez's 6:17AM Problem list, cosigned by Dr. Guy at 7:38PM, excluded pancytopenia and acute kidney injury. Dr. Guy did state on 05/08/2015 that Decedent "required vasopressor support" (i.e. pressors).

Problem List (continued) Date Reviewed: **3/4/2015**

	ICD-9-CM	Priority	Class	Noted - Resolved
Increased oropharyngeal secretions	528.9			6/4/2015 - Present
PAIN	780.99			5/28/2015 - Present
Air hunger	786.09			5/28/2015 - Present
At risk for spiritual distress	V49.89			5/28/2015 - Present
Sacral decubitus ulcer, stage II	707.03 707.22			5/22/2015 - Present
Feeding by G-tube	V44.1			5/14/2015 - Present
Nosocomial pneumonia	486			5/9/2015 - Present
Bacteremia due to Enterococcus	790.7 041.04			5/9/2015 - Present
On mechanically assisted ventilation	V46.11			5/9/2015 - Present
Hypoxic ischemic encephalopathy (HIE)	768.70			3/28/2015 - Present
HERPES LABIALIS	054.2			3/27/2015 - Present
Candidemia	112.5 995.91			3/27/2015 - Present
Colonization with multidrug-resistant bacteria	V09.91			3/27/2015 - Present
*Goals of care, counseling/discussion	V65.49			3/12/2015 - Present
Acute and chronic respiratory failure	518.84			3/6/2015 - Present
Hypoxia	799.02			3/4/2015 - Present
CHF (congestive heart failure)	428.0			3/4/2015 - Present
Abnormal chest x-ray	793.2			2/11/2014 - Present
HTN (hypertension)	401.9			1/25/2014 - Present
Retroperitoneal sarcoma	158.0			12/25/2013 - Present
DM (diabetes mellitus)	250.00			12/13/2013 - Present
RESOLVED: AKI (acute kidney injury)	584.9	High		3/4/2015 - 5/7/2015
RESOLVED: ALL (acute lymphoblastic leukemia of infant)	204.00	High		3/4/2015 - 3/4/2015
RESOLVED: Neutropenia	288.00	High		12/20/2013 - 5/7/2015
RESOLVED: PANCYTOPENIA	284.8	High		12/13/2013 - 5/7/2015
RESOLVED: Hypernatremia	276.0			4/25/2015 - 5/7/2015
RESOLVED: Hypokalemia	276.8			4/25/2015 - 5/7/2015
RESOLVED: Renal failure	586			3/26/2015 - 5/7/2015
RESOLVED: Chest pain	786.50			3/4/2015 - 3/4/2015
RESOLVED: Thrombocytopenia	287.5			3/4/2015 - 5/7/2015
RESOLVED: CHEMOTHERAPY	V58.11			5/15/2014 - 3/4/2015
RESOLVED: Tinea cruris	110.3			5/15/2014 - 3/4/2015
RESOLVED: H/O malaria	V12.03			5/14/2014 - 3/4/2015
RESOLVED: S/P chemotherapy, time since less than 4 weeks	V66.2			1/25/2014 - 3/4/2015
RESOLVED: Neutropenic fever	288.00 780.61			1/18/2014 - 1/25/2014
RESOLVED: Scrotal mass	608.89			1/18/2014 - 3/4/2015
RESOLVED: Tooth pain	525.9			1/18/2014 - 3/4/2015
RESOLVED: Mucositis	528.00			1/16/2014 - 3/4/2015
RESOLVED: Ulcer mouth	528.9			1/14/2014 - 3/4/2015
RESOLVED: Groin rash	782.1			1/11/2014 - 3/4/2015
RESOLVED: CHEMOTHERAPY	V58.11			12/27/2013 - 1/14/2014
RESOLVED: Adjustment disorder	309.9			12/25/2013 - 12/25/2013
RESOLVED: Emotional stress	308.9			12/25/2013 - 1/25/2014
RESOLVED: Counseling and coordination of care	V65.49			12/22/2013 - 1/14/2014
RESOLVED: Diastolic dysfunction	429.9			12/21/2013 - 3/4/2015
RESOLVED: Abnormal chest CT	793.2			12/16/2013 - 12/20/2013
RESOLVED: Abdominal mass	789.30			12/14/2013 - 12/25/2013
RESOLVED: Pulmonary infiltrate	793.19			12/14/2013 - 1/25/2014
RESOLVED: Neutropenic fever	288.00 780.61			12/14/2013 - 12/20/2013
RESOLVED: Shortness of breath	786.05			12/13/2013 - 12/20/2013
RESOLVED: H/O malaria	V12.03			12/13/2013 - 12/20/2013
RESOLVED: GERD (gastroesophageal reflux disease)	530.81			12/13/2013 - 3/4/2015
RESOLVED: Dry cough	786.2			12/13/2013 - 12/20/2013
RESOLVED: Fatigue	780.79			12/13/2013 - 1/25/2014
RESOLVED: Insurance coverage problems	V60.89	Low		1/25/2014 - 3/4/2015

ED TRIAGE INFORMATION

Arrival	Acuity	Arrival Complaint
3/4/2015 07:22	ESI 2	SOB/CP x2 months worsening over last two days

ED Disposition

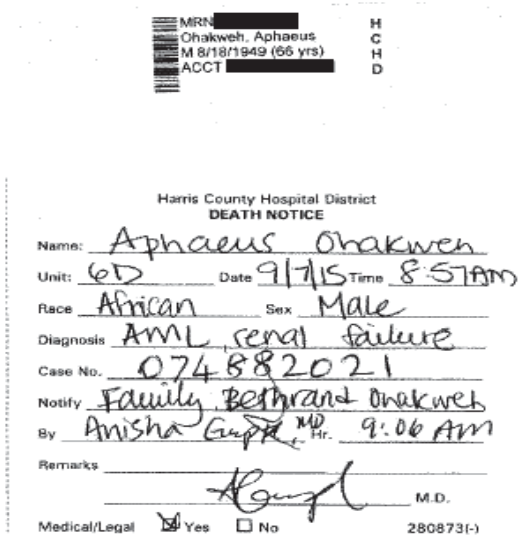
Hospitalization	Anticipated Service: Medicine [58] Accommodation Code: Intermediate (IMU) [10015] Provider Pager/Phone #: 39343 (Core A)	Winograd, Dina, Resident (MD

Printed by 83811 at 7/24/15 12:37 PM

Decedent died of renal (kidney) failure and AML per his death notice. His death certificate included Hypoxic Ischemic Encephalopathy (HIE), and respiratory failure, as well as the renal

failure and AML. The death certificate only lists the AML as the cause of death, and the HIE, renal failure, and respiratory failure as other significant contributions to the cause of death.

Decedent was never examined or evaluated by a cardiologist throughout his period at Ben Taub hospital. The cardiologist knew Decedent was a patient that needed his services.



MRN [redacted]
Ohakweh, Aphaeus
M 8/18/1949 (66 yrs)
ACCT [redacted]
H C H D

Harris County Hospital District
DEATH NOTICE

Name: Aphaeus Ohakweh
Unit: 6D Date 9/7/15 Time 8:57AM
Race African Sex Male
Diagnosis AML, renal failure
Case No. 07488202 1
Notify Family Bethrand Ohakweh
By Amisha Gupta MD Hr. 9:06 AM
Remarks
M.D.
Medical/Legal ☒ Yes ☐ No 280873(-)

Deprivation of 14th Amd. Due Process & Equal Protection Rights

In the second hospital visit that began in March 2015, Decedent – an elder man of African origin, had no insurance nor Gold Card, but again had capacity to pay for the treatment he needed. He even worked to get a Green Card by the second hospital visit, and leased an apartment in Harris County, so there would be no issues in regards to getting him the treatment that he needed and was willing to pay for out of pocket. Yet, the physicians and health care providers wrongfully, arbitrarily, capriciously, and irrationally discriminated against Decedent and his family in

treatment/health care services, thereby depriving them of their clear and secured 14th Amendment equal protection rights. They were also deprived of the substantive due process rights in the second hospital visit – including substantive due process right to consent or withhold consent, and right to essential health care needs, in violation of their 14th Amendment due process rights.

Simply put, amongst others, the physicians discriminated against Decedent and Plaintiffs again, in regards to health care services, including oncology and cardiology services, deprived Plaintiffs of their substantive due process rights to consent to unwanted BAL treatments, further harmed Decedent in their wrongful BAL procedures, withheld necessary treatment on Decedent and prematurely DNR'd him – thereby accelerated making his condition irreversible, misrepresented his condition and health information in the medical records to justify discriminating against him in treatment and depriving him of his right to life and essential health care, and then ***killed*** him a day after six months of inflicting serious injuries on him (e.g. multiple organ failure) amongst others, (a) because he was Nigerian, of African origin, vulnerable, elderly, and/or lacked insurance, (b) to cut their financial or damages exposure, and (c) to justify their premature DNR of Decedent, their misrepresentations, and premature 03/27/2015 qualification of Decedent as terminal for DNR purposes.[68]

Equal Protection

They physicians' discrimination against Decedent and his family (i.e. Plaintiffs) in the second

[68] "Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 is presumed to have a terminal condition for purposes of this chapter. *THSC §166.002(13)*

hospital visit, was again because of, amongst others, (a) Decedent's lack of funding in place – e.g. Gold Card or insurance, and (b) his origin. Such is supported by (1) the history of discrimination against Decedent because of his alienage and origin, and the Gold Card or insurance issues in the first hospital visit, (2) Dr. Wayne Shandera's disclosure on 06/29/2015, "…*no funding with his being Nigerian*…" in the second hospital visit, (3) Dr. Gupta's 09/07/2015 death notice that discloses Decedent as African, and (4) the fact that Decedent needed LTAC hospital services due to the injuries the BCM physicians caused him, but the physicians – *because he was from Nigeria, and he did not have a Gold Card, medicaid, or funding in place* – rather sought to (i) wrongfully, irrationally, capriciously, arbitrarily, and unjustly discharge him home or to a nursing facility at his own expense, or (ii) wrongfully, irrationally, capriciously, arbitrarily, and unjustly DNR or kill him without his nor his family's consent, and in violation of his rights to equal protection of the laws, including all federal, state, and local rights, as well as this U.S. Constitutional substantive due process rights, and procedural due process rights.

Amongst others, as already established in this pleading, the discrimination against Decedent due to lack of funding is a deprivation of Decedent's 14th Amendment U.S. Constitutional equal protection rights that does not meet rational basis test. Also as already established, the discrimination against Decedent because of his origin is a deprivation of Decedent's 14th Amendment equal protection rights that does not pass strict scrutiny, or even rational basis. The State has an interest in protecting life, and the U.S. Constitutional due process to life is a fundamentally protected interest. Furthermore, continuously leaving Decedent in the hands of inexperienced or unsupervised staff is malicious, knowing, intentional, bad faith, and/or deliberate

indifferent discrimination in treatment, especially after they caused Decedent the severe injuries on 03/06/2015. Such clearly also subjected Decedent to elderly abuse, or caused Decedent to be further and continuously tortured or incur severe injuries to his reproductive organs. Interestingly, the physicians – who supposedly conducted physicals on and examinations of Decedent – knew and should have documented and reported the abuse on Decedent. They acted either with malice, knowingly, intentionally, with bad faith, and/or with deliberate indifference to Decedent's constitutional rights, health, and safety, and caused, directed, or acquiesced to the wrongful, irrational, and unjust discriminatory abuse.

Also, amongst others, Decedent's AML, pancytopenia, and retroperitoneal sarcoma were still not treated. Without qualified staff attending to Decedent, and without supervision of the health care providers to whom Decedent was dumped in the hands of, Decedent was used equivalent to medical experiment specimen by unstaffed, unequipped, and inexperienced health care providers – some acting out of the scope of their duties. Meanwhile, the attending staff and specialist physicians who are obligated to be present and oversee the actions of the residents and fellow level health care providers in Decedent's matter, disregarded their duties/obligations with malice, knowingly, intentionally, in bad faith, and/or deliberate indifference Decedent's serious health care needs, his constitutional right to necessary and timely treatment for his health care needs without discrimination, his health, and his safety.

Amongst others, Dr. Fisher falsely stated during and for the sake of DNRing Decedent against his and his family's wishes, that since 04/01/2015, Decedent did not need dialysis. Yet (a) Decedent had kidney injury and failure from the 03/06/2015, (b) the wrongful and discriminatory

treatment actions or inactions of the physicians had exacerbated Decedent's kidney injury and failure, (c) Decedent was requiring dialysis almost every other day, (d) the Nephrologist team on 04/02/2015 even stated that Decedent was unable to be taken off dialysis, and there was no evidence of renal (kidney) recovery, and (e) at the 04/01/2015 meeting with the family where the physicians tried to get the family to consent to DNR, the family stated that they still wanted him to receive all necessary treatment, and informed the physicians that their father was a fighter who would have wanted everything done to keep him alive. Therefore, Dr. Fisher's statement was not only clearly false, but arbitrary, capricious, and irrational discrimination against Plaintiffs for the sake of DNR'ing Decedent, depriving Plaintiffs of their 14th Amendment equal protection and due process rights; and amongst others, further the conspiracy to deprive Plaintiffs of said rights.

The fact that with Decedent's oxygen, heart based, and low blood oxygen issues, BCM physicians never provided Decedent with a cardiologist for evaluation and treatment, is further clear evidence of the continuous malicious, knowing, intentional, bad faith, and/or deliberate indifferent discrimination that Decedent endured while at Ben Taub hospital. They knew and documented all over the records, that most of Decedent's issues were oxygen and blood circulation based; with many – including his brain issue – consequent to the 03/06/2015 cardia arrest. Decedent arrived complaining of shortness of breath. His medical records problem list included hypoxia from 03/04/2015. The residents and subsequent physicians that reviewed the resident's records, saw the hypoxia and the volume overload both noted multiple times in the medical records since 03/04/2015 and thereafter. A cardiologist only reviewed Decedent's electrocardiogram, but never saw Decedent. Decedent tested negative for any cardiovascular issues in 12/13/2013 per Dr.

Vishal Delman. Decedent's assigned care team included cardiology as of 03/18/2015. Yet, Decedent never saw or was not provided a cardiologist throughout the second hospital visit; even after the cardiac arrest events on 03/06/2015. Rather, the brain physician evaluation provided Decedent, was (1) after their conspiracy to DNR Decedent began, and/or (2) for the sake of their conspiracy to DNR. The first and chief neurologist, Dr. Kass, saw him once. Thereafter, Decedent next saw an unsupervised neurology resident about a month or so later. The same Dr. Kass was part of HHS ethics board advocating to wrongfully DNR Decedent against Plaintiffs' consent.

The physicians did not want to treat Decedent in the first hospital visit and discriminated against him. They denied him full treatment for his ills, and knew that he would sustain injuries due to the incomplete treatment. Dr. Mims knew that on 06/11/2014 when he mentioned the 06/17/2014 admission that never occurred. When Decedent returned in 03/04/2015, the physicians did not want to treat him, and did admit him in good faith. Although a U.S. and Harris County resident, he did not have a Gold Card. They continued to irrationally and unjustly[69] discriminated against him in regards to necessary essential care – e.g. anesthesiology, cardiology, and oncology services – that they knew that he needed. Decedent was an exploited patient for, amongst others, the benefit of inexperienced and unsupervised physicians.

Simply put, considering that AML rapidly expands in the body overnight, Decedent should have immediately seen an oncologist when he arrived at the hospital on 03/04/2015. Also, considering that his problem list included both hypoxia and AML, Decedent should also have seen a cardiologist after the chest x-rays post the late night 03/04/2015 rapid response breathing event,

[69] Without a compelling state interest, or even a rational basis…

and after the chest x-rays showed "volume overload," after his electrocardiogram was interpreted to include sinus tachycardia and abnormal rhythm ecg. The MICU physicians and all physicians involved in Decedent's care had a duty to request the full consult of Dr. Lakkis, or a cardiologist – both on 03/04/2015 and thereafter. Dr. Lakkis himself knew Decedent was a patient that needed his services, but never went and saw and examined Decedent. Furthermore, Decedent should have been given blood transfusions and platelets on 03/06/2015 before any intubation if said intubation was necessary. Rather, they irrationally and unjustifiably continuously discriminated against Decedent in regards to health care services, and continuously denied him his due process rights, by having Dr. Lakkis only review and interpret his electrocardiogram reports, and do so without seeing or examining Decedent.

Furthermore, they withheld necessary blood transfusions and platelets, and withheld sedating him before the wrongful and unsupervised 03/06/2015 intubations and BAL attempt done without consent. They had knowledge of his condition, and deteriorating state, and still withheld the blood transfusions and the platelets before the wrongful intubation. They also had knowledge of the need for anesthesia before the intubation, and still withheld said sedation/anesthesia services before the wrongful intubation. The physicians, amongst others, irrationally, capriciously, and unjustly discriminated against Decedent in provision of health care services; and deceptively[70] exploited Decedent for, amongst others, the benefit of inexperienced and unsupervised physicians; to the deprivation of Decedent's 14th Amendment U.S. Constitutional equal protection rights, as well as his 14th Amendment due process rights.

[70] Decedent even signed a consent form for the blood transfusion, that was withheld.

Everyone's cover-up story and misrepresentations, are further evidence of denial of Decedent and his family's equal protection right against arbitrary, unjust, and/or capricious discrimination in treatment or essential health care services, right to doctor-patient fiduciary obligations, right to candid disclosure of all that occurred, and right to proper redress per Federal, State, and local laws including HHS policies and procedures.[71]

Amongst others, the BCM physician staff disregarded the known or obvious current and future consequences (e.g., the worsening of Decedent's terminal heart condition, the worsening of his terminal AML condition and his death without chemo, the worsening of Decedent's condition and death from the pancytopenia, the worsening of Decedent's condition and death from the retroperitoneal sarcoma, and death) their discriminatory actions or inactions of, amongst others, (i) delaying or withholding the chemo treatment for the AML, the pancytopenia, and the disclosure and/or treatment of the retroperitoneal sarcoma cancer (ii) delaying or withholding treatment for the multiple organ failure – including dialysis, and (iii) withholding necessary anesthesiology and oncology services, and cardiology evaluation and treatment for his alleged heart and respiratory issues.

[71] It is worth noting that any of BCM or HHS' policies and procedures, customs and/or practices that authorizes health care providers including physicians to make entries in the medical records of patients hours after such an event, procedure, operation, etc, or any policies, procedures, custom and/or practice that does not preclude or deter against said late entry, or that does not require entry of preparation, pre-operation or pre-procedure disclosures, assessments, evaluations, etc., is unconstitutional on its face and as applied; and is a tool used to subject or cause Plaintiffs to be deprived of their equal protection and due process rights and cause them harm; and a tool used to cover up the deprivation of constitutional rights, impede, hinder, obstruct, or defeat the due course of justice within Texas and the United States, with intent to deny Plaintiffs the equal protection of the laws, or injure Plaintiffs for lawfully enforcing or attempting to enforce their rights to have authorities investigate and press criminal charges, and impedes, hinders, and/or obstructs their Texas State open court rights, due course rights, and their Federal access to courts/petition rights, equal protection rights, and due process rights, and cause them harm.

The physician staff also knew or disregarded the obvious consequences their discriminatory actions or inactions of, amongst others, (a) executing the evaluations and treatments of Decedent upon his 03/04/2015 admission without qualified staff supervision, (b) withholding platelet and blood transfusions on 03/06/2015, (c) withholding sedation and anesthesia services, (d) executing the 03/06/2015 and 03/09/2015 BAL without consent or proper supervision, (e) executing the ongoing evaluations and treatments of Decedent after the 03/06/2015 traumatic events without qualified or proper staff supervision (f) executing the withholding or withdrawal of life-sustaining treatment from Decedent without consent and/or without qualifying Decedent as terminal or irreversible pursuant to §166.031(2) and Harris County Hospital District's Medical Staff Rules and Regulations, (g) continuously denying or withholding essential health care services from Decedent including oncology and cardiology services, and (h) withholding or failing to provide Decedent's family with records in compliance with THSC §166.046(b)(4)(c) while simultaneously withholding and withdrawing life-sustaining treatment from Decedent without consent.

Furthermore, the fact that the BCM physicians and HHS staff conspired and acted to discharge Decedent right after the 03/06/2015 events, then conspired and rushed to DNR decedent and kill him rather than place him in LTAC for ongoing care of the injuries they caused him, and conspired and acted to do so simply because he was because he was from Nigeria, and he did not have a Gold Card, Medicaid, or funding in place, is a deprivation of his equal protection right to essential health care services without discrimination.[72]

Since the rights deprived affect a fundamental interest that the state has an interest in

[72] Other 14th Amendment equal protection rights irrationally, capriciously, arbitrarily, and/or unjustly deprived Decedent and his family in the first and second hospital visit, are rights to equal protection of HHS policies and procedures; including those attached in the Appendix to this pleading.

protecting, such as right to life and right to consent or withhold consent to the BALs and DNR, the malicious, knowing, intentional, bad faith, and/or deliberate indifferent actions of BCM and HHS staff does not pass strict scrutiny. Amongst others, the fact they discriminated against him because was from Nigeria, is unconstitutional national origin based discrimination, that also does not pass strict scrutiny since (a) they caused him the injuries that led to the need for LTAC, there is a special relationship, and he is therefore entitled to essential health care; and (b) their end goal of their wrongful discrimination results in the wrongful deprivation of one of the highly protected fundamental rights – right to life. Also, the fact that they discriminated against Decedent for the sake of funding, including after they harmed him on 03/06/2015 and rushed to discharge him, when Decedent had a right to essential health care, passes neither rational basis nor strict scrutiny.

Finally, BCM and HHS staff, managers, decision makers, and/or executives' clear arbitrary enforcement of HHS' applicable policies and procedures, and terms of the THSC §312.001 co-op agreement in regards to Plaintiffs and/or patients at HHS, or the unchecked arbitrary authority allowed BCM and HHS staff by BCM and HHS managers, decision makers, and/or executives in maliciously, knowingly, intentionally, with bad faith, and/or deliberately disregarding the policies and procedures in the operations at HHS facilities, is clearly an irrational and unjustified deprivation of Plaintiff's equal protection rights. Such also constitutes, amongst others, a deliberate indifference to Plaintiffs' constitutional rights, health, and safety; and in some circumstances, meets the "shocks the conscience standard." It's equivalent to knowingly, intentionally, maliciously, and with bad faith, disregarding the highly predictable wrongful outcomes of the deprivation of Plaintiff, including Decedent's equal protection right to treatment

without irrational, arbitrary, unreasonable, and/or invidious discrimination; as well as consequence of the prevalent custom or practice of BCM & HHS's failure to enforce policies and procedures, and/or the prevalent custom or practice of BCM & HHS's failure to train or supervise the staff to ensure compliance with the policies and procedures. The applicable policies and procedures are discussed in further detail in this pleading.

Due Process

Amongst others, the 03/04/2015 resident evaluation, e.g. Dr. Chang, of Decedent upon post his admission resulted in the proposal/recommendation and preparation for the 03/06/2015 BAL. The evaluation was done without proper staff oversight. There was no notice to or consent from Decedent or his family for the 03/06/2015 BAL, nor the 03/09/2015 BAL. Decedent only consented to an endotracheal intubation per Dr. Weei-Chin Lin. The intubation was for the sake of his respiratory issues. Dr. Weei-Chin Lin never stated that Decedent consented to a BAL. As of 03/05/2015 Dr. Lin actually stated that Decedent sought treatment for his AML and was willing to prescribe him Decitabine – a chemotherapy medication. Decedent should have been given blood transfusion and platelets, then if necessary, intubated by a qualified physician or under the proper supervision of one, and then immediate induction of chemo executed by an oncologist professional. Such would have complied with Decedent's AML treatment choice or decisions.

The high-risk BALs were prescribed and executed without consent or proper required supervision. They resulted in severe bodily injuries to Decedent, that were a substantial factor in

causing his death.[73] Such is evidence of the wrongful, capricious, arbitrary and irrational discrimination against Decedent and his family's in regards to health care services. They had a substantive due process right to consent or withhold consent to the 03/06/2015 and 03/09/2015 BAL, and were irrationally denied said rights.

Furthermore, in regards to their due process right to consent or withhold consent to treatment, common knowledge doctrine applies to consent to treatment, because it is a fundamental right known by all mankind that one need consent before invasive procedures or invasion of their body. The consent for the 03/06/2015 & 03/09/2015 BAL, high-risk invasive procedures, require consent or informed consent. Furthermore, the DNR of Decedent requires consent or informed consent. Such is standard substantive due process rights. Expert witness is not necessary to prove such.

Bethrand's affidavit states that the signature on the 03/06/2015 consent form is not Decedent's signature. When the head anesthesiologist, Dr. Suman, arrived in the emergency situation created after the failed 03/06/2015 BAL, she stated "**verbal consent was not obtained**," nor "**written consent obtained.** Such supports that there was no consent or informed consent to the failed 03/06/2015 BAL procedure. An anesthesiologist is required to be present for the BAL procedure.

The unwitnessed consent form, created by Van Hoang, was a means to hide the non-consent or non-informed consent to the 03/06/2015 failed and unsupervised BAL, that then caused the need for the emergency tracheostomy. The fact that it is time stamped 10:10am and unwitnessed is troubling. For it to be valid per HHS policies and procedures on "Consent for Medical Treatment,"

[73] On 03/16/2015, after the results of the 03/09/2015 BAL returned, the same Martha Mims from the first hospital visit, in charge of AML, stated "the family - I know the son from the last hospitalization. I don't think there is much we are going to be able to do for his AML." Decedent's AML was one of the listed causes of his death, per the 09/07/2015 death notice.

there must be a witness signature from someone other than the physician(s) who performed the medical/surgical procedure.[74] The 12/2013 BAL consent document met all requirements including a witness signature. Decedent also provided informed consent to a blood transfusion at 8:00am on 03/06/2015. The informed consent form for the blood transfusion was properly executed (i.e. signed and witnessed). The physicians planned and tried to execute the BAL, without approval from Decedent, since 03/04/2015 via Resident Dr. Elaine Chang. No attending physician authorized a 03/06/2015 bronchoscopy or BAL.

Per Dr. Suman she arrived after the unsuccessful intubation attempt by the inexperienced and unsupervised MICU team. She does not state that Dr. Guerra or Guy was present for the prior intubations. She then states that Decedent was already experiencing low oxygen levels upon her arrival, and that the MICU team reported had difficulty in ventilating Decedent with a bag valve mask, but they were able to do so orally and manually with two hands. Again, this is signs of their inexperience and lack of supervision. She then states that Decedent was then sedated for the first time, there was no improvement in in his oxygen levels, then they decided to intubate Decedent given his acute respiratory distress syndrome situation.

It is logical that the intubations for the 03/06/2015 BAL attempt would be unsuccessful. (A) The MICU team Decedent's care was left in their hands were unsupervised and inexperienced; (B) Decedent did not consent to the BAL; and/or (C) Decedent was not sedated at all prior to said wrongful intubation attempts.

There is evidence to support that the MICU physicians withheld sedating him. Fentanyl was

[74] See Note in §I(B)(2), *Consent For Medical Treatment, Harris County Hospital District Policy & Procedures Manual, Policy No. 4215, Effective 12/07/2006.*

ordered at 8:46am and cancelled a minute afterwards. Per Nurse Eke, Decedent was "chatting it up" before he was taken to the operating room for the 03/06/2015 bronchoscopy procedure. Hence, there was no emergency situation before the 03/06/2015 vents began for the planned elective bronchoscopy intubation, and he was not sedated yet. Furthermore, Decedent was "fighting vent." Hence, his body was resisting the oxygenation tube, as he was not sedated or properly sedated. Finally, the anesthesiologist who should have been in charge of the sedations (i.e. order and administer sedatives and protocol), was not called in or present until after multiple failed wrongful attempts, and after Decedent was already harmed. She could not list all the sedations ordered.

Decedent had experienced a BAL on 12/19/2013, and knew that it entailed putting an apparatus in his body and taking samples. Decedent never consented to a BAL in the second hospital visit. He may have consented to an endotracheal intubation for the sake of oxygenation for his respiratory issues (e.g. his shortness of breath), but he clearly did not consent to a BAL. Furthermore, he did not consent to an unsupervised procedure. Decedent, or anyone with common sense, would not have consented to such high-risk procedure that required proper preparation, supervision and sedation, to be done without such proper supervision, sedation, and/or preparation – including being given platelets beforehand.

The intubation for the wrongful BAL was forced upon him, without his consent. After they failed, they *then* decided to intubate him for the sake of his acute respiratory issues. By then, Decedent had already lost oxygen and was severely harmed. They then tried to provide him with oxygen via a failed and unsupervised emergency tracheostomy by an inexperienced ENT physician, during which Decedent sustained cardiac arrest, multiple organ failure, etc. After

Decedent was revived and finally oxygenated post the emergency tracheostomy, the physicians *still* executed a bronchoscopy on Decedent on said 03/06/2015, and the full out unconsented BAL three days later on 03/09/2015.

Aside of the evidence that the 10:10am 03/06/2015 BAL informed consent form is fraudulent, i.e. alleged to be obtained in violation of Texas Penal Code §32.21(1)(A) including §32.21(1)(A)(i) and/or §32.21(1)(A)(i), the consent form evidences an issue even troubling within the Courts. See also, *Earle v. Ratliff*, 998 S.W.2d 882, 891 – 892 (Tex. 1999) ("… it permits the presumption of proper disclosure to be rebutted only by showing the invalidity of the consent form, such as by proof that the patient's signature was forged, or that the patient lacked capacity to sign.").

OHAKWEH,APHAEUS **Scan on 9/11/2015 by Jamilosa, Andrew C [103872] of DISCLOSURE AND CONSENT FOR ME**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Dr. Gay as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: respiratory failure

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedure(s): endotracheal intubation, bronchoscopy with bronchoalveolar lavage, biopsy and other interventions

3. I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

4. I (we) (do not) consent to the use of blood and blood products as deemed necessary.

5. I (we) understand that any tissues, organs, parts surgically removed or medical waste not utilized will be disposed of by the Harris Health System in accordance with its accustomed practice.

6. I (we) understand that no warranty or guarantee has been made to me as to result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

8. I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

9. I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

10. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

11. I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

Date 3/6/2013 Time 10:10 AM/PM

Patient / Other Legally Responsible Person's Signature

Physician/Authorized Provider Signature / Title / ID # Vanessa Hwang MD 56376

Witness/Healthcare worker Signature / Title / ID #

FOR INTERPRETATION ONLY

I provided interpretation for (name of patient or responsible person) _____. I certify that I can read and speak the _____ language and the English language fluently. I further certify that the interpretation I provided was accurate, that the patient verbalized understanding of the information contained within this form and had the opportunity to ask questions and have them answered. I also acknowledge that the matters discussed are confidential and agree to maintain the confidentiality of any communications concerning (patient's name) _____ as provided by the laws of the State of Texas.

Interpreter's Name or Signature & ID #	Title	Department	Address
Witness's Name or Signature	Address		City, State, Zip Code

Patient ID

HARRISHEALTH SYSTEM

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Retention: HR-4800-04 280331 (11/13)

PAGE 1

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 59092

OHAKWEH,APHAEUS Scan on 9/11/2015 by Jamilosa, Andrew C [103872] of DISCLOSURE AND CONSENT FOR ME

Risks and Hazards

The following are the risks and hazards associated with treatments and procedures established by the Texas Medical Disclosure Panel. Full disclosure of these risks and hazards is required by the physician or health care provider to the patient or person authorized to consent for the patient.

1. Administration of blood and blood products

☒ Transfusion of blood and blood components.
a) Fever.
b) Transfusion reaction, which may include kidney failure and/or anemia.
c) Heart failure.
d) Hepatitis.
e) AIDS(Acquired Immune Deficiency Syndrome).
f) Other infection(s). Pt. Initials:

2. Refusal to authorize administration of blood or blood products.

Use Refusal to Authorize Administration of Blood or Blood Products and Release from Liability Form

3. X-Rays of the abdomen and/or pelvis of a pregnant or potentially pregnant woman.

☐ a) X-ray radiation to you and your unborn child.
b) Very small risk of harm to you or your unborn child.
c) Increased risk of cancer in later life.
d) Responsible to tell technologist or radiologist if you may be pregnant, or have had this same x-ray or test within the last year. Pt. Initials:

☒ bleeding
infection
damage to surrounding structures
vocal cord dysfunction
respiratory failure
pneumothorax

The Texas Medical Disclosure Panel has not established a risk disclosure standard for the proposed procedure(s). My physician has discussed with me the risks of the procedure(s) such that I am able to give my informed consent. Pt. Initials:

4. Anesthesia

Use Discussion and Consent — Anesthesia and/or Perioperative Pain Management (Analgesia) Form.

5. Cardiovascular system

☐ (A) Cardiac
(1) Surgical
(a) Coronary artery bypass, valve replacement.
(i) Acute myocardial infarction.
(ii) Hemorrhage.
(iii) Kidney failure.
(iv) Stroke.
(v) Sudden death.
(vi) Infection of chest wall/chest cavity.
(vii) Valve-related delayed onset infection.
(b) Heart transplant.
(i) Infection.
(ii) Rejection.
(iii) Death.
Pt. Initials:

☐ (2) Non-Surgical – Coronary angioplasty, coronary stent insertion, pacemaker insertion, AICD insertion, and cardioversion
(a) Injury to or occlusion (blocking) of artery which may require immediate surgery or other intervention.
(b) Hemorrhage (severe bleeding).
(c) Damage to parts of the body supplied by the artery with resulting loss of use or amputation (removal of body part).
(d) Worsening of the condition for which the procedure is being done.
(e) Stroke and/or seizure (for procedures involving blood vessels supplying the spine, arms, neck or head).
(f) Contrast-related, temporary blindness or memory loss (for studies of the blood vessels of the brain).
(g) Paralysis (inability to move) and inflammation of nerves (for procedures involving blood vessels supplying the spine).
(h) Contrast nephropathy (kidney damage due to the contrast agent used during procedure).
(i) Thrombosis (blood clot forming at or blocking the blood vessel) at access site or elsewhere.
(j) Acute myocardial infarction (heart attack).
(k) Rupture of myocardium (hole in wall of heart).
(l) Life threatening arrhythmias (irregular heart rhythm).
(m) Need for emergency open heart surgery.
(n) Sudden death.
(o) Device related delayed onset infection (infection related to the device that happens sometime after surgery). Pt. Initials:

☐ (3) Diagnostic
(a) Cardiac catheterization.
(i) Injury to or occlusion (blocking) of artery which may require immediate surgery or other intervention.
(ii) Hemorrhage (severe bleeding).
(iii) Damage to parts of the body supplied by the artery with resulting loss of use or amputation (removal of body part).
(iv) Worsening of the condition for which the procedure is being done.
(v) Stroke and/or seizure (for procedures involving blood vessels supplying the spine, arms, neck or head).
(vi) Contrast-related, temporary blindness or memory loss (for studies of the blood vessels of the brain).
(vii) Paralysis (inability to move) and inflammation of nerves (for procedures involving blood vessels supplying the spine).
(viii) Contrast nephropathy (kidney damage due to the contrast agent used during procedure).
(ix) Thrombosis (blood clot forming at or blocking the blood vessel) at access site or elsewhere.
(x) Acute myocardial infarction (heart attack).
(xi) Contrast nephropathy (injury to kidney function due to use of contrast material during procedure).
(xii) Heart arrhythmias (irregular heart rhythm, possibly life threatening).
(xiii) Need for emergency open heart surgery. Pt. Initials:

☐ (b) Electrophysiologic studies
(i) Cardiac perforation.
(ii) Life threatening arrhythmias.
(iii) Injury to vessels that may require immediate surgical intervention.
Pt. Initials:

☐ (c) Stress testing – Acute myocardial infarction.
Pt. Initials:

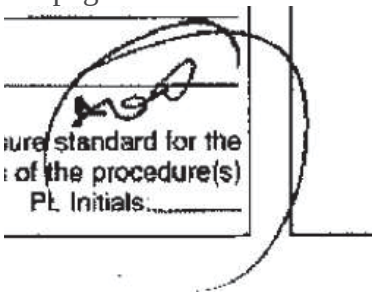
☐ (d) Transesophageal echocardiography – Esophageal perforation.
Pt. Initials:

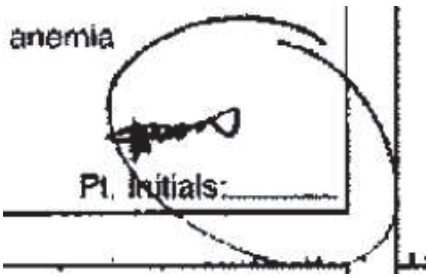
☐ (B) Vascular
(1) Open surgical repair of aortic, aortobifem, and iliac artery aneurysms or stenosis and renal artery bypass.
(a) Hemorrhage (c) Kidney damage (e) Acute myocardial infarction
(b) Paralysis (d) Stroke (f) Infection of graft
Pt. Initials:

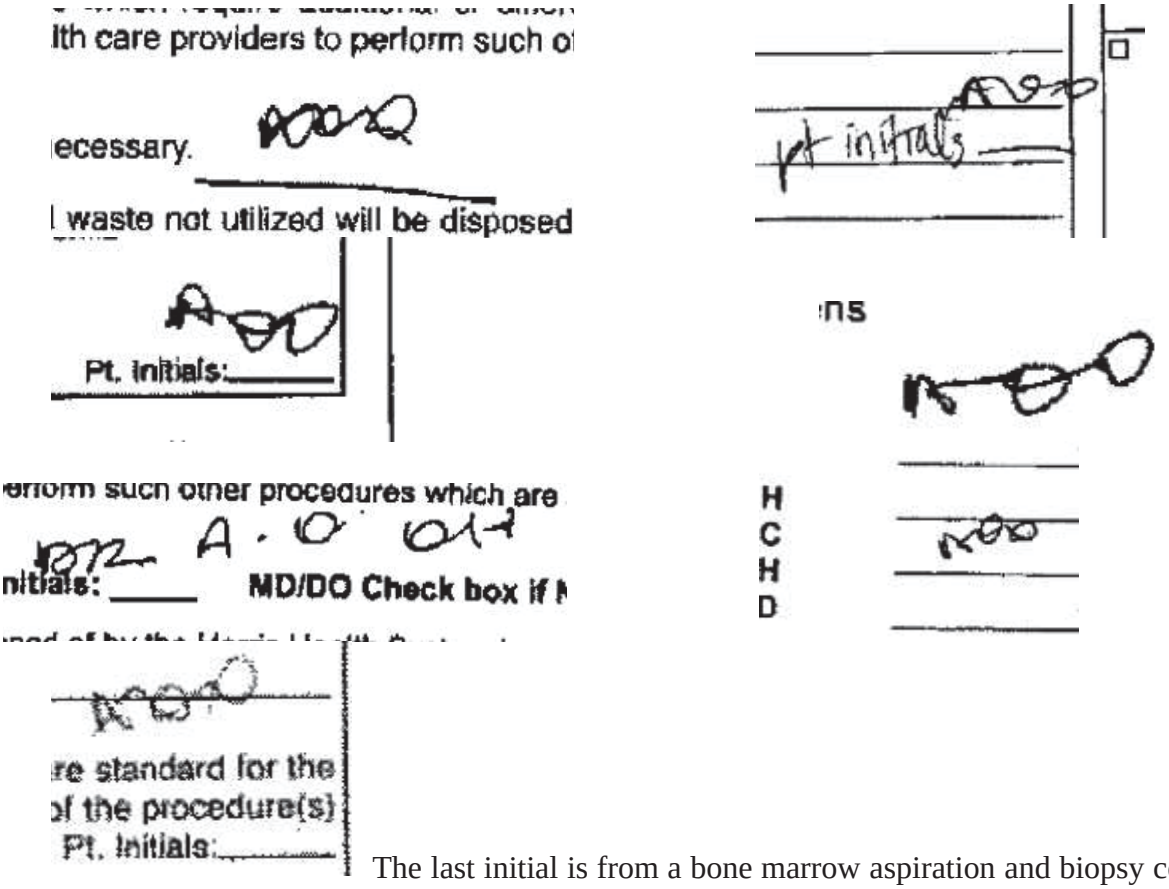
Cardiovascular System continued on Page 3
PAGE 2

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 59093

Amongst others, Decedent does not sign his initials as indicated in the contested consent form's second page. The below are screenshots of Decedent's initials in other consent forms:







The last initial is from a bone marrow aspiration and biopsy consent form from 05/05/2014, that even stated that Decedent had bleeding, hematoma, infection, etc.

Furthermore, the 10:10am 03/06/2015 BAL informed fraudulent consent form is also alleged to be obtained in violation of Texas Penal Code §32.46(a)(1); i.e. that the unwitnessed consent form was even forced upon him in an emergency situation they wrongfully created after (a) they ***withheld*** sedating him, (b) after they failed in their wrongful attempt to intubate him for the unconsented BAL, and (c) while Decedent was not at capacity to give such consent; because he either was already sedated, or he was unconscious. Such also evidences an issue the Court's find troubling. See, *e.g.*, *A Woman's Choice-East Side Womens Clinic v. Newman*, 305 F.3d 684, 716 – 717 (7th Circ. 2002) ("… 'informed consent,' which cannot be given by persons already under anesthesia. See, *e.g.*, *Culbertson v. Mernitz*, 602 N.E.2d 98, 103 (Ind.1992) (endorsing the

American Medical Association's 1992 Code of Medical Ethics with respect to necessary consent, and rejecting as invalid consent given 'where the patient is unconscious or otherwise incapable of consenting'). I would be surprised if many Indiana doctors were in the habit of obtaining consent for medical procedures from unconscious or drugged patients; they would risk loss of their medical license if they did, whether they were performing an appendectomy, knee surgery, a vasectomy, a prostate removal, or an abortion."

Now, considering that (a) the consent form is unwitnessed, (b) Decedent's alleged signatures and initials are highly questionable as to the state of mind of the executor, and (c) the second page states that Decedent was already bleeding at that time, had infections, damage to surrounding structures, vocal cord dysfunction, respiratory failure, and pneumothorax,[75] the 03/06/2015 consent form is clearly both forged, and the alleged execution was secured with deception; both a violation of Texas Penal Code §32.46(a)(1), §32.21(1)(A)(i), and/or §32.21(1)(A)(ii).

Decedent was not expected to have any bleeding or vocal cord dysfunction issues before or when they began the wrongful and unsupervised intubation for the BAL. The bronchoscopy is for examination of his bronchi in his lungs. The laryngoscopy is for vocal cords. There was no consent for the laryngoscopy. The forged 03/06/2015 BAL consent form document does not include laryngoscopy. No one ever mentioned a laryngoscopy as occurring until Dr. Guy and Paul Kwak did so in their disclosures. The inexperienced and unsupervised MICU physicians harmed him in the wrongful intubation for the wrongful BAL, the laryngoscopy, and tracheostomy. The vocal cord dysfunction is from the failed unconsented laryngoscopy.

[75] A collapsed lung that occurs when air enters the space around lungs.

There was no emergency respiratory issue for there not to be proper consent or informed consent, time out, pre-op procedure note, and sedation for the 03/06/2015 BAL and laryngoscopy. The clear evidence that the 03/06/2015 BAL consent form was executed *after* the Decedent was bleed from the unconsented BAL intubation, had vocal cord dysfunction issues from the unconsented laryngoscopy, damages to surrounding areas, had been sedated, was already in or was post being on the operating room table, is that Decedent had thrombocytopenia and pancytopenia, had low platelets, and had not been given platelets since his time at the hospital since 03/04/2015. With thrombocytopenia and pancytopenia, Decedent is unable to make blood clots for any cuts. Hence, any procedure that would leave him exposed to bleeding, without platelet infusion for blood clots, would have risked him bleeding to death. This is also clear evidence that, amongst others, the 03/06/2015 events were executed by unsupervised, inexperienced, and unqualified physicians; which constitutes not only malicious, knowing, intentional, bad faith, and/or deliberate indifference standard, but also meets "shocks the conscience" standard. Furthermore, it is also evidence that Dr. Guy, Guerra, Eicher, etc., i.e. the alleged supervising or management staff, were not present to supervise the procedures as they allege in their cover-up disclosures/stories/reports. The lack of platelets before the 03/06/2015 events, is also evidence that Decedent was dumped in the hands of unsupervised, inexperienced, and unqualified physicians since his admission; a deprivation of his 14th Amendment equal protection and due process rights to essential health care without discrimination.

Dr. Suman stated that she observed a color change in the carbon dioxide detector along with Decedent's chest rising during the emergency tracheotomy event. Hence, Dr. Suman observed the

pneumothorax event. And since Dr. Suman was called bedside for an event that began at 12:04pm, and the chest rise observation occurred after the emergency tracheostomy decision was made and began, that 03/06/2015 consent form could NOT have been signed at 10:10am. It was back-timed, hence *forged*, per Texas Penal Code §32.21(1)(A)(ii). If Decedent signed that document, it was while or after he was on the operating room table equivalent, after he was sedated with etomidate and succinylcholine, after the multiple attempts to intubate him for the wrongful and unconsented BAL and laryngoscopy had already occurred, after he was already unconscious per Dr. Suman's report, after he was already operated on, after he already bled and sustained "damage to his surrounding structures" including his lungs, all from their failed attempts. Decedent lacked capacity to sign the 03/06/2015 BAL document. It's worth noting the obvious, again, that Van Hoang solely ordered and authorized the 03/06/2015 and 03/09/2015 BAL at 11:53am and 9:37am respectively.

The evidence is clear that fraudulent 03/06/2015 BAL consent form was also a fraudulent means to justify the lack of consent to the unnecessary 03/09/2015 BAL. There was no emergency respiratory issue for the 03/09/2015 BAL for there not to be consent. Also, Decedent was already oxygenated via a ventilator. Mostly, after the physicians revived Decedent post the 03/06/2015 traumatic incidents, Dr. Hoang and/or Dr. Guy, had various opportunities to get the necessary and required consent to the unnecessary 03/09/2015 BAL procedure from Decedent's family members. They did not do so, but rather embarked on another unnecessary BAL on Decedent without consent. The evidence of cover-up is that the 03/06/2015 BAL was then discontinued on 05/04/2015 after the events already occurred, and by resident Dr. Lopez.

Also, no sedation was ordered and administered before the emergency events; afterwards, fentanyl, etomidate and/or succinylcholine were allegedly ordered and given. The medication orders do not state when they were administered. Just that they were ordered. Considering (a) the inconsistencies and the cover-ups in everyone's statement for the 03/06/2015 event, (b) everyone placing blame on each other, (c) that Paul Kwak never states that he saw Decedent provided any anesthesia, (d) that Dr. Eicher also lied about being present, (e) the fact that the "code sheet" physician's summary does not state that Decedent was ever sedated, nor does it state a bronchoscopy or laryngoscopy was done at any time, (f) the fact that the 03/06/2015 bronchoscopy order is able to be discontinued months later on 05/04/2015, and (g) the fact that they even tried to discharge Decedent immediately after the 03/06/2015 traumatic event, it is even unclear that Decedent was ever sedated.

The inconsistencies and uncertainty as to the sedations, who ordered, and who administered them, and when they were administered, makes it uncertain that the sedatives allegedly ordered were ever administered. Regardless, if they were administered, based on (a) the statements of Dr. Suman and Guy, and Mr. Kwak, and (b) the contents of the second page of the consent form that states Decedent's bleeding, damage to surrounding function, pneumothorax, and vocal cord dysfunction; Decedent had already experienced shock, he was on the operating room table equivalent or had already been on the operating room table equivalent, the intubation attempt for the wrongful and non-consented bronchoscopy had already failed, the unconsented *laryngoscopy* attempt had already failed, and Decedent was already sedated; all before the forged and deceitful 03/06/2015 BAL consent form was executed. Such meets the "shock the conscience standard" for

Plaintiffs' constitutional rights deprivations claim even in such an emergency situation which the alleged yet forged consent form for both the 03/06/2015 and 03/09/2015 BAL were created. That document could not have been created at 10:10am.

Per the evidence, prior to the unconsented 11:53am bronchoscopy failure, Decedent was not bleeding, he did not have any vocal cord dysfunction or damage to surrounding function, nor did he have pneumothorax. These were all results of the wrongful bronchoscopy intubation, unplanned laryngoscopy. Per Dr. Suman's version of sequence, the pneumothorax event occurred right after the decision for the tracheostomy, and right before it began. Per Dr. Guy's version, although she evades the fact that the original intubation attempt was for the resident's planned and unapproved wrongful BAL – done without consent[76], the laryngoscopy occurred before the pneumothorax event. Therefore, the reasons listed in the 10:10am BAL consent form as reason for the BAL, endotracheal intubation, etc., indicates unexpected events that occurred much later.

Neither Plaintiffs nor Decedent would have consented to such a bronchoscopy or BAL, especially under such condition. The 03/06/2015 BAL was obtained via civil and criminal fraud.

Furthermore, the fact that there was clearly no supervision of Dr. Guy, Guerra, and/or Eicher, also meets the "shocks the conscience standard" for the 03/06/2015 events. Dr. Guy and Eicher's stories are an attempt to cover-up the traumatic event, and the fact that unqualified, inexperienced, and unsupervised individuals did the procedures. Dr. Guerra, the alleged person in charge per the code sheet, stayed mute. Within hours after the event, the physicians were already moving to discharge Decedent.

[76] versus intubation for simple oxygenation purposes

The fact that Dr. Eicher, the supervising ENT, was not present during the tracheostomy, meets the "shocks the conscience standard" for the 03/06/2015 emergency tracheostomy event. The situation required her presence. Without her supervision, the inexperienced and unsupervised ENT resident, Kwak, presumed the position of Decedent's trachea; and unqualified, inexperienced, and unsupervised physicians attempted to execute her high-risk and specialized duties. She provides no excuse or explanation for her absence, but a false cover-up that she was present. She names someone who does not appear in the medical records until two days later.

The fact that, amongst others, Dr. Guy states that she had to call in Dr. Guerra after the failed 03/06/2015 attempts means that Dr. Guerra was clearly also not present. She was the physician in charge at the time. Her authority is confirmed per the code sheet, and supported by Dr. Guy's conflicting/bogus statement. Hence the inexperienced, unqualified, and unsupervised Van Hoang, who ordered and authorized the BAL alone, attempted the intubation for the BAL and the laryngoscopy without proper supervision. Such meets the "shocks the conscience standard" for the 03/06/2015 BAL, bronchoscopy, and/or laryngoscopy events.

The fact that Dr. Guy was not present for the any 03/06/2015 BAL intubation and/or laryngoscopy, meets the "shocks the conscience standard" for the 03/06/2015 events, including the emergency situation. It also supports that the 03/06/2015 consent form was also obtained under civil fraud. It shows that Van Hoang and/or residents acted without supervision, and she acquiesced to and participated in the cover-up; after she had a chance to review all documents and get the stories. Decedent would clearly not have consented to any procedure by unsupervised and inexperienced, unqualified and/or unlicensed physicians. Decedent did not want to die.

Dr. Guy was not present for her alleged endotracheal intubation or the unconsented BAL. There is no formal report for a 03/06/2015 laryngoscopy or BAL. Hence, the 03/06/2015 events even meet the "shocks the conscience." Dr. Guy's cover-up story makes it seem as if she was present from the beginning. But she fails in, amongst others, the sequence of events. She states that all anesthesia, etomidate, fentanyl and succinylcholine, were given before the anesthesiologist was called in. Such cannot occur per Ben Taub Hospital rules. An anesthesiologist must be present for such a procedure, and is the personnel to order and administer such anesthesia for such procedure. Also, Decedent's oxygen levels she states, differs from that stated by Kwak and the anesthesiologist. Furthermore, she indicates that she was present since the beginning, and per the forged BAL document she was to be the person in charge. However, the code sheet states that Dr. Guerra was the person in charge.

Also, if she was present from the start, including for the endotracheal intubation as she tries to indicate in her cover-up statement, there would have been a pre-op with sedation documented, and time-out stated. There also would have been a consent properly executed for the BAL and the alleged endotracheal intubation she alleges, versus a forged document. Mostly, no procedure that subjected Decedent to risk of bleeding would or should have occurred because Decedent was not yet given any platelets, and Decedent had thrombocytopenia and pancytopenia. Her lack of complete/full supervision of the 03/09/2015 unconsented and unnecessary BAL, is further evidence of her continuous malicious, knowingly wrongful, intentionally wrongful, and/or deliberate indifference to Decedent's rights, health and safety, and her continuous acquiescence to Van Hoang continuously acting without supervision. Her 03/06/2015 3:17pm statement is merely

a cover-up for Van Hoang and others, who acted without proper supervision. Her later execution of the 03/09/2015 report for the unconsented BAL is another evidence of her participation and support of the wrongful activities, and the cover-ups.

There was no emergency on the morning of 03/06/2015 before the events began. Her statement alleges that Decedent was given sedation. However, her disclosure is made at 3:16pm or 3:17pm. If she alleges that the intubation was done in an emergency, she is required to make a note of Decedent's condition prior to induction of anesthesia and start of the procedure.

Dr. Guy was not present as she indicates in her statement. Dr. Eicher was not present as she indicates in her statement. Dr. Guerra does not even give a statement. Dr. Guerra's only medical records entry on 03/06/2015 is as below, filed on 03/07/2015, and it is in regards to a service done on 03/07/2015:

Progress Notes - All Notes (continued)

Progress Notes by Guerra, Diana M. MD at 3/6/2015 5:21 PM Version 1 of 1

Author: Guerra, Diana M. MD | Service: BT MICU | Author Type: Physician
Filed: 3/7/2015 12:19 AM | Note Time: 3/6/2015 5:21 PM | Status: Signed
Editor: Guerra, Diana M. MD (Physician)
Related Notes: Related Note by Gilmore, Brendan A. Resident (Resident) filed at 3/6/2015 8:12 PM

MICU ATTENDING PHYSICIAN NOTE

Date of Service: 3/7/2015
Time: 12:16 AM

I performed a detailed evaluation of the patient, including physical examination, review of systems and discussed management with Dr. Gilmore, Brendan A. Resident, MD and the ICU team.
I reviewed the resident's note and agree with the documented examination findings, assessment and plan of care.

I have provided critical care services to this patient in the unit, including the following items:

- Serial assessment of:
  - Lab and other diagnostic studies: Yes
  - Diagnostic radiographs: Yes
- Management of:
  - Mechanical ventilation: Yes
  - Sedative and/or vasoactive medications:Yes
  - Organ failure or impending organ failure: Yes
  - Nutrition: Yes
- Discussion with consultants: Yes
- Personally updated patient: Yes

Critical care time (separate from procedures): 45 minutes

Diana M. Guerra, MD
Assistant Professor
Pulmonary & Critical Care Medicine
Baylor College of Medicine

Electronically signed by Guerra, Diana M. MD on 3/7/2015 12:19 AM

Her only entry in the medical records on 03/05/2015 are as below:

H&P by Guerra, Diana M, MD at 3/5/2015 5:29 AM Version 1 of 2

Author: Guerra, Diana M, MD | Service: BT MICU | Author Type: Physician
Filed: 3/5/2015 3:46 PM | Note Time: 3/5/2015 5:29 AM | Status: Signed
Editor: Guerra, Diana M, MD (Physician)
Related Notes: Related Note by Lemaster, William B, Resident (Resident) filed at 3/5/2015 5:51 AM
Addendum by Guerra, Diana M, MD (Physician) filed at 3/5/2015 5:55 PM

MICU ATTENDING PHYSICIAN NOTE

Date of Service: 3/5/2015
Time: 3:31 PM

I performed a detailed evaluation of the patient, including physical examination, review of systems and discussed management with Dr. Lemaster, William B, Resident, MD and the ICU team.
I reviewed the resident's note and agree with the documented examination findings, assessment and plan of care.

I have provided critical care services to this patient in the unit, including the following items:

- Serial assessment of:
  - Lab and other diagnostic studies: Yes
  - Diagnostic radiographs: Yes
- Management of:
  - Mechanical ventilation: Yes
  - Sedative and/or vasoactive medications:Yes
  - Organ failure or impending organ failure: Yes
  - Nutrition: Yes
- Discussion with consultants: Yes
- Personally updated patient: Yes

Critical care time (separate from procedures): 45 minutes

Assessment/ Plan:
Acute hypoxic respiratory failure
- Bilateral pulmonary infiltrates: Atypical pneumonia - Multifocal + volume overload
- on continuous Non invasive mechanical ventilation and requiring high FiO2
- Broad spectrum Abx
- Intermittent lasix

AKI
- good urinary output after lasix

AML

Printed by 83811 at 7/24/15 12:37 PM

H&P - All Notes (continued)

H&P by Guerra, Diana M, MD at 3/5/2015 5:29 AM (continued) Version 1 of 2

- 70% blasts on peripheral smear
- LDH-451, Uric acid-9.7; Phos and K wnl- unlikely that there is TLS

Diana M. Guerra, MD
Assistant Professor
Pulmonary & Critical Care Medicine
Baylor College of Medicine

Electronically signed by Guerra, Diana M, MD on 3/5/2015 3:46 PM

H&P - All Notes

H&P by Guerra, Diana M, MD at 3/5/2015 5:29 AM Version 2 of 2

Author: Guerra, Diana M, MD | Service: BT MICU | Author Type: Physician
Filed: 3/5/2015 5:59 PM | Note Time: 3/5/2015 5:29 AM | Status: Addendum
Editor: Guerra, Diana M, MD (Physician)
Related Notes: Related Note by Lemaster, William B, Resident (Resident) filed at 3/5/2015 6:51 AM
Original Note by Guerra, Diana M, MD (Physician) filed at 3/5/2015 3:46 PM

MICU ATTENDING PHYSICIAN NOTE

Date of Service: 3/5/2015
Time: 3:31 PM

I performed a detailed evaluation of the patient, including physical examination, review of systems and discussed management with Dr. Lemaster, William B, Resident, MD and the ICU team.
I reviewed the resident's note and agree with the documented examination findings, assessment and plan of care.

I have provided critical care services to this patient in the unit, including the following items:

- Serial assessment of:
  - Lab and other diagnostic studies: Yes
  - Diagnostic radiographs: Yes
- Management of:
  - Mechanical ventilation: Yes
  - Sedative and/or vasoactive medications:Yes
  - Organ failure or impending organ failure: Yes
  - Nutrition: Yes
- Discussion with consultants: Yes
- Personally updated patient: Yes

Critical care time (separate from procedures): 45 minutes

Assessment/ Plan:
Acute hypoxic respiratory failure
- Bilateral pulmonary infiltrates: Atypical pneumonia - Multifocal + volume overload
- on continuous Non invasive mechanical ventilation and requiring high FiO2
- Broad spectrum Abx
- Intermittent lasix

AKI
- good urinary output after lasix

AML
- 70% blasts on peripheral smear
- LDH-451, Uric acid-9.7; Phos and K wnl

Diana M. Guerra, MD
Assistant Professor
Printed by 83811 at 7/24/15 12:37 PM

H&P - All Notes (continued)

H&P by Guerra, Diana M, MD at 3/5/2015 5:29 AM (continued) Version 2 of 2

Pulmonary & Critical Care Medicine
Baylor College of Medicine

Electronically signed by Guerra, Diana M, MD on 3/5/2015 5:59 PM

However, she was willing to only co-sign the write-up of a resident, Brendan Gilmore:

Progress Notes by Gilmore, Brendan A, Resident at 3/6/2015 5:21 PM — Version 1 of 1

Author: Gilmore, Brendan A, Resident | Service: BT MICU | Author Type: Resident
Filed: 3/6/2015 6:12 PM | Note Time: 3/6/2015 5:21 PM | Status: Signed
Editor: Gilmore, Brendan A, Resident (Resident)
Related Notes: Cosigned by Guerra, Diana M, MD (Physician) filed at 3/7/2015 12:19 AM

Daily MICU Progress Note

Date of Service: 3/6/2015
Time: 5:48 PM

Hospital LOS: 2 days
ICU Day: 2 days

65y.o. male with a h/o AML diagnosed in 2013 and treated with chemotherapy but was lost to follow up, diastolic heart failure, DM2, and hypertension who presented with worsening SOB for the last 2 weeks. Per patient he recently traveled to Nigeria in late February. He stated that from the time he arrived in Nigeria he noticed he was short of breath and it continued to worsen during the 2 weeks he was there. For 2 days prior to admission, he has also noticed nonexertional chest pain that radiates to

his back. CXR on arrival revealed diffuse patchy opacities concerning for volume overload and ARDS. CT chest showed mediastinal lymphadenopathy and multiple airspace and interstitial opacities. On the day of admission an RRT was called because the patient had worsening hypoxia and increased work of breathing but he improved after being placed on BiPAP. The patient subsequently became confused so the MICU was consulted for possible intubation given that patient had CO2 of 47.9 and pH of 7.19 on ABG. Patient's repeat ABG improved with a pH of 7.45 and CO2 of 33.3 on bipap. Patient had O2sats at 96% on 45% O2 with bipap.

On morning of 3/6/15, decision was made intubation/bronchoscopy. However, issues arose when patient was attempting to be intubated - very difficult airway. Patient began to decompensate. Oxygen saturations in the 40s-50s. ENT and Anesthesia were called for assistance. Patient had PEA - multiple rounds of compressions received. Patient regained pulse, tracheostomy tube was placed - and was ventilated mechanically.

Currently, patient requiring pressure support with epinephrine and levophed. Patient was started on broad spectrum ABx (Vancomycin, cefepime, clindamycin and levaquin). Patient

PLAN
Neurological:
#AMS
- most likely related to hypoxia on presentation
- currently intubated and sedated

Cardiac:

#PEA arrest
- s/p multiple rounds of compressions - regained pulse
- concern that brain function has been severely compromised after prolonged episode of hypoxia

#Hypotension
- most likely secondary to cardiogenic vs septic shock
- requiring epinephrine and levophed with MAPs goal of 55-60

#Diastolic heart failure
- TTE done 3/5/15 showed findings suggestive of RV pressure overload. LVEF is 65-69%.

Respiratory:
#Hypoxia from ARDs
- CT chest w/o contrast on 3/4/15 showed multifocal airspace and interstitial opacities concerning for multifocal PNA vs leukemic infiltration consistent with CXR findings
- Continue - Started on Vanc, cefepime, clindamycin, levofloxacin and Tamiflu to treat for sepsis due to possible multifocal pneumonia
- repeat ABG ordered for evening of 3/6/15

Renal:

Progress Notes - All Notes (continued)

Progress Notes by Gilmore, Brendan A, Resident at 3/6/2015 5:21 PM (continued) Version 3 of 3

#AKI
- Concern for possible tumor lysis syndrome
- Baseline Cr ~ 1.3 per labs from 2014, now 3.1
- FeNA of 0.5% consistent with prerenal etiology, but as patient had some lower extremity edema concerning for volume overload, will start Lasix
- Per renal recommendations, will work up for vasculitis and autoimmune disorders. Results pending
- Renal u/s normal
- holding lasix for now, Cr=2.7, BUN=55

ID:
#Possible sepsis (Tachypneic, tachycardic) w/ multifocal CXR infiltrates
- Started on Vanc, cefepime, clindamycin and levofloxacin
- On Oseltamivir 75 mg daily, renal dosing
- Intubated and sedated

GI/Nutrition:
- NPO
- No active issues

Heme:
#AML
- S/p chemotherapy but patient did not finish entire course
- 70% blasts on peripheral smear
- Heme/Onc consulted: appreciate recommendations
- LDH-451, Uric acid-9.7; Phos and K wnl
- also likely contributing to anemia and thrombocytopenia
- Started on Allopurinol po BID with one dose of Rasburicase for TLS prophylaxis on 3/5/15
- Per Hematology recs, no plans for induction chemotherapy for now

Endo:
#DM 2
- Elevated BG's in the 200's-300's
- On NPH 25 units BID (will halt as patient is NPO) with Regular insulin sliding scale
- Patient previously on Metformin at home
- q6hrs accuchecks

Skin:
-No active issues

Prophylaxis:
DVT Prophylaxis: SCDs only
GI Prophylaxis: Nexium

Disposition: ICU
Code Status: Full

Printed by 83811 at 9/10/15 2:13 PM

Dr. Guerra was clearly not present, and everyone lied to cover for her.[77]

Dr. Suman's was also not present. As the anesthesiologist, and per hospital policy, she is required to be present. The fact that she misses the administration of fentanyl that was ordered

[77] Dr. Guerra and the BCM physicians, including Drs. Hanani, Xandera, Peacock, and Kass, had a habit of actions equivalent to signing in to the system over 6, 8, or 12 hours, and sometimes days, weeks, or months, (a) before they actually see and evaluate Decedent, (b) before they make their actual entries or dictations in the medical records, and/or (c) before the actually electronically sign and/or file their medical records. This makes it seem as if they saw Decedent at the time of their signing into the system. However, the time of their service, or the time of their electronic signature of the records show a delay of hours, days, weeks, or sometimes months. It's equivalent to clocking-in at work, and then disappearing for the whole day, then coming back later to do something, and signing off on what you did. The medical records then become deceptive because it shows that an entry was made at 5:30am, but the service was provided at 6:00pm per the dictation of the physician, and it was electronically signed and filed thereafter or the following day, or sometimes days, weeks, or months later. Per the records, Dr. Guerra habitually did this since 03/05/2015, since Decedent was admitted in MICU. Other physicians habitually did this also.

around 11:23am, shows that she was not there.

Dr. Suman mentions that etomidate and succinylcholine sedations were given after she arrived. Yet, Dr. Guy's version states that etomidate, fentanyl and succinylcholine were given before a glidescope was used to view Decedent's larynx, then fentanyl and succinylcholine were given before the anesthesia team were called. The records show that fentanyl and etomidate were ordered at 11:24am, and succinylcholine ordered at 11:26am. Dr. Suman as the head anesthesiologist, is required to be present for any procedure that requires anesthesia, and to provide a pre-op; all per Ben Taub Hospital anesthesiology department policy. She is the person to order the anesthesia for any procedure. If she was present, she would have noted that fentanyl was ordered. Dr. Suman was not present. She also provided a cover-up story.

Even the nurse was not present from the start as she indicates in her statement. Her late story is also a cover-up. If she was present, there would have been a consent form properly executed. If any of the physicians that indicate that they were present from the start were truly present, there would have been a proper and coherent disclosure, and informed consent sheet prepared and executed.

Simply put, it is clear that Decedent was dumped in the hands of inexperienced, unsupervised, and unqualified residents and fellows; in violation of his U.S. 14th amendment rights its resulting harm. Decedent, a patient who BCM and HHS staff, managers, and/or executives continuously discriminated against in the provision of essential health care services, was therefore used as an experiment. The unqualified and inexperienced residents and fellows planned and executed an intubation for a bronchoscopy and laryngoscopy without consent or supervision. After things went

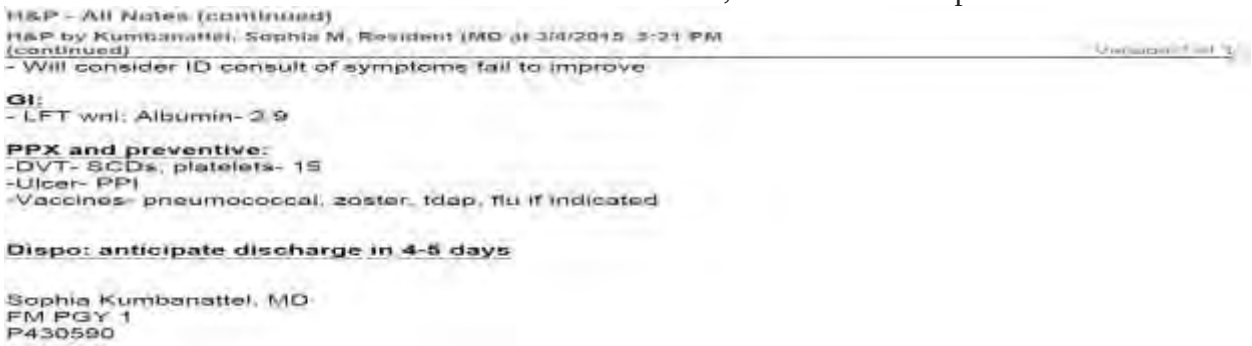
wrong, and Decedent went into cardiac arrest and was resuscitated, the staff physicians then wrote their inconsistent cover-up versions of what occurred; full of misrepresentations, and for the sake of, amongst others, impeding, hindering, deterring, and obstructing the due course of justice; to the deprivation of Plaintiffs U.S. Constitutional rights to equal protection of the laws, and due process rights, and Plaintiffs' resulting harm.

With Decedent's condition at 4:24pm on 03/06/2015, after the traumatic events, before the physicians and nurses wrote their statement, and before resident Gilmore wrote a statement for Dr. Guerra to sign off, the physicians and HHS staff already planned and attempted to discharge Decedent. Such further supports the claim of malice, knowingly wrongful, intentionally wrongful, bad faith, and deliberate indifferent discrimination against Decedent, and denial of his right to essential health care, and their attempts or efforts to cover-up their actions; a deprivation of his 14th amendment equal protection and due process rights.

Decedent was clearly not in a state to be discharged. Per their unconstitutional, malicious, knowing, intentional, bad faith, and/or deliberate indifferent wrongful actions and inactions, even after the 03/06/2015 event, Decedent's condition deteriorated. With the untreated, amongst others, retroperitoneal sarcoma, heart issues, blood pressure issues, AML, pancytopenia, and thrombocytopenia, Decedent was clearly going to further deteriorate and/or die had he been discharged. Such a discharge is clearly, amongst others, a wrongful attempt to cover-up their wrongs, and evade justice and liability.

Interestingly, upon his admission, resident Sophia Kumbanattel foretold his discharge in 4 – 5 days; evidence that their wrongful actions were pre-planned. They clearly never intended to

provide him with the essential health care services he needed, nor treat his retroperitoneal sarcoma.



H&P - All Notes (continued)

H&P by Kumbanattel, Sophia M, Resident (MD at 3/4/2015 3:21 PM (continued)

- Will consider ID consult of symptoms fail to improve

GI:
- LFT wnl; Albumin- 2.9

PPX and preventive:
-DVT- SCDs, platelets- 15
-Ulcer- PPI
-Vaccines- pneumococcal, zoster, tdap, flu if indicated

Dispo: anticipate discharge in 4-5 days

Sophia Kumbanattel, MD
FM PGY 1
P430590

Furthermore, there was no need for the 03/09/2015 BAL. Considering the events of the 03/06/2015 events, Decedent's immunocompromised state, and Decedent's pancytopenia, the 03/09/2015 unsupervised and unconsented BAL was an irrational and unnecessary risk, that simply subjected or caused Decedent more harm. There was no emergency need for said 03/09/2015 BAL. After all, they already tried to wrongfully discharge Decedent. The 03/09/2015 BAL is evidence of the wrongful, capricious, arbitrary and irrational discrimination against Decedent and his family's in regards to health care services; and a cover-up attempt. It is also evidence of the deprivation of their substantive due process liberty and privacy right to consent or withhold consent to the invasion of Decedent's bodily integrity. Plaintiffs had a right to consent or withhold consent to the 03/09/2015 BAL, and were irrationally and unjustly denied said rights.

After the 03/06/2015 and 03/09/2015 BAL events, nobody considered, prepared, nor provided Decedent with the necessary chemo he needed for his terminal illness. They alleged that he was not the condition to receive chemo treatment, immediately began to suggest DNR (i.e. withholding or withdrawal of life-sustaining treatment) thereafter, and began to execute said DNR procedures on Decedent against his wishes and his family's wishes, without qualifying Decedent as terminal or irreversible, as required by THSC §166.031(2) and Harris County Hospital District's Medical

Staff Rules and Regulations.

Harris County Hospital District's Medical Staff Rules and Regulations THSC §166.031(2) equivalent certification requirement is as follows:

ADVANCE DIRECTIVES FOR THE TERMINALLY ILL: When an adult terminally ill patient is admitted with an executed Directive, the attending staff and one other physician (both physicians having personally examined the patient) shall certify in the patient's medical record:

HARRIS HEALTH - OHAKWEH - 59703

GENERAL RULES FOR ALL SERVICES

1. The patient has an incurable or irreversible condition caused by injury, disease, or illness;
2. This condition, without the application of life sustaining procedures, would within reasonable medical judgment, produce death, and;
3. The application of life-sustaining procedures serves only to postpone the moment of death of the patient.

Even after the March 2015 BAL procedures were wrongfully done without consent, the physicians still wrongfully, invidiously irrationally, maliciously, knowingly, intentionally, with bad faith, and/or with deliberate indifference, discriminated against Decedent in regards to provision of the necessary chemo that he needed and was entitled to for his terminal AML condition.

The execution of the ongoing evaluations and treatments of Decedent after the 03/06/2015 traumatic events without qualified or proper staff supervision, further supports the wrongful, irrational, arbitrary, invidious and capricious discrimination against Plaintiffs in regards to the health care services in the second hospital visit.

In the second hospital visit, Decedent was a U.S. resident, and rented an apartment in Harris County. He was no longer a visa holder. As disclosed per the first hospital visit meeting with Dr. Martha Mims, Decedent also had money to pay for the necessary medical treatment in the second

hospital visit. Decedent also fulfilled his financial obligations to the hospital for the first hospital visit health care services, after he finally received the necessary chemo treatments.

Dr. Mims and the physicians outright mention any Gold Card or insurance issues as reason for delay in the beginning of the second hospital visit. They had common sense enough to keep that out of the medical records initially.[78] The physicians – including Ghana Khan – already knew about the past discrimination history and the resulting hostile relationship from the Dec 2013 hospital visit, when Decedent arrived again at the hospital in March 2015. Hence, they simply outright discriminated against Decedent by wrongfully admitting him and leaving him in the hands of unqualified and unsupervised physicians, whose wrongful actions, coupled with the lack of supervision, allegedly rendered him unable to receive the necessary and/or essential treatment for his AML.

Decedent was admitted on 03/04/2015 for respiratory issues, and his respiratory issues worsened post his admission. They physicians and decision makers knew of his AML, pancytopenia, and retroperitoneal sarcoma issues upon his admission. Decedent did not see a fully licensed hematologist/oncologist until after the 03/06/2015 events. The physicians and decision makers knew that improper health care services (e.g. wrongful BAL or egregious errors in intubation or in health care services would occur) was a highly predictable outcome of their failure to provide Decedent with essential health care services with proper qualified staff or supervision. The risk of harm (i.e. multiple organ failure, cardiac arrest, severe brain injury, internal injury from

[78] But the truth came out again when Dr. Xandera, a physician with no history with Decedent in the first hospital visit, slipped up and boldly disclosed it in writing via "*no funding with his being Nigerian*" on 06/29/2015, during their attempts to justify their wrongful DNR of Decedent. Such is evidence that discrimination against patients – especially patients with serious issues – due to amongst others, funding, insurance, alienage, and origin, is a common practice at the facilities.

the intubation, constant bleeding due to the unresolved pancytopenia and low platelet count, death, etc.) from the wrongful and unsupervised health care services – e.g., the intubation, BAL, and tracheostomy attempts, all done without proper staff supervision, were a highly predictable outcome.

The qualified/specialized Baylor physician defendants and HHS staff, and/or decision makers were on actual or constructive notice of Decedent's presence in the ward. Considering that Decedent's health care needs were not met in the first hospital visit, and that they prematurely discharged him without fully treating, amongst others, the AML, pancytopenia, and retroperitoneal sarcoma, they should have been present to oversee or supervise the residents and fellows' work. They knew and disregarded the highly predictable outcome. Even the cardiologist knew on multiple occasions in the second hospital visit that Decedent was a patient and needed his services. He did not go and see Decedent. Decedent was denied the cardiological services. The nurses in the second hospital visit also clearly know of Decedent's injuries and knowingly, intentionally, invidiously, in bad faith, maliciously, and denied him or disregarded providing him with the care that he needed, nor report and escalate Decedent's matter. Rather, Decedent was further knowingly and intentionally harmed, and was knowingly and intentionally left or caused to accumulate infections, bed sores and other injuries.

The resulting injuries to Plaintiffs, including the known and highly predictable harm resulting from the malicious, knowing, intentional, bad faith, and/or deliberate indifferent wrongful actions or inactions of Defendants, were a known and highly predictable consequence of said wrongful actions or inactions that deprived Decedent of his due process right to necessary and essential

health care services. They were also a known or highly predictable consequence of the prevalent custom or practice of BCM & HHS's failure to enforce policies and procedures, and/or the prevalent custom or practice of BCM & HHS's failure to train or supervise the staff to ensure compliance with the policies and procedures. The applicable policies and procedures are discussed in further detail in this pleading.

Conspiracy Claims

There is evidence of an agreement and act in furtherance of such agreement, i.e. conspiracy, to discriminate against Decedent in provision of essential health care services, including oncology services, by not providing him with the necessary chemo or treatments that he needed.

There is clear evidence to support that said conspiracy began in the first hospital visit and continued into and throughout the second hospital visit. Said conspiracy (1) resulted in the delay and denial of essential health care services or treatment that Decedent needed, (2) resulted in his wrongful discharge, (3) resulted in the denial of the third and final stage of chemo treatment, (4) resulted in his return, (5) resulted the efforts of the hospital not to admit him in the second hospital visit, (6) resulted in the dumping of Decedent in the hands of inexperienced, unqualified, and unsupervised physicians, (7) resulted in the denial of necessary and timely health care services that he needed – e.g. cardiology and oncology services, (8) resulted in the deprivation of Plaintiffs' rights to consent or withhold consent to the BALs, (9) resulted in the injuries Plaintiffs sustained in March 2015 and until his death, (10) resulted in the failure to timely treat and remedy the harm the BCM physician caused Decedent in the second hospital visit, (11) resulted in the rush to DNR Decedent in violation of Plaintiffs' constitutional rights, (12) resulted in the killing of Decedent,

and (13) resulted in the damages pled in the DAMAGES section.

The evidence of said conspiracy's beginning in the first hospital visit is when Decedent's son was met with questions about Gold Card or payment, especially when he met with Dr. Mims in the first hospital visit; and delay it took before Decedent was finally given chemo. Ghana Kang's alteration of the chemo treatment/induction schedule further evidences an act in furtherance of said conspiracy. The first hospital visit conspiracy is further evidenced by, amongst others, (a) Decedent's premature and wrongful discharge without the provision of all three stages of chemo, (b) the withholding of the retroperitoneal sarcoma information and treatment from Decedent, and (c) the denial of screenings such as chest x-rays for the sake of Gold Card. Furthermore, the conspiracy, and Dr. Mims' further and material involvement – as a BCM chief physician for oncology services and a decision maker in the chain-of-command per HHS' policies and procedures – is shown when Decedent met with her on 06/11/2014 at the outpatient facility, and was met with inquiry as to Gold Card or "funding in place." She even noted that Decedent was to be given his third stage of chemo 6 days later, but such was never scheduled nor given. Decedent was informed that funding in place is required for oncology patients before he left the facility, and treatment for his serious medical conditions were withheld.

When Decedent arrived at the hospital in 2015, the physicians continued their conspiracy to discriminate against him in regards to the necessary treatment that he needed. It is clear that after the past hostile relationship created by the physician's discrimination against Decedent and his family, Decedent was a red flag, and they did not want to admit Decedent.

Upon his arrival at the ER, the physicians knew of his AML condition and past prior treatments

at Ben Taub. They tried to have him admitted as Decedent needed to be admitted. Resident Dr. Dina Winograd, working with and under the supervision of Dr. Tolulope Olade, contacted the admission department hospital physician, a Family Medicine physician named Dr. Varughese, to inform them of Decedent's presence and his necessary admission. But the response she received from the admitting physician, Dr. Varughese, was that he wanted the MICU team to first see and consult with Decedent before they admit him. Decedent was in the ER at that time.

After about an hour, the non-ER physician informed the ER physicians that they were going to send a resident physician, Dr. Elaine Chang, to come to the ER and evaluate Decedent. Decedent received his MICU consult in the late afternoon of 03/04/2015, while in the emergency department. The MICU resident on his bedside stated that he will not be admitted to MICU. Such is further evidence of the continuous discrimination conspiracy against Decedent. The ER physicians, including Dr. Tolue and resident Dr. Winograd, noted Decedent's critical condition and serious urgent need for care. Yet, they BCM ward physicians stated that Decedent would not be admitted to MICU. Hours later, they reluctantly admitted to the hospital floor and left him in the hands of unsupervised and inexperienced staff.

Upon Decedent's admission, Decedent was left in the hands of only unsupervised residents and fellows. The residents noted his volume overload, AML, and hypoxia. Chest x-rays were done, but a cardiologist was never consulted to see and evaluate Decedent. BCM physicians and HHS staff did not want to treat Decedent. The facts support that they were rather out to continue to subject or cause Decedent to be deprived of his U.S. constitutional rights to essential health care, and his rights to such care without discrimination rights; seriously harm Decedent or subject him

to serious harm; and/or kill him.

Decedent was not moved to MICU until after the rapid response situation on the night of 03/04/2015. Decedent did not see a licensed physician until the following day, 03/05/2015 at 3:31pm when he saw a Pulmonary and Critical Care Physician – Dr. Diana Guerra. Decedent was also left in the hands of unsupervised, unqualified, and inexperienced staff while in MICU. Dr. Guerra signed in at 5:35am in the morning, but did not see Decedent until 3:31pm. Her seeing Decedent was merely to provide the very basic minimum, a health and physical ("H&P"), and to blindly sign off on the work of the residents and fellows.

The physicians knew of his AML condition since Decedent was in the ER. The concerned ER physicians communicated it to the hospital ward physicians. Even the MICU resident, Dr. Chang, knew of Decedent's AML. The only hematology-oncology staff that saw Decedent until after the 03/06/2015 incident, were a resident, a fellow, and a pharmacist; no fully licensed hematology-oncology staff.[79]

Furthermore, amongst others, aside of the fact that Decedent was not sedated for the wrongful 03/06/2015 intubations, the 03/06/2015 BAL consent document was criminally fraudulent. It was executed after Decedent was already operated on, after he was already bleeding, after he was unconscious, after he was allegedly sedated, and/or while he lacked capacity to execute the document. Nobody discussed the lack of consent to the 03/06/2015 BAL. Dr. Guy, Van Hoang, Mimi Pham, Nurse Railey, etc, that provided a disclosure of the events, except for Dr. Suman, excluded the fact that a BAL was being done. Rather they couched the 03/06/2015 event as to be

[79] Keep in mind that AML rapidly spreads throughout the body within days, and Decedent arrived in a serious condition. Furthermore, Decedent was in a Level 1 hospital and in its MICU, where there should be qualified and capable physicians at all time, 24hrs a day.

only for an endotracheal intubation. Meanwhile, a BAL was ordered by Van Hoang, and the consent form was forged in their presence. They only, and rightfully refused to witness the document because it was invalid. Hence, Dr. Suman stated that no verbal nor written consent was obtained, and tried to cover herself, that she was involved was an emergency situation. Dr. Guerra, the person in charge since Decedent's arrival in MICU, did not provide a statement.

Even though the forged consent form is no consent, if Decedent wrote on that sheet of paper, he had enough brain activity to scribble something on the forged consent form that was signed after he was already sedated, after he was unconscious, after the first failed attempt at the bronchoscopy/BAL, laryngoscopy, and/or tracheostomy, and while Decedent was being operating on or afterwards. Hence, had the physicians provided the necessary care Decedent needed for the multiple organ failure and brain injury he sustained, Decedent would have been able to recover, and then get the chemo treatment he needed.

However, the physicians did not provide Decedent with the necessary/essential health care that he needed for the brain injury and organ failures. Rather, they still wrongfully executed the BAL three days later without consent, and left him wounded, deteriorating, and helpless afterwards.

The physicians never provided Decedent with a neurologist for weeks after the 03/06/2015 traumatic events. Rather, as of 3/8/2015, per residents Dr. Gilmore and Uyemura, Decedent was taken off sedation and pressors[80], while his brain and kidneys were also harmed from, amongst others, the AML effects on his blood and the 03/06/2015 cardiac arrest and multiple organ failure. Considering that Decedent needed vasopressors for his brain injuries sustained from the lack of

[80] a life-sustaining treatment needed.

oxygen and multiple organ failure during the 03/06/2015 events, the physicians knew, and disregarded the highly predictable outcome that taking Decedent off vasopressors that he needed to remediate the brain injury would further perpetuate the brain injury, make said injury permanent, and accelerate Decedent into a vegetative state. The decision to take Decedent off vasopressors should have been the decision of a neurologist and/or cardiologist, or after both had been consulted.

No neurologist ever certified that Decedent's brain injury was irreversible. The BCM physicians never certified that the benefit of providing Decedent with treatment for his injuries far outweighed its costs. To state such would be an outright lie, especially for the brain injury. Rather, amongst others, Dr. Sarkar wrongfully and prematurely stated that Decedent was in a terminal condition – for the sake of the DNR process. The physician's focus was that they could not give Decedent chemo for his brain injuries. Starting from 03/08/2015, Decedent was on a physical exercise-type or physical evaluation-type plan of care executed by nurses, in which its goal included optimizing his brain's oxygen, pressure, and blood flow due to his brain injury sustained from the 03/06/2015 traumatic events.

Yet, on 03/09/2015, they executed an unnecessary 03/09/2015 BAL, done without supervision or consent; and thereafter, Decedent was bleeding from his trach area – the area of the source of his oxygen. Hence Decedent's source of body oxygen intake at that time was compromised.

Most importantly, Decedent should have been provided a licensed neurologist and cardiologist after the 03/06/2015 events, and should have seen one at least every other day, if not every week. The physicians that oversaw his care after the 03/06/2015 events were respiratory (i.e. Pulmonary, Critical Care, and Sleep Medicine) physicians and other non-neuro staff, who were sometimes

uncertain as to this cerebral condition or causes of his issues. The physicians and residents were more focused on covering up their 03/06/2015 wrongful actions and inactions, and pretending that nothing wrong or out of the ordinary happened, to request a neurologist consult.

Per Harris Health System policies and procedures on (a) Incident Reporting, (b) Abuse, Neglect, and Exploitation of Patients, (c) Medical Record Documentation, and (d) Chain of Command, Decedent's injures, death, and all incidents in Plaintiffs' case, including the continuous neglect, elderly and sexual abuse, should have been disclosed to, documented by, reported to, escalated to, and investigated by all necessary and applicable parties or personnel. The escalation must be to the responsible personnel(s) in the chain of command until proper and legal resolution is reached. The abuse, neglect, and exploitation of Plaintiffs should also have been (1) documented or reported including in the eIRS system, (2) escalated up the chain of command until resolution, (3) risk management protocol instituted, (4) reports to proper internal and external government authorities and agencies, and (5) investigations done. BCM, HHS, their applicable physicians and staff, should have also reported and escalated the incidents, abuse, sexual assault/harassment, neglect, the resulting injuries and death of Decedent, to the criminal authorities as well as all necessary authority agencies including Department of Family and Protective Services.

Per BCM and HHS's discovery responses, such was not done. Merely, on the HHS level, there was only a peer review cover-up that was done.

Furthermore, Decedent did not see a neuro specialist (i.e. neurologist) until the last week of March 2015, as they were instituting the hospital level DNR procedures, after multiple harm was already perpetuated. The neurologist, Dr. Kass, never stated that Decedent's brain condition was

terminal or irreversible within the meaning of *THSC §166.002(9)* and *§166.002(10).* Yet, the physicians on 04/01/2015, were already trying to withhold vasopressors from Decedent, a life-sustaining treatment he needed to optimize his brain's oxygen, pressure, and blood flow due to the brain injury sustained from the 03/06/2015 traumatic events. Dr. Kass also never stated that Decedent's brain could not handle chemo treatment for his AML or if necessary, for treatment for his retroperitoneal sarcoma. Decedent ever saw a cardiologist, even after one was supposed to be on the health care team assigned to him. Rather, they had a cardiologist review his electrocardiogram, but never a full cardiologist consult.

After Bethrand returned to see his father's condition on 03/12/2015, Dr. Sarkar told him about the bronchoscopy, told that two anesthesiology trained staff were present for the bronchoscopy, told him to forget about his father, and informed him that Decedent was eventually going to be DNR'd and started to seek consent for said DNR. Bethrand had strong words with Dr. Sarkar.

3/12, patient received a transfusion with jumbo platelets for Platelet=8. Patient had bleeding from his trach overnight and coffee ground emesis. Nephrology attempted to do dialysis overnight, but were only able to remove 394mL as the catheter was not functioning well. Dr. Sarkar spoke with patient's son who desired that his dad remain full code with supportive care until he has the opportunity to speak with other family members.
3/13, patient was transfused with jumbo platelets for Platelet=21 and 3 units of pRBCs for Hgb=5.2. He had HD day prior with 1.4L taken off. HD again this day. Patient continued to have some bleeding at his trach site, but his coffee ground emesis improved. Gastric lavage done day prior was clear. Patient's son and daughter-in-law planned to come in this day for a family meeting regarding the patient's prognosis.
3/13, Dr. Sarkar and Dr. Birnbaum had a family meeting with the patient's son and daughter reviewing the patient's hospital course and prognosis given his acute respiratory failure, renal failure, and AML recurrence. They desired to continue all measures of support at this time. HD with removal of 4.5L UF

Hence one can understand that the already hostile environment Defendants created by their ongoing discrimination in treatment/health care services were further enhanced.

After Bethrand's reactions to Dr. Sarkar, after the family's request that Decedent be provided full treatment, and while depriving Decedent of essential or proper health care services all in anticipation of executing the 166.046 procedures to DNR Decedent against his family's wishes,

on 03/16/2015 Dr. Mims – the oncology decision maker for stated "the family - I know the son from the last hospitalization. I don't think there is much we are going to be able to do for his AML," and made decision to refuse and withhold necessary essential health care from Decedent.

Dr. Mims could have easily visited and examined Decedent on 03/04/2015, on 03/06/2015, on 03/09/2015, on 03/10/2015, on 03/12/2015, or at least on 03/15/2015 before making her 03/16/2015 statement. Considering that Decedent was her oncology patient, and she is an internal medicine Chief specialist and the decision maker on behalf of HHS & BCM, had she in good faith executed her fiduciary and statutory[81] obligations, she would have visited and examined Decedent on 03/04/2015 or 03/05/2015, the events of 03/06/2015 would not have occurred. She would have evaluated Decedent, assured proper supervision of or been directly involved in his intubation, and/or authorized administration of Decitabine.

On 3/25/2015, while Decedent's catheter was not functioning and he was losing oxygen, Dr. Joslyn Fisher was already executing the plan of withholding life sustaining treatment from Decedent. At 4:06pm, in her Ben Taub Ethics Consult notes, she wrote "…Medically appropriate treatment option(s) for end of life care - consider offering several options -including withdrawal of all life-sustaining care, withdrawal of some life- sustaining/prolonging care, or limiting escalation of care." She also wrote that Dr. Sarkar must document this in the medical records. Under the circumstances, such is further clear evidence of her participation in the agreement and act in furtherance of the agreement to DNR Decedent against Plaintiffs' wishes.

Per Dr. Sarkar's progress notes on **3/27/2015** - exactly three weeks after the 03/06/205 BAL

[81] Aside of the obvious, since there was no good faith admission in the first hospital visit, Decedent was prematurely discharged, and the physicians and hospital clearly did not stabilize Decedent's emergency medical conditions (e.g. AML, retroperitoneal sarcoma, and pancytopenia), EMTALA also applies.

incident, "This patient has relapsed AML that cannot be treated given his current condition and as untreated has very poor prognosis… In my view, **the patient's condition is terminal**[82], given the number of organ injury and lack of any improvement in nearly 3 weeks of full medical care. Life expectancy in a case of untreated AML is also poor (from days to few months)… **We have suggested that at this time our medical recommendation will be to withdraw life sustaining measures e.g. Hemodialysis and mechanical ventilation."** Hence, Dr. Sarkar was the key figure that acted to wrongfully, arbitrarily, and capriciously qualify Decedent, and make him subject to DNR procedures.

Dr. Sarkar did not rule Decedent as irreversible on 03/27/2015. Dr. Sarkar and the physicians simply refused to provide necessary and proper treatment. They knew and disregarded the fact or highly predictable outcome that without essential and proper health care, Decedent would continue to deteriorate to the stage that he will become irreversible. Once irreversible, Decedent would definitely not qualify for any chemo treatments. Furthermore, if Decedent deteriorated to the extent that he would die within 6 months of the multiple organ injury, Dr. Sarkar, the key figure in qualify Decedent for THSC Chapter 166 purposes, would be correct and all co-conspirators would appear correct.

Yet, contrary to Dr. Sarkar's wrongful diagnosis or certification of Decedent as terminal, Decedent did not die within six months of the 03/06/2015 multiple organ failure, within six months of diagnosing his AML condition, nor did Decedent die within six months of said events with the

[82] For Decedent's condition to be terminal, his condition had to be an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. *THSC §166.002(13)*

physicians providing him available life-sustaining treatment in accordance with the prevailing standard of medical care. Simply put, Decedent ***was killed/murdered*** on the first day after the six months wrongful deadline that Dr. Sarkar argued terminal injuries had passed. Decedent had AML since 2013, was provided incomplete treatment, and still lived for more than six months. Decedent had AML upon his admission in March 2015 and still lived for more than 6 months and 2 days. Had Decedent been provided with life-sustaining treatment in accordance with the prevailing standard of medical care, it is obvious that Decedent would have lived much longer. Hence Decedent was not terminal.

Dr. Sarkar's wrongful and premature qualification was merely a means to justify BCM & HHS physicians and staff decision makers' irrational, arbitrary, capricious, wrongful, and premature agreement or decision, and act in furtherance of said agreement and decision, to institute the DNR procedures on Decedent pursuant to THSC §166.046, and to deprive Plaintiffs of their due process right including Decedent's right to life, his and his family members' right to consent or withhold consent to DNR, Decedent's right against deprivation of his life without complying with THSC Chapter 166 procedures – which includes (a) that Decedent must be given life-sustaining treatment since there is clear and convincing evidence and knowledge that such would be his desires in the situation, and (b) that Decedent be given life-sustaining treatment for at least 10 days after the later of (i) the physicians provide his family or representatives with medical records in compliance with THSC §166.046 (b)(4)(c) and (ii) the hospital or ethics board's render their final decision to DNR him.

The failure to provide the medical records in compliance with the statute since the hospital

level equivalent of THSC §166.046 procedure began in late March/early April 2015, and the fact that medical records finally provided Plaintiff in late July 2015 after the HHS level ethics board meeting, were tampered with in violation of Texas Penal Code §37.10(a)(1) and/or §37.10(a)(3), supports Plaintiffs' §1983 and §1985(2) and §1985(3) conspiracy claims.

Amongst others, they were clearly tampered with (a) for the purpose of depriving, either directly or indirectly, Plaintiffs of their equal protection of the laws, including their 1st & 14th Amendment U.S. Constitutional right to petition the government for redress of grievance, and their Texas Constitution Article 1 Sec. 13 and 19, open courts, due course of law rights; (b) the purpose of impeding, hindering, obstructing, or defeating the due course of justice in Texas, with intent to deny to Plaintiffs their equal protection of the laws of their (i) 1st & 14th Amendment U.S. Constitutional right to petition the government for redress of grievance, and (ii) their Texas Constitution Article 1 Sec. 13, open courts, and due course of law rights; and (c) intent to injure Plaintiffs for lawfully enforcing, or attempting to enforce, amongst others, their 14th Amendment U.S. Constitutional equal protection right (i) to withhold consent to the DNR of Decedent, and (ii) to timely obtain an injunction to protect their rights and that of Decedent against the wrongful DNR by petitioning probate court to halt the injunction, or have proper records for timely claims.

Dr, Kass, the neurologist, was also a material figure in the wrongful DNR. As the neurologist, his opinion that Decedent had "no chance of meaningful neurological recovery, and that he was going to enter a vegetative or minimally conscious state," was material in giving the physicians the tool they needed to wrongfully deny Decedent of, or withhold from Decedent, essential health care including pressors life-sustaining treatment, brain injury treatment, and also to DNR decedent.

Again, Dr. Kass ***never*** mentioned that Decedent's brain condition was terminal or irreversible for the sake of THSC §166.002(9) and §166.002(10). Dr. Kass knew that per the medical records that he reviewed on 03/27/2015, that BCM physicians were trying to DNR decedent, and justify reasons to DNR Decedent. Dr. Kass was also part of the Harris County Ethics Board §166.046 Committee, and was a proponent of DNR'ing Decedent.

The fact that the medical records that he reviewed or should have reviewed upon seeing Decedent on 03/27/2015, showed trauma and brain injury as a result of the 03/06/2015 events, showed that Decedent was taken of necessary vasopressors on 03/08/2015 right after the 03/06/2015, and showed that Decedent had not seen a qualified brain specialist (i.e. neurologist) since the event, nor a cardiologist, yet they were trying to DNR Decedent all of a sudden, should have put Dr. Kass and all BCM physicians, chief physicians, HHS staff and executives, and the ethics board, on alert of the grievous harm already caused Plaintiffs, the harm being perpetuated on Plaintiffs, and the harm to be caused Plaintiffs including the DNR, death, or killing of Decedent.

The fact that Decedent did not sign an advanced directed, the fact that the physicians and ethics board members, and the hospital staff had knowledge that Decedent would have wanted everything done to keep him alive, including his statement to resident Dr. Atur Sheth that he wanted full code and CPR/chest compressions, should have put Dr. Kass and all BCM physicians, chief physicians, the ethics board, and HHS staff and executives on alert of the grievous harm already caused Plaintiffs, the harm being perpetuated on Plaintiffs, and the harm to be caused Plaintiffs including the DNR, death, or killing of Decedent.

The fact that Dr. Kass was not willing to state that Decedent's brain condition was terminal or

irreversible, also such all should have put Dr. Kass on alert of the grievous harm already caused Plaintiffs, the harm being perpetuated on Plaintiffs, and the harm to be caused Plaintiffs including the DNR, death, or killing of Decedent.

Even worse, after his 03/27/2015 neurologist visit, Decedent did not see another licensed neurologist for months. Dr. Kass's next involvement in Decedent was in the 166.045 Ethics Board Meeting, where he was also a proponent to DNR Decedent against the family's wishes. Dr. Kass was BCM's head of neurology at that time.

Amongst others, including the physicians, Ben Taub hospital 166.046 board members, and HHS level ethics board members, Dr. Kass and Dr. Fisher knew and disregarded the highly predictable consequence of his actions and inactions in failing to provide timely and/or essential neurological, cardiology, oncology, and all essential treatment to Decedent. They also knew that the BCM physicians and staff were trying to take Decedent off pressors, which he needed for life-sustaining treatment and/or his sustained brain injuries.

Considering that Dr. Kass was not willing to qualify Decedent's brain condition as terminal or irreversible, he could have simply stated that Decedent should not be DNR'd. He, as the chief neurologist, never stated that Decedent's brain could not handle chemo treatment for his AML, or if necessary, treatment for his retroperitoneal sarcoma. He simply stated, "…patient has essential no chance of meaningful neurological recovery and that he is going to enter a vegetative or minimally conscious state."

The neurology resident that Dr. Kass agreed with her findings, stated that even though Decedent had "persistent brain stem reflexes… [the] likelihood of meaningful recovery very poor

(e.g. severely cognitively disabled/fully dependent state or minimally conscious state/ vegetative state.).” She recommended that the health care providers continue to address the goals of care. However, at that time, the goals of care was long term acute care within the hospital, if Decedent had funding, or DNR Decedent if he lacked funding.

The fact that as of 03/27/2015, even with all the harm done to Decedent including withholding of pressors, that Decedent “was going to enter a vegetative or minimally conscious state,” means that Decedent was not yet in either a vegetative nor minimally conscious state at that time. Furthermore, the fact that Decedent was going to enter a vegetative or minimally conscious state does not mean that he was not going to recover from said states if provided all necessary treatments. Dr. Kass never states that Decedent would remain in, and would not recover from the alleged vegetative state or minimal conscious state. Dr. Kass and resident Cobb never states that there is no change of *any* recovery; just meaningful recovery.

Per Dr. Kass and his resident Cobb’s report and its elaboration on meaningful recovery, Decedent could have moved into a persistent vegetative state or minimal conscious state, and recovered to a severely cognitively disabled state, or fully dependent state. Their neurological evaluation and report never stated that Decedent was going to be in a coma or be brain-dead. They even suggest that the physicians continue to address the goals of care. But again, at that time, the goal of the physicians was to DNR Decedent if he did not have funds in place.

Amongst others, considering that Decedent suffered his cardiac arrest and brain injury while in the hospital MICU, had he seen and been timely and properly treated by a neurologist, Decedent had a higher chance of recovery or meaningful recovery.

If the neurologist team was willing to suggest that the physicians continue to address the DNR plans and activities, and if they doubted that Decedent's brain injury condition had no chance of recovery, then Dr. Kass and his resident should at least be willing to simply state that Decedent's brain injury was either terminal or irreversible. He did not.

Dr, Kass and the BCM physicians knew the position of the family versus the wrongful DNR intentions of the BCM physicians, and participated or acquiesced to it in their actions or inactions. Every after the 03/09/2015 BAL event, and after the 03/26/2015 neurologist consult, they did not provide him with proper and/or timely neurology staff and/or treatment. They further harmed, including his brain, and amongst others, leveraged the injuries the caused Decedent and his family as reason to conspire and deny Decedent of his U.S. Constitutional rights to essential health care without discrimination, and his life to right via the wrongful DNR.

Even Dr. Elaine Chang's report on the 03/24/2015 meeting with Dr. Mims, Sarkar, and Decedent's family in regards to the DNR intentions, supports the conspiracy.[83] For example, Dr. Chang states that at least 15 physicians have seen Decedent in the past week or two and all agree on his lack of progress. Yet, none of the physicians that saw Decedent as of 03/24/2015 was a neurologist. Furthermore, most of the physicians that saw Decedent were compromised, had conflict of interest, and/or were inexperienced and unqualified.

Dr. Fisher's consult notes on 05/18/2015 further included that Decedent did not need dialysis

[83] On tangential note, the fact that Dr. Mims reiterated that AML can rapidly progress overnight. Such supports that the delay in chemo treatment for his AML in the first and second hospital visit were unreasonable. Decedent therefore should have been evaluated by a fully licensed staff oncologist, such as Dr. Lin or Mims, within hours of his admission to the hospital, and proper treatment or treatment measures timely executed.

as of 04/01/2015. Yet Decedent died of renal failure per the death notice, and dialysis was one of the life-sustaining treatment Decedent needed and that was denied him on multiple occasions including when his daughter asked Dr. Gupta that he be given dialysis. Dr. Fisher was one of the Harris County Ethics Board members, who along with Dr. Sarkar and others, were proponents of DNRing Decedent, and were participants in the conspiracy to prematurely withholding life-sustaining treatment from Decedent in violation of THSC Chapter 166, and participants in arbitrarily terminating Decedent's life.

Amongst others, the BCM physicians withheld both chemo and dialysis from Decedent starting in March, and Decedent died of AML and renal (kidney) failure. Decedent needed chemo for his AML issues, and later needed dialysis for his kidney failure issues. The kidney failure and need for dialysis was proximately caused by Defendants per the 03/06/2015 traumatic events resulting from the wrongful BAL done without consent or informed consent.

Post the wrongful 03/06/2015 events that led to Decedent's multiple organ failure and cardiac arrest, which then affected his heart function, his blood pressure, and kidney functions, Decedent needed dialysis. The harmful effects of the 03/06/2015 events led to the continuous need for dialysis. However, the BCM physicians rather wrongfully, maliciously, knowingly, intentionally, with bad faith, invidiously, and/or deliberate indifference, discriminated against Decedent and his family, and denied Plaintiffs of their U.S. Constitutional due process and equal protection right to life, right essential medical care, and right to consent or withhold consent to DNR, by (a) withholding the necessary chemo treatment, (b) withholding the necessary dialysis, and (c) DNR'ing him against his and his family's wishes with clear and convincing knowledge and

evidence that Decedent would have wanted chemo and dialysis – necessary treatments for him to stay alive, and would not have wanted to be DNR'd.

BCM and HHS, their staff, executives, and decision makers' actions in furtherance of their conspiracy to deprive Plaintiffs of their due process and equal protection rights under the 14th Amendment, include the wrongful withholding of **dialysis** and life-sustaining treatment from Decedent, (a) even after Decedent's family informed Defendants – i.e. gave them knowledge – of Decedent's wishes in such a situation, and informed Defendants to provide him with all necessary and full treatment, and (b) even after it was clear in the medical records – i.e. per resident Sheth's medical records note that Decedent wanted CPR.

On 4/1/2015, Defendant, Dr. Christina Kao, the MICU attending physician, Dr. Joslyn Fisher, and others met with the Decedent's family. Per Dr. Kao's entry in the medical records, she suggested that the hospital and family should agree to make Decedent a DNR patient, and recommended withholding of life-sustaining treatment such as ***dialysis***, vasopressors, and transfusions. Pertinent parts of her writing in the medical records of Decedent on 4/1/2015 at 7:47am reads as follows:

> "A status of DNR in case of cardiac arrest was suggested as well as the recommendation by myself to withhold **dialysis**, vasopressors, and transfusions. The family wishes patient to remain at current status." (Exhibit 66)

However, the family refused to allow the withholding of life-sustaining treatments and informed the physicians that Decedent would have wanted any fighting chance to stay alive.

As of 4/16/2015, Decedent was in a conscious state per a video of him crying and responding to Bethrand's apologetic communication for the harm he sustained at the hands of the physicians while Bethrand was away. Decedent was not yet in a persistent vegetative state or ruled as terminal

or irreversible at that time. Yet, they were already weeks deep into acting in furtherance of DNRing him, and continuously pressuring the family to give them consent to DNR him.

On 4/18/2015 at 2:46pm, Nurse Tochukwu B Onyekwelu wrote that "Air detector in the line, attempted to flush but not able, **called dialysis nurse Robert who told me to stop the dialysis and blood was returned back. Patient was stable, no apparent respiratory distress**.

In Dr. Joslyn Fisher's consult notes on 5/18/2015 at 2:10pm, at the 4/1/2015 meeting with the family, "Family-Plaintiffs describe Mr. Ohakweh as a "fighter" who would want "everything done to save his life." She also wrote "Since the family discussion on 4/1/15, the patient no longer requires dialysis." (Exhibit 67)

Had the physicians provided Decedent with necessary dialysis and blood transfusions, the cause of Decedent's premature death would not have included renal (i.e. kidney) failure. Had they not operated with the intent to DNR Decedent, the resulting injuries to Plaintiffs would not have occurred.

Dr. Fisher's false assertion in the medical records was merely a reason to withhold to necessary life-sustaining treatment Decedent needed, in concert with the wrongful, malicious, knowing, intentional, with bad faith, invidious, and/or deliberate indifferent, and discriminatory agreement and/or decision made by Dr. Mims and other BCM staff and executives, and the hospital staff, to withhold necessary health care from Decedent, cause his death or subject him to death, or simply, outright kill him.

Amongst others, the BCM physicians knew and disregarded the highly predictable outcome that that without said dialysis, Decedent would prematurely die of kidney failure. They knew and

disregarded the highly predictable outcome that Decedent was going to relapse since they prematurely discharged him and did not give him all 3 stages of chemo treatment for the AML back in 2014. They knew and disregarded the highly predictable outcome that his pancytopenia and retroperitoneal sarcoma conditions were going to worsen without treatment in the first or second hospital visit, and that said conditions would be fatal without treatment. They knew and disregarded the highly predictable outcome that without addressing his thrombocytopenia or heart issues, his condition would worsen and would be fatal.

They knew, and disregarded that Decedent had a constitutional right to essential health care especially since (a) they put his kidneys in further danger via the 03/06/2015 traumatic events, and (b) they had fiduciary, statutory, contractual, and policy and procedure obligations to provide him with essential health care at all times.

They also knew, and disregarded that Decedent had a right to health care services including chemo, blood transfusions, and vasopressors, and dialysis without discrimination. They knew, and disregarded the highly predictable outcome that without health care services, Decedent would die. They also knew, and disregarded the highly predictable outcome that as Decedent's condition worsened without timely and proper treatment, including with proper supervision, for his AML, pancytopenia, acute kidney injury, and his retroperitoneal sarcoma, Decedent will be subject to the harm he incurred while in their custody, his condition will worsen and he will die.

They knew, and disregarded the fact that Decedent did not sign an advanced directive, nor consented to the BALs, nor wanted to be DNR'd. The evidence was clear by the preponderance of the evidence. Decedent wanted and sought treatment for his cancer. He did not consent to a

BAL. He did not sign an advanced directive. He wanted CPR/chest compressions. He did not want to die. His family even told the physicians that Decedent would have wanted everything done to keep him alive.

Even worse is the fact that after the severely injured him, and continued to exacerbate their injuries on him, they resorted to elderly abuse and sexual assault on him, and acted to cover it up. The evidence of elderly abuse, wrongful neglect, and sexual assault, is clear in the injuries he sustained due to the infections, the ulcers, and most of all the lacerations to his scrotum. The scrotum injury was not noted by a nurse until April 2015. Prior to that, as of 03/10/2015, Decedent sustained serious lacerations to his ear. As of 04/30/2015, it was noted that he sustained lacerations to his left lower leg. Furthermore, he sustained ulcers throughout his body, with multiple infections. A lot of these injuries were not only unnecessary, but should have been prevented with good faith essential care, and/or timely noted and escalated. Some of the assessments did not occur until weeks or months after the had occurred. Yet, there were physicians and nurses that supposedly saw and evaluated Decedent, or should have done so, on a daily basis. This is evidence of further unjust discrimination, i.e. equal protection rights, and due process rights deprivation Decedent sustained; and actions in furtherance of the conspiracy to subject him to such rights deprivations. Decedent had a 14th Amendment U.S. Constitutional equal protection and due process right against such sexual abuse, elderly abuse, wrongful neglect, and sexual assault.

The discrimination and conspiracy activities continued during throughout the period in which the physicians were wrongfully DNR'ing Decedent against his and his family's wishes.

By June 2015, before Decedent was ruled irreversible, and before he was declared to be in a

persistent vegetative state – if that is actually true, the BCM physicians and HHS staff had already pressured and tried to coerce the family to wrongfully give them consent to DNR Decedent, to which the family constantly refused.

On 6/1/2015, they resorted to undue pressure and coercion via wrongful attempts at financial pressure, further coercion, and intimidation. At 1:18pm, HHS staff social worker, Vinny Oommen, wrote in his discharge care coordination plan, "…primary team is also consulting ethics committee for futility of care in a pt with persistent vegetative state." Decedent was not deemed to be in a persistent vegetative state until July 9, 2015. But their physician's attempt was to withhold necessary care from Decedent, in their attempt to wrongfully put him in an irreversible condition or futile state, and justify their reason to kill Decedent.

According to Vinny Oommen's medical records entry, including on 06/01/2015, the family was not willing to pay for Decedent's transfer nor did they want Decedent transferred.[84] The CEO of Ben Taub Hospital was also involved of Decedent's situation before said 06/01/2015. Regardless, the family's refusal to pay for Decedent's transfer makes sense because (1) the hospital, while depriving Decedent of his U.S. Constitutional rights to essential health care without discrimination, wrongfully caused the injuries to Decedent (i.e. the multiple organ failure and his current worsened condition) that led to their wrongful attempt to transfer Decedent out of the

[84] This is after Vinny Ommenn and her team already flooded Bethrand with calls in the months of April, May, and/or June, during the period in which (a) the BCM staff and executive physicians were wrongfully DNR'ing Decedent against his and his family's wishes and with knowledge of their wrongful DNR actions and withholding necessary or essential care, (b) trying to coerce Bethrand and Decedent's family to give them consent to wrongfully DNR/kill Decedent, (c) the BCM physicians and HHS staff still could not provide a true or logical explanation to the family as to what occurred on 03/06/2015, (d) Vinny Oommen could not explain to Decedent the meaning and implication of the liability clause on the Texas Medicaid Recovery Act document she wanted him to sign.

hospital; (2) the cost of the transfer would be quite the bill that the physicians and hospital caused, so why should Decedent and his family bear such cost; and (3) the BCM & HHS personnel and staff recommended for Decedent to be discharged to another facility without being in a condition for appropriate transfer or movement from the hospital, gave them a list of locations, and told them that the facilities on the list will cost them $1000 per day. On the latter, in other words, after they harmed Decedent and worsened his condition, they tried to make the family wrongfully consent to DNR, or have the family take Decedent out of the hospital at the family's own cost; when they could have provided necessary treatment and/or moved him to the long-term acute care facility.

Vinny Oommen stated that Decedent did not qualify for insurance. Yet, Decedent had succeeded in becoming a U.S. and Harris County resident. He also had suffered kidney failure, thanks to BCM and HHS staff's 03/06/2015 wrongful activities, and their discriminatory actions or inactions. Decedent was above 65yrs old. As a U.S. and Harris County resident, over 65, and with kidney injury, Decedent would have qualified for Medicare at the least.[85] Also, Decedent fulfilled his financial obligations for past discriminatory health care services.

The actions to Mr. Oommen, the HHS staff and executives, BCM staff and executives or decision makers, clearly show malice, knowledge, intent, bad faith, invidious activity, and/or actions with deliberate indifference to the constitutional rights, health, and safety of Plaintiffs; and in many situations, shocks the conscience. Plaintiffs were not treated with dignity or in a humane manner. They were clearly, and with deliberate indifference, discriminated against because of, amongst others, their national origin.

[85] This is evidence that the discrimination was also more than funds, but extended to his being of African or of African/Nigerian origin, as finally disclosed by Dr. Xandera.

Furthermore, the conspiracy to, amongst others, deprive Decedent of his life, is further supported by Dr. Gupta's actions when she called Bethrand on or about the evening of 8/25/2015, and indicated that Dr. Ohawkeh was in imminent death, and that Bethrand should come to the hospital if he wanted to see his father one last time. Upon their arrival at the hospital, the nurses on staff informed them, that Decedent was not in imminent death. Dr. Gupta was allegedly away in the ER, and did not arrive after a long wait for an explanation from her.

BCM risk management personnel were even made aware of the wrongful action of the physicians, including Dr. Gupta's actions.

Also, the continuous administration of medication with "bar codes torn off" that occurred during Dr. Gupta's wrongful and continuous involvement in Decedent's care, is clearly wrongful and against HHS policies and procedures on Medical Administration. Medications with bar codes torn off are to be returned to the HCHD Pharmacy for disposal.

In regards to all the resident or fellow physicians ordering medications in the first and second hospital visit, such as Ghana Kang's alteration of Decedent's chemo treatment schedule that led to delay in treatment, and the residents and fellows under Dr. Guerra *et al*, who were allowed to order medications and act without supervision, such also violates HHS policies and procedures. BCM residents and fellows do not fall within the definition of QMP allowed to order medications. They are not fully licensed physicians. Ordering medications is out of the scope of their licensure.

The continuous unchecked discretion HHS and its executives or decision makers allows the BCM personnel, including their residents and fellows to order medications, is a violation of HHS policies and procedures by BCM; and is a wrongful custom of operations established and allowed

by BCM and HHS for the THSC §312.004 co-op agreement based operations at Ben Taub and/or HHS facilities. Even though the co-op agreement states that BCM is to make sure that their physicians comply with all Federal, State, and local laws, HHS allows BCM an unchecked authority in operations. The main issue with that co-op agreement is that it has no default and/or remedy section for violation of the terms of the agreement, and THSC §312.004(d) gives the parties full discretion in regards to the terms of operations. *See THSC §312.004(d)* ("The contracting parties may determine the terms of and the consideration for a contract authorized under this section.")

Therefore, even in situations when the actions or inactions of BCM or their staff is clearly wrongful and/or constitutes a malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent violation of the terms of the agreement, including violation of Federal, State, and local laws, and a malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent deprivation of the U.S. constitutional rights of patients and their families such as Plaintiffs, BCM and HHS staff and executives can acquiesce to the wrongful actions via cover-ups, without any recourse under the basis of the relationship operations.

BCM and their physicians, has unchecked authority to work with HHS and its staff at HHS facilities to secure funds via Gold Card, Medicare, or Medicaid reimbursement for services from the Federal, State, and Local government entities; even if such means executing unnecessary or wrongful health care services, or denying Plaintiffs and other patients of their rights.

Decedent's sudden and unexplained death on 08/07/2019, was clearly deliberate difference and shocks the conscience result of discriminatory based injuries and murder; and was also executed

to cover up the wrongful actions of BCM, HHS, and their personnel, and cover up their conspiracy actions to deprive Plaintiffs of their 14th Amendment equal protection and due process rights.

The Baylor physicians, including Dr. Mims, Fisher, Sarkar, Guy, Guerra, *et al*, consciously disregarded the known or obvious consequence of their discriminatory decisions and/or actions of amongst others delaying, and withholding or withdrawing the necessary or essential medical services that Decedent needed (e.g. chemo for his AML, treatment for his retroperitoneal sarcoma, treatment for his pancytopenia – including infusion of platelets, dialysis and blood transfusions for his kidney failure issue, proper health care services for his multiple organ failure, etc.).

Overall, their wrongful conscious decisions to delay, withhold, and/or withdraw necessary health care services/treatment from Decedent and his family, constitutes a conscious or reckless disregard of the consequences of their actions, exudes wrongful acts or inactions of malice, knowingly wrongful, intentionally wrongful, bad faith, and invidious actions or inactions, and also constitutes a deliberate indifference to (a) Plaintiffs' constitutional due process and equal protection rights, (b) Plaintiffs' health, and (c) Plaintiffs' safety.

The U.S. Supreme Court has noted the due process right to life, and State's interest in guarding against the mistakenly or involuntary deprivation of said right. *Washington v. Glucksberg*, 521 U.S. 702, 782 (1997) (Souter, D., Concurring) Justice Souter's concurring opinion in Washington goes as far as to discuss situations similar to Decedent's case and held that there is a State's interest in protecting the against such situation:

"but with a recognized state interest in the protection of nonresponsible individuals and those who do not stand in relation either to death or to their physicians as do the patients whom respondents describe. The State claims interests in protecting patients from mistakenly and involuntarily deciding to end their lives, and in guarding against both voluntary and involuntary euthanasia. Leaving aside any difficulties in coming to a clear concept of imminent death, mistaken decisions may result from inadequate palliative care

or a terminal prognosis that turns out to be error; coercion and abuse may stem from the large medical bills that family members cannot bear or unreimbursed hospitals decline to shoulder. Voluntary and involuntary euthanasia may result once doctors are authorized to prescribe lethal medication in the first instance, for they might find it pointless to distinguish between patients who administer their own fatal drugs and those who wish not to, and their compassion for those who suffer may obscure the distinction between those who ask for death and those who may be unable to request it." Id at 782 – 783 (Souter, D., Concurring)

Therefore, even SCOTUS recognizes that the State has an interest to guard against Defendants BCM physicians and HHS staffs' unconstitutional and wrongful actions and inaction, including in furtherance of their conspiracy to deprive Decedent and his family – the nonresponsible individuals – of their due process rights, by executing involuntary euthanasia, coercion and abuse against said nonresponsible individuals because of the consequential large medical bills, wrongful or mistaken decision that may result from inadequate palliative care or terminal prognosis that turns out to be error. Hence, amongst others, (a) the actions of Dr. Sarkar in his wrongful and premature terminal prognosis that turned out to be an error, (b) the inadequate palliative care in withholding or withdrawing life-sustaining treatment such as hemodialysis, and (c) the coercion and abuse from the physicians and hospital staff – e.g. (i) Vinny Ommen coercion and harassment attempts to have Bethrand sign the Texas Medicaid Recovery Act document so that the hospital can be reimbursed for the expenses in Decedent's care, or have him find another facility that will provide him the care he needed and pay the $1000/day cost for said services and the cost of transfer to out of the hospital to another facility, and (ii) the multiple calls and requests from the physicians and Dr. Halphen to Bethrand and the family to wrongfully give them authority to DNR Decedent, in Plaintiffs' situation, are also clearly protected against under the 14th Amendment due process clause. The fact that the CEO of Ben Taub knew of the situation and got involved, yet the coercion and intimidation attempts, and the DNR continued, resulting in the death or killing of Decedent,

shows how much up the chain-of-command the a malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent discrimination and equal protection rights deprivations reached.

The a malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent discriminatory and/or arbitrary, capricious, and/or irrational nature of such actions or inaction in providing necessary or required health care, are also protected against by the 14th Amendment of the U.S. Constitution's equal protection clause.

The Defendants' wrongful, a malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions, i.e. irrational, arbitrary, capricious, malicious, intentional[86], or knowing deprivation of Plaintiffs' due process and equal protection rights to health care services without discrimination, were a substantial factor that caused the resulting harm/damages to Plaintiffs; including Decedent's death from the AML and renal failure, pain and suffering of all Plaintiffs, mental anguish on all Plaintiffs, and all damages complained of in the damages section of this pleading.

The physicians and hospital staff embarked on the Texas Health & Safety Code Advanced Directives procedures within weeks of the wrongful and failed BAL and tracheostomy – i.e. as of about 03/25/2015. Decedent at that time was not ruled as in a persistent vegetative state, nor was he ruled as irreversible. Per the evidence and as already pled, he was prematurely ruled terminal.

Decedent as of 03/25/2015 was not at a qualified patient - i.e. certified by a good-faith physician in his medical records as terminal or irreversible - as required by Texas Health & Safety

[86] Intentionally delaying medical care for a known injury has been held to constitute deliberate indifference. *Farmer v. Brennan*, 511 U.S. 825 (U.S. 1994).

Code §166.031(2) and Harris County Hospital District's Medical Staff Rules and Regulations for patients such as decedent, being made subject to THSC §166.046 Advanced Directives procedures by the physicians. After Dr. Sarkar mentioned DNR to Bethrand, and lied[87] to Bethrand about what occurred on 03/06/2015, and Bethrand exchanged heated words with Dr. Sarkar, Dr. Sarkar should not have been allowed to participate in or oversee the treatment of Decedent.[88] Hence, as of 03/12/2015, there was clearly a conflict of interest between Dr. Sarkar and Decedent and his family. If said conflict of interest extended throughout the HHS staff and/or BCM physicians, considering the circumstances and that the family and Decedent were not the responsible parties for the harm, the BCM physician Defendants, hospital staff, BCM, and/or HHS, should have immediately sought good-faith physicians to administer proper care to Decedent, or immediately acted to appropriately transfer Decedent to a facility that will provide him with proper care.

Otherwise, BCM or HHS staff therefore, disregarded the highly predictable consequence (i.e. the conspiracy to deprive and actual deprivation of right to life, right to consent or withhold consent to withholding of life-sustaining treatment ("DNR"), the actual DNR and premature death of Decedent, coercion and intimidation by BCM and HHS staff to get Medicaid reimbursement for their services, the misrepresentations and withholding of the 03/06/2015 BAL details and reports to cover-up the wrongful BAL activities, Dr. Sarkar's wrongful and premature determination of

[87] There was no trained anesthesiologist during the original unconsented BAL attempt that led to the emergency situation. The anesthesiologist, Dr. Suman, arrived after the unsupervised and inexperienced MICU staff already failed in their wrongful intubation for the wrongful BAL executed without sedation, consent, or supervision. Dr. Sarkar was merely covering for the BCM physicians by misrepresenting material details/information.

[88] Even resident Dr. Elaine Chang posed a conflict of interest with Decedent since she first suggested the bronchoscopy that Decedent did not consent to, which the wrongful attempt at the bronchoscopy led to severe injuries and inability to provide Decedent with the necessary chemo. The 03/24/2015 meeting with Dr. Sarkar, Dr. Mims, and Dr. Chang, Dr. Sarkar's the premature deem of Decedent as terminal to wrongfully qualify him for withholding and withdrawal of life-sustaining treatment, the wrongful DNR in violation of THSC 166, amongst others, supports the conflict of interest. These physicians were in a rush to DNR Decedent and cover-up their wrongful actions.

Decedent as terminal, Dr. Fisher's wrongful actions in support of the DNR, the withholding of necessary brain stem evaluation and treatment for Decedent, the withholding of hemodialysis from Decedent, the falsification and misrepresentation of information including in Decedent's medical records to justify the wrongful DNR and/or killing of Decedent, etc.) of their wrongful actions or inactions by leaving Decedent at the hands of such physicians and staff with such conflict of interest.

Without properly qualifying Decedent as terminal or irreversible, the physicians – for months – wrongfully executed advanced directives procedures and wrongfully withheld life sustaining treatment from Decedent; including months before the ethics board meeting. Such is in violation of TTHC and its Advanced Directives Act, and Plaintiffs' rights as dictated in the Plaintiffs' rights section of this pleading.

Neither the applicable physicians nor other applicable health care providers Defendants, provided Family Plaintiffs with Decedent's medical records as required by THSC §166.046(b)(4)(C), before or after they wrongfully executed the statutory advanced directives DNR procedures.

Per THSC §166.046(b)(4)(c), when applicable Defendants executed the hospital or ethics board level meeting required by Texas Advanced Directives Act and Harris Health System policies and procedures, Plaintiffs were entitled to Decedent's medical records for the lesser of:(i) the period of the patient's current admission to the facility; or (ii) the preceding 30 calendar days; and also receive a copy of all of the patient's reasonably available diagnostic results and reports related to the medical record's written explanation of the decision reached during the review process.

Per THSC §166.046(e), Family Plaintiffs had a 10-day statutory guaranteed deadline to get a court order to halt the withholding or withdrawal of life sustaining treatment from Decedent. However, the 10-day deadline does not begin run until the physicians and health care providers provide them with Decedent's medical records that are in compliant with the statutory requirements of THSC §166.046(b)(4)(C).

Plaintiffs requested Decedent's medical records on or about June 24, 2013. The records provided were not in compliance with in compliance with HIPPA nor THSC §166.046(b)(4)(C). Therefore, per THSC §166.046(e), the physicians/health care providers were required to provide Decedent with life sustaining treatment and the 10-day deadline did not begin to run until they provided Decedent's family or authorized representative with medical records in compliance with THSC §166.046(b)(4)(c).

Neither Decedent nor Family Plaintiffs consented to the withholding or withdrawal of life-sustaining treatment via prior signing of an advanced directive, as required by law or HHS policy and procedure. Decedent's family members actually refused to consent to the withholding or withdrawal of life-sustaining treatment on behalf of Decedent at all times when Defendants asked them to provide informed consent on his behalf to withdraw or withhold life-sustaining treatment.

Per the medical records, Decedent's family members actually made Decedent's desires in such situation clear to Defendant physicians. When asked for consent to withhold or withdraw life-sustaining treatment, Decedent's family members made clear to Defendants physicians that Decedent would have wanted everything done for him to stay alive, and always asked that he receive all necessary treatment to keep him alive. Therefore, Defendants had knowledge of

Decedent's desires in such a situation, but with their wrongful and malicious, knowing, intentional, bad faith, invidious approach to or attitude towards Plaintiffs, and/or their deliberate indifference to Plaintiffs' (a) 14th Amendment U.S. constitutional equal protection and due process rights to non-discriminatory health care services, (b) their health, and (c) their safety, still conspired and/or acted to withhold and withdraw life-sustaining treatment from Decedent.

Dr. John Halphen's malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent intimidation and coercion actions during and after the ethics board 166.046 meeting, also supports evidence of irrational, arbitrary, and capricious discrimination against Plaintiffs rights to consent or withhold consent to DNR, Decedent's right to essential health care, Decedent's right to life, and Decedent's rights against deprivation of life without due process of law. The decision to DNR Decedent, even though wrongful, is not Halphen's sole decision. It's a committee group decision. Hence, his intimidation or coercion attempt at the 07/24/2015 meeting stating that it was his decision, is false, deceitful, and wrongful. Furthermore, his actions of constant calls to Bethrand after the meeting to obtain consent to the DNR, even after the family were to have time to deliberate, is unnecessary pressure or coercion, and irrational, arbitrary, and/or capricious acts to directly or indirectly deny Plaintiffs of their rights. Such coercion and discriminatory actions are also, under the circumstances, actions that Justice Souter warned about in *Washington v. Glucksberg*, which the State has an interest in protecting against.

Dr. Halphen even knew that the decision must be one in which Decedent would have wanted for himself if he was in the situation. Dr. Halphen and the ethics board had multiple written knowledge of what Decedent would have wanted for himself in said situation, i.e. everything done

to keep him alive including continuous provision of life-sustaining treatments. Yet, Dr. Halphen and the ethics board, filled with BCM physicians with conflicts of interest, irrational, arbitrary, and/or capriciously ruled to deny Plaintiffs of their due process and equal protection rights. Halphen was clearly also part of the conspiracy. He agreed and/or acquiesced to it via his wrongful actions. Part of the ethics board members' duties include to review Decedent's medical records prior to making their DNR decision. The medical records even show that Decedent stated that he wanted CPR/chest compressions, and full code treatment, per resident Dr. Atur Sheth entry on 03/05/2015 at 12:32pm.

Halphen, BCM, HHS, their executives and decision makers, managers, the Baylor physician defendants, and/or HHS staffs' malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions in discriminating against Plaintiffs in provision of health care services, subjected or caused Decedent to be deprived of his equal protection rights - i.e. Decedent's right to essential and/or proper/timely health care services without discrimination. Halphen, BCM, HHS, their executives and decision makers, managers, the Baylor physician defendants, and/or HHS staffs' malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions in depriving Plaintiffs of their right to consent or withhold consent to the BALs and DNR, subjected or caused Plaintiffs to be deprived of, amongst others, their due process liberty and privacy rights to consent or withhold consent to the BALs and the DNR, and Decedent's right to life.

Halphen, the BCM physicians and executives and HHS staff and executives wrongfully executed their agreement, with malice, knowledge, intent and bad faith, invidiously, and/or with

deliberate indifference, and via various actions and inactions, to directly or indirectly (a) impede, hinder, obstruct, or defeat the due course of justice within Texas and the United States, with intent to deny Plaintiffs the equal protection of the laws, or injure Plaintiffs for lawfully enforcing or attempting to enforce their rights discussed in this pleading, to the equal protection of the laws; and (b) deprive Decedent and his family of their equal protection rights, including their right to essential health care services without discrimination, right to consent or withhold consent to treatment, right to consent or withhold consent to DNR, right to life, and/or right to petition the government for redress of their grievances and right of access to courts. The troubling fact is that the CEO of Ben Taub Hospital knew of and was involved in the equal protection and due process rights deprivations.

Amongst others, Halphen, the BCM physicians and executives or decision makers, and HHS staff and executives or decision makers, knew that the dead does not testify, that a lawsuit was coming, and that they maliciously, knowingly, intentionally, with bad faith, invidiously, and/or with deliberate indifference to the highly probable consequences of their actions or inactions, caused Decedent the resulting harm. Hence, they acted to cover themselves and/or mitigate their damages exposure by amongst others, (a) mispresenting information regarding events, Decedent's condition, and their activities in the medical records, which they controlled, (b) withholding material reports and/or details required to be disclosed such as the 03/06/2015 BAL event and its report, (c) falsifying and/or forging consent forms, (d) manipulating information in the medical records, (e) withholding material medical records at necessary times from Plaintiffs, (f) intimidating and coercing Decedent's family members to give consent to wrongfully DNR

Decedent and/or accept financial liability for the injuries the BCM physicians and HHS staff caused, (g) wrongfully executing procedures to DNR Decedent and wrongfully DNR'ing Decedent, (h) accelerating his death, (i) killing Decedent, and (j) withholding necessary escalations or report to the proper parties or authorities of their known wrongful activities, including their criminal activities.

Since the 03/06/2015 event, considering that Decedent was alone at the hospital, Decedent was vulnerable. The BCM physicians and HHS staff controlled the situation, as well as all evidence – e.g. the medical records. Hence, they can do whatever they want, and write whatever they want – especially misrepresentations of facts, conditions, and obligations, and expect to get away with their wrongful actions, including by covering it up with further acts or inactions that amount to conspiracy to (a) hinder, impede, obstruct, or deter the due course of justice, and (b) deprive or subject Plaintiffs to the deprivation of their U.S. Constitutional rights.

BCM, HHS, and their personnel's control of the situation and information, their cover-up activities, and their wrongful expectation to evade due course of justice to the harm of Plaintiffs are further clearly evident with the multiple false statements and conflicting stories as to the 03/06/2015 traumatic event. The BCM physicians and HHS staff could not even tell a coherent lie. Some people required to make statements, e.g. Herbert Ortiz and Dr. Guerra, who are mentioned to be present, have no statements in the records. Consent forms are forged, individuals blaming others, and misrepresentation continues. And then Dr. Fisher claims, at the ethics board meeting, that there is no video camera footage of the 03/06/2015 event. Meanwhile she and all physicians, including BCM chief physicians – e.g. Kass and Mims, and HHS ethics board

physicians, have been long working to further harm Decedent, and/or wrongfully DNR him.

By further injuring Decedent to worsen his condition via their wrongful actions or inactions, they would be assured that he can't talk, he can't recover, and he will die. Again, *the dead don't testify*; *nor can the severely injured*. Without any video camera footage, the majority of evidence against them for any legal retribution would be the evidence that they created; evidence under their custody and control at all times, and evidence that *they* manipulated, including all misrepresentations within said evidence, and any further orally or written misrepresentations to justify their wrongful actions. Their cover-up and the custom at HHS facilities set by HHS and BCM, which allows such wrongful, malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent cover-up or obstruction of justice actions is further evident in the "peer review" resolution to the incidents, injuries, and death of Decedent that occurred. No report to outside authorities and/or criminal and/or civil investigations done. After all, the 312.004 co-op agreements have no remedy section.

The wrongful, malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions of Baylor physician defendants and/or HHS staff also include, amongst others, the applicable physicians' failure to train the physicians and staff on the applicable laws, and/or failure to supervise the BAL or endotracheal intubation, their cover-up activities by misrepresenting information and Decedent's condition, premature DNR of Decedent, and intimidation, undue pressure or coercion on his family to give consent. It also includes their discussed wrongful, malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions, in furtherance of their conspiracy to (a) wrongfully discriminate

against Plaintiffs in regards to health care services, (b) deprive Plaintiffs of their right to consent or withhold consent to the BAL and/or the DNR, and (c) deprive Decedent of his right to life or his life. Sadly, even the BCM executives including Dr. Kass, Dr. Mims and Dr. Hyman, as well as Mr. Banfield of BCM risk management, knew of the activities going on and did their part to deprive Plaintiffs of their 14th Amendment U.S. Constitutional equal protection and due process rights.

Halphen, the Baylor physician defendants, and/or HHS staffs' wrongful, malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions, and/or their wrongful actions or inactions in furtherance of their conspiracy to subject or cause Plaintiffs to be deprived of their equal protection and due process rights, were a substantial factor that caused the resulting harm/damages to Plaintiffs.

Decedent and his family (i.e. Plaintiffs) harm/injuries that were caused by the wrongful, malicious, knowing, intentional, bad faith, invidious, and/or deliberate indifferent actions or inactions, of Halphen, the Baylor physician defendants, and/or HHS staffs,' including acts or inactions in furtherance of their conspiracy, to subject or cause Plaintiffs to be deprived of their 14th Amendment U.S. Constitutional due process and equal protection rights, include the bodily injury sustained due to the delay or withholding of, and/or non-treatment of his AML in the second hospital visit, the non-treatment of his pancytopenia and/or the retroperitoneal sarcoma, multiple organ failure, brain injury, mental anguish sustained, anxiety sustained due to the delayed treatment or non-treatments, financial harm such loss of income and/or income opportunities, and other injuries as dictated in the "DAMAGES" section of this pleading.

Failure to Supervise

The failure to supervise by the teaching staff and/or supervising physicians also renders said supervising and/or teaching staff physicians liable. Their failure to supervise or oversee the necessary treatment or health care services provided Decedent in the second hospital visit, was a deliberate indifferent action or inaction on their part. They were wrongful, malicious, show knowledge and intent to deprive rights and harm, show bad faith, exude invidiousness and deliberate indifference to Decedent's 14th Amendment U.S. Constitutional rights to essential health care without discrimination.

The supervising physicians either directed the subordinates to take actions that deprived Decedent and his family of their equal protection and due process rights. The supervising physicians also had actual knowledge of their subordinate's violations of the equal protection and due process rights of Decedent and his family, and acquiesced to said violations. Furthermore, BCM and/or HHS supervisors, maliciously, knowingly, intentionally, with bad faith, invidiously, and/or with deliberate indifference to the highly predictable consequences of their actions and inactions, deprived Plaintiffs and patients at HHS facilities of their constitutional rights, and/or compromised health and safety of Plaintiffs and patients at HHS facilities. They established and maintained a policy, practice, or custom in their operations at HHS facilities, which directly subjected or caused the deprivation of the equal protection and due process rights of Decedent and his family (i.e. Plaintiffs).

Amongst others, the residents and fellows themselves knew and disregarded the highly predictable outcome; i.e. that the resulting injuries to Plaintiffs were a highly predictable consequence of their wrongful actions or inactions by, amongst others, (a) failing to have the licensed and qualified supervising physicians are present to approve their work and/or oversee

their treatment activities, even in cases in which they are directed by the supervisor staff to act alone in high risk situations; (b) delaying or withholding necessary essential care from Decedent including timely oncology and neurology treatments from qualified specialists; (c) failing to sedate Decedent before the 03/06/2015 wrongful BAL done without consent; (d) fraudulently creating consent from for the wrongful 03/06/2015 BAL; failing to obtain consent for the 03/09/2015; (e) misrepresenting Decedent's condition for the sake of the DNR; and more. The unsupervised residents and fellows were clearly wrongful, malicious, invidious, and/or deliberately indifferent to Decedent's 14th Amendment U.S. Constitutional rights to essential health care without discrimination.

Amongst others, pre and post the BAL events, the qualified/specialized BCM physician defendants and HHS staff that were on actual notice of Decedent's presence in the ward (e.g. pre and during while in MICU), were aware of his AML condition and his serious health issues, and were aware of the serious injuries Decedent sustained as a result of the 03/06/2015 events and thereafter. They were also on actual notice of the highly predictable consequences of their wrongful actions or inactions in failing to supervise their subordinates, directing their subordinates to act in high risk situations without proper supervision, and acquiescing to the constitutional rights deprivations of their subordinates – including the deprivation of Decedent's equal protection and due process rights. The qualified/specialized BCM or staff physicians were deliberately indifferent to the health care needs, the safety, and constitutional rights of Decedent and his family by allowing, directing, or acquiescing to the resident and fellow physicians' unsupervised management of Decedent's care. Obviously, the resulting deprivation of the 14th Amendment due process and equal protection rights of Decedent and his family were a highly predictable consequence of their failure to supervise said residents and fellows. More so, the supervising

staff's actions and inactions to acquiesce to the resulting deprivation of Plaintiffs' 14th Amendment due process and equal protection rights of Decedent and his family further supports that said supervising staff, were also deliberately indifference to the constitutional rights, health, and safety of Plaintiffs in their failure to supervise their subordinates.

For example, amongst others, on 05/07/2015, resident Dr. Brock was the only neurologist who, without oversight, oversaw Decedent's neurological evaluation. Her findings and recommendations were never approved by any fully licensed neurologist. Dr. Kass was BCM's Chief of Neurology at that time, directed resident Dr. Brock to act alone, or acquiesced to her in acting alone without his supervision on 05/07/2015. Consequently, in subsequently physician activities, the physicians and neurologists used resident Dr. Brock's un-vetted findings as basis for their treatment or non-treatment justifications, including their DNR recommendations and activities, and justification of DNR'ing Decedent against Plaintiffs' wishes, in violation of Federal, State, and local laws including HCHD policies and procedures. Also, amongst others, Van Hoang's activities with the 03/06/2015 and 03/09/2015 BAL and the acquiesce to said activities by Dr. Guy, Guerra, and the MICU staff physicians, goes without further discussion.

Unfortunately, resident, fellow, staff, and executive physicians that were hostile towards Decedent and his son Bethrand since the first hospital visit, including those who knowingly failed to be present during the BAL and lied about being present for the BAL, were also allowed to continuously oversee and participate in the wrongfully administered health care services on Decedent. Such includes Ghana Kang and Dr. Mims in the second hospital visit.

Proper supervisory custom or practice would have been to (a) execute better oversight of said health care providers, and/or (b) reassign the physicians, and/or (c) transfer Decedent to a physician, facility, or location that would comply with Federal, State, and local laws in the

provision of the health care services Decedent needed. Yet, the usual custom or practice of lack of supervision of BCM staff, and giving the BCM physicians and/or HHS staff unilateral and unchecked authority in their activities at Ben Taub and/or HHS facilities, led to Decedent's care continuously delegated in the hands of compromised physicians with conflicts of interest, who continuously acted with malice, knowingly, intentionally, with bad faith, invidiously, and/or with deliberate indifferent to the consequences of their wrongful actions or inactions; continuously acted to deprive Plaintiffs of their 14th Amendment due process and equal protection rights; and continuously conspired to deprive them of such rights.

Further example: During the period in which BCM and HHS physicians and health care providers were wrongfully trying to coerce Decedent's family members into wrongfully giving them consent to DNR Decedent, Dr. Guy, who misrepresented information in an effort to cover-up her culpability in failing to supervise the 03/06/2015 BAL, wrongfully approved and signed off on resident Dr. Sanitago Lopez's problem list, diagnoses, and plans of care. The resident, Dr. Lopez, excluded Decedent's hypokalemia[89], acute kidney injury, pancytopenia, and thrombocytopenia on his 05/08/2015 problem list, approved by Dr. Guy. The problem list on 05/07/2015 included said injuries, and was approved by a pulmonary physician, Dr. Guntupalli. Without the acute kidney injury disclosed as a problem, the current and future physicians would have disregarded treating Decedent's renal (kidney) issues, and/or would have withheld necessary dialysis, a life-sustaining treatment – from Decedent. Also, without the thrombocytopenia and pancytopenia, Decedent would not be given platelets. Finally, without the hypokalemia on the problem list and addressed, Decedent is at risk of death from heart failure or cardiac arrest. Overall, Dr. Guy's approval of Mr. Lopez's wrongful actions, is just one of many examples of the

[89] Per the problem list, Decedent developed hypokalemia (i.e. low levels of potassium in his blood that increases the risk for abnormally low heart rhythm, and can cause cardiac arrest.) on 04/25/2015.

unchecked authority custom of practice, that allows the BCM staff to act with, amongst others, malice, ill intent, bad faith, invidiously, and/or with deliberate indifference to Plaintiffs' constitutional rights, health, and safety, and to deny conspire to and/or deny Plaintiffs' their 14th Amendment equal protection and due process. Dr. Guy directed, or clearly acquiesced to the knowingly and intentionally wrongful, bad faith, malicious, and/or deliberate indifferent actions of resident Dr. Lopez.

Dr. Guy and resident Dr. Lopez knew – or should have known – that Decedent's death from renal and/or heart failure was a highly predictable consequence of their removal of the acute kidney injury and the hypokalemia from the diagnosed problem list; especially considering that he needed dialysis for his exacerbated kidney injuries from the 03/06/2015 multiple organ failure events and his untreated AML, and had low levels of potassium in his blood that can lead to heart complications and/or cardiac arrest. Basically, as of 05/07/2015, while acting in furtherance of the BCM physicians' agreement to wrongfully DNR and kill Decedent, resident Lopez and Dr. Guy, further accelerated things in motion. And again, the unsupervised physicians did so because of (a) BCM's custom of practice at the facility to grant unquestioned authority to their staff, (b) the resulting already on-going conspiracy to deprive Plaintiffs of their constitutional rights, and (c) the support of the unquestioned and unsupervised chief physicians' and/or decision makers' constant support of and/or acquiescence to the actions of the BCM physicians at the facility overseeing Decedent's care.

Dr. Peacock's actions while she oversaw the care of Decedent from 06/01/2015 to about 06/13/2015 is even more evidence of the custom or practice in failure to supervise. Her last teaching physicians note was on 06/12/2015. Thereafter, Decedent's care was left to her resident, a resident Dr. Aradhna Seth. Said Dr. Seth even authored and signed the "Teaching Physician's

Note" in Decedent's medical records on 06/12/2015 and 06/13/2015. Such is her duty as the teaching physician. Such is further evidence of BCM and/or HHS' custom of continuous unchecked or unquestioned authority allowed the physicians, and the continuous failure to supervise physicians and staff.

***

Furthermore, the 03/06/2015 multiple organ failure event directly resulted in Decedent dependence on ventilator support, dialysis support and GI tube feeding. A 03/10/2015 hemodialysis catheter placement was even executed on Decedent. As of 03/10/2015, Decedent's son Bethrand had not yet returned to find out everything that had occurred, nor did anyone know about the 03/09/2015 BAL. Also, as of 03/10/2015, Dr. Sarkar, Dr. Guy, and fellows Dr. Mimi Phan and Dr. Van Hoang, were overseeing the health care of Decedent. Considering the history of discrimination against Decedent, the presumption of his inability to pay, the breach of fiduciary duties that led to the 03/06/2015 events and the actions of many of the BCM physicians thereafter – especially the MICU and Pulmonary team, amongst others, Dr. Hanania, Phan, Hoang, Dr. Guy, and Dr. Guerra, should not have been involved in the care of Decedent. Resident Dr. Lopez should not have been involved in Decedent's care as of 05/08/2015 at the most. And in retrospect, Dr. Sarkar should not have been involved in the care of Decedent ***at all***, especially since the exchange between him and Bethrand on 03/12/205. Dr. Sarkar became a key figure in the conspiracy to deprive Decedent and Plaintiff their due process rights, including Decedent's right to life, and their equal protection and due process rights.

Furthermore, amongst others, BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants' custom of practice in failing to supervise of the staff and/or granting them unilateral and unchecked authority

in their operations or activities at Ben Taub, evidences malice, knowingly and/or intentionally wrongful, bad faith, invidiousness, and/or deliberate indifference to the rights, health, and/or safety of the patients and their families or surrogates, including Plaintiffs; and evidences a custom of failure to supervise the staff under which HHS and/or BCM are liable. There were clear and continuous violations of Plaintiffs' constitutional rights to due process and equal protection of the laws by individuals that ranged from the residents to BCM and HHS physician executives. Such supports that BCM and/or HHS supervisors, were malicious, knowingly and intentionally, invidious, and deliberately indifferent to the constitutional rights, health and safety of Decedent and his family; and they established and maintained a practice or custom which directly caused or subjected Plaintiffs to the deprivation of their equal protection and due process rights. Such makes BCM and/or HHS liable to Plaintiffs for the resulting injuries under both §1983; and also §1985 under the circumstances.

The fact that, amongst others, Mr. Banfield, Dr. Mims, Dr. Fisher, Dr. Kass, and Dr. Hyman, acting in their individual and official capacity, were aware of Decedent's situation and the events going on, continuously acquiesced to or participated in the wrongful actions or inactions, including the conspiracy to deprive Plaintiffs of their right to give or withhold consent to treatment and DNR, their right to treatment, right to life, right against discrimination, right against deprivation of life without due process, and right to petition the government for grievance, shows that even BCM's management or executive level personnel had knowledge of the constitutional rights violations. Said BCM Management level's knowledge of the constitutional violation actions, were necessary to set things right.

Mr. Banfield is director of risk management at BCM. Dr. Mims, Fisher, Kass, and Hyman are decision makers within their divisions, who are delegated with authority to make decisions on

behalf of BCM while at HHS facilities. Furthermore, said Drs. Mims, Fisher, Kass and Hyman[90] are HHS ethics board executives that make decision on behalf of HHS, at least for the purposes of 166.046 and/or for the purposes of the 312.004 co-op operations at HHS facilities. Their actions, including that of Mr. Banfield, may fairly be said to represent the custom[91], and official acts on behalf of BCM and HHS in regards to 166.046, and/or on behalf of BCM for the purposes of the 312.004 co-op operations at HHS facilities. Hence, since said physicians – including Dr. Mims. – knew of, were involved or participated in, directed, and/or acquiesced to the deliberate indifferent and continuous wrongful actions and inactions that, since the first hospital visit, subjected or caused Plaintiffs to be deprived of their equal protection and due process rights, and said deliberate indifference wrongful actions and inactions continued throughout the second hospital, there is clearly a pattern of unconstitutional practice that is so permanent and well settled as to constitute a custom, practice, or usage with the force of law, and that renders BCM and/or HHS liable for the resulting harm to Plaintiffs under both §1983 and §1985. *City of Canton Ohio v. Harris, 489 U.S. 378, 385 (1989); Monell v. Dep't of Social Servs., 436 U.S. 658, 694 (1978).*

Mr. Banfield, Dr. Mims and BCM were on actual and/or constructive notice of the continuous constitutional equal protection and due process rights violation events from the first hospital visit.

---

[90] Hyman's signing of the death certificate in a manner that precludes authorities from investigating the injuries and death of Decedent, and affects Plaintiffs' Federal Civil Rights §1983 & §1985 causes of actions, was – under the circumstances – the final major action, including as part of the ongoing conspiracy, to maliciously, knowingly, intentionally, in bad faith, invidiously, and/or with deliberate indifference (a) subject or cause Plaintiffs to be deprived of their equal protection and due process rights, but also (b) irrational and unreasonably cover up the deprivation of constitutional rights, impede, hinder, obstruct, or defeat the due course of justice within Texas and the United States, with intent to deny Plaintiffs the equal protection of the laws, or injure Plaintiffs for lawfully enforcing or attempting to enforce their rights to have authorities investigate and press criminal charges, and impedes, hinders, and/or obstructs their Texas State open court rights, due course rights, and their Federal access to courts/petition rights, equal protection rights, and due process rights.

[91] *Monell v. New York City Dept. of Social Services*, 436 U.S. 658, 690-691 (1978)

Dr. Mims deliberately disregarded his rights, and denied him all three necessary treatments for his AML and treatment for his retroperitoneal sarcoma. As risk management, even when Decedent was harmed in the second hospital visit, and after he was made aware of Decedent's situation, he was on notice and had or should have had Decedent's records reviewed to confirm for himself. BCM risk management department is also in charge of the 312.004 co-op agreement relationship, which includes terms that BCM is in charge of staffing HHS facilities with physicians. Furthermore, if his BCM duties are only for litigation purposes, since he was also on the phone while the physicians were trying to wrongfully DNR Decedent, and was aware of the conflict of interest, BCM staff and executives were therefore concerned of litigation. Common sense would lead him to confirm that there was no consent to the March 2015 BALs, that Decedent had been discriminated against in regards to treatment at Ben Taub in the first and second hospital visit, and that BCM physicians and executive decision makers had agreed, and were acting to wrongfully DNR Decedent in violation of Plaintiffs' equal protection and due process of law.

As BCM's risk management director, Mr. Banfield was required to investigate, and/or report Decedent's situation and incidents to proper authorities for their investigation and for proper protocol. Mr. Banfield, in charge of the relationship between BCM's contracting entity with Harris County Hospital District – i.e. Affiliated Medical Services, and the relationship with Texas Higher Educational Board. Under the THSC 312.004 co-op contract, as BCM's representative and acting on behalf of BCM, he had the obligation/responsibility to report Decedent's incidents to not only Affiliated Medical Services, Texas Higher Educational Board and Department of State Health Services, but to all necessary authorities for their investigation and protocol. Instead he participated in the malicious, invidious, knowing, willful, and deliberate indifferent discrimination and/or deprivation of rights conspiracy against Plaintiffs, the obstruction of justice cover-up

conspiracy against Plaintiffs, and the resulting harm to Plaintiffs.

Mr. Banfield, Dr. Mims, and other supervising physicians and staff, were on actual and/or constructive notice of the pattern of Plaintiffs' constitutional rights violations that occurred at Ben Taub. Due to the clear custom or practice of unchecked or unquestioned authority of BCM staff at Ben Taub and/or HHS facilities, they were deliberately indifferent to Plaintiffs' constitutional rights, health, and safety. They were in the position to reassign Dr. Gupta, Lopez, Dr. Mims, Dr. Chang, Dr. Guy, Dr. Guerra, etc., from Decedent's care. There is also evidence that they were on notice of the discriminatory events from the first hospital visit because, amongst others, Ghana Kang, a participant in the first hospital visit's constitutional rights deprivation and hostile events, was reassigned from Decedent in the second hospital visit after Decedent's admitted.

The supervising staff including Dr. Banfield, was also in the position to ensure that the physicians comply with all Federal, State, and local laws per the co-op agreement, and in the position to ensure that Plaintiffs were provided with medical records in compliance with 166.046(b)(4)(c). Amongst others, they were in the position to ensure that all physician staff complied with Chapter 166. Yet again, BCM's custom or practice of granting unquestioned authority and not supervising their staff and subordinates, allowed them to also leverage the withholding of the medical records from Plaintiffs to impede, hinder, and/or obstruct the due course of justice with the intent to directly or indirectly deny Plaintiffs their 14th Amendment due process rights and equal protection of the laws, including right to petition the government for redress, and right against deprivation of life without due process.

While acting in their official capacity and on behalf of BCM, they supported the BCM physicians and HHS staff's acts in furtherance of the agreement to accelerate Decedent's condition to futility, DNR, and kill Decedent, all executed for the purpose of depriving Plaintiffs of their

equal protection and due process rights, and again, for the purpose impeding, hindering, obstructing, or defeating the due course of justice in Texas and United States; with intent to deny to Decedent and his applicable family members (e.g. son, daughter, and wife) the equal protection of the laws, or to injure Plaintiffs or Decedent's estate property for lawfully enforcing, or attempting to enforce, their right to the equal protection of the laws.[92] Mr. Banfield's continuous actions or inactions in his official capacity and on behalf of BCM, were not merely negligent, but rises to the level of knowingly, willfully, with deliberate indifference to the constitutional rights, health, and safety of Plaintiffs. It also evidences and supports his acquiesce to the wrongful actions and inactions of the physicians, and evidences BCM's custom of practice in the co-op agreement – i.e. failure to supervise its staff, managers, executives, and subordinates' and granting them unquestioned authority in their activities even, when the actions of BCM staff subject or cause patients such as Decedent to be directly or indirectly deprived of their U.S. constitutional rights. Such therefore, also renders BCM liable for Plaintiffs' harm under §1983 & §1985.

The BCM and HHS decision makers adopted the plan to, amongst others, leave Decedent in the hands of inexperienced and unsupervised physicians, deprive Decedent of his right to essential health care services without discrimination, deprive Plaintiffs of the right to consent or withhold consent to treatment and DNR, cover-up the forged document, and DNR Decedent against his wishes. Amongst others, the actual and constructive knowledge, and participation of said physicians and decision makers in depriving Decedent of his constitutional rights, including right to life and right against deprivation of life without due process, even with knowledge of Decedent's wish to be kept alive in such circumstances, and their efforts to misrepresent Decedent's condition

[92] Laws that protect Plaintiffs' right to give or withhold consent to treatment and DNR, Decedent's right to treatment, Decedent's right to life, right against discrimination in health care services, right against deprivation of life without due process, and right to petition the government for grievance.

for the sake of withholding life-sustaining treatment, accelerating his condition to futility, withholding necessary and statutorily required medical records from Plaintiffs, wrongfully DNR'ing Decedent, shows the decision makers' authorization or approval of the unconstitutional misconduct of themselves and of their subordinates including the physicians and health care providers. Hence, they are also liable in their individual capacity for Plaintiffs' resulting injuries from the constitutional rights deprivations. *Rizzo v. Goode*, 423 U.S. 362, 370-71 (1976).

By agreeing and acting in furtherance of the agreement to wrongfully DNR Decedent, along with Dr. Sarkar and other physicians, the chief physicians set in motion a series of acts by others which they knew or reasonably should have known would cause others to deprive Plaintiffs of their equal protection and due process rights, and the resulting injuries via (a) their own affirmative acts in the process to deny Decedent and Plaintiff of their equal protection right to treatment without discrimination and due process rights; (b) participating in other physicians and health care providers' affirmative acts such as (i) withholding essential health care such as timely neurological and oncological services, (ii) misrepresenting Decedent's condition or necessary health care needs including his need for dialysis, and (iii) assigning Decedent inexperienced and unqualified physicians and those with conflict of interest; and (c) omitting to perform acts which they are legally required to do such that causes the deprivation of Plaintiffs' rights such as (i) a report and investigation is done in regards to the 03/06/2015 events and the BAL consent form, (ii) ensuring that physicians with conflict of interest are not assigned to Decedent, (iii) ensuring that Decedent is provided with timely and non-discriminatory health care services including oncological and neurological services, (iv) ensuring that Plaintiffs are provided with Decedent's medical records in compliance with 166.046(b)(4)(c) before they DNR Decedent – i.e. withhold life-sustaining treatment from Decedent, and (v) that DNR decision complies with knowledge of what Decedent

would have wanted in the situation if he was alive. See e.g., *Sims v. Adams* 537 F.2d 829 (5th Cir. 1976).

It is clear that the BCM and/or HHS supervisors, continuously acted wrongfully, maliciously, knowingly, intentionally, in bad faith, invidiously, and/or with deliberate indifference to the harmful consequences of their actions on the constitutional rights, health and safety of Plaintiffs. They established and maintained a practice or custom that subjected or caused the deprivation of Plaintiffs' equal protection and due process rights, and also allowed them to conspire to do so as well as conspire to impede, hinder, obstruct, or defeat the due course of justice with intent to deny Plaintiffs equal protection of the laws, and deny them due process rights; directly or indirectly. The BCM and/or HHS supervisors continuously allowed their subordinates unchecked power to execute wrongful action and inactions that resulted in such constitutional rights deprivations and harm to Plaintiffs. Such is evidence of malice, knowingly and intentionally wrongful behavior, bad faith and invidious behavior, and/or deliberate indifferent failure to supervise custom or practice of BCM and/or HHS; invidious, malicious, intentional, knowing, bad faith, and/or deliberate indifferent participation in or acquiescence to said failure to supervise custom or practice; and invidious, malicious, intentional, knowing, bad faith, and/or deliberate indifferent participation in or acquiescence to the wrongful actions or inactions that resulted in Plaintiffs' constitutional rights deprivations, and resulting harm to Plaintiffs.

The BCM and/or HHS supervisors were aware of the unreasonable risks that existed, and were deliberately indifferent to said risk of the deprivation of the constitutional equal protection rights and due process rights of Plaintiffs in their continuous failure to ensure that the BCM physicians and HHS staff complied with all Federal, State, and local laws including HHS policies and procedures. They also acted invidiously, with malice, intent, with knowledge, and in bad faith to

subject or cause the deprivation of Plaintiffs' constitutional rights, and subject or cause Plaintiffs' resulting harm.

For example, the supervisors must review all the medical records and work or activities of the BCM physicians and HHS staff, or instill monitoring mechanisms to ensure that the work or activities of the BCM physicians and HHS staff complies with all Federal, State, and local laws. They must report any issues that violation of the terms of the 312.004 co-op agreement, and violate Federal, State, and local laws, including the statutory and/or constitutional rights of patients, to Texas Higher Educational Board, Affiliated Medical Services, and both the Federal and State level Department of Health Services.

However, the custom or practice is that BCM and HHS staff and their subordinates are allowed to continuously deprive Plaintiffs of their 14th Amendment equal protection right to treatment without discrimination by their actions and inactions, as well as their due process rights by their actions and inactions.

One of the results of the custom or practice established and maintained by BCM and/or HHS at Ben Taub and/or HHS facilities, via their executives, personnel and their supervisors, and that penetrates down to their subordinates, is the invidious, irrational, arbitrary, capricious, and/or unjustified discrimination in health care services because of alienage, origin, race, vulnerability, and/or funding. As already mentioned, another custom or practice established and maintained by BCM and/or HHS at Ben Taub and/or HHS facilities, via their executives, personnel and their supervisors, and that penetrates down to their subordinates, is the unchecked authority to deprive patients and their families, e.g. Decedents and his family, of their due process rights to life, consent or withhold consent to treatment, right to right to give or withhold consent to treatment and DNR, their right to treatment, right to life, right against discrimination, right against deprivation of life

without due process, and right to petition the government for grievance.

A serious result of said wrongful failure to supervise and unchecked authority custom or practice established and maintained by BCM and/or HHS at the facilities, is the wrongful conspiracy[93] in Plaintiffs' case and the damages resulting from said conspiracy by BCM and HHS staff at Ben Taub and/or HHS facilities, done for the purpose of impeding, hindering, obstructing, or defeating, in any manner, the due course of justice in Texas and United States, with intent to deny to Decedent and his applicable family members (e.g. son, daughter, and wife) the equal protection of the laws; or to injure said Plaintiffs or Decedent's estate property for lawfully enforcing, or attempting to enforce, their right to the equal protection of the laws including law that protect their right to give or withhold consent to treatment and DNR, their right to treatment, right to life, right against discrimination, right against deprivation of life without due process, and right to petition the government for grievance.

Simply put, such custom or practice failure to supervise, of unchecked authority, and/or by allowing or acquiescing to BCM personnel to continuously violate the Federal, State, and local laws, policies and procedures, allows BCM and HHS staff and/or personnel to do whatever they want in the HHS/HCHD facilities, including depriving Plaintiffs of their equal protection and due process rights, or conspiring to do such via blatant actions or inactions.

The known actions or inactions of said BCM and/or HHS officials, executives, and/or personnel in establishing, participating, or acquiescing to said customs or practices, constitute a deliberate indifference to the constitutional rights, health, and safety of Plaintiffs overall, and of patients at HHS facilities. Their deliberate indifferent to the consequences of wrongful actions or inactions – e.g., their failure to supervise, resulted (a) that there was no consent to any of the March

[93] i.e. agreements and actions or inactions in furtherance of the agreements

2015 BAL procedures, (b) that Decedent was continuously, invidiously, unjustly and/or irrationally discriminated against in regards to essential health care services, including oncology and cardiology services, and (c) that Plaintiffs were deprived of their unconstitutional rights including their due process and equal protection rights. Sadly, even the BCM and HHS executives participated or acquiesced to the cover-up of the wrongful actions and resulting harm via, amongst others, further withholding of necessary essential care, misrepresenting Decedent's conditions in the medical records, wrongfully instituting DNR procedures on Decedent, rapidly acting to wrongfully DNR Decedent, leveraging coercion and intimidation on multiple occasions to attempt to wrongfully get Decedent's family to consent to the DNR, withholding statutorily required medical records from Decedent's family necessary for them to secure an injunction against the DNR, wrongfully DNR'ing Decedent against Plaintiffs' wishes, and rapidly accelerating and causing his Decedent death against Plaintiffs' wishes.

The multiple invidious, malicious, intentional, knowing, bad faith, and/or deliberate indifferent actions and/or inactions of the BCM and HHS via their decision makers, executives, and management, including the Chief physicians and executives that act on the behalf of HHS and BCM, as well as HHS staff such as Vinny Ommen, was a causal connection to the constitutional rights deprivations Plaintiffs complain of, and evidences actions so permanent and well settled as to constitute a custom, practice, or usage of BCM and/or HHS with the force of law, and that amounts to invidious, malicious, intentional, knowing, bad faith, and/or deliberate indifferent actions of said entities to the unreasonable risk of harm and consequences of said harm created by such failure to supervise or unquestioned authority custom or continuous practice; and renders BCM and/or HHS liable to Plaintiffs under both §1983 and §1985.

The wrongful custom, practice, or usage of BCM and/or HHS' failure to supervise and/or grant

unchecked authority to its personnel in operations at Ben Taub or HHS facilities under the 312.004 co-op agreement, and BCM and/or HHS' continuous and malicious, intentional, knowing, bad faith, deliberate indifferent acquiescence or participation to the resulting deprivation of rights and resulting harm of Plaintiffs, are further shown by the below discovery responses in Appendix 1, 2, and 3. They evidence that there was no investigation or proper investigation done as to the injuries and harm Plaintiffs sustained at Ben Taub in the second hospital visit. HHS and/or BCM did nothing; no institutional, civil, criminal, or professional investigations were done. No reports to or investigations by Texas Higher Educational Board, Affiliated Medical Services, BCM, and HHS.

The BCM and HHS supervisors should have, amongst others, at least supervised or instituted supervision protocols, or ideally, re-assigned said current or putative applicable Defendants – e.g., Dr. Martha Mims, Ghana Kang, Elain Chang, Parlay Sarkar, Van Hoang, Santiago Lopez, Diana Guerra, Paul Kwak, and more.

Halphen, the Baylor physician defendants, and/or HHS staffs' malicious, intentional, invidious, knowing, bad faith, and/or deliberate indifferent wrongful actions or inactions, and/or their wrongful actions or inactions in furtherance of their conspiracy to subject or cause Plaintiffs to be deprived of their equal protection and due process rights, were a substantial factor that caused the resulting harm/damages to Plaintiffs.

Also, the continuous wrongful, malicious, intentional, knowing, invidious, bad faith, and/or deliberate indifferent actions of, amongst others, the multiple failure to supervise, and custom or practice issues complained of, caused or subjected Plaintiffs to be deprived of equal protection and due process rights. The wrongful, invidious, malicious, intentional, knowing, bad faith, and/or deliberate indifferent actions of BCM and/or HHS executives, staff physicians, residents and

fellows in the first and second hospital visit: e.g. (a) the forged document by Van Hoang, the participation in other staff physicians, executives, fellows, and residents, in amongst others, covering up or conspiring and continuously acting on their agreement/conspiracy to cover up[94] the fraudulent 03/06/2015 consent form and wrongful BALs, (b) BCM and/or HHS executives, staff physicians, residents and fellows' include their malicious, intentional, knowing, bad faith, and/or invidious actions and inactions to defeat, hinder, obstruct, impede, or defeat the due course of justice, by amongst others, misrepresenting details or withholding reporting of the wrongful BAL, (c) misrepresenting the individuals present at various material times, (d) withholding or withdrawing necessary treatment (e.g. neurological services, vasopressors, etc.) from Decedent to further harm Decedent to create his irreversible state, (e) assign Decedent compromised physicians or those with conflict of interest, etc., (f) misrepresent Decedent's conditions for the sake of DNR, (g) premature qualification of Decedent for the sake of DNR, (h) wrongful DNR of Decedent, etc. and/or (i) the killing of Decedent.

Amongst others, BCM & HHS supervisors' failure to supervise customs or continuous practices complained of, the conspiracy against Plaintiffs resulting from the wrongful customs or continuous practice complained of, the direct or indirect participation of BCM decision makers, executives, staff physicians, residents and fellows, and the BCM and HHS executives and staff physicians acting in their official and individual capacities and directing their subordinates to execute or acquiescing to their subordinates' wrongful actions, including the conspiracies or the resulting equal protection and due process rights deprivations, were a substantial factor in causing

[94] The conspiracy – i.e. agreement and act in furtherance of the agreement – alleged in this pleading includes for the purpose of impeding, hindering, obstructing, or defeating, in any manner, the due course of justice in Texas and United States, with intent to deny to Decedent and his applicable family members (e.g. son, daughter, and wife) the equal protection of the laws, or to injure said Plaintiffs or Decedent's estate property for lawfully enforcing, or attempting to enforce, their right to the equal protection of the laws including law that protect their right to give or withhold consent to treatment and DNR, their right to treatment, right to life, right against discrimination, right against deprivation of life without due process, and right to petition the government for grievance.

the resulting harm to Plaintiffs as pled throughout this pleading and in the DAMAGES section.

BCM and/or HHS, and the physicians and/or staff themselves, are therefore liable for Plaintiffs' harm under §1983 & §1985.

Failure to train or Inadequate Training[95]

Additionally and alternatively, there is also failure to train or adequately train the physicians, staff, and interim executives as to (i) obtain proper consent or informed consent to treatments and DNR, and (ii) THSC Chapter 166 and its Section 166.046 procedures; which all holds HHS and BCM[96] liable for damages for the actions of their staff and physicians under §1983 and §1985; all which should survive a motion to dismiss and summary judgment.

BCM and/or HHS's failure to train or adequately train of their staff or physicians in regards to the applicable Federal, State, and local laws, and procedures necessary to properly execute their duties under the co-op agreement, constitutes intentional, knowing, bad faith dereliction statutory and contractual obligation to the State, Plaintiffs, and patients at HHS facilities, as well as deliberate indifference (i.e. conscious or reckless disregard of the consequences of their actions or

[95] The inadequate training allegation focuses on the deficiencies in the substance of training of the individuals, and not on the format of their training.

[96] The Civil Rights claims are based on constitutional violations alleged against Defendants. Hence sovereign immunity of Baylor College of Medicine is inapplicable. *Department of Revenue v. Kuhnlein*, 646 So.2s 717, 721 (Florida Supreme Court 1994) ("Sovereign immunity does not exempt the State from a challenge based on violation of the federal or state constitutions, because any other rule self-evidently would make constitutional law subservient to the State's will. Moreover, neither the common law nor a state statute can supersede a provision of the federal or state constitutions.")

Per *Lincoln County v. Luning*, 133 U.S. 529 (1980), Harris Health System, as a local government agency or an entity of Harris County – a county or municipality, is not entitled to sovereign immunity from suit.

Finally, Baylor College of Medicine, Harris Health System, a UT Health Science Center executive staff, and Baylor physician defendants, removed the case from state court to federal court. Hence the 11th Amendment Sovereign Immunity for Baylor College of Medicine, as a state agency, does not apply. The state agencies consented to suit for damages on the claims by invoking the Federal Court's removal jurisdiction when they removed the case to Federal Court themselves. *Lapides v. Board of Regents of University System of Georgia*, 535 U.S. 613 (2002). See also, *Meyers Benzing v. Texas*, 410 F.3d 236 (5th Circ. 2005). Also, BCM's damages are not paid from a government/centralized public treasury or funds, but from that of the private institution. State of Texas is not liable nor does it indemnify BCM and its employees, or HHS employee for damages liability per Tex. Health & Safety Code Sec. 104.002(a)(2)'s exception for "bad faith, or with conscious indifference or reckless disregard;" the latter being the legal definition of "deliberate indifference."

inactions by failing to train the staff) to the rights, health, and/or safety of the patients at HHS facilities, including Decedent at Ben Taub Hospital. It also evidences a custom or practice of failure to train or adequately train staff in regards to the applicable governing laws of operation, under which HHS and/or BCM are liable under §1983 and §1985.

BCM's only response to discovery responses support that there is a failure to train or adequately train their physicians in regards to consent or THSC §166.046 procedures.

[SECOND] REQUEST FOR PRODUCTION NO. 3: Provide an authenticated copy of any training, seminars, or professional educational materials pertaining to Texas Health & Safety Code §166.046 and its procedures, provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: Baylor will supplement this the response to this Request if relevant and responsive documents are identified.

INTERROGATORY NO 4: Provide each date within the past 3 years that materials produced for Request For Production No. 3 above, were provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: Baylor will supplement the answer to this Interrogatory if documents relevant and responsive to the [Second] Request No. 3 are identified.

REQUEST FOR PRODUCTION NO. 4: Provide an authenticated copy of any training seminars or professional educational materials pertaining to Written or Informed Consent prior to executing medical procedures, which were provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: Baylor will supplement this the response to this Request if relevant and responsive documents are identified.

6

HOU 3698719.1

INTERROGATORY NO 5: Provide each date within the past 3 years that materials produced for Request For Production No. 4 above, were provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: Baylor will supplement the answer to this Interrogatory if documents relevant and responsive to Request No. 4 are identified.

REQUEST FOR PRODUCTION NO. 5: Provide an authenticated copy of any training, seminars, or professional educational materials pertaining to employee governmental immunity, provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: None.

INTERROGATORY NO 6: Provide each date within the past 3 years that materials produced for Request For Production No. 5 above, were provided to and used to educate or train Baylor College of Medicine physicians and/or contractors that provide health care services at Ben Taub Hospital.

ANSWER: Not applicable.

Said wrongful action or inaction of BCM and/or HHS, and their necessary or applicable departments management, or executive decision makers, in their failure to train or adequately train, or their lack of evaluation of the applicable health care provider staff, including applicable current or putative Defendants, constitutes a knowing, bad faith, invidious, intentional, action or inaction, and deliberate indifference to the fact that deprivation of Plaintiffs' equal protection and due process rights to health care services including oncology and cardiology services, as well as the resulting harm to Plaintiffs, are a highly predictable consequence of their wrongful actions or inactions (i.e. their failure to train or adequately train the physicians and other health care providers in regards to the Federal, State, and local laws).

Furthermore, amongst others – aside of the forged document and the cover-up attempts by the physicians and staff, (a) Dr. Xander's writing in the medical records of "*no funding with his being Nigerian*, family is trying to decide on goals of care, a meeting tomorrow with them will take place with Ethics committee," and (b) the physician's failure to provide Decedent and his family with medical records in compliance with THSC §166.046(b)(4)(c), meanwhile they (i) deprived Decedent of necessary life-sustaining treatment in violation of THSC §166.046(e) for months,

and (ii) withheld essential and proper health care services from Decedent for months, also supports that BCM physicians are not trained in regards to Federal law, State law, local law, and policies and procedures including substantive due process rights, and antidiscrimination laws including 14th Amendment U.S. Constitutional equal protection rights.

Vinny Ommen's actions use of undue pressure and coercion to get reimbursement from Plaintiffs for the services, have Decedent improperly transferred out of Ben Taub, pressure Berthand to give consent to DNR Decedent, and deeming Decedent as incapable of getting Medicare considering Decedent's age, his renal failure, and his U.S. resident status, is also evidence that HHS staff are not trained in regards to Federal law, State law, local law, and policies and procedures including substantive due process rights, antidiscrimination laws including 14th Amendment U.S. Constitutional equal protection rights, and Medicare/Medicaid health care qualification laws.

Had BCM and/or HHS trained their staff or physicians in regards to the applicable Federal, State, and local laws – including policies and procedures and even 42 U.S.C. §1983 and §1985 – as necessary to properly execute their duties under the co-op agreement, they would not have subjected Decedent to the deprivation of this 14th Amendment equal protection and due process rights, nor caused said rights to be deprived from Decedent; nor would they have conspired and acted in furtherance of their conspiracy to Decedent and Plaintiffs of their 14th Amendment equal protection and due process rights. Also, the resulting harm to Decedent and his family from the conspiracy and wrongful actions and inactions in furtherance of the conspiracy to deprive Decedent and Plaintiffs of their 14th Amendment equal protection and due process rights, would not have occurred. Simply put, Decedent would have received the necessary and timely treatment he needed for his conditions, and the hospital and its health care providers would have been paid.

BCM and/or HHS' malicious, intentional, knowing, invidious, bad faith, and/or deliberate indifference in their failure to train or adequately train the physicians and other health care providers in regards to the Federal, State, and local laws, subjected or caused the deprivation of Decedent and his family's U.S. Constitutional equal protection and due process rights, and was a substantial factor that caused the resulting harm to Decedent and his family members. Decedent and his family members incurred harm resulting from the, amongst others, irrational discrimination in treatment – an equal protection rights deprivation, and the deprivation of Plaintiffs' due process right to life, right to health care, right to consent or withhold consent to Decedent's treatments, and right to consent or withhold consent to DNR.

The continuous violations of Decedent's due process rights to consent or withhold consent to treatment and DNR in the second hospital visit is sufficient enough to demonstrate malice, ill intent, knowledge of the wrongful acts and their consequences, bad faith, and/or deliberate indifference for the purposes of failure to train. The continuous violations of Plaintiffs' equal protection rights to treatment without discrimination in both hospital visits, are also sufficient enough to demonstrate malice, ill intent, knowledge of the wrongful acts and their consequences, bad faith, and/or deliberate indifference for the purposes of failure to train. BCM physicians and HHS staff should have been trained in regards to all the Federal, State, and local laws mentioned in this pleading including constitutional laws, §1983, §1985, THSC §166.046, THSC Chapter 166 overall, THSC Chapter 313, and all the federal and state case laws ranging from *Washington v. Glucksberg*, to *Canton v. Harris*, to *England v. Louisiana State Board of Medical Exam*, *Cruzan v. Missouri*, to *Earle v. Ratliff*, and all pled cases in this pleading. Such would have provided them with the needed training and knowledge necessary to properly execute their duties.

Furthermore, the continuous failure to supervise the residents and fellows in the second

hospital visit, that amongst others subjected or caused Plaintiffs the deprivation of their 14th Amendment due process and equal protection rights, are also sufficient enough to demonstrate malice, ill intent, knowledge of the wrongful acts and their consequences, bad faith, and/or deliberate indifference for the purposes of failure to train; and make BCM liable for Plaintiffs' harm under §1983 & §1985.

Per the THSC §312.004 co-op agreement, BCM and/or HHS knew that Federal, State, and local laws including policies and procedures, were material elements to be complied with by applicable all Defendants including all physicians and/or health care providers, during their provision of health care services to patients at Ben Taub Hospital or HHS facilities. BCM and/or HHS decision makers knew that Defendants would have to know all applicable laws, policies, and procedures, in order to comply with them during their provision of services at HHS facilities.

The THSC §312.004 co-op agreement also imposed a contractual obligation on BCM to staff HHS facilities with physicians that will provide all health care services in the facilities, in compliance with all Federal, State, and local laws, and for 24 hours a day, 7 days a week. Hence, BCM and their applicable staff, knew that that their physicians should have been trained in regards to all the laws such as the Federal, State, and local laws mentioned in this pleading.

Decedent and his family members' resulting harm from BCM and HHS's deliberate indifference in their failure to train or adequately train their physicians and staff, include bodily injuries, mental anguish, anxiety, financial harm including loss of income or income opportunities, death and death expenses, travel and lodging expenses, and more. Decedent and his family members' other resulting harm are dictated in the DAMAGES section of this pleading.

***

Finally, aside of the obvious reasons already pled, there is also deprivation of right to medical

care per state created danger doctrine[97], since the constitutional "special relationship" existed between Decedent and Defendants when, amongst others, (a) Defendants assumed responsibility for Decedent's medical welfare upon admission and/or instituting any treatment on Decedent, (b) when Defendants "placed [Decedent] in a worse situation than he would have been had [Defendants] not acted at all" and admitted him, (c) when the "state affirmatively placed [Decedent] in a position of danger" by admitting and dumping him in the hands of unsupervised and inexperienced staff, and/or (d) amongst others, when they sedated him for the wrongful bronchoscopy.[98]

Therefore, Defendants are also liable for any failure to treat Decedent.

Failure to Screen or Inadequate Screening

Alternatively, and additionally, had BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants, properly screened their applicable staff health care providers prior to their hiring and/or assignment to Ben Taub Hospital and/or the medical unit where Plaintiff was treated in the second hospital visit, the applicable Defendants and/or HHS and BCM staff would not been hired and/or assigned to the unit or department that resulted in their involvement of Plaintiff's matter.

Had applicable current and/or putative Defendants been screen and/or evaluated during their hiring and/or assignment in the unit or department that resulted in their involvement of Plaintiff's matter, BCM and/or HHS, their necessary or applicable departments management or decision makers, and/or the necessary and applicable Defendants would have acted to mitigate or deter the violation of Federal law, State law, local law, and/or HHS policies and procedures, that evidently continuously occurred, including in Decedent's case.

[97] *Johnson v. Dallas Independent School District*, 38 F.3d 198, 200 (1994)
[98] *Wideman v. Shallowford Community Hospital, Inc.*, 826 F.2d 1030, 1035, (11th Cir. 1987)

The intentional, knowing, bad faith, and/or deliberate indifference actions or inactions of BCM and/or HHS, their necessary or applicable departments management or decision makers, in their failure to screen or inadequate screening and/or evaluate the applicable health care provider staff – including applicable Defendants – amongst others, subjected or caused Decedent and his family members to be deprived of the due process and equal protection rights guaranteed them under the 14th Amendment of the U.S. Constitution. It also harmed them by impeding, hindering, obstructing, and/or depriving them of having and/or exercising said rights to the equal protection of the laws.

Said action or inaction of BCM and/or HHS, their necessary or applicable departments management or decision makers, in their failure to screen or inadequate screening of the applicable health care provider staff – including applicable current or putative Defendants, constitutes an intentional, knowing, and bad faith action or inaction in regards to their statutory and contractual obligations to the government, Plaintiffs, and patients at HHS facilities. Such action or inaction also constitutes BCM and HHS' deliberate indifference to the fact that deprivation of Decedent and his family's equal protection and due process rights to health care, are a highly predictable consequence of their wrongful actions or inaction(s).

Said deliberate indifference, knowing, intentional, malicious, and bad faith action or inaction of BCM and/or HHS, their necessary or applicable departments management, and/or their decision makers, in their failure screen or adequately screen applicable health care provider staff – including applicable Defendants, was a substantial factor in causing the resulting injuries to Decedent as complained of.

BCM and/or HHS's deliberate indifference, knowing, intentional, malicious, and bad faith action or inaction in their failure to screen or inadequate screening of health care providers,

subjected or caused Decedent and his family, the deprivation of their 14th Amendment U.S. Constitutional equal protection and due process rights, and was a substantial factor that caused the resulting harm to Decedent and his family.

Decedent and his family incurred harm resulting from the, amongst others, irrational, invidious, deliberate indifferent, intentional, and/or knowing discrimination in treatment – an equal protection and due process rights to health care services deprivation. Decedent and his family members' resulting harm include bodily injuries, mental anguish, anxiety due to the delayed chemo treatment, exposure to illegal immigrant status due to the limitation of his visa, financial harm including loss of income or income opportunities, health care and expenses for said temporary/ineffective health care provided due to the delay in treatment (e.g. blood products needed to maintain adequate erythrocyte and platelet levels). Decedent and his family members' other resulting harm are dictated in the DAMAGES section of this pleading.

EMTALA Civil Money Penalties, & Damages Alternative

First Hospital Visit

Realtors and the United States of America, have claims for civil money penalties under 42 U.S.C. §1395dd ("EMTALA") due to Ben Taub Hospital, Baylor physician defendants, and Ben Taub Hospital staff's breach of duties owed Decedent under 42 U.S.C. §1395dd. *42 U.S.C. §1395dd(d)(1)(A); 42 U.S.C. §1395dd(d)(1)(B)*

Decedent arrived at Ben Taub Hospital's emergency room complaining of shortness of breath. While in the ER he was diagnosed with various emergency medical conditions including AML, pancytopenia, and thrombocytopenia.

It is clearly evident that Decedent's admission was not a good-faith admission.

Per the evidence, it is clear that there was not enough staff in place to provide the timely and necessary treatment to stabilize Decedent's emergency medical condition; and Defendants knew such. For example, it took an unreasonable 6 days delay from the day of his AML diagnosis and notice that Decedent needed chemo for Baylor physicians to order the BAL, an unreasonable additional 4 days delay for the BAL results to return, and an unreasonable additional 4 days before Decedent was given his first chemo treatment. Overall, took an unreasonable delay of 14 days after Decedent's AML diagnosis and notice that Decedent needed chemo, for applicable Baylor Defendants to institute the first stage of chemo treatment.

Secondly, it is also clear that Baylor physicians admitted Decedent with no intention of providing the timely and necessary treatment to stabilize Decedent's emergency medical conditions (AML, pancytopenia, etc.) unless they were assured that he had "funding in place." E.g., per the evidence, starting since 12/14/2015, Decedent was always questioned of payment means or Gold Card insurance. Defendants leveraged the lack of Gold Card or insurance funding as reason not to provide necessary chemo treatment he needed for stabilization of his AML, and as a reason not to provide him with chest x-rays that he needed. Decedent's diagnosed retroperitoneal sarcoma was not treated at all.

Upon Decedent's arrival at the ER and after his non-good faith admission into the hospital ward, Ben Taub Hospital and Defendant physicians and the hospital staff had a duty to, amongst others, provide necessary stabilizing treatment for Decedent's emergency medical conditions (e.g. AML, retroperitoneal sarcoma, pancytopenia, etc.) so that within reasonable medical probability,

no material deterioration of the condition is likely to result from or occur during (1) Decedent's discharge from the Ben Taub Hospital facility he is in, or (2) Decedent being moved outside the Ben Taub Hospital facility he is in. Other statutory rights of Decedent and statutory duties of Ben Taub Hospital and Defendant physicians and the hospital staff, include Decedent's right against Ben Taub Hospital and its physicians and/or staff's delay in providing appropriate medical screening examination required under *42 U.S.C. §1395dd(a)* or further medical examination and treatment required under *42 U.S.C. §1395dd(b)* in order to inquire about Decedent's method of payment (e.g. Gold Card) or insurance status.

The Baylor physicians and hospital staff had a statutory EMTALA and common law fiduciary duty to comply with all sections of 42 U.S.C. §1395dd, including not to make misrepresentations in regards to Decedent's condition or misrepresentations in regards to any information including their obligations under 42 U.S.C. §1395dd.

Ben Taub Hospital and Defendant physicians and the hospital staff continuously deprived Decedent and his family of rights secured under 42 U.S.C. §1395dd, thereby breaching their EMTALA statutory and common law duties to Decedent. Evidence including the medical records contain multiple Baylor physician and Ben Taub Hospital staff misrepresentations, and actions in furtherance of, and results of said wrongful misrepresentations, in regards to Decedent's conditions, misrepresentations of information including obligations under 42 U.S.C. §1395dd.

For example, the diagnosed AML and pancytopenia were not fully treated, even after the physicians knew – or should have known – that reasonable within medical probability, Decedent's condition will materially deteriorate and die without their acting to stabilize the AML and

pancytopenia. Without fully treating the AML and pancytopenia, Decedent was at risk of further deterioration or serious harm from any surgery, invasive procedure, or any activity that resulted in cuts to Decedent inside or outside the Ben Taub facility he was in. Without fully treating the AML and pancytopenia, Decedent was at risk of further serious harm or deterioration from any surgery, invasive procedure, or any activity that rendered him subject to infections or compromised his immune system while Decedent inside or outside the Ben Taub facility he was in. Hence the unresolved/non-stabilized pancytopenia, was a high priority on Decedent's noted problem list since 12/2013, continued as a problem with high priority after he was wrongfully discharged on 01/26/2014, and readmitted for second stage of chemo for his AML in 05/2014, remained as a high priority problem for Decedent before and after his readmission in 03/2015, and was a high priority problem upon Decedent's injuries 03/2015 and death in 09/2015.

The diagnosed retroperitoneal sarcoma was not discussed nor treated at all, even after the physicians knew – or should have known – that Decedent's retroperitoneal sarcoma condition will materially deteriorate and die without their health care services (e.g. surgery, radiotherapy, or chemotherapy) to stabilize the retroperitoneal sarcoma. Such is evidence because the retroperitoneal sarcoma condition began to spread from his left pelvis to his right pelvis. Yet, they discharged Decedent from the hospital without informing him of the sarcoma, never treated nor informed him of the sarcoma in upon subsequent admissions for chemo treatment, and never readmitted Decedent for oncology treatment of the retroperitoneal sarcoma.

Throughout the first hospital visit, the physicians and hospital staff did not act to stabilize Decedent and offer to transfer him to a facility that would provide him with the necessary health

care services that he needed for the retroperitoneal sarcoma, AML, and pancytopenia. They breached their duty to obtain, and Decedent's right to give, (a) written informed consent to refuse examination and treatment of Decedent's emergency medical conditions, after Ben Taub Hospital and its physicians and/or staff (1) offers Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) examination and treatment of his emergency medical condition, and (2) informs Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) of the risks and benefits to Decedent of such examination and treatment.

Furthermore, throughout the medical records in regards to Decedent's first hospital visit, the physicians continuously misrepresented Decedent's condition or other information, including Ben Taub Hospital's obligations under 42 U.S.C. §1395dd. For example, amongst others, they continuously misrepresented Decedent's time of diagnosis of his AML alleging that it was noted much later on 12/19/2013, versus on 12/13/2013. Decedent was diagnosed on 12/13/2013 while in the ER. Furthermore, they misrepresented the date of diagnosis of his retroperitoneal sarcoma, which occurred on 12/18/2013. They continuously claimed alleged that it was first noted on 12/25/2013.

Defendants physicians and health care providers, also continuously misrepresented their obligations under 42 U.S.C. §1395dd, including their obligation to provide necessary stabilizing treatment for Decedent's emergency medical conditions (e.g. AML, retroperitoneal sarcoma, pancytopenia, etc.) so that within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during (1) Decedent's discharge from the Ben Taub

Hospital facility he is in, or (2) Decedent being moved outside the Ben Taub Hospital facility he is in. They discharged Decedent prematurely without completing the necessary chemo stages or treatment that Decedent needed to stabilize his AML and pancytopenia. They also did not schedule and admit him for his final stage of chemo for his AML, nor did they provide the necessary treatment for the retroperitoneal sarcoma.

Defendants physicians and health care providers, also continuously misrepresented their obligations under 42 U.S.C. §1395dd(h). They were obligated to provide necessary screenings, examinations, and treatments to stabilize his – amongst others – AML, retroperitoneal sarcoma, and pancytopenia, before discharging him or referring and moving him to an alternate facility, or before moving him out of the Ben Taub medical ward. They were obligated to provide said necessary screening, examination and treatment services without delay or in order to inquire about Decedent's method of payment (e.g. Gold Card) or insurance status.

Yet, from the day of Decedent's admission to the hospital, 12/14/2103, they delayed or withheld necessary screenings, examinations, and treatments Decedent was entitled to and they were obligated to provide him, due because they were not assured of "funding in place" via Gold Card insurance or Medicaid.

They delayed or denied him necessary chemo because of, amongst others, lack of payment assurance in place (e.g. Gold Card, or insurance); sometimes even after they were told that he had money to pay, and even after Decedent paid out of pocket for their services. They denied or delayed providing him with necessary chest x-rays and necessary screening and stabilization treatment services for his emergency medical conditions because he lacked the Gold Card or

"funding in place."

They also wrongfully discharged him and referred him to an outside facility, where the oncologist Dr. Mims was supposed to address both his AML and retroperitoneal sarcoma. They discharged/transferred him without any signed written informed consent or request for discharge or transfer, without any physician certification for appropriate transfer, and without proper protocol required by 42 U.S.C. §1395dd(b)(1)(B).

Before Decedent's discharge or referral and transfer to the outpatient facility, Decedent's emergency medication conditions were not stabilized. There was no certification that the benefits of the discharge or being moved out of Ben Taub hospital for treatment at the outpatient facility outweighed the risks of him being treated at Ben Taub Hospital. There was also assurance or certification that the outpatient facility would accept him and provide him with necessary treatment to stabilize his emergency medical conditions.

While at the outpatient facility with Dr. Mims, Dr. Mims stated that he needed to be readmitted for his third and final stage of chemo treatment, but Ben Taub Hospital, its Baylor physicians, and its staff never readmitted Decedent for said necessary treatment for his emergency medical condition(s). Rather Decedent was met with inquisition as to "funding in place" for oncology services. Meanwhile, Decedent willing paid out of pocket for the services.

The Baylor physicians and Ben Taub Hospital or Harris Health System staffs' multiple breached of their duties not to mispresent information regarding Decedent's condition or in regards to any information including their obligations under 42 U.S.C. §1395dd, their breach of their fiduciary duties to Decedent, and their violation of Decedent and his family members (i.e. family

Plaintiffs) rights secured under 42 U.S.C. §1395dd, and their breach of their duty not to delay or withhold examination or treatment (e.g. the first hospital visit BAL, the chest x-rays, the non-treatment of the retroperitoneal sarcoma) subjects the physicians and HHS d/b/a Ben Taub hospital to civil money penalties under 42 U.S.C. §1395dd(d)(1)(A); 42 U.S.C. §1395dd(d)(1)(B).

Second Hospital Visit

Realtors and the United States of America, also have claims for civil money penalties under 42 U.S.C. §1395dd ("EMTALA") for Ben Taub Hospital, its staff, and BCM physician's breach of duties owed under the statute. *42 U.S.C. §1395dd(d)(1)(A); 42 U.S.C. §1395dd(d)(1)(B)*

Per *Thorton v. Southwest Detroit Hospital*, 895, F.2d. 1131, 1135 (6th Cir. 1990), 67 Fed. Reg. 31506-31507 (May 9, 2002), and 42 CFR §489.24(d)(2)(i), there is a good-faith admission requirement that makes EMTALA applicable to inpatients – i.e. post the patient's admission to the hospital. Hence, hospitals and their physicians cannot admit patients in non-good-faith, in order to circumvent the EMTALA statute – i.e. use the patient's admission post ER as a defense to the EMTALA statute.

Furthermore, Decedent's case fits another exception that makes inpatients subject to EMTALA. Per 42 CFR §489.24(d)(2)(ii), EMTALA still applies to a patient that was admitted for an elective (nonemergency) diagnosis or treatment. Decedent's MICU consult with Dr. Elaine Chang, occurred while Decedent was in the ER. He informed her that his illness – i.e. his AML – had returned. She then noted that a bronchoscopy was to be done, and the reported his admission to be approved by the internal physicians. The bronchoscopy was an elective (nonemergency) diagnosis or treatment procedure. Hence, his admission was also for the sake of screening for the bronchoscopy. The same bronchoscopy, done without consent, was the procedure that was being wrongfully done on 03/06/2015 by unsupervised and inexperienced physicians, that led to the

03/06/2015 traumatic events.

Simply put, Decedent was not admitted in good-faith for the treatment of his necessary medical condition, he was admitted for the sake for an elective diagnosis or treatment procedure. Therefore, EMTALA clearly applies in Decedent's case.

When Decedent was admitted into the hospital, post his arrival at the emergency room on 03/04/2015, the hospital and staff also knew that they did not have the necessary staff to treat him. They also did not seek to stabilize his medical emergency conditions (i.e. his AML cancer, heart issues, retroperitoneal sarcoma, etc.), nor did they succeed in stabilizing his emergency medical conditions (i.e. AML, hypoxia, pancytopenia, retroperitoneal sarcoma, thrombocytopenia, renal condition, respiratory failure, AML, etc.). Rather, Decedent was admitted and dumped – in violation of the anti-dumping EMTALA statute – into the hands of hostile and/or inexperienced residents, and without adequate or proper staff and/or supervision.

Defendants' decision to admit Decedent in a hostile environment, without adequate or proper staff and/or supervision, is not a good faith admission. Defendants could have simply transferred Decedent to another hospital for his necessary and desired chemo treatment, and treatment for his emergency medical conditions. Rather, Decedent was admitted for an elective procedure and exploitation.

Amongst others, aside of the fact of the elective bronchoscopy admission, the evidence of the non-good faith admission and discrimination is also clear because (1) there was a delay in admitting Decedent that caused the ER physician to be very concerned about the effects of Decedent's deterioration, (2) there was "allegedly" no beds in the MICU – which is yet to be supported by evidence, (3) Decedent was not evaluated by a cardiologist even after he was found to have heart issues, (4) the cardiologist was only consulted to review electrocardiogram images,

which sometimes were even improperly executed, (5) Decedent did not see a fully licensed physician for almost 24hrs after his admission, but rather was in the hands of inexperienced and unsupervised residents and fellows, (6) upon his admission to MICU, Decedent still did not see a cardiologist – even after one was supposed to be put on his primary care team, (7) no fully licensed physician authorized the 03/06/2015 bronchoscopy or laryngoscopy intubation nor did Decedent, (8) Decedent had pancytopenia, thrombocytopenia, and low platelet count, and was not given platelet transfusion; yet the inexperienced and unsupervised physicians and staff tried to and executed a wrongful intubation for bronchoscopy and laryngoscopy, (9) there was no supervising staff present for the bronchoscopy, laryngoscopy, and emergency tracheostomy, (10) after the traumatic 03/06/2015 events, the physicians immediately tried to dump Decedent by wrongfully discharging him, (11) there was no consent nor emergency situation for the 03/09/2015 BAL, (12) the physicians even noted on 03/05/2015 that they would consider giving him chemo treatment for his AML, but such treatment never came – allegedly because of the results of the wrongful, unapproved, and unconsented intubation, (13) Decedent was continuously deprived of oxygen even after the 03/06/2015 events, (14) the physicians and hospital staff denied him timely and necessary neurological evaluations and treatment after the 03/06/2015 events, (15) the physicians and hospital staff tried to wrongfully discharge Decedent when he would have qualified for long-term acute care within the hospital, but did not transfer him to long-term acute care because of the lack of Gold Card or Medicaid, (16) the physicians and hospital staff tried to and did DNR Decedent rather than providing him of treatment for his emergency medical conditions because of, amongst others, his lack of funding in place; and more as pled in sections above and throughout this pleading.

Further evidence of the non-good-faith admission, discrimination, hostility and abuse towards

Decedent is also shown by (a) the lack of sedation provided for the 03/06/2015 BAL intubation, (b) the lack of anesthesiologist consult before the intubation began, (c) the lack of platelets provided Decedent before the intubation, (d) the lack of consent to 03/09/2015 BAL, and (e) the physical assault, batter, and/or sexual abuse and neglect that Decedent encountered in the second hospital visit – including the lacerations to his body including his scrotum, multiple bed scores, and more.

Amongst others, rather than giving Decedent, amongst others, the necessary chemo treatment or subsequent stages of chemo treatment, as well as the platelets, cardiological evaluation and treatment he needed, the inexperienced and unsupervised staff instituted the wrongful bronchoscopy without consent, which led to the 03/06/2016 traumatic events that occurred.

Ben Taub Hospital/Harris Health System's hospital's obligations under EMTALA does not end because upon Decedent's admission to the hospital. The good faith clause is meant so that hospitals and physicians do not admit patients to circumvent the statute. However, per the Order Denying Motion to Dismiss in *Jesus Lopez v. Contra Costa Regional Medical Center*, Cause No. C 12-03726 LB (N.D.C.A California Apr. 5, 2013), the fact that Decedent (1) had an emergency medical conditions (e.g. AML and retroperitoneal sarcoma cancers, pancytopenia, kidney injuries, heart and respiratory issues,) that were never treated to stabilization as required by the statute, (2) the hospital did not have or provide the proper qualified staff to stabilize his emergency medical conditions, (3) Decedent was reluctantly admitted and dumped in the hands of hostile, inexperienced and unsupervised staff; the admission was therefore not done in good faith to stabilize the AML or any of his emergency medical conditions.[99]

[99] This is also shown by the fact that Decedent was left in the hands of inexperienced and unsupervised residents. Pursuant to Texas Health and Safety Code Chapter 314 co-op agreement between Baylor College of Medicine, Harris Health System, and Texas Higher Educational Board, Ben Taub hospital is required to be staffed fully, 24 hrs/day 7 days/week, with qualified/competent staff to provide health care treatment to patients at the hospital, and they are

Alternatively, and additionally, the non-good faith admission and the admission for elective diagnosis and treatment procedures, including the bronchoscopy, were also substantial factor in contributing to or causing Decedent's injuries sustained on 03/06/2015 and thereafter. Decedent's admission (1) was clearly not a good faith admission, and (2) was an admission to (i) circumvent the EMTALA statute, (ii) provide experience to unsupervised, unqualified, and/or inexperienced physicians, and (iii) make money off the Federal, State, and local government without providing the efficient or necessary treatment to stabilize his material and emergency medical conditions – e.g., Decedent's AML, retroperitoneal sarcoma, cardiology issues, renal issues, etc.

For example, in the second hospital visit, Decedent should have been given platelets transfusion and his blood clot capability established, before any health care provider began any invasive procedures that would expose him to risk of bleeding. Furthermore, amongst others, Decedent was to be provided a cardiologist consult and full evaluation since 03/05/2015, considering that he had heart issues that included volume overload. Decedent should have seen a fully licensed oncologist before any intubation began, not just a resident or fellow. Such did not occur.

Rather, inexperienced and unsupervised individuals, who were clearly unaware of Decedent's conditions and issues, were allowed to execute a high-risk procedure on Decedent without his consent, and caused him harm. Thereafter, the physicians and staff tried to rush Decedent out of the hospital via a wrongful discharge. Once unable to do so, they delayed and/or denied him treatment, and then rushed to DNR him against his and his family's wishes, rather than providing him with stabilization treatment, essential health care, or long-term acute care services available within the hospital.

required to comply with all State, Federal, and Local laws.

Furthermore, there is no evidence that there were no beds in the MICU provided. Rather, there is evidence that the no beds allegation was merely an excuse not to admit and treat Decedent since his time at the ER. Rather, it is further evidence that Decedent was in a hostile environment.

For example, The ER physician, Dr. Tolu, had to document his concern about Decedent's serious condition and its rapid deterioration after there was delay in admitting him. The same Ghana Kang that was part of the hostility and discrimination Decedent encountered in the first hospital visit, and participated in said hostility, discrimination, and denial of full chemo treatment for his AML and denial of treatment for his retroperitoneal sarcoma, once again encountered Decedent in the ER. Thereafter, he appears again in the medical records after Decedent was admitted, and Decedent's needed chemo was still not addressed, nor Dr. Mims, his oncologist, consulted. The internal physicians knew of his serious condition, and knew of him. Decedent was someone who they did not want to treat or provide the necessary treatment to stabilize his emergency medical conditions, especially his need for oncology services. The reluctantly admitted him, were hostile to him, abused and neglected him, and tried to wrongfully discharge him.

Further evidence is that upon Decedent's non-good-faith admission, resident Sophia Kumbanattel foretold his discharge in 4 – 5 days. This was even before he was admitted to the MICU, where he needed to be. Decedent's injuries clearly required more than 5 days. Decedent did not see a fully licensed physician upon his admission for about 24 hours. Rather Decedent was in the care of residents, fellows, and pharmacists working with residents and fellows, to rush him through the hospital in a half-hazard manner; e.g. Sean Riley and his allopurinol high dosage, alleging to be aggressive and that they only had a few days. The health care providers were clearly trying to wrongfully rush their services, and get him out of the hospital, and be able to minimize their expenses and/or collect whatever funds they can from the government or from him, without

properly stabilizing or treating his emergency medical conditions in good faith.

Furthermore, even with the no beds excuse, Decedent was admitted into the MICU within hours of his rapid response. However, before such, they contemplated intubating Decedent and providing him with ventilation while he was in the intermediate care unit. MICU treatment involves more costly treatment services that the health care providers did not want to provide because of, amongst others, (a) Decedent's origin and lack of insurance funding; and (b) their hostility towards him and discrimination against him since the first hospital visit. It took a rapid response and the obvious deterioration of Decedent for them to move Decedent to MICU. Thereafter, Decedent was still dumped in the hands of mostly inexperienced, unqualified, and unsupervised physicians while in the MICU.

The physician in charge, Dr. Guerra, merely did a health and physical on Decedent. She did not fully consult a cardiologist for his heart condition, nor was Dr. Mims, the known prior provider consulted. Meanwhile, Decedent's AML was rapidly spreading and causing more harm per his deteriorating condition, and his heart condition persisted. Cardiology specialist services are also very expensive compared to other services. Hence a Decedent was denied full cardiology services. Neurology services are also very expensive. Hence Decedent was also denied full and proper neurological services after the 03/06/2015 traumatic events. Furthermore, Decedent was not sedated for the unsupervised intubations. He needed proper and advanced anesthesiology services for the procedures, and was denied such. The lack of anesthesiology and withholding of said services, led to (a) a resident ordering fentanyl on 8:46am on 03/06/2015 without authority, then cancelled the sedation order, and (b) the anesthesiologist Dr. Suman, unable to describe all sedations that were ordered and administered during the emergency medical situation. Hence one can imagine the pain or agony Decedent experienced at the hands of the physicians while at the

hospital; including during the wrongful intubation attempts done without sedation or supervision.

Dialysis is also expensive. Hence dialysis was prematurely and wrongfully withheld from Decedent per Dr. Fisher. Long-term acute care required further in-hospital services. Decedent did not have insurance or Gold Card. Hence said services were withheld from Decedent; even though Decedent had money to pay for the services, per his payment for the first visit services.

Decedent's had right to the necessary stabilizing treatment for Decedent's emergency medical conditions (i.e. his AML cancer, heart issues, retroperitoneal sarcoma, pancytopenia, thrombocytopenia, renal condition, respiratory failure, etc.) so that within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during (1) Decedent's discharge from the Ben Taub Hospital facility he is in, or (2) Decedent being moved outside the Ben Taub Hospital facility he is in.[100]

Per Decedent' death certificate, and per the medical records, Decedent died of AML, Renal (i.e. Kidney) Failure, Respiratory Failure, and Hypoxic Ischemic Encephalopathy, respiratory issues. Therefore, Decedent's AML, his renal condition issues or acute renal injury, his respiratory condition issues, and his hypoxia, all known since his ER and admission to the ward, were never stabilized.

All physicians and health care providers involved in Decedent's care, had a duty to stabilize Decedent's AML, his renal condition issues or acute renal injury, his respiratory condition issues, and his hypoxia. Furthermore, all physicians and health care providers involved in Decedent's care since the first hospital visit, had a duty to stabilize his AML before he was discharged.

The all physicians and health care providers involved in Decedent's care breached their duty to provide all necessary stabilizing treatment for Decedent's emergency conditions (i.e. Decedent's

[100] *42 U.S.C. §1395dd(b)(1)(A)*

AML, his renal condition issues or acute renal injury, his respiratory condition issues, and his hypoxia). This should have included, amongst others, (a) timely or immediate cardiological consults from a qualified and licensed specialist for evaluation and treatment, and (b) timely or immediate oncological consults by a qualified and licensed specialist for evaluation and treatment.

Decedent also had a right, and all physicians and health care providers involved, had a duty to be discharged from the Ben Taub facility Decedent is in, or moved outside the Ben Taub facility Decedent is in to another facility if said discharge or movement outside the Ben Taub facility Decedent is in to another facility complies with *42 U.S.C. §1395dd(C)(1)(A)(i)*, *42 U.S.C. §1395dd(C)(1)(A)(ii)*, *42 U.S.C. §1395dd(C)(1)(A)(iii)*, and *42 U.S.C. §1395dd(C)(1)(B)*.

BCM physicians and the health care provider breached this transfer duty from the start. Rather than moving to stabilize Decedent's respiratory issues with qualified and supervised physicians and staff, and then comply with their statutory obligations and work to find and properly transfer him to a facility that will accept him and providing necessary stabilizing treatment for his emergency conditions, they chose to do an elective high-risk procedure without consent, and without providing Decedent with the platelets that he needed to mitigate the risk of him continuously bleeding to death.

The BCM physicians and HHS staff never informed Decedent nor his family of the lack of beds, and that the risks of him being in the hospital outweighed the benefits. Rather, they reluctantly admitted him in non-good faith, for an elective procedure that was done without consent, and for other wrongful reasons as already pled. Decedent was exploited for the benefit of the inexperienced, unqualified, and/or unsupervised residents and fellows.

Even after the injuries on 03/06/2015, the BCM physicians and HHS staff further breached their duty to Decedent by moving to immediately discharge him home, without stabilizing his

emergency medical conditions. Per the discharge staff's documentation, funding was the issue. Decedent had no funding for alternative placement or care, and no Harris Health System benefits – e.g. Gold Card. Hence, they tried to discharge him home. Such wrongful transfer efforts occurred even before any of the qualified or fully licensed physician had signed a certification that includes a summary of the risks and benefits upon which the certification is based, and that based on the information available after the 03/06/2015 traumatic events, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility or by him being outside the hospital, outweigh the increased risks to Decedent by being in the hospital. Such certification clearly did not occur because, per (1) Ben Taub is a Level 1 trauma hospital that has everything that any facility would have, (2) Decedent was in the MICU of said level 1 trauma hospital, and (3) the benefits of treating Decedent – if done by qualified and/or properly supervised physicians, clearly outweigh the risks of him being discharged. If discharged, Decedent would clearly deteriorate rapidly and would die prematurely.

The BCM physicians and HHS staff further breached their duty to Decedent by moving to discharge him from the MICU or hospital, rather than transferring him to LTAC via an appropriate transfer as required per 42 U.S.C. §1395dd(C)(1)(B). They irrationally, capriciously, and arbitrarily denied him LTAC care because of the lack of insurance or funding in place, and because of his national origin/race. Thereafter, they wrongfully acted to DNR and kill him.

The supervising physician in charge of MICU, never signed the required certification for his transfer from MICU to any other facility. Rather, as of early May, since the MICU staff were unable to obtain wrongful consent to DNR Decedent since March 2015, they disregarded their duty to stabilize his emergency medical condition, including the ones they created, then worked to further misrepresent information in the records to cover their liability exposure, and withdrew

necessary treatment measures. On 04/27/2015, they simply transferred him from MICU back to the general medicine floor under the care of residents, and a Dr. Hanania. The main focus/goal of care at this time, was the DNR activities.

Within the next day, 04/28/2015, Decedent was back in MICU because of an emergency event that occurred while on the general medicine floor. Decedent was ozzing secretions out of his trachea. Hence his oxygen intake was again compromised. Clearly, he needed to be in MICU where there would *hopefully* be multiple physicians and health care providers to oversee or watch the activities on or around him.

On 05/21/2015, it is clear that Dr. Guerra did not want him in MICU. Hence, she deemed him as "vegetative status," and had Decedent transferred from MICU to Room 5E, without said 42 U.S.C. §1395dd(C)(1)(A)(ii) certification for long-term acute care. No physician wanted to execute such certification, nor did the hospital and its staff search for a facility (1) under which at the time in question, Decedent's transfer to said facility would be more beneficial than the risks of his being at the hospital, (2) said facility has agreed to accept Decedent as their patient and provide him with the necessary care he needed, and (3) the transfer would also comply with 42 U.S.C. §1395dd(C)(2)(C), 42 U.S.C. §1395dd(C)(2)(D), and 42 U.S.C. §1395dd(C)(2)(E).

Even upon his arrival at room 5E, the goal was then to get him to long-term acute care within the hospital, or get him out of the hospital. They disqualified him from LTAC within the hospital because of his lack of Medicaid or Gold Card insurance, or funding in place; and instead sought to discharge him from the hospital, to which his family did not give informed consent.

The physicians and hospital staff did not search for any facilities that would accept Decedent and provide him the care he needed as required under EMTALA. Rather, they transferred the obligation/duty on Decedent's family; without providing them with the medical records necessary.

Without the medical records, it is impossible for any transfer to be an appropriate transfer as required under 42 U.S.C. §1395dd(C)(2)C).

Overall, during the Ben Taub staff and BCM physicians' efforts to transfer Decedent out of the facilities or hospital, no physician ever provided a certification as required under 42 U.S.C. §1395dd(C)(1)(A)(ii) or 42 U.S.C. §1395dd(C)(1)(A)(iii). Their lack of provision of medical records to a facility that would provide the necessary care needed, also precludes any transfer as being compliant with EMTALA due to 42 U.S.C. §1395dd(C)(2)C).

Furthermore, the fact that there is no informed consent to refuse transfer out of the hospital to another facility, including LTAC or nursing facility, also shows that the hospital and physicians breached their duty to secure the informed consent to refuse any transfer in writing as required by 42 U.S.C. §1395dd(B)(3), and supports that any transfer of Decedent from the facility would not have been an appropriate transfer, and would have been in violation of the EMTALA.

Decedent and his family also had a right to written informed consent to refuse examination and treatment of Decedent's emergency medical condition, after Ben Taub Hospital and its physicians and/or staff (1) offers Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) examination and treatment of his emergency medical condition, and (2) informs Decedent (or a legally responsible person acting on the individual's behalf – e.g. his family members or a guardian) of the risks and benefits to Decedent of such examination and treatment.[101]

Decedent and his family had a right to refuse to consent to the 03/06/2015 and 03/09/2015 BALs as well as the laryngoscopy. The physicians and hospital staff did not take reasonable steps to explain the risks and benefits of the BAL and obtain refusal to consent to the BAL from

[101] *42 U.S.C. §1395dd(B)(2)*

Plaintiffs. Rather, they breached their duty to Plaintiffs, and failed to obtain informed consent to such refuse said BALs, as well as the laryngoscopy; and still wrongfully executed said BALs and laryngoscopy. The wrongful 03/06/2015 BAL consent form is merely an effort to hid the fact that there was no consent for the 03/06/2015 and 03/09/2015 BALs, and laryngoscopy, and that the physicians and hospital staff breached their duties to obtain the necessary refusal to said elective procedures in writing.

Finally, Ben Taub Hospital and its physicians and/or staff's had a duty not to delay in providing appropriate medical screening examination required under *42 U.S.C. §1395dd(a)* or further medical examination and treatment required under *42 U.S.C. §1395dd(b)* in order to inquire about Decedent's method of payment (e.g. Gold Card) or insurance status.[102] They breached their duty under the statute by delaying or withholding necessary neurological, cardiology, and oncology examination and treatment services in the second hospital visit, with funding issues as part of their reason and the other being his national origin and presumed alienage status. They even withheld necessary long-term acute care treatment services all because of, amongst others, Decedent's payment method/funding issue – e.g. his insurance, lack of Gold Card, or social security issue.

Applicable BCM physicians and HHS staffs' breach of the various duties owed Plaintiffs under EMTALA in the second hospital visit, and their breach of their duties not to negligently misrepresent Decedent's condition or other information about their services, including their obligations under EMTALA, subjects said applicable said applicable BCM physicians and HHS d/b/a Ben Taub Hospital to civil money penalties under *42 U.S.C. §1395dd(d)(1)(A); 42 U.S.C. §1395dd(d)(1)(B).*

Also, under the circumstance, there is also clear evidence of a custom or practice of the

[102] *42 U.S.C. §1395dd(h)*

violations as applicable in Decedent's case:

(1) failure to provide appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists for ER patients;

(2) failure to provide within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition for admitted patients that meet the exceptions in 42 CFR §489.24(d)(2);

(3) delay or withholding the provision of an appropriate medical screening examination required under EMTALA's subsection (a) or further medical examination and treatment required under EMTALA's subsection (b) in order to inquire about HHS patients' method of payment or insurance status, for both ER patients and admitted patients that meet the exceptions in 42 CFR §489.24(d)(2);

(4) failure to provide within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or filing to provide for transfer of the individual to another medical facility in accordance with EMTALA's subsection (c), for both ER patients and admitted patients that meet the exceptions in 42 CFR §489.24(d)(2);

(5) misrepresentation of various patient's individual conditions or other information about their health care services, including a Harris Health System and its staff or physicians' obligations under EMTALA;

Realtors have claims on behalf of the United States for all patients who's EMTALA rights have been violated under 42 U.S.C. §1395dd(d)(1)(A) & (d)(1)(B), per its 6-year retroactive

statutory of limitations for claims allowed under 42 U.S.C. §1320a-7a(C).

Finally, considering that there is evidence from Decedent's case of continuous efforts to obtain improper Federal Medicare and Medicaid reimbursements for wrongful services or health care activities, including for services provided by non-licensed physicians, Realtors also have claims on behalf of the United States for HHS' improperly filed claims that violate 42 U.S.C. §1320a-7a(a)(1)(A), 42 U.S.C. §1320a-7a(a)(1)(B), 42 U.S.C. §1320a-7a(a)(1)(C)(i), 42 U.S.C. §1320a-7a(a)(1)(D), 42 U.S.C. §1320a-7a(a)(1)(E), 42 U.S.C. §1320a-7a(a)(3), 42 U.S.C. §1320a-7a(a)(7); for violations of said statutes for the past 6-year retroactive statute of limitations for claims allowed under 42 U.S.C. §1320a-7a(C).

Such is evident. Considering the works and/or actions of the BCM physicians including Dr. Mims and Wayne Shandera, and social workers Sam Mildred and Vinny Ommen, in the first and second hospital visits, there is clear evidence of a custom or practice of using patients to collect Medicare and Medicaid insurance funds. Provision of the most efficient, necessary, essential, and proper health care services to patients are secondary to profit incentive.

Unnecessary health care services are provided to patients for the sake of Medicare and Medicaid reimbursement, and experience for the student resident or fellow physicians. Consequently, unsupervised, unnecessary and/or elective procedures are executed on patients like Decedent with ulterior motives that are against the patient's interest or best interest. The goal of providing the necessary and/or essential health care services to patients, in exchange for the right experience and reimbursement is a lesser priority. The purpose of THSC Chapter 312, as dictated in THSC Sec. 312.001(a), and 312.001(b)(1)'s "enhance the education of students, interns, residents, and fellows…," (b)(2)'s "enhance patient care", and (b)(3)'s "avoid waste of public money," are disregarded and/or not being achieved. Patients like Decedent, and others, are merely

a vessel for an unconsented experiment and profit.

After review of BCM's annual tax-return financials, it is clear that the reimbursements from Medicare and Medicaid for health care services is a major financial incentive as shown in BCM's operating income. BCM receives about or over eighty-five million[103] United States Dollars ($85,000,000.00) annually in income to itself just from the Medicare and Medicaid recouped funds from the government, for alleged health care services provided at HHS facilities. Considering the rate that Medicare and Medicaid pays out, one can only imagine the amount of false or fraudulent procedures that are occur and/or are fraudulently, knowingly or intentionally submitted annually for said reimbursements to be at such magnitude.

HHS and/or Ben Taub Hospital, and the 312.004 co-op contract, are vessels that enable them to receive those funds. The BCM physicians provide the health care services, HHS bills the government, and when funds are received, BCM receives either all or a portion of the funds. Hence one can understand (a) the bargaining power of BCM, (b) another reason for BCM's unchecked authority at HHS facilities, (c) the importance of BCM-HHS relationship, (d) why provision of essential health care for patients are and/or can be compromised for the sake of ulterior motives of the health care providers, (e) an additional explanation for Vinny Ommen's determination to knowingly, intentionally, and fraudulently have Bethrand to sign the Medicaid document in the second hospital visit, and (f) the profit incentive, amongst others, for both BCM and HHS to allow the wrongful, unsupervised, and unnecessary procedures, and allow the blatant discrimination/equal protection and due process rights violations to continuously occur.

Per BCM's audited public financials, the HHS and BCM operating relationship have existed since 1966. Under these circumstances, Realtors clearly have claims on behalf of the United States

[103] The number materially/significantly grows annually.

for HHS' improperly filed claims that violate 42 U.S.C. §1320a-7a(a)(1)(A), 42 U.S.C. §1320a-7a(a)(1)(B), 42 U.S.C. §1320a-7a(a)(1)(C)(i), 42 U.S.C. §1320a-7a(a)(1)(D), 42 U.S.C. §1320a-7a(a)(1)(E), 42 U.S.C. §1320a-7a(a)(3), 42 U.S.C. §1320a-7a(a)(7); for violations of said statutes for the past 6-year retroactive statute of limitations for claims allowed per 42 U.S.C. §1320a-7a(C).

Damage Claims Under EMTALA for First & Second Hospital Visit Injuries

Alternatively, and/or additionally, the breach of the duties owed Decedent and his family under EMTALA in the first and second hospital visit, were a proximate cause of the injuries/harm Decedent and each of his family members as pled in the DAMAGES section.

Therefore, All Plaintiffs, including Decedent, have claims under 42 U.S.C. §1395dd ("EMTALA") against HHS for harm/damages they sustained, that were proximately caused by Ben Taub Hospital, Baylor physician defendants, and Ben Taub Hospital staff's breach of duties owed Decedent under 42 U.S.C. §1395dd. *42 U.S.C. §1395dd(d)(2)(A)*

V. CLASS ACTION

Standing: Decedent's estate, including his heirs (i.e. Family Plaintiffs), have standing to bring a class action suit against Defendants Harris County Hospital District d/b/a Harris Health System, and its employees and contractors including Baylor College of Medicine and its employees.

Plaintiffs were subject to and were deprived of their 14th Amendment U.S. Constitutional substantive and procedural due process rights, and their equal protection rights.

Plaintiffs were also deprived of 14th Amendment U.S. Constitution equal protection of their rights under Texas Constitution such as Article 1 of Texas Constitution Sections 3, 3a, 13 and 19 equal protection, open courts and due course of law clause; Futility care rights under Texas Health & Safety Code Chapter 166 including §166.004(c), §166.004(d), §166.031(2), §166.039(b), §166.039(c), and §166.046's prescribed requirements and its legislative intent; rights under Texas

Human Resources Code §102.003; consent rights under THSC Chapter 313; rights under HHS or Harris County Hospital District's ("HCHD") policies and procedures including those attached in the appendix; and rights of patients in HCHD/HHS facilities subject to the benefit of the Texas Health & Safety Code §312.004 co-op agreement. Plaintiffs were also deprived of their rights under 42 U.S. Code §1395dd as pled in this pleading.

Plaintiffs' have incurred and continue to incur, and are subject to harm as a result of the deprivations of said 14th Amendment U.S. Constitution substantive and procedural due process rights, and equal protection rights, and 42 U.S. Code § 1395dd rights.

Said rights deprivations, and damages/injuries resulting from said rights deprivations, were proximately or substantially caused by HHS and BCM's applicable and unconstitutional customs or practice of subjecting or causing Plaintiffs and patients at HHS facilities to be deprived or subjected to the deprivation of said 14th Amendment U.S. Constitution substantive and procedural due process rights, and equal protection rights, and rights under 42 U.S. Code § 1395dd.

Amongst others, the subjection or cause of deprivation of said rights, hails from the custom or practice of unchecked authority of physicians, and BCM and HHS decision makers, managers, and/or staffs' deliberate indifferent acquiescence to the 14th Amendment U.S. Constitutional and rights deprivations, and/or BCM and HHS decision makers, managers, and/or staffs' deliberate indifferent participation in the 14th Amendment U.S. Constitutional rights deprivations, and/or BCM and HHS and/or their applicable decision makers, managers, and/or staffs' deliberate indifferent failure to train their staff in regards to the applicable Federal, State, and/or local laws necessary for compliance with the 312.004 co-op agreement – e.g. the laws, policies, and procedures mentioned throughout this pleading; and/or BCM and HHS decision makers, managers, and/or staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent failure to

supervise their subordinates.

Amongst others, the subjection or cause of deprivation of Plaintiffs' rights under 42 U.S. Code § 1395dd, hails from the custom or practice of unchecked authority of physicians, and BCM and HHS decision makers, managers, and/or staffs' acquiescence to the rights under 42 U.S. Code § 1395dd rights deprivations, and/or BCM and HHS decision makers, managers, and/or staffs' participation in the rights under 42 U.S. Code § 1395dd rights deprivations, and/or BCM and HHS applicable decision makers, managers, and/or staffs' failure to train their staff in regards to rights under 42 U.S. Code § 1395dd, necessary for compliance with the 312.004 co-op agreement – e.g. the laws, policies, and procedures mentioned throughout this pleading; and/or BCM and HHS decision makers, managers, and/or staffs,' failure to supervise their subordinates.

Defendants' malicious, knowing, intentional, bad faith, and/or deliberate indifferent violation of the purpose and terms of the statutory required co-op agreement of Texas Health & Safety Code Chapter 312 including §312.004, §312.006, and §312.007 that grants Defendants and future similarly situated putative physician and health care provider Defendant(s) state agency and state agency employee status, governmental immunity, and limitation of liability. It also grants Plaintiffs standing to bring a class action on behalf of all patients at HHS/HCHD facilities that were harmed as a result of the malicious, knowing, intentional, bad faith, and/or deliberate indifferent violations of said statutes, and the resulting 14th Amendment equal protection rights deprivations.

Defendant's breach of their duties or obligations to patients at HHS/HCHD facilities as required under 42 U.S. Code § 1395dd that grants Defendants and future similarly situated putative physician and health care provider Defendant(s) state agency and state agency employee status, governmental immunity, and limitation of liability. It also grants Plaintiffs standing to bring a

class action on behalf of all patients at HHS/HCHD facilities that were harmed as a result of the breach of duties or obligations under said 42 U.S. Code § 1395dd statute.

Hence Plaintiffs' and class members' claims are still ripe for redressability.

Numerosity: The class is so numerous that joinder of class members is impracticable.

All the Federal, State, and Local laws, including HCHD/HHS policies and procedures, mentioned in the preceding "Standing" section are applicable to similarly situated or all putative plaintiffs, as patients in HHS/HCHD facilities, who's 14th Amendment equal protection and due process rights, and rights under 42 U.S. Code § 1395dd have been deprived. They are all subject to the benefit of the Texas Health & Safety Code §312.004 co-op agreement which dictate that the operations at the facilities must comply with all Federal, State, and local laws including HHS policies and procedures and its patient's rights and responsibilities.

All similarly situated or putative Defendants, including putative physicians and health care provider Defendants, are also subject to the terms of the Texas Health & Safety Code §312.004 co-op agreement, as well as HHS/HCHD policies and procedures and its patients' rights and responsibilities. They are all required to provide health care services in compliance with all Federal, State, and local laws, including HHS/HCHD policies and procedures. Said Federal laws include 42 U.S. Code § 1395dd and 14th Amendment of the U.S. Constitution's equal protection and due process clauses, and HHS/HCHD patients' rights and responsibilities.

Without a doubt, 14th Amendment to U.S. Constitution is applicable to all persons subject to U.S. jurisdictional laws including physicians and health care providers, government or private industry employees and business entities. Furthermore, all 14th Amendment Constitutional equal protection and due process rights, and rights under 42 U.S. Code § 1395dd, are applicable to all patients at HHS/HCHD.

Texas Health & Safety Code Chapter 313 on sent, and Chapter 166 including §166.004(c), §166.004(d), §166.039(b), §166.039(c), §166.046's prescribed requirements and its legislative intent in regards to withholding or withdrawal of life-sustaining treatment, are applicable to all persons (Plaintiffs, putative plaintiffs, Defendants, and putative defendants) subject to the jurisdictional laws of Texas, as patients or health care providers at HCHD/HHS facilities. Also, the Texas Health & Safety Code §312.004 co-op agreement is applicable to all physicians and health care providers subject to said agreement, and is applicable to all patients and HCHD/HHS facilities.

Texas Human Resources Code Chapter 102 via §102.001(3)(D) and §102.001(4) also applies to all elderly patients at HCHD/HHS facilities, and applies to HCHD/HHS and/or Ben Taub Hospital. Hence the rights and obligations dictated under THSC §102.003 also applies to Decedent and other HCHD/HHS and/or Ben Taub Hospital's elderly patients, and the applicable current and putative health care providers Defendants.

All HCHD/HHS patients and health care providers are also subject to the HHS/HCHD rights and responsibilities.

Commonality: There are questions of law or fact common to the class because the matter is in regards to claims brought under 42 U.S.C. §1983, §1985, and §1395dd.

Defendants, acting malicious, knowing, intentional, bad faith, and/or with deliberate indifference to the constitutional rights, health, and safety of Decedent, Decedent's family, and putative Plaintiffs, deprived them of their clearly established rights under 14th Amendment U.S. Constitutional equal protection, procedural and/or substantive due process clauses.

Said rights deprivations include the equal protection of their rights/benefits conferred under the Texas Health & Safety Code §312.004 co-op agreement, and HHS/HCHD policies and

procedures including the patient's rights and responsibilities. Said 14th Amendment U.S. constitutional equal protection rights deprivations also include malicious, knowing, intentional, bad faith, and/or deliberate indifferent deprivation of rights secured under Article 1 of Texas Constitution, Sections 3, 3a, 13 open courts and due course of law clause, and 19; rights secured under HCHD/HHS's policies and procedures including its patients' rights and responsibilities; rights secured under Texas Health & Safety Code Chapter 313 in regards to consent or withholding of consent, and Chapter 166 including §166.004(c), §166.004(d), §166.031(2), §166.039(b), §166.039(c), §166.046 in regards to Advanced Directives; and elderly rights secured under Texas Human Resources Code Chapter §102.003.

The due process rights include right to consent or withhold consent to treatment and DNR, right against deprivation of life without compliance with THSC Chapter 166 enumerated requirements including §166.046.

The current and putative Defendants also breached their duties/obligations owed to current and putative Plaintiffs, that are secured under 42 U.S.C. §1395dd.

Defendants' violation of the purpose and terms of Texas Health & Safety Code Chapter 312, including §312.004 and the co-op agreement that allows for Defendant physicians operation at HHS/HCHD facilities, are also an applicable statute and agreement that applies to all current and putative Defendant physicians. The clause that grants patients at HHS/HCHD facilities, and requires the Defendant physicians to comply with all Federal, State, and local laws including HHS/HCHD policies and procedures, is also a basis of commonality for all putative Plaintiffs (i.e. other HHS/HCHD patients).

While Texas Health and Safety Code §312.006, and §312.007 that grants BCM, its current physician Defendants, and putative physician Defendants, state agency and state agency employee

status, hence governmental immunity, and limitation of liability, such laws are not applicable for the HHS, BCM, and their physicians and staffs' malicious, knowing, intentional, bad faith, and/or deliberate indifferent deprivation or subjection to deprivation of Plaintiffs' 14th Amendment U.S. Constitutional equal protection and due process rights. They are also not applicable to the resulting 42 U.S.C. §1983, 1985(2), and §1985(3) conspiracy claims alleged in this pleading, that is also part of this class action and alleged on behalf of the class. Texas Health and Safety Code §312.006, and §312.007 is also not applicable against HHS in regards to the class action claims brought under 42 U.S.C. §1395dd per 42 U.S.C. §1395dd(d)(2)(A). Non-BCM physician Defendants that worked at HHS/HCHD during the applicable periods, and that are also liable for damages under 42 U.S.C. §1983, 1985(2), and §1985(3), are also subject to, but not entitled to governmental or qualified immunity.

All the applicable Federal, State, and local laws, policies and procedures, including Sections 1983, 1985, and 1395dd were all in place during and within the applicable statutory period to allowed to bring the class action suit.

All current and putative Plaintiffs were also patients at HCHD/HHS during and within the applicable statutory period to allowed to bring the class action suit, and were subject to the rights and/or benefits of the Federal, State, and local laws, policies and procedures, patients' rights and responsibilities, and the §312.004 co-op agreement that are the basis for the class action claims under 42 U.S.C. §1983, §1985, and §1395dd.

All current and putative Defendants, e.g. BCM, HHS/HCHD, and their staff, physicians, health care providers, managers, decision makers – e.g. governing individual or entity persons, and/or executives, were subject to the responsibilities, duties, and/or obligations derived from the Federal, State, and local laws, policies and procedures, patients' rights and responsibilities, terms of the

THSC §312.004 co-op agreement, and purpose of the THSC Chapter 312 that allows for said co-op agreement; during and within the applicable statutory period to allowed to bring the class action suit. Said alleged violations or rights deprivations by the current and/or putative Defendants, are a common basis for the current and Putative class action 14th Amendment equal protection and due process rights claims, and EMTALA claims, all actionable under 42 U.S.C. §1983, §1985, and §1395dd.

All applicable laws, rights, benefits, and/or obligations were all in place during and within the applicable statutory period to allowed to bring the class action suit.

Typicality: The claims or defenses of the class representatives are typical of those of the class.

The typicality of the claims of the class has been alleged/discussed in the "commonality" section above, and is hereby incorporated by reference.

All defenses including affirmative Defenses as already pled by BCM and its employee Defendants, and by HHC, are typical of all current and putative Defendants. All current and putative Defendants are state and local government entities, executive personnel within the entities, and/or government employee individuals or executives, all subject to the affirmative Defense of qualified immunity, sovereign immunity and/or governmental immunity; e.g. sovereign/governmental state agency immunity for BCM, local governmental immunity for HHS/HCHD.

Adequacy: The class representatives, Estate of Aphaues Ohakweh acting on its behalf and on behalf of family Plaintiffs, who are heirs of the estate, will fairly and adequately protect the interests of the class.

Plaintiffs have been subject to harm as a result of 14th Amendment U.S. Constitution equal protection, and due process rights deprivations by Defendants; as well as deprivations of rights secured under 42 USC §1395dd.

Amongst others, as already pled, Defendants and/or putative defendants' continuous actions that violate of the purpose and terms of Texas Health & Safety Code Chapter 312, and default on the terms of the §312.004 co-op agreement, also subjects or causes Plaintiffs to be deprived of their equal protection and due process rights.

Relief: 42 U.S.C. §1983 and §1985 claims allow for claims and conspiracy claims for damages, and also injunctive relief against similarly situated Defendants, current or putative physicians, and health care provider Defendants including HHS/HCHD, and its employees and executives, BCM and its executives, staff, or physicians.

42 U.S.C. §1395dd allows for claims for damages, and injunctive relief against HHS/HCHD for actions of this staff and physicians that operate in HHS/HCHD facilities that violate the statue.

Federal Rules of Civil Procedure Rule 23(a) and Rule 23(b)(1)(b) allow for both injunctive relief and declaratory relief on a class wide basis. Therefore, declaratory relief, injunctive relief, as well as damages are proper on a class wide basis as allowed by Federal Rules of Civil Procedure Rule 23(b)(2). *Fed. R. Civ. P. Rule 23(a) & (b)(1)(2).*

Plaintiffs in this case are citizens of the United States as defined under 14th Amendment of U.S. Constitution, are subject to U.S. Jurisdictional laws, and are valid class representatives for the declaratory judgment action and action for damages under the 42 U.S.C. §1983, §1985, and §1395dd for the class actions.

Federal Rules of Civil Procedure Rule 23(a) and Rule 23(b)(1)(b) allow for both injunctive relief and declaratory relief on a class wide basis. *Fed. R. Civ. P. Rule 23(a) & (b)(1)(2).*

Therefore, declaratory relief, injunctive relief, as well as damages are proper on a class wide basis; as well as award for attorney's fees and costs.

VI. RELIEF

Actions for Damages:

Plaintiffs respectfully ask for an aggregate award of $2 Billion for (a) economic and non-economic compensatory damages as pled in this pleading including in the "DAMAGES" section of this pleading, against BCM, HHS, and all applicable current and putative Defendants; and (b) exemplary or punitive damages against BCM and all applicable current and putative Defendants, as allowed by 42 U.S.C. §1983 and 42 U.S.C. §1985, and equity. Plaintiff also ask for attorney's fees and costs as allowed under 42 U.S.C. §1988, class certification and an award of damages for the class, and any equitable relief (e.g. injunction, etc.) justified and deemed proper by law, equity, and this Court.

Alternatively, and/or additionally, Plaintiffs respectfully ask for an award for damages for economic and non-economic compensatory damages as pled in the DAMAGES section of this pleading, against HHS, as allowed under 42 U.S.C. §1395dd(d)(2)(A), and equity. Plaintiffs also ask an award of Damages on behalf of the class. Plaintiffs also ask for attorney's fees and costs as allowed by law and equity, and any other relief justified and deemed proper by law, equity, and this Court; including but not limited to class certification on the 42 U.S.C. §1395dd claims.

Action for Civil Money Penalties:

Realtors, acting on behalf of the United States of America, seek for an award of $50 Billion for civil money penalties against HHS and current and putative BCM physician defendants, as allowed under 42 U.S.C. §1395dd(d)(1)(A) & (d)(1)(B), and 42 U.S.C. §1320a-7a, & their 6 year retroactive statutory of limitations for claims per 42 U.S.C. §1320a-7a(C).

Relators also ask for attorney's fees and costs, and any equitable relief (e.g. injunction, etc.) justified and deemed proper by law, equity, and this Court.

VII. APPENDIX

1. Additional Material BCM discovery responses

REQUESTS FOR PRODUCTION, ADMISSIONS, & INTERROGATORIES

REQUEST FOR ADMISSION NO. 1:
Admit or Deny: That there was not a Baylor College of Medicine institutional investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: Defendant objects to this Request as vague and undefined as to what is meant by an "institutional investigation" and therefore can neither admit or deny this Request as phrased. Subject to these objections and without waiving same, Baylor admits that, in anticipation of litigation by the Ohakweh family based on 20 page letters dated August 26, 2015 that were sent to ten Baylor physicians asserting compensatory and punitive damages claims and claims based on alleged criminal acts and the September 2, 2015 telephone and email communications of the Ohakweh family's attorney with Ms. Johnson in Baylor's Department of Risk Management, which confirmed that a lawsuit would be filed against Baylor, these ten Baylor physicians and other Baylor physicians, Ms. Johnson had discussions about the asserted claims with some of the Baylor physicians against whom litigation had been threatened and retained the law firm of Andrews Kurth LLP to represent it and its physicians in the anticipated litigation.

REQUEST FOR ADMISSION NO. 2:
Admit or Deny: That there was not a civil investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: Defendant objects to this Request as vague and undefined as to what is meant by a "civil investigation" and therefore can neither admit or deny this Request as phrased. Subject to these objections and without waiving same, Baylor admits that, in anticipation of litigation by the Ohakweh family based on 20 page letters dated August 26, 2015 that were sent to ten Baylor physicians asserting compensatory and punitive damages claims and claims based on alleged criminal acts and the September 2, 2015 telephone and email communications of the Ohakweh family's attorney with Ms. Johnson in Baylor's Department of Risk Management, which confirmed that a lawsuit would be filed against Baylor, these ten Baylor physicians and other Baylor physicians, Ms. Johnson had discussions about the asserted claims with some of the Baylor physicians against whom litigation had been threatened and retained the law firm of Andrews Kurth LLP to represent it and its physicians in the anticipated litigation.

REQUEST FOR ADMISSION NO. 3:
Admit or Deny: That there was not a criminal investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: Defendant objects to this Request as vague and undefined as to what is meant by a "criminal investigation" and therefore can neither admit or deny this Request as phrased. Subject to these objections and without waiving same, Baylor admits that, in anticipation of litigation by the Ohakweh family based on 20 page letters dated August 26,

2015 that were sent to ten Baylor physicians asserting compensatory and punitive damages claims and claims based on alleged criminal acts and the September 2, 2015 telephone and email communications of the Ohakweh family's attorney with Ms. Johnson in Baylor's Department of Risk Management, which confirmed that a lawsuit would be filed against Baylor, these ten Baylor physicians and other Baylor physicians, Ms. Johnson had discussions about the asserted claims with some of the Baylor physicians against whom litigation had been threatened and retained the law firm of Andrews Kurth LLP to represent it and its physicians in the anticipated litigation.

REQUEST FOR ADMISSION NO. 4:
Admit or Deny: That there was not a professional investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: Defendant objects to this Request as vague and undefined as to what is meant by a "professional investigation" and therefore can neither admit or deny this Request as phrased. Subject to these objections and without waiving same, Baylor admits that, in anticipation of litigation by the Ohakweh family based on 20 page letters dated August 26, 2015 that were sent to ten Baylor physicians asserting compensatory and punitive damages claims and claims based on alleged criminal acts and the September 2, 2015 telephone and email communications of the Ohakweh family's attorney with Ms. Johnson in Baylor's Department of Risk Management, which confirmed that a lawsuit would be filed against Baylor, these ten Baylor physicians and other Baylor physicians, Ms. Johnson had discussions about the asserted claims with some of the Baylor physicians against whom litigation had been threatened and retained the law firm of Andrews Kurth LLP to represent it and its physicians in the anticipated litigation.

REQUEST FOR PRODUCTION NO. 1: Provide an authenticated copy of any written reports or documentations regarding any Baylor College of Medicine institutional, civil, criminal, hospital, or professional investigations that were done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: Defendant objects to this request as vague and undefined as to what is meant by an "institutional, civil, criminal or professional investigation," and therefore cannot accurately answer this Request, other than to say that it has no reports or documentation of an investigation by Ben Taub Hospital. Subject to these objections and without waiving same, although unknown whether it is responsive to this Request, Baylor College of Medicine states that it is withholding one document that was created in anticipation of litigation by Ms. Johnson in Baylor's Department of Risk Management. This document is privileged under Federal Rule of Civil Procedure 26(b)(3)(A).

Ms. Johnson anticipated litigation and created this document in anticipation of retaining and informing defense counsel at Andrews Kurth LLP about the Ohakweh family's claims. This document was created because of the 20 page letters dated August 26, 2015 that were sent to ten Baylor physicians asserting compensatory and punitive damages claims and claims based on alleged criminal acts and because of the September 2, 2015 telephone and

email communications of the Ohakweh family's attorney with Ms. Johnson, which confirmed that a lawsuit would be filed against Baylor, these ten Baylor physicians and other Baylor physicians, and it would not have otherwise been created.

For purposes of compliance with Rule 26(b)(5)(A), Baylor states that the withheld document was created in early September 2015 by Ms. Johnson and contains the mental impressions, conclusions and opinions of Baylor physicians with whom she spoke about the asserted claims and against whom litigation had been threatened in the August 26, 2015 claim letters and/or the telephone and email communications with Plaintiffs' counsel on September 2, 2015, and the mental impressions, conclusions and opinions of Ms. Johnson about the asserted claims and the Ohakweh family's attorney.

REQUEST FOR PRODUCTION NO. 2: Provide an authenticated copy of any written reports or documentations regarding any of Baylor College of Medicine's notification to Texas Higher Education Board, Harris Health System or Harris County Hospital District, and Affiliated Medical Services in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: None.

REQUEST FOR PRODUCTION NO. 3: Provide an authenticated copy of any written reports or documentations regarding the results of any investigations that were done by Texas Higher Education Board, Harris Health System or Harris County Hospital District, and Affiliated Medical Services in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital during the months of March 2015 – September 2015.

ANSWER: None.

VERIFICATION

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

BEFORE ME, the undersigned authority, on this day personally appeared James Banfield, Director of Risk Management and Associate General Counsel of Baylor College of Medicine, who after being by me first duly sworn on his oath, deposes and says that he has read the foregoing Answers to the First Set of Interrogatories to Baylor College of Medicine, and that based upon his personal knowledge, the records of Baylor College of Medicine and/or Mr. Ohakweh's Ben Taub Hospital medical records, the factual statements contained therein are true and correct.

Signature: James Banfield

Printed Name: James Banfield

Title: Director of Risk Management and Associate General Counsel

SUBSCRIBED AND SWORN TO BEFORE ME on this 20 day of July, 2016, to certify which witness my hand and seal of office.

MELANIE RODEN
My Commission Expires
June 7, 2019

Melanie Roden
Notary Public in and for the
STATE OF TEXAS

2. Material HHS discovery responses

REQUEST FOR ADMISSION NO. 5:
Admit or Deny: That there was not a hospital investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital.

ANSWER: Defendant objects to this discovery request to the extent that it is overly broad, vague, ambiguous, undefined, and/or unintelligible as to "hospital investigation." Defendant objects to this discovery request to the extent that it is not relevant or reasonably calculated to lead to the discovery of admissible information. Defendant objects to this request as not within the scope of discovery pursuant to Federal Rule of Civil Procedure 26(b)(1). Defendant objects to this discovery request as overly broad, burdensome, and to the extent it calls for information protected by the attorney-client privilege of Rule 503 of the Texas Rules of Evidence and/or the work product privilege of Rule 192.5 of the Texas Rules of Civil Procedure. Defendant objects to this request to the extent it seeks information/documents that are privileged pursuant to Federal Rule of Evidence 501, the peer review and healthcare committee privileges of Chapter 160 of the Texas Occupations Code and §161.032 of the Texas Health & Safety Code, and to the extent applicable, the self-critical analysis privilege. Subject to the foregoing objections and without waiving the same, deny.

REQUEST FOR ADMISSION NO. 6:
Admit or Deny: That there was not a civil investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital.

ANSWER: Defendant objects to this discovery request to the extent that it is overly broad, vague, ambiguous, undefined, and/or unintelligible as to "civil investigation." Defendant objects to this discovery request to the extent that it is not relevant or reasonably calculated to lead to the discovery of admissible information. Defendant objects to this request as not within the scope of discovery pursuant to Federal Rule of Civil Procedure 26(b)(1). Defendant objects to this discovery request as overly broad, burdensome, and to the extent it calls for information protected by the attorney-client privilege of Rule 503 of the Texas Rules of Evidence and/or the work product privilege of Rule 192.5 of the Texas Rules of Civil Procedure. Subject to the foregoing objections and without waiving the same, Defendant can neither admit nor deny this request as it is unclear what is being requested.

REQUEST FOR ADMISSION NO. 7:
Admit or Deny: That there was not a criminal investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital.

ANSWER: Defendant objects to this discovery request to the extent that it is overly broad, vague, ambiguous, undefined, and/or unintelligible as to "criminal investigation." Defendant objects to this discovery

request to the extent that it is not relevant or reasonably calculated to lead to the discovery of admissible information. Defendant objects to this discovery request as overly broad, burdensome, and to the extent it calls for information protected by the attorney-client privilege of Rule 503 of the Texas Rules of Evidence and/or the work product privilege of Rule 192.5 of the Texas Rules of Civil Procedure. Subject to the foregoing objections and without waiving the same, Defendant can neither admit nor deny this request as it is unclear what is being requested.

REQUEST FOR ADMISSION NO. 8:
Admit or Deny: That there was not a professional investigation done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital.

ANSWER: Defendant objects to this discovery request to the extent that it is overly broad, vague, ambiguous, undefined, and/or unintelligible as to "professional investigation." Defendant objects to this discovery request to the extent that it is not relevant or reasonably calculated to lead to the discovery of admissible information. Defendant objects to this request as not within the scope of discovery pursuant to Federal Rule of Civil Procedure 26(b)(1). Defendant objects to this discovery request as overly broad, burdensome, and to the extent that it calls for information protected by the attorney-client privilege of Rule 503 of the Texas Rules of Evidence and/or the work product privilege of Rule 192.5 of the Texas Rules of Civil Procedure. Defendant objects to this request to the extent it seeks information/documents that are privileged pursuant to Federal Rule of Evidence 501, the peer review and healthcare committee privileges of Chapter 160 of the Texas Occupations Code and §161.032 of the Texas Health & Safety Code, and to the extent applicable, the self-critical analysis privilege. Subject to the foregoing objections and without waiving the same, Defendant can neither admit nor deny this request as it is unclear what is being requested.

REQUEST FOR PRODUCTION NO. 3:
Please provide an authenticated copy of any written reports or documentations regarding any civil, criminal, hospital, or professional investigations that were done in regards to the injuries sustained and/or death of Plaintiff, Dr. Aphaeus Ohakweh while he was at Ben Taub Hospital.

RESPONSE: Defendant objects to this discovery request to the extent that it is overly broad, vague, ambiguous, undefined, and/or unintelligible as to "civil, criminal, hospital, or professional investigation." Defendant objects to this discovery request to the extent that it is not relevant or reasonably calculated to lead to the discovery of admissible information. Defendant objects to this request as not

within the scope of discovery pursuant to Federal Rule of Civil Procedure 26(b)(1). Defendant objects to this discovery request as overly broad, burdensome, and to the extent it calls for information protected by the attorney-client privilege of Rule 503 of the Texas Rules of Evidence and/or the work product privilege of Rule 192.5 of the Texas Rules of Civil Procedure. Subject to the foregoing objections and without waiving the same, see the attached CD containing the Harris Health System Security Field Report, labeled 59823-59824. Other documents are being withheld. The withheld documents are privileged pursuant to Federal Rule of Evidence 501, the peer review and healthcare committee privileges of Chapter 160 of the Texas Occupations Code and §161.032 of the Texas Health & Safety Code, and to the extent applicable, the self-critical analysis privilege. In compliance with Federal Rule of Civil Procedure 26(b)(5)(A), the withheld documents consist of an incident report dated August 31, 2015, concerning the medical care provided to Aphaeus Ohakweh on March 6, 2015, and an incident report dated September 1, 2015, concerning the family's report to Houston Police Department on August 31, 2015, regarding Aphaeus Ohakweh. These reports were prepared at the direction of the Quality Governance Council, a medical peer review committee/medical committee of Harris Health System, authorized to evaluate the quality of medical and health care services and are confidential and not subject to disclosure.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Aguocha-Ohakweh, et al. Plaintiffs	§	
v.	§	Civil Action No 4:16-cv-00903
Harris County Hospital District, et al. Defendants	§	

VERIFICATION

BEFORE ME, the undersigned Notary Public, on this day personally appeared Stacey Mitchell, Administrative Director, Risk Management and Patient Safety, who being by me duly sworn on her oath and said that she is an agent for Harris County Hospital District d/b/a Harris Health System for the purposes of the above and foregoing answers of Harris County Hospital District d/b/a Harris Health System in the First Set of Interrogatories and that the statements contained herein are true and correct to the best of her knowledge and/or the persons who provided the facts as stated in the interrogatory answers stated that they are true and correct.

Stacey Mitchell

SWORN AND SUBSCRIBED TO BEFORE ME, the undersigned Notary Public, on this 25th day of July, 2016, to certify which witness my hand and official seal of office.

Notary Public in and for the State of Texas

Agnieszka ...
Notary Public ... Texas
My Comm. Exp. .../2020
Notary ID 130...

3. Exhibit Bethrand's "Affidavit"

CAUSE NO. 201576259

Emily-Jean Aguocha-Ohakweh *et al*	§	In the 270th
Plaintiffs	§	JUDICIAL DISTRICT COURT
v.	§	HARRIS COUNTY, TX
Baylor College of Medicine, Harris Health System, et al		
Defendants		

3/23/2016 3:07:15 PM
Chris Daniel - District Clerk Harris County
Envelope No. 8757091
By: SASHA PRINCE
Filed: 3/23/2016 3:07:15 PM

AFFIDAVIT

BEFORE ME, the undersigned authority, this day personally appeared BETHRAND OHAKWEH, who after being duly sworn, on oath deposes and voluntarily says:

1. My name is BETHRAND OHAKWEH.
2. I am over the age of 21 and a resident of the State of TEXAS. I have personal knowledge of the facts herein, and if called as a witness, could testify competently thereto,
3. The Estate Administrator and Son of Dr. Aphacus Ohakweh (Decedent) in cause number 201576259.
4. I know my father's signature. I have watched him sign his signatures many times and can verify or spot an authentic signature of his if presented to me.
5. The two signatures on the 3/6/2015 Bronchoscopy document in Exhibit M, are not his signatures as alleged in the pleadings.

STATE OF TEXAS
COUNTY OF BRAZORIA

I declare under penalty of perjury that the foregoing is true and correct, and the statements above are made on my own volition.
Executed this 23 day of March 2016.

Signature of Affiant: _____
Name of Affiant: BETHRAND OHAKWEH
SWORN TO AND SUBSCRIBED BEFORE ME before me on this 23 day of March 2016.

_____
Notary Public in and for the State of Texas
My commission expires: 02/19/17

JAIME D MUSNI JR
NOTARY PUBLIC
STATE OF TEXAS
MY COMM. EXP. 2/19/17

CAUSE NO. 201576259

Emily-Jean Aguocha-Ohakweh *et al*	§	In the 270th
Plaintiffs	§	JUDICIAL DISTRICT COURT
v.	§	HARRIS COUNTY, TX
Baylor College of Medicine, Harris Health System, et al		
Defendants		

AMENDMENT EXHIBIT

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW **Emily-Jean Aguocha-Ohakweh *et al***, Plaintiffs, and files this additional exhibit to its petition:

Exhibit M: March 6, 2015 alleged bronchoscopy consent document.

Respectfully submitted,

/s/ Ernest C. Adimora-Nweke Jr

By Ernest Adimora-Nweke
State Bar No: 24082602
Adimora Law Firm
5100 Westheimer Rd, Suite 200
Houston, TX 77056
281.940.5170
Attorney *for Plaintiffs*
Ernest@adimoralaw.com

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Dr. Guy as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: respiratory failure

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedure(s): endotracheal intubation, bronchoscopy with bronchoalveolar lavage, biopsy and other interventions

3. I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

4. I (we) (YES) (do not) consent to the use of blood and blood products as deemed necessary.

5. I (we) understand that any tissues, organs, parts surgically removed or medical waste not utilized will be disposed of by the Harris Health System in accordance with its accustomed practice.

6. I (we) understand that no warranty or guarantee has been made to me as to result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure.

8. I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

9. I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

10. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

11. I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

Date: 3/6/2015 Time: 10:10 (AM) PM

Patient / Other Legally Responsible Person's Signature

Van Buren MO 63776

Physician/Authorized Provider Signature / Title / ID #

Witness/Healthcare worker Signature / Title / ID #

FOR INTERPRETATION ONLY

I provided interpretation for (name of patient or responsible person) _____. I certify that I can read and speak the _____ language and the English language fluently. I further certify that the interpretation I provided was accurate, that the patient verbalized understanding of the information contained within this form and had the opportunity to ask questions and have them answered. I also acknowledge that the matters discussed are confidential and agree to maintain the confidentiality of any communications concerning (patient's name) _____ as provided by the laws of the State of Texas.

Interpreter's Name or Signature & ID #:	Title:	Department:	Address:
Witness's Name or Signature:	Address:		City, State, Zip Code:

Patient ID

MRN [redacted]
Ohakweh, Aphaeus
M 8/18/1949 (65 yrs)
ACCT [redacted]4

HCHD

HARRISHEALTH SYSTEM

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Retention: HR-4800-04 280331 (11/13)

PAGE 1

TO THE PATIENT: You have the right as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure or alternatives, if any, to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Dr. Kang as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: AML.

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize this procedure(s): Chemotherapy Clofarabine & Cytarabine

3. I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

4. I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary.

5. I (we) understand that any tissues, organs, parts surgically removed or medical waste not utilized will be disposed of by the Harris Health System in accordance with its accustomed practice.

6. I (we) understand that no warranty or guarantee has been made to me as to result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure. (See the following pages.)

8. I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

9. I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

10. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) have sufficient information to give this informed consent.

11. I (we) certify the information contained on this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Date: 12/26/13 Time: 10 AM/PM

X [signature] Patient / Other Legally Responsible Person's Signature

Ghuna Kang 53395 Physician/Authorized Provider Signature / Title / ID #

[signature] Witness/Healthcare worker Signature / Title / ID # 103169

FOR INTERPRETATION ONLY

I provided interpretation for (name of patient or responsible person) _____. I certify that I can read and speak the _____ language and the English language fluently. I further certify that the interpretation I provided was accurate, that the patient verbalized understanding of the information contained within this form and had the opportunity to ask questions and have them answered. I also acknowledge that the matters discussed are confidential and agree to maintain the confidentiality of any communications concerning (patient's name) _____ as provided by the laws of the State of Texas.

Interpreter's Name or Signature & ID #:	Title:	Department:	Address:
Witness's Name or Signature:	Address:		City, State, Zip Code:

Patient ID

Ohakweh, A

07488 2021

HARRISHEALTH SYSTEM

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

MRN 074882021
Ohakweh, Aphaeus
M 8/18/1949 (64 yrs)
HARRIS HEALTH

Retention: HR-4600-04 080031 (09/12)

PAGE 1

HCHD OHAKWEH - MEDICAL RECORDS - 58805

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure or alternatives, if any, to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Dr. KAO / HOWARD as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: LUNG INFILTRATES

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize this procedure(s): **Bronchoscopy with bronchoalveolar lavage, biopsy and other related indicated procedures under moderate conscious sedation.**

3. I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

4. I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary. ROAO

5. I (we) understand that any tissues, organs, parts surgically removed or medical waste not utilized will be disposed of by the Harris County Hospital District in accordance with its accustomed practice.

6. I (we) understand that no warranty or guarantee has been made to me as to result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure. (See the following pages.)

8. I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

9. I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

10. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) have sufficient information to give this informed consent.

11. I (we) certify the information contained on this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in and that I (we) understand its contents.

Date: 18 DEC 13 Time: 5 AM/PM X [signature] Patient / Other Legally Responsible Person's Signature

[signature] 50618 [signature] RN 75008

*Physician/Authorized Provider Signature / Title / ID # Witness/Healthcare worker Signature / Title / ID #

*The Physician/Authorized Provider signing this form must hold privileges for the procedure being consented.

FOR INTERPRETATION ONLY

I provided interpretation for (name of patient or responsible person) _____. I certify that I can read and speak the _____ language and the English language fluently. I further certify that the interpretation I provided was accurate, that the patient verbalized understanding of the information contained within this form and had the opportunity to ask questions and have them answered. I also acknowledge that the matters discussed are confidential and agree to maintain the confidentiality of any communications concerning (patient's name) _____ as provided by the laws of the State of Texas.

Interpreter's Name or Signature & ID #	Title:	Department:	Address:
Witness's Name or Signature	Address:		City, State, Zip Code:

Patient ID

MRN 074882021
Ohakweh, Aphaeus
M 5/18/1949 (64 yrs)
ACCT 965013621549
HCHD

Harris County Hospital District

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Retention: HR-4600-04 280331 (03/12)

PAGE 1

HARRIS HEALTH - OHAKWEH - MEDICAL RECORDS - 59816

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the above petition has this day, January 28, 2016 been delivered to all necessary parties, in this case or to the various attorneys of such necessary parties pursuant to Texas Rules of Civil Procedure.

/s/ Ernest C. Adimora-Nweke Jr

By Ernest Adimora-Nweke
State Bar No: 24082602
Adimora Law Firm
5100 Westheimer Rd, Suite 200
Houston, TX 77056
281.940.5170
Attorney *for Plaintiffs*
Ernest@adimoralaw.com

4. HHS's Patient's Rights & Responsibilities Policy – HHS discovery response

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

You have rights because you get care at Harris Health System:

RIGHT TO A REASONABLE RESPONSE TO REQUESTS FOR TREATMENT. You have the right to have things you ask about at Harris Health be heard and acted on if it is possible, does not go against the Harris Health mission and is legal to do. If you are transferred to another hospital, you have a right to know why and the risks, benefits and alternatives to the transfer.

RIGHT TO EQUAL ACCESS TO TREATMENT. You have the right to treatment or care from all Harris Health System services, programs and facilities no matter what your age, race, color, religion, sex, national origin, ethnicity, disability, language, culture, genetic information (including family medical history), or other protected status.

RIGHT TO INFORMATION ABOUT PATIENT RIGHTS. You have the right, to get information about Harris Health System's patient rights policies when you are admitted to the hospital. You also have the right to know how Harris Health System will investigate and when possible, resolve your complaints about quality of care.

RIGHT TO KIND AND RESPECTFUL CARE. You have the right to get kind and respectful care while you are at Harris Health System. This care includes, but is not limited to:

- Thinking about your psychosocial, spiritual, and cultural needs, wishes or beliefs that guide how you view your illness;
- Focusing on your comfort and dignity while treating primary and secondary symptoms that you or your legal representative want treated and there is a treatment for;
- Managing your pain to the best of our ability; and
- Accepting you and your family's psychosocial and spiritual concerns about dying and how you and your family express grief.

RIGHT TO MAKE DECISIONS ABOUT YOUR CARE. You have the right to make decisions about your care with your physician. You have the right to join or share in making and carrying out your plan of care. You have the right to be given facts about your care and to ask those who take care of you to tell you their name and what they are going to do to take care of you. You have the right to accept or to refuse medical treatment, and to be told of what may happen with your health if you refuse treatment.

RIGHT TO GIVE INFORMED CONSENT. You have the right to get information you need to make choices about your care before the care is given. This includes the name of the treatment and its risks, the name of the person doing the treatment, how long it will take you to get better, and your treatment choices. You and your legal representative also have the right to be included if there are ethical issues about your care.

RIGHT TO HAVE AN ADVANCE DIRECTIVE. You have the right to have an advance directive (such as a directive to physicians, declaration for mental health treatment, or medical power of attorney) concerning treatment. You also have the right to choose another adult to make health care decisions for you as allowed by law. Your care will not be changed because you do or do not have an advance directive.

HARRISHEALTH SYSTEM

RIGHT TO PRIVACY AND CONFIDENTIALITY. You have the right to expect that all communications and records about your care will be treated as confidential, except in cases such as suspected abuse and public health hazards or when reporting is permitted or required by law. You have the right to have a place and equipment for a private telephone conversation, if you wish.

RIGHT OF ACCESS TO YOUR MEDICAL RECORD. You and your designated legal representative have the right to view information contained in your medical record, as allowed by law.

RIGHT TO BE FREE FROM ABUSE. You have the right to get care in a safe setting and to be free from all forms of abuse, harassment, neglect, and exploitation.

RIGHT TO BE FREE FROM RESTRAINT OR SECLUSION. You have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of you, a staff member, or others and must be stopped at the earliest time possible.

RIGHT TO PARTICIPATE IN RESEARCH. You have the right to consent to or refuse to be part of any human experimentation or other research or educational projects that may affect your care or treatment or that require your direct involvement. You also have the right to have the research or educational projects fully explained to you before you consent to or refuse to be in them. If you refuse, your care will not change.

RIGHT TO RECEIVE EXPLANATION OF YOUR BILL. You have the right to have your bill explained to you, no matter who paid or will be paying the bill.

RIGHT OF ACCESS TO INTERPRETER AND COMMUNICATION SERVICES. You have the right to an interpreter that speaks your language. If you have a hearing or speech impairment, you have the right to communication services which meet your needs.

RIGHT TO A LEGAL REPRESENTATIVE. You have the right to have your legal guardian, next of kin, or legal representative use your rights, as allowed by law, if you are:

- Judged incompetent by law;
- Found by your physician to not be able to understand your needed treatment or procedure because of a medical condition;
- Not able to communicate your wishes regarding treatment; or
- A minor.

RIGHT OF NOTIFICATION. You have the right to have a family member or representative of your choice and your physician told promptly of your admission to a Harris Health hospital.

RIGHT TO HAVE VISITORS. You have the right to decide who may or may not visit you while you are in the hospital, as clinical conditions permit. Subject to your consent, you have the right to have visitors whom you name/list including, but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend. You have the right to say you no longer want to have a named visitor at any time. Harris Health does not restrict, limit, or otherwise deny anyone the chance to visit on the basis of race, color, national origin, sex, gender identity, sexual orientation, or disability. Harris Health will ensure that all visitors enjoy full and equal chance to visit using your stated list.

ADDITIONAL RIGHTS OF PATIENTS UNDER THE AGE OF 18 AT QUENTIN MEASE HOSPITAL. You have the right to ask to be given care away from adult patients and to have regular communication with your family.

PATIENT RESPONSIBILITIES

RESPONSIBILITY TO PROVIDE INFORMATION. You or your legal representative are responsible for giving full and honest facts about your health and your health history. Your health history includes any illness, hospital stay, medicines you take or have taken, instructions to your doctor about your care, and other health matters.

RESPONSIBILITY TO FOLLOW TREATMENT PLAN. You and your legal representative are responsible for being a partner in your healthcare plan. Talk about your treatment. Follow the plan of care. Tell your doctor if you cannot follow the plan of care. Tell your doctor about any changes in your health.

RESPONSIBILITY TO ASK QUESTIONS. You and your legal representative are responsible to ask questions when you do not understand. Go to classes to learn about your health. You may bring a written list of questions to your appointment.

RESPONSIBLIITY TO KEEP YOUR CONTACT INFORMATION UP-TO-DATE. You or your legal representative are responsible to tell us about changes in your address, phone number and insurance. Give us the correct address and phone number for you and your next of kin.

RESPONSIBILITY TO USE OUR SERVICES CORRECTLY. You and your legal representative are responsible to use our services to get well and stay well. Refill your medicine on time. Make regular health appointments. Call us for an appointment if you feel sick or need help filling out a form. Keep your appointments. Call at least two days before to cancel your appointment, or as soon as you know that you cannot keep your appointment.

RESPONSIBILITY TO PAY YOUR BILL. You are responsible to pay your part of the bill.
Apply for help to pay your medical bills, if you need help.

RESPONSIBILITY TO BE CONSIDERATE OF RIGHTS OF OTHERS. You, your legal representative, and your visitors are responsible to treat the people who take care of you, other patients and our property with respect and courtesy. Maintain a clean and quiet area. Respect the privacy of other patients. Limit your use of cell phones in patient care areas. Do not take pictures or record conversations without first talking with staff.

5. Relevant Harris County Hospital District Medical Staff Rules and Regulations

GENERAL RULES FOR ALL SERVICES

PATIENT SAFETY

It is the policy of the Hospital District to inform the patient and/or family in the event of any significant unanticipated outcome. A significant unanticipated outcome is defined as an unexpected occurrence involving death or serious physical or psychological injury. The practitioner, or the resident with the attending, will discuss the outcome with the patient and/or family when appropriate, to include all measures to be taken, and document the discussion on the Confidential Memorandum.

TELEMEDICINE SERVICES

Telemedicine refers to the use of interactive audio, video, or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. For additional information regarding the telemedicine process, refer to Hospital District Policy 7.09, Telehealth Services/Telemedicine Medical Services.

RESIDENT SUPERVISION

SCOPE: Attending staff are responsible for the patient care provided, and must be familiar with patients for whom they are responsible. Fulfillment of that responsibility requires involvement with the patients and residents participating in patient care. Each patient must have an attending staff whose name is recorded in the patient record. It is recognized that other attending staff may at times be delegated responsibility for the care of the patient and supervision of the residents involved. It is the responsibility of the attending staff to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending staff at all times.

Within the scope of the training program and funding by the District, all residents function under the supervision of the attending staff. Each service must establish a schedule that indicates the responsible attending staff and the method to contact those physicians.

Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. The determination and documentation of graduated levels of responsibilities are determined by the training program.

In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, an appropriately privileged attending staff should be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending staff for each clinic. Attending staff are responsible for ensuring the coordination of care that is provided to patients.

Training institutions are to ensure that their training programs provide appropriate supervision for all residents funded by the District, as well as a duty hour schedule and a work environment that are consistent with proper patient care, the educational needs of residents, and the applicable program requirements.

SUPERVISION CRITERIA: Each clinical service will develop the policies of the medical staff specific process for supervision of participation in the program in carrying out their patient care responsibilities.

All residents are supervised by members of the attending staff, and shall be evaluated on a regular basis by the responsible training program, which shall maintain a confidential record of his/her evaluation. The patient care responsibilities granted to residents shall be in accordance with the policies of the individual training program/department which delineates the level of responsibility granted at each level of postgraduate education.

The direct and ultimate responsibility for supervision of patient care rendered by residents shall be by the patient's attending staff. Overall supervision of the quality of the performance and educational development of residents shall be by the Department Chairman, Service Chief, or Program Director.

Resident physicians may write any order on their patients except those specifically limited by their service or GME guidelines. Resident orders do not need to be co-signed.

This does not preclude licensed independent practitioners from writing orders on their patients without restriction.

The position of resident entails provision of care commensurate with the resident's level of advancement and competence, under the general supervision of appropriately privileged attending teaching staff in accordance with the Policy on the Supervision of Residents, and the policies of the Service.

Staff involvement in operating room procedures will be documented.

REPORTING PROCESS: Where residents are present, the Associate Dean or designee of GME at Baylor College of Medicine and The University of Texas Medical School will report annually to the Medical Executive Board on the status of the training programs. Any changes in the status of affiliations, and a specific analysis of resident supervision issues identified through the reviewing and/or monitoring progresses. Any problems identified will be reported together with a plan of action for their remedy.

ADMISSION REQUIREMENTS

ELIGIBILITY: With the exception of emergencies, no patient shall be given service in a Hospital District facility until he or she has met eligibility criteria.

IDENTIFICATION NUMBER: No patients shall be given service until a record has been made and a chart number issued, except in the case of an emergency.

INPATIENT ADMISSIONS: Patients may be admitted to the hospital only upon order of a member of the Active Medical Staff, or resident staff assigned to duty within the hospital. No staff member or resident will directly admit to a service other than their own without prior consultation from the service involved. All practitioners will be governed by the official admitting policy.

INTERHOSPITAL TRANSFERS: Transfer of patients from non-Harris County Hospital or Quentin Mease Hospital must be approved in advance by the Administration of the Hospital District.

CHARGES FOR PROFESSIONAL SERVICES: All charges for services rendered to patients in any facility of the Harris County Hospital District by physicians of the Medical Staff shall be collected in

accordance with the agreement between the Hospital District and AMS, Baylor College of Medicine and the University of Texas Medical School at Houston.

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

PRINCIPLES AND GUIDELINES (POLICY):

1. A consent for Medical/Surgical treatment form *(HCHD 6384)* shall be obtained on ALL patients who present to a District facility for medical care.

2. **DISCLOSURE:** The physician shall be responsible for disclosure to the patient, or the person authorized to consent for medical care, the risks and hazards involved in any medical/surgical procedure, including but not limited to those procedures that appear on the Texas Medical Disclosure Panel's List(s), whenever written Informed Consent is obtained. *(25 Texas Administrative Code #601)* The disclosure must also include, as appropriate:

   - alternative options to the procedure, if these exist;
   - the need for and risk of blood transfusion and available alternatives, and
   - the need for and alternatives to any form of anesthesia.

   a. The physician shall be considered to have made such disclosure if a properly executed Disclosure and consent – Medical/Surgical Procedures form (HCHD 6357) is obtained prior to the rendering of any medical/surgical procedure. The person who renders the medical/surgical care will be legally liable for the adequacy of the consent.

   b. The witness of the explanation of risks/hazards may be another health care provider, a member of the clergy, and/or a family member, but should not be the physician(s) who perform the medical/surgical procedure.

   c. In the event the patient refuses examination or treatment, the physician must take reasonable steps to explain the risks and benefits of examination, treatment or procedure and secure the patient's written informed consent to refuse such examination, treatment or procedure.

3. **PERSONS ELIGIBLE TO CONSENT:** The District, in accordance with the *Texas Health & Safety Code #313*, Consent for Medical Treatment Act, recognizes the following as who may consent to medical/surgical treatment:

   Adult

   1. A patient who is eighteen (18) years or older UNLESS:

      - The patient specifically has designated another person to consent to the patient's medical care in a properly executed Durable Power of Attorney for Health Care.
      - The patient has a court appointed guardian;
      - The patient is comatose, incapacitated, or other wise mentally or physically incapable of communication and does NOT have either a legal guardian or a Durable Power of Attorney for Health Care.

2. If the patient is comatose, incapacitated or otherwise mentally or physically incapable of communication, an ADULT surrogate from the following priority list, who has decision making capacity, may consent to medical treatment provided they are available after a reasonably diligent inquiry (and is willing to consent to medical treatment on behalf of the patient):

   - The patient's spouse;
   - An adult child who has the waiver and consent of all other qualified adult children to act as the sole decision-maker;
   - A majority of the patient's reasonably available adult children;
   - The patient's parents;
   - The individual clearly identified to act for the patient by the patient before the patient became incapacitated, the patient's nearest relative, or a member of the clergy.

   Any dispute as to the right of a party to act as a surrogate decision-maker may be resolved only by a court of record. Any medical treatment consented to must be based on knowledge of what the patient would desire, if known. Notwithstanding, a surrogate decision maker may NOT consent to:

   - Voluntary inpatient mental health services;
   - Electroconvulsive treatment;
   - Withhold or withdraw life sustaining treatment *(see HCHD 4550, Do Not Resuscitate);*
   - The appointment of another surrogate decision maker.

3. In the event a surrogate decision maker's consent to medical treatment is NOT made in person (i.e., by telephone), the consent shall be reduced to writing in the patient's medical record, signed by both a physician and a witness to the proceedings. The surrogate decision maker should countersign the documented consent or Discharge and Consent for Medical/Surgical Procedures (HCHD 6357) as soon as possible. Telephone consents should not be relied upon for medical or surgical treatment, except in emergency situations where a delay in treatment would jeopardize the life or the health of the patient and the legally responsible representatives of the patient are not available except by telephone.

Consent for Emergency Care

1. Consent for emergency care of an individual is not required if the person is unconscious or otherwise unable to communicate because of an injury, accident or illness and is suffering from what reasonably appears to be a life-threatening illness or injury. (Texas Health & Safety Code, Sections. 773.008 and 311.021);

2. When in medical judgment there appears to be a life-threatening injury or illness and it is impossible to obtain immediate consent from either the patient or a surrogate decision maker, the physician shall provide appropriate medical treatment/intervention.

   NOTE: It is advisable in this circumstance for two (2) additional physicians, one (1) being either the Chief Resident or Faculty, to document pertinent medical assessment and medical care needed or delivered in an emergency.

3. Consent is not required for a minor suffering from what reasonably appears to be a life threatening injury or illness whose parent, managing or possessory conservator, or guardian IS NOT present.

HOSPITAL PROCESS:

1. The Medical Executive Board will take action on any Credential Committee's recommendation and/or make a further recommendation to the Governing Board. A record of this will be made a permanent part of the appointee's credentials file.

2. The Governing Board of the Hospital District, upon recommendation of the Medical Executive Board, may terminate Practitioner's privileges to practice medicine in the Hospital District. Termination of a practitioner from the hospital staff may be reported to the Texas State Board of Medical Examiners in accordance with the Health Care Quality Improvement Act, 42, U.S.C., Section 423.

DELINEATION OF RESPONSIBILITIES

1. Chiefs of Service are responsible for:

   - Communicating with the practitioners in their service to ensure that delinquent records are completed timely
   - Ensuring alternate arrangements are made for suspended practitioners scheduled for the service on call schedule

2. Attending Practitioners are responsible for:

   - Monitoring and ensuring that the residents complete dictations timely
   - Documenting in the medical record to substantiate the active participation in, and supervision of, the patient's care
   - Ensuring that the principal and secondary diagnosis and procedures (including complications and comorbidities) are documented at the time of discharge, without the use of symbols or abbreviations

OWNERSHIP: The medical record is the property of the Hospital District and shall not be removed from its environment except upon court order, subpoena, statute, inter-hospital transfer, clinic appointments, and off site storage. District Medical Records will be transferred to an offsite storage facility based upon District retention policy. The offsite storage facility will maintain records in accordance with district policies regarding retention, security and confidentiality.

UNIT NUMBERING: Each patient shall be assigned a unit number at his/her first contact with the Hospital District and shall retain that number for all subsequent visits within any Hospital District facility.

AVAILABILITY OF RECORDS: Medical records must be available and accessible at all times for patient care. The records, or any part thereof, may not be placed in desk drawers, cabinets, or other areas that render them inaccessible for prompt retrieval. Records should not be moved from nursing stations or clinics without notification to the Medical Records Department.

CONTENT: The practitioner is responsible for assuring that the complete medical record is prepared for each patient. Completion of the medical record may be performed directly by the LIP or by authenticating the services performed by the housestaff, fellow or QMP. Its contents shall be pertinent and current.

MEDICAL RECORD ENTRIES; All medical record entries must be legible, complete, dated (month, day, year), timed (military time or notation of a.m./p.m. should be used for 24-hour facilities; standard time may be used for ambulatory clinics) using authorized identification numbers and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided.

Physicians must make entries in the medical record at a frequency determined by the appropriate service, within the standards of practice for that service and in accordance with regulatory agencies.

Signature stamps may not be used on medical record documentation. Printed practitioner identification stamps should be used when available in the Harris County Hospital District.

HISTORY AND PHYSICAL EXAMINATION: History and physical (H&P) examinations should be performed by a licensed independent practitioner (LIP) or Qualified Medical Personnel (QMP) with privileges; cosigned medical student notes shall not be accepted. An appropriate complete history and physical examination pertinent to the medical condition must be recorded.

Inpatient: A complete history and physical examination shall, in all cases, be written and placed in the record within twenty-four (24) hours after admission of the patient. If a complete history and physical examination has been obtained within thirty (30) days prior to admission a legible copy of this report may be used in the patient's hospital medical record at the time of admission. If there are subsequent changes in the patient's condition or if there have been no changes in patient's condition, this information may either be recorded on the H&P as an addendum or recorded on an initial progress note no later than twenty-four (24) hours following admission and prior to surgery.

Outpatient: A history and physical will be performed at the initial ambulatory visit. A history and physical examination is encouraged, but not required for minor procedures performed in the outpatient setting.

Surgical, Invasive, or Interventional Procedures: Prior to a surgery, invasive or interventional procedure occurring during the hospitalization but after twenty-four (24) hours of admission, the history and physical findings must be reviewed, updated and documented in the medical record.

Emergency: In case of emergency surgery, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed.

Outpatient: All outpatients undergoing surgical procedures, cardiac catherization, endoscopy, or angiographic procedures shall have a pertinent history and physical examination recorded in the medical record. If a complete history has been recorded and physical examination performed prior to the patient's admission to the hospital a legible copy of these reports may be used in the patient's hospital medical record provided these reports were recorded no more than thirty (30) days prior to the admission date. If there are subsequent changes in the patient's condition or if there have been no changes in patient's condition, this information may either be recorded on the H&P as an addendum or recorded on an initial progress note no later than twenty-four (24) hours following admission and prior to surgery.

Short Stay: The "Short Stay History and Physical" form is acceptable for any day surgery procedure with a length of stay of up to or under 48 hours. A short stay history and physical shall contain at least: chief complaint, history of present illness, allergies, current medications, review of relevant systems, physical examination and an assessment and the plan for medical care.

INDIVIDUAL SERVICE RULES AND REGULATIONS

ANESTHESIOLOGY

BEN TAUB GENERAL HOSPITAL

MISSION

The members of the Department of Anesthesiology are committed to high quality health care delivered in a timely, cost-effective, and compassionate manner, the advancement of the science and art of anesthesiology, and stimulating interest and promoting progress in the scientific, cultural, and economic aspects of the specialty of anesthesiology.

AUTHORITY

The Anesthesiology Service at Ben Taub General Hospital is under the general direction of the Anesthesiologist-in-Chief, who will be a member of the faculty of Baylor College of Medicine. The Anesthesiology Service at Lyndon B. Johnson General Hospital is under the general direction of the Anesthesiologist-in Chief, who will be a member of the faculty of the University of Texas Medical School at Houston.

DEFINITION OF ANESTHESIOLOGY

Anesthesiology is a discipline within the practice of medicine specializing in:

1. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures.
2. The protection of life functions and vital organs under the stress of anesthetic, surgical and other medical procedures.
3. The management of problems in pain relief.
4. The management of cardiopulmonary resuscitation.
5. The management of problems in pulmonary care.
6. The management of critically ill patients in special care units.

POLICY ON SCOPE OF SERVICES

Anesthesiology is the practice of medicine. It is the goal of the Anesthesiology Service to have an anesthesiologist provide medical direction for every anesthetic administered by the department.

The Department of Anesthesiology provides 24 hours a day, seven days a week medical management of all patients (inpatient and outpatient) requiring anesthesia care or management during surgical, obstetrical, or other medical procedures.

Patients receiving care from the Anesthesiology Service can expect the following:

1. Preanesthetic evaluation of the patient;
2. Prescription of the anesthesia plan by an anesthesiologist;
3. Personal participation by an anesthesiologist in the most demanding procedures in this plan, especially those of induction and emergence;
4. Following of the course of anesthesia at frequent intervals by an anesthesiologist;
5. An anesthesiologist remaining physically available for the immediate diagnosis and treatment of emergencies and.
6. An anesthesiologist providing indicated post anesthesia care.

A team of Anesthesiology Service personnel, including at least one staff anesthesiologist is available in the hospital twenty-four (24) hours per day, seven (7) days per week.

A call schedule is available in all places required by the hospital and specifies the members of the Anesthesiology Service on call.

STAFF

Anesthesiologists: Provide medical direction for patient care, supervision of registered nurse anesthetist, training for residents and student registered nurse anesthetists, and supervision for medical students.

Registered Nurse Anesthetists: Provide patient care under the medical direction of the anesthesiologist.

Anesthesia Trainees: Provide patient care under the medical direction of the staff anesthesiologists and within the scope of their individual training requirements.

Medical Students: The anesthesiology faculty will be responsible for supervision of any medical student activity.

CONSULTATION

Requests for consultation can be submitted in writing on the usual forms. Emergency consultation should be submitted by telephone directly to a faculty anesthesiologist.

RE-APPOINTMENT CRITERIA

Physicians must participate in the care of an average of 6 OR patients per year as documented in the OR logging system or see at least one patient in consultation per year, at the request of an HCHD physician, as documented in the Pro-Fee billing system.

CRNAs must participate in the care of an average of 6 OR patients per year as documented in the OR logging system.

ANESTHESIOLOGY - BTGH

Physician Services should request OR case documentation directly from Operative Services or IS, if they are unable to access this data directly using a standard query. Consultation information, but not OR care, can be requested from the Pro-Fee billing office.

6. Harris Health System Policy & Procedure on Incident Reporting

HARRISHEALTH SYSTEM

Policy No: 3.63
Page Number: 1 of 5

Effective Date: 3/2013
Board Motion No.:

TITLE: **INCIDENT REPORTING**

PURPOSE: To provide guidance regarding the reporting of Incidents involving patients, visitors, or Workforce members, which are inconsistent with the standard of care, and/or the routine operations of Harris Health System.

POLICY STATEMENT:

All injuries and hazards involving patients, visitors, and Workforce members shall be reported using the Harris Health System (Harris Health) electronic incident reporting system (eIRS). Harris Health does not tolerate retaliation against Workforce members who report Incidents.

ELABORATION:

I. DEFINITIONS:

A. **ADVERSE EVENT:** A patient care event that is unfavorable, undesirable, and usually unanticipated that causes death or serious injury, or the risk thereof. Adverse events may result from unintentional acts or omissions. Adverse Events may include, but are not limited to:

1. Patient falls;
2. Medication errors;
3. Procedural errors/complications;
4. Completed or attempted suicides;
5. Iatrogenic injuries, i.e., injuries due to medical treatment or procedure;
6. Failure to make a timely diagnosis;
7. Untimely implementation of appropriate therapeutic intervention; and
8. Missing patient events.

B. **INCIDENT:** An accident or injury that occurs within Harris Health staffed locations that is inconsistent with the standard of care of a patient or routine operations of Harris Health which may result in an unanticipated harm or injury to patients, visitors, affiliates, employees, and others. "Incident" shall include, but is not limited to events that are:

1. Inconsistent with any Harris Health policy or procedures; or
2. Non-anticipated and non-routine patient, employee, affiliate, contractor, visitor, volunteer or other injuries resulting from accidents or errors.

HARRIS HEALTH - OHAKWEH - 59635

C. **NEAR MISS:** An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. An example of a Near Miss would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification but caught at the last minute by chance. Near Misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near Misses will receive the same level of scrutiny as Incidents that result in actual injury.

D. **SENTINEL EVENT:** An incident involving a serious adverse outcome error including death, serious physical or psychological injury or the risk thereof, or other resulting from any process variation for which a recurrence would carry a significant risk of a serious adverse outcome error. Serious injury specifically includes loss of limb or function. Events qualifying as sentinel events include, but are not limited to:

1. Unanticipated death;
2. Major, permanent loss of function;
3. Suicide;
4. Infant abduction;
5. Infant discharged to the wrong family;
6. Rape;
7. Hemolytic transfusion reaction involving major blood group incompatibilities;
8. Surgery on the wrong patient or wrong body part;
9. Prolonged fluoroscopy;
10. Death of a full term infant;
11. Severe neonatal hyperbilirubinemia;
12. Intrapartum maternal death;
13. Elopement (See Harris Health Policy 4205 Absences from Nursing Unit: Against Medical Advice (AMA), Elopement, Requests to Leave the Unit); or
14. Unintentional retention of a foreign body.

E. **WORKFORCE:** Employees (permanent or temporary), Board of Managers, volunteers, trainees, and other persons whose conduct, in the performance of work for Harris Health, is under the direct control of Harris Health, whether or not they are paid by Harris Health.

II. GENERAL PROVISIONS:

A. The Workforce member who discovers an Incident involving a patient shall immediately notify the patient's care team.

B. All Incidents involving patients, visitors or Workforce members shall be documented in the eIRS system or using downtime forms when the eIRS is not available.

C. An objective description of the Incident should be written in the medical record by both the medical and nursing staff along with any observations, diagnostic studies and results, and/or related treatment; however, the reporter should **not** write in the medical record that the Incident was reported in eIRS.

D. Workforce members are accountable for ensuring all Incidents are documented in the eIRS.

III. EXAMPLES OF INCIDENTS THAT MUST BE REPORTED:

A. All Incidents, Sentinel Events, Adverse Events, and Near Misses;

B. Patient identification issues (incorrect medical record number, mislabeled or wrong lab/diagnostic results reported, etc.);

C. Blood product administration errors;

D. Procedural errors;

E. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than two hundred and fifty (250) grams;

F. A patient death or serious injury associated with the use or function of a device designed for patient care that is used for or functions other than as intended (See Harris Health Policy 7503 Safe Medical Device Reporting Program); and

G. Major high-risk issues and/or critical incidents shall be reported and preceded with a telephone call to the Harris Health Risk Management Administrative Director.

H. Falls for any reason, with or without injuries;

I. Medication errors;

J. Needle sticks punctures and/or occupational exposures;

K. Diagnostic/therapeutic procedures performed on wrong patients;

L. Burns resulting from devices used in patient care;

M. Any faulty/defective equipment;

N. The existence of hazardous conditions within Harris Health staffed locations;

O. Vocal or written expressions of dissatisfaction from a patient or a patient's family concerning professional and non-professional services and/or treatment received within a Harris Health staffed location (Refer to Harris Health Grievance Policy 4200);

P. Patients exhibiting threatening or aggressive behavior that requires assistance by Security or law enforcement; or

Q. Patient or visitor's lost, stolen, or damaged property, claimed or actual.

7. Harris Health System Policy & Procedure on Disclosure of Adverse Events

HARRISHEALTH SYSTEM

POLICY AND REGULATIONS MANUAL

Policy No: 3.64
Page Number: 1 of 4
Effective Date: 03/2015
Board Motion No:

TITLE: **DISCLOSURE OF ADVERSE EVENTS**

PURPOSE: To establish the procedures for informing patients and/or their Legal Representative when an Adverse Event has occurred.

POLICY STATEMENT:

Harris Health System (Harris Health) shall communicate timely with patients regarding any Adverse Event.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ADVERSE EVENT:** A patient care event that is unfavorable, undesirable, and usually unanticipated that causes death or serious injury, or the risk thereof. Adverse events may result from unintentional acts or omissions. Adverse Events may include, but are not limited to:

1. Patient falls;
2. Medication errors;
3. Procedural errors/complications;
4. Completed or attempted suicides;
5. Iatrogenic injuries;
6. Failure to make a timely diagnosis;
7. Untimely implementation of appropriate therapeutic intervention; and
8. Missing patient events.

B. **ATTENDING PRACTITIONER:** The faculty Practitioner who is responsible for the management and care of a patient.

C. **DISCLOSURE:** The process by which an Adverse Event is communicated to the patient and/or Legal Representative.

D. **LEGAL REPRESENTATIVE:** An individual who has the legal status under state law to make medical decisions, including decisions about visitation, for a patient when the patient is unable to do so. Such legal status can arise from a

HARRIS HEALTH - OHAKWEH - 59640

relationship to the patient (e.g., parent or spouse); from an Advance Directive; or from a Court Order (e.g., a guardian).

E. **PRACTITIONER:** Unless otherwise expressly limited, any Physician, Podiatrist, or Dentist holding a current license to practice in the State of Texas.

II. DISCLOSURE PROCESS:

A. Disclosure may include but is not limited to the following:

1. Acknowledging that an Adverse Event has occurred;
2. Disclosing specific known facts about the Adverse Event;
3. Providing a general expression of care, empathy, concern, and regret;
4. If known, definite implications of the event for the patient's health and treatment plan (and, if there are potential or anticipated consequences, a clear description of what and how the team will be monitoring for their emergence);
5. Disclosing the actions that were taken or will be taken to treat or ameliorate the consequences of the event;
6. Providing an explanation of how the clinical situation can be improved if possible;
7. Providing an assurance that appropriate steps, if possible, will be taken to prevent a similar occurrence from happening to others; and
8. Providing the contact number for Harris Health System Patient Customer Relations, if the patient or family expresses a desire to file a grievance or complaint. (See Harris Health Patient Grievance Policy).

B. The Attending Practitioner shall serve as the primary communicator of an Adverse Event to the patient or Legal Representative unless another clinician is deemed to have a better working relationship with the patient/family.

C. At least one other member from the patient's treatment team shall be present during the disclosure process.

D. If a patient is incapable of understanding a discussion of this nature, the disclosure should be made to patient's Legal Representative.

HARRISHEALTH SYSTEM
POLICY AND REGULATIONS MANUAL

Policy No: 3.64
Page Number: 3 of 4
Effective Date: 03/2015
Board Motion No:

III. DOCUMENTATION:

The Attending Practitioner shall document the Disclosure in the patient's medical record, including what was disclosed, to whom the Disclosure was made, who was present for the Disclosure, and any other responses or discussions that occurred related to the Adverse Event.

8. Harris Health System Policy & Procedure on Abuse, Neglect, and Exploitation of Patients

HARRISHEALTH SYSTEM

POLICY AND REGULATIONS MANUAL

Policy No: 3001
Page Number: 1 of 18

Effective Date: 01/1998
Board Motion No: 03.13-47

TITLE: ABUSE, NEGLECT, AND EXPLOITATION OF PATIENTS OCCURRING AT HARRIS HEALTH SYSTEM FACILITIES

PURPOSE: To outline the duties of Staff regarding the abuse, neglect, and exploitation of patients while at Harris Health System facilities.

POLICY STATEMENT:

Harris Health System (Harris Health) prohibits abuse, neglect, and exploitation of Patients at any Harris Health facility. All Staff shall report suspected or actual abuse, neglect and exploitation of Patients where the alleged perpetrator is another Patient, a visitor, or Staff. Staff shall abide by mandatory reporting laws regarding abuse of a Child, Elderly Persons and Disabled Persons. For any allegation of abuse, neglect, or exploitation, an internal investigation shall be conducted and notifications shall be made to the appropriate legal and regulatory agencies. Staff members shall cooperate with all investigations of reported suspected or actual abuse, neglect, and exploitation of a Patient.

POLICY ELABORATIONS:

I. **DEFINITIONS:**

A. **ABUSE:**

1. **CHILD:** Includes the following acts or omissions by a person:

a. The mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;

b. Causing or permitting the child to be in a situation in which the child sustains a potential mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;

c. Physical injury that results in potential substantial harm to the child, or the genuine threat of potential substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given for the injury, and excluding an accident or reasonable discipline by a parent, guardian, or managing

or possessory conservator that does not expose the child to a substantial risk of harm;

d. Failure to make a reasonable effort to prevent an action by another person that results in potential physical injury that results in potential substantial harm to the child;

e. Sexual conduct potentially harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of indecency with a child, sexual assault, or aggravated sexual assault;

f. Failure to make a reasonable effort to prevent sexual conduct potentially harmful to a child;

g. Compelling or encouraging a child to engage in sexual conduct, including conduct that constitutes a potential offense of trafficking of persons, prostitution, or compelling prostitution;

h. Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of a child, if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene or pornographic;

i. The use by a person of a controlled substance in a manner or to the extent that the use results in potential physical, mental, or emotional injury to a child;

j. Causing, expressly permitting, or encouraging a child to use a controlled substance; or

k. Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child.

2. **ELDERLY OR DISABLED PERSON:** The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment resulting in physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, and other individual who has an ongoing relationship with the person, or other person; or sexual abuse of an elderly or disabled person.

B. **ASSAULT:** Intentionally, knowingly, or recklessly causing bodily injury to another; threatening another with imminent bodily injury; or intentionally or knowingly causing physical contact with another when the person knows or should reasonably believe that the other will regard the contact as offensive or

provocative (*e.g.*, pushing, shoving, hitting, kicking, biting, or striking another with a part of the actor's body or with an object).

C. **ATTENDING PHYSICIAN:** a physician selected by or assigned to a Harris Health patient who has primary responsibility for the patient's treatment and care.

D. **CHILD:** A person under eighteen (18) years of age who is not and has not been married or who has not had the disabilities of minority removed for general purposes.

E. **DISABLED PERSON:** A person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and who is (a) 18 years of age or older or under eighteen (18) years of age; or (b) who has had the disabilities of minority removed.

F. **ELDERLY PERSON:** A person sixty-five (65) years of age or older.

G. **EXPLOITATION:** The illegal or improper act or process of a caretaker, family member, or other individual, who has an ongoing relationship with an elderly or disabled person that involves using, or attempting to use, the resources of the elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.

H. **FORENSIC NURSE:** A registered nurse with specialized training and education to provide care, collect evidence, and document injuries for Patients and perpetrators of violence, abuse, neglect, and/or exploitation.

I. **HEALTH CARE WORKER:** Physician, nurse, nurse practitioner, physician assistant, emergency medical technician, unlicensed assistive personnel, social worker, physical therapist, occupational therapist, students, or other clinical employee working with Patients.

J. **INCAPACITATED OR INCOMPETENT:** Lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision.

K. **LICENSED INDEPENDENT PRACTITIONER ("LIP"):** Any individual permitted by law and by Harris Health to provide care and services, without relevant direction or supervision, within the scope of the individual's license.

L. **NEGLECT:**

1. **CHILD:** Includes:

a. The leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child;

b. The following acts or omissions by a person:

i. placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child;

ii. failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child;

(iii) the failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability unless relief services had been offered and refused;

(iv) placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child; or

(v) placing a child in or failing to remove the child from a situation in which the child would be exposed to acts or

omissions that constitute abuse committed against another child; or

(c) the failure by the person responsible for a child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away.

2. **ELDERLY OR DISABLED PERSON:** The failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

M. **PATIENT:** An individual receiving medical care or treatment at a Harris Health facility.

N. **PERSON RESPONSIBLE FOR A CHILD'S CARE, CUSTODY, OR WELFARE:** A person who traditionally is responsible for a child's care, custody, or welfare, including:

1. A parent, guardian, managing or possessory conservator, or foster parent of the child;
2. A member of the child's family or household;
3. A person with whom the child's parent cohabits;
4. School personnel or a volunteer at the child's school; or
5. Personnel or a volunteer at a public or private child-care facility that provides services for the child or at a public or private residential institution or facility where the Child resides.

O. **SEXUAL ASSAULT:**

1. Intentionally or knowingly causing the penetration of the anus or sexual organ of another person by any means, without the person's consent; causing the penetration of the mouth of another person by the sexual organ of the actor, without that person's consent; or causing the sexual organ of another person, without that person's consent, to contact or

penetrate the mouth, anus, or sexual organ of another person, including the actor; or

2. Intentionally or knowingly causing the penetration of the anus or sexual organ of a child by any means; causing the penetration of the mouth of a child by the sexual organ of the actor; causing the sexual organ of a child to contact or penetrate the mouth, anus, or sexual organ of another person, including the actor; causing the anus of a child to contact the mouth, anus, or sexual organ of another person, including the actor; or causing the mouth of a child to contact the anus or sexual organ of another person, including the actor.

This definition includes the use of foreign objects. A Sexual Assault is without the consent of the other person if the actor compels the other person to submit or participate by the use of physical force or violence; the actor compels the other person to submit or participate by threatening to use force or violence against the other person, and the other person believes that the actor has the present ability to execute the threat; the other person has not consented and the actor knows the other person is unconscious or physically unable to resist; the actor knows that as a result of mental disease or defect the other person is at the time of the sexual assault incapable either of appraising the nature of the act or of resisting it; the other person has not consented and the actor knows the other person is unaware that the sexual assault is occurring; the actor has intentionally impaired the other person's power to appraise or control the other person's conduct by administering any substance without the other person's knowledge; the actor compels the other person to submit or participate by threatening to use force or violence against any person, and the other person believes that the actor has the ability to execute the threat; the actor is a public servant who coerces the other person to submit or participate; or the actor is a mental health services provider or a health care services provider who causes the other person, who is a Patient or former Patient of the actor, to submit or participate by exploiting the other person's emotional dependency on the actor.

P. **SEXUAL HARASSMENT:** Unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. Harassment does

not have to be of a sexual nature and can include offensive remarks about a person's sex.

Q. **STAFF:** Employees (permanent or temporary), medical staff, contractors, volunteers, trainees, and other persons whose conduct, in the performance of work for Harris Health, is under the direct control of Harris Health, whether or not they are paid by Harris Health.

R. **VERBAL OR EMOTIONAL ABUSE:** The use of words to cause harm to another person. This may include shouting, insulting, demeaning, intimidating, threatening, shaming, or the use of other derogatory language.

II. TYPES OF ABUSE, NEGLECT AND EXPLOITATION REQUIRING INVESTIGATION

Abuse, Neglect, and Exploitation of Patients requiring investigation include, but are not limited to:

A. Physical Abuse/Assault:

1. Allegations of, or the presence of, any suspicious injuries on a Child, a Disabled Person, an Elderly Person, or an otherwise Incapacitated or Incompetent person shall require investigation. All physical injuries shall be documented. Serious injuries require immediate intervention.
2. An appropriate LIP assigned to the Patient shall be notified that injuries are present and shall provide necessary medical treatment.

B. Sexual Assault:

1. Allegations or suspicions of Sexual Assault shall require investigation. Examples of Sexual Assault include, but are not limited to:

   a. Injuries to the breasts, genitalia, and anal areas;
   b. Presence of a newly acquired sexually transmitted infection in a Child, Elderly Person, Disabled Person, or otherwise Incapacitated or Incompetent person shall require investigation;

c. Presence of semen or sperm in or on a Child, Elderly Person, Disabled Person, or otherwise Incapacitated or Incompetent person shall require investigation; or
d. Verbal allegations of a sexual nature.

2. Allegations or suspicions of sexual harassment shall require investigation.

C. Verbal or Emotional Abuse. Allegations or suspicions of Verbal or Emotional abuse shall require investigation. Examples of Verbal or Emotional Abuse include, but are not limited to:

1. Name calling, ridiculing, insulting a Patient;
2. De-valuing the thoughts of a Patient;
3. Isolating a Patient; and
4. Propositioning a Patient.

D. Exploitation. Any allegations of suspicions of exploitation shall require investigation. Examples of Exploitation include, but are not limited to:

1. Stealing from or defrauding a Patient;
2. Withholding money from a Patient needed to buy food or obtain medical treatment;
3. Denying a Patient access to his/her own financial resources;
4. Taking a Patient's Social Security or Supplemental Security Income (SSI) checks; and
5. Human trafficking.

E. Sexual Harassment. Any allegations of suspicions of exploitation shall require investigation. Examples of Sexual Harassment include, but are not limited to:

1. Requesting sex from a Patient;
2. Inappropriate touching of a Patient; and
3. Repeated requests to a Patient for dates.

III. MANAGEMENT PLAN IN CASES OF ALLEGATIONS OF ABUSE, NEGLECT, AND EXPLOITATION OF PATIENTS:

A. Prevention:

1. Screening of Staff.

   a. All Staff shall be screened for criminal charges and/or convictions as outlined in Harris Health's Employment Policy No. 6.12.
   b. All employment applications shall be screened through the Employee Misconduct Registry.
   c. All employment applications for licensed Staff shall be screened through the applicable licensing board.

2. Screening of Patients. Patients shall be screened for abuse, neglect, and exploitation upon arrival at a Harris Health facility per Harris Health's Response to Family Violence and Abuse, Neglect, or Exploitation of Children, the Elderly, and/or Disabled Policy No. 4025.

3. Training of Staff regarding abuse, neglect, and exploitation of Patients.

   a. Health Care Workers and other Staff who interact with Patients shall receive training and education regarding abuse, neglect, and exploitation of Patients during general orientation and annually thereafter.
   b. Specialty areas such as Rehabilitation and Psychiatric Services shall receive additional training per applicable federal and state laws or regulatory requirements.
   c. Records of Staff attendance and completion of required training shall be maintained by Harris Health's Learning and Resource Center.

B. Identification of Allegations Requiring Investigation and Reporting:

1. Abuse, neglect and exploitation of Patients may be identified through any of the following manners:

   a. A staff member witnessing the alleged abuse, neglect, or exploitation of a Patient.
   b. The Patient makes an outcry, disclosing the alleged abuse, neglect, or exploitation.
   c. A Patient not involved in the alleged abuse, neglect, or exploitation notifies Staff.

c. During the course of providing Patient care, a Health Care Worker identifies suspicious injuries or other findings or notes comments made by the Patient.

e. Alleged abuse, neglect, or exploitation is suspected in a Patient or Patient population that cannot consent (*e.g.*, a Child, an unconscious Patient, an Incapacitated or Incompetent Patient, a Patient who is under psychiatric care who is unable to make his/her own decisions).

f. A visitor reports an allegation of abuse, neglect, or exploitation of a Patient.

2. Reports of abuse, neglect, or exploitation of a Patient shall be entered into Harris Health's electronic incident reporting system ("eIRS) and shall be made to the immediate supervisor, as appropriate. In addition, suspicions regarding abuse of children, disabled, or elderly are made directly to the Department of Family and Protective Services as outlined in state statute.

3. Other incidents that require investigation and reporting:

a. Death of a Patient or visitor where the circumstances cast doubt upon it being a natural death.

b. Missing or kidnapped Child, Disabled Person, Elderly Person, or otherwise Incapacitated or Incompetent person.

C. Investigation of Abuse, Neglect and Exploitation Allegations:

1. Upon identification of a suspicion of abuse, neglect, or exploitation of a Patient, the following shall be notified immediately (See Attachment A):

a. Immediate supervisor.

Staff shall notify the most immediate supervisor. If the most immediate supervisor is not available, escalate notification to one of the following individuals:

i. Unit director or manager;
ii. Hospital supervisor (if on hospital property); or
iii. Health center director (if on Ambulatory Care Services ("ACS") property);

b. Hospital supervisor or health center director;
c. Harris Health Department of Public Safety ("DPS");
d. Administrator or Administrator on-call;
e. Human Resources Department ("HR");
f. Forensic Nurse on-call;
g. Risk Management Department;
h. Accreditation and Regulatory Affairs Department;
i. Clinical case management social worker, if the Patient is a Child, a Disabled Person, an Elderly Person, or an otherwise Incapacitate or Incompetent person;
j. Law enforcement, if the Patient wants to make a police report or if the alleged abuse, neglect, or exploitation falls under mandatory reporting laws. Harris Health DPS shall facilitate all contact with law enforcement, as appropriate.
k. Attending physician;
l. Patient Rights Officer;
m. Corporate Compliance Department; and
n. Corporate Communications Department.

2. When the alleged perpetrator named by the Patient or visitor in the allegation is a Staff member, that Staff member shall be removed immediately from direct Patient care or from the area where the Patient is located. Harris Health DPS shall be contacted as appropriate. The hospital supervisor, the immediate supervisor, HR, and the Administrator shall jointly determine whether the Staff member shall remain on duty or shall be suspended without pay until the investigation is either concluded or reveals the Staff member may return to work.

3. Investigation Responsibilities:

a. The immediate supervisor shall:

i. Make appropriate notifications;
ii. Remove alleged perpetrator from immediate area, as indicated;
iii. Notify the Patient's designated contact of the allegation; and

iv. Provide non-protected health information to the HR regarding the allegation.

b. The hospital supervisor shall:

i. Ensure appropriate notifications are made;
ii. Assist with relocating Patient(s), if necessary;
iii. Ensure implementation of a coordinated response; and
iv. Ensure notification of the Patient's designated contact, if immediate supervisor is not available.

c. Harris Health DPS shall:

i. Preserve the scene, if necessary;
ii. Interview the Staff involved;
iii. Notify law enforcement, if necessary;
iv. Document investigation;
v. Report to administrators and Risk Management Department; and
vi. Remove the alleged perpetrator, as indicated.

d. The Administrator/Administrator on-call shall:

i. Ensure implementation of a coordinated response and reporting, as appropriate; and
ii. Notify the Corporate Communications Department, as appropriate.

e. HR shall (if the alleged perpetrator is a Staff member):

i. Collaborate with the immediate supervisor, manager, director, unit manager, or administrator to determine immediate action to be taken regarding the Staff member (*e.g.*, suspended without pay, moved to another department, etc.);
ii. Receive non-protected health information from those charged with investigating the allegation; and

iii. Provide guidance regarding employment issues and questions.

f. Forensic Nurse:

i. Obtain detailed information from the Patient and/or reporter;
ii. Perform and document the medical-forensic examination;
iii. Collect and preserve any potential evidence;
iv. Document the scene as necessary;
v. Obtain information from other sources as needed; and
vi. Report findings to administrators, Risk Management Department, Accreditation and Regulatory Affairs Department, and law enforcement.

g. Risk Management Department shall:

i. Provide review, oversight, and coordination of the investigative process;
ii. Retain documents generated as a result of the investigation; and
iii. Track, trend, and report occurrences to determine if changes in policy and procedure should be considered.

h. Accreditation and Regulatory Affairs Department shall:

i. Compile documents generated throughout the investigation;
ii. Report findings to applicable regulatory agencies; and
iii. Respond to on-site follow-up, if applicable.

i. Clinical Case Management Social Worker shall:

i. Assist with mandatory notifications, as needed; and
ii. Provide support to Patient and family, as requested.

j. The attending physician shall provide necessary orders for continued care, as needed.

k. Patient Rights Officer shall:

i. Discuss with the Patient the allegation of abuse, neglect, or exploitation;
ii. Be available to communicate with the Patient, family, or Patient's representative; and
iii. Document the event per established protocols.

4. The Patient shall be immediately assessed by a registered nurse to determine if treatment or further assessment is necessary. If so, the attending physician shall be notified and care shall be provided as indicated.
5. If the alleged perpetrator is also a Patient, he/she shall be immediately assessed by a registered nurse to determine if treatment or further assessment is necessary. If so, the attending physician shall be notified and care shall be provided as indicated.

D. Protection of Patients During an Investigation:

1. The alleged perpetrator shall be immediately removed from the vicinity of the Patient.
2. Nursing staff and Harris Health DPS shall ensure the immediate safety of the Patient.
3. When applicable, Harris Health DPS shall notify the appropriate law enforcement agency.

E. Post Investigation:

1. Any Harris Health Staff who has cause to believe that the physical or mental health or welfare of a Patient has been or may be adversely affected by abuse, neglect or exploitation caused by another person must immediately report the abuse, neglect or exploitation to the department manager.
2. The Risk Management Department shall follow up with the Corporate Compliance Department and the Harris County Attorney's Office as appropriate. The Accreditation and Regulatory Affairs Department shall make necessary notifications to regulatory agencies as required.

IV. VISITOR OR PATIENT ABUSE AND EXPLOITATION OF OTHER PATIENTS:

A. The procedures set forth herein shall be followed for allegations of abuse, neglect, or exploitation by one Patient against another Patient, with the exception of the involvement of HR.

B. The procedures set forth herein shall be followed for allegations of abuse, neglect, or exploitation by a visitor against a Patient, with the exception of the involvement of HR.

HARRISHEALTH SYSTEM

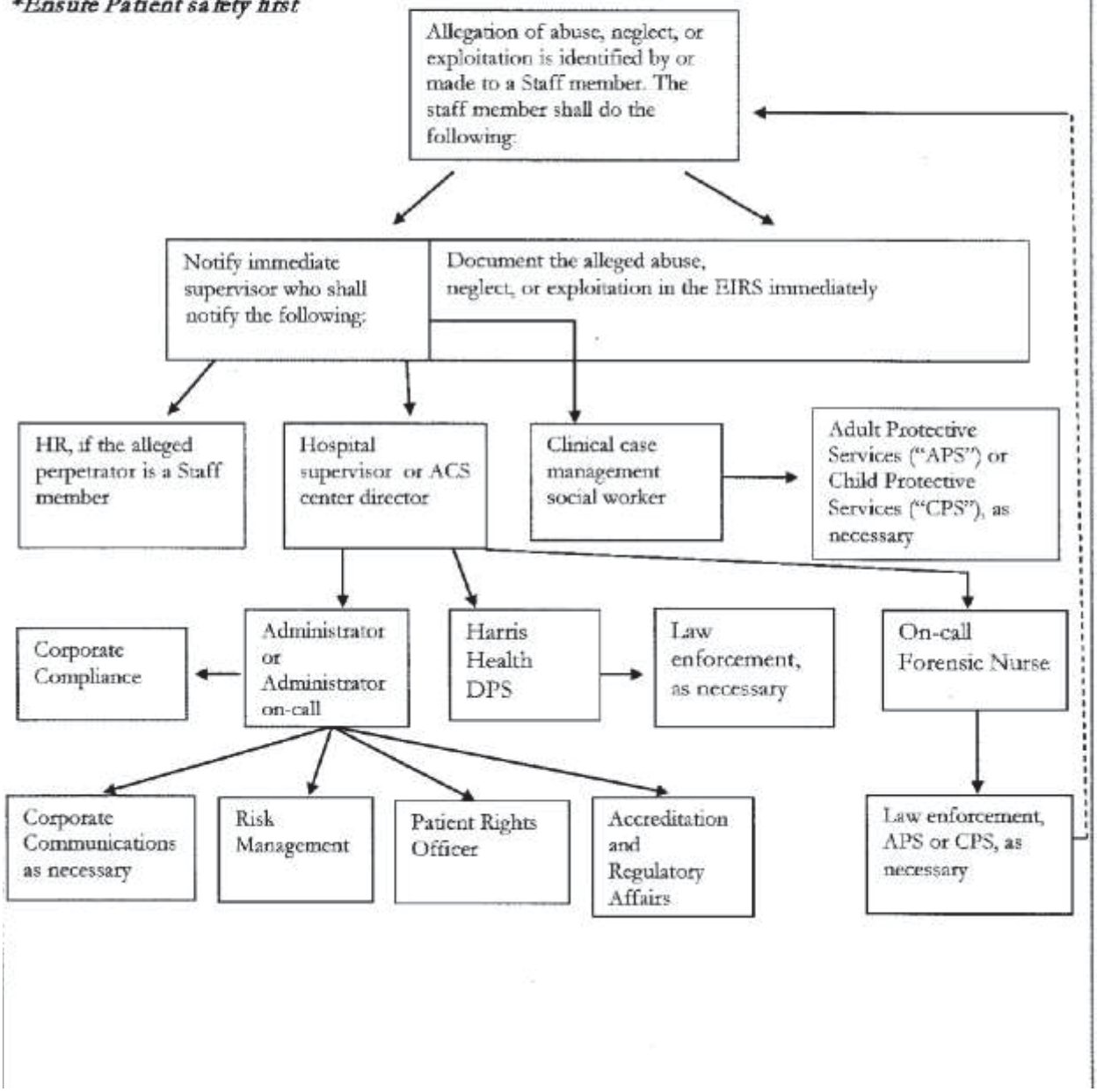
POLICY AND REGULATIONS MANUAL

Policy No: 3001
Page Number: 18 of 18

Effective Date: 01/1998
Board Motion No: 03.13-47

ATTACHMENT "A"
NOTIFICATION PROCESS IN RESPONSE TO ABUSE, NEGLECT, OR EXPLOITATION ALLEGATIONS

**Ensure Patient safety first*



9. Harris Health System Policy & Procedure on Chain of Command

Harris County Hospital District

DISTRICT WIDE

POLICY AND REGULATIONS MANUAL

Policy No: 227
Page Number: 1 of 8

Effective Date: 2/05
Board Motion No:

TITLE: **CHAIN-OF-COMMAND**

PURPOSE: To provide the process, using the Chain-of-Command to address clinical/administrative/safety issues, breakdowns in communication, or behaviors that affect patient care, patient safety, or delays in treatment.

POLICY STATEMENTS:

All Harris County Hospital District (HCHD) employees and medical staff are responsible for immediately reporting any unusual events or concerns, occurring during his or her assigned shift. Any HCHD employee or medical staff member may initiate and utilize the next step in the Chain-of-Command, if clinical, administrative, or safety issues remain unresolved at the preceding step.

POLICY ELABORATIONS:

Initiating the Chain-of-Command ensures that:

1. The appropriate people are made aware of situations;
2. Issues progress from the level closest to the event and move up as a situation warrants; and
3. Accountability is maintained when issues are no longer being managed effectively.

I. DEFINITIONS:

A. **CHAIN-OF-COMMAND:** Refers to an authoritative structure established to resolve administrative, clinical, or other patient safety issues by allowing employees and medical staff to present an issue of concern through the lines of authority until a resolution is reached.

B. **LICENSED INDEPENDENT PRACTITIONER:** Means any individual permitted by law and by the Hospital District to provide care and services, without relevant direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

C. **MEDICAL STAFF:** Means all physicians, dentists, podiatrists and oral-maxillofacial surgeons who are appointed to the Medical Staff and who either (i) hold a faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston and are selected pursuant to the AMS Affiliation Agreement to provide healthcare services, or (ii) are employed by the Hospital District to provide healthcare services at designated District Facilities. Medical school faculty appointment status is not required for locum tenens or medical staff employed by the Hospital District.

D. **RESIDENT/INTERN/HOUSESTAFF/FELLOW:** Means an individual who, licensed as appropriate, is a graduate of a medical, dental, osteopathic, or podiatric school and who is appointed to the Hospital District's professional graduate training program and who participates in patient care under the direction of Medical Staff members who have Clinical Privileges for the services provided by the Housestaff.

E. **SITUATION BACKGROUND ASSESSMENT RECOMMENDATION (SBAR):** A recognized model used to improve efficiency and clarity in the communication of patient information among healthcare providers.

II. ACTIVATION OF THE CHAIN-OF-COMMAND:

Specific occurrences, which may require activation of the Chain-of-Command, include, but are not limited to, situations where there are concerns that need appropriate action/response/interventions; and/or breakdowns in communication that may affect patient care, patient safety, or delays in treatment:

A. Patients with significant changes in medical status, or acuity level occurring during a shift, especially those necessitating transfer to a higher level of care;

B. Unexpected deaths;

C. Accidents or incidents to patients, employees, or visitors;

D. Employee/staff issues or concerns disrupting unit operation;

E. Unresolved problems and or complaints by physicians, patients, employees,

visitors and other departments;

F. Inability to contact or locate physicians within an appropriate and timely manner to address concerns;

G. Inability to obtain medications or treatments in a reasonable and appropriate timeframe based on judgment by nursing staff and the patient's health needs;

H. Notification of dismissal of a "patient on police hold;"

I. Calls for information from the media including: television, radio or the newspaper;

J. Incorrect narcotic counts;

K. Critical call result(s) not acknowledged or addressed timely;

L. Adverse blood or medication reactions;

M. Refusals to adhere to procedures, or

N. Other patient safety issues or concerns.

III. CHAIN-OF-COMMAND WORKFLOW:

A. The Chain-of-Command Workflow for each unit/service/clinic/department should begin at the appropriate level for problem resolution and may include the following individual(s):

1. HCHD employees and Medical Staff;
2. Unit Charge Nurse/Team Leader/Resident/Departmental Supervisor;
3. Nursing Clinical Manager/Nursing Program Manager/Nurse Manager/ Hospital Supervisor/Director of Nursing/Fellow/Chief Resident/ Departmental Director;
4. Administrative Director of Nursing/Departmental Administrative Director/Attending/Faculty/Medical Director/Chief of Service; and

Harris County Hospital District
DISTRICT WIDE
POLICY AND REGULATIONS MANUAL

5. Administrator/ Chief Nursing Officer/Chief of Staff/Administrator on Call.

B. All steps taken in the Chain-of-Command for a clinical patient care issue will be documented as appropriate in the HCHD Electronic Incident Reporting System (eIRS) or in the patient's medical record. Documentation shall include the name of the person contacted, date and time of contact, orders/directions received, and any other pertinent information. The use of SBAR will be utilized when reporting a change in patient's condition or when patient's clinical needs or concerns are not adequately addressed or resolved.

Harris County Hospital District

DISTRICT WIDE

POLICY AND REGULATIONS MANUAL

Policy No: 227
Page Number: 7 of 8

Effective Date: 2/05
Board Motion No:

ATTACHMENT 1
GUIDELINES FOR COMMUNICATING USING THE CHAIN-OF-COMMAND

Prior to initiation and escalation of the Chain-of-Command, follow these steps:

1. Assess the issue/situation before initiating the Chain-of-Command;

2. Discuss the issue/situation with the unit charge nurse/team leader/supervisor/ resident to obtain further direction:

   a) Determine if the issue involves patient care needs, patient safety, or clinical concerns that necessitate emergent escalation of the Chain-of-Command; and
   b) Determine if the issue involves unit operations, non-patient care concerns; or other issue(s)/situation(s) that do not affect patient safety that may necessitate escalation of the Chain-of-Command;

3. Contact the next level of the Chain-of-Command (follow Chain-of-Command listed on policy) and provide complete information regarding the issue/situation;

4. Provide recommendation of resolution, if possible, and agree/act/collaborate with the recommendation from the Chain-of-Command;

5. If the issue/situation has not been addressed/resolved satisfactorily and/or patient safety continues to be in question, the charge nurse/team leader/supervisor must escalate to the next level of the Chain-of-Command until resolution is reached satisfactorily or until reaching the top level of the Chain-of-Command (i.e., Administrator; Chief Nursing Officer; Chief of Staff);

6. As indicated, clinical staff documents the clinical concerns and the escalation of Chain-of-Command as appropriate in the patient's medical record and/or the eIRS and/or Corporate Compliance; and

7. Communicate the use of the Chain-of-Command to the respective unit/departmental leadership of issue/situation and resolution(s). Follow up to be determined by unit/departmental leadership as necessary.

Harris County Hospital District

DISTRICT WIDE

POLICY AND REGULATIONS MANUAL

Policy No: 227
Page Number: 8 of 8

Effective Date: 2/05
Board Motion No:

ATTACHMENT 2
HOW TO REPORT UTILIZING SBAR

S SITUATION:

I am calling about .....patient name & location
The problem I am calling about is .....
What you fear will be patient outcome
Vital Signs are B/P.....Pulse.....Respiration....Temp.....
I am concerned about the vital signs because: ..The B/P/pulse/respirations/temp is much higher/lower than what is normal for this patient

B BACKGROUND:

The patient's mental status is:
Alert and oriented to person, place and time
Confused and cooperative or uncooperative
Agitated or combative
Lethargic but conversant and able to swallow
Stuporous and not talking clearly
Comatose, not responding to stimulation
The skin is: warm and dry, mottled, pale, diaphoretic, extremities are cold, extremities are warm
The patient is/is not on oxygen
The patient has been on ___l/min or % oxygen for ____minutes
The oximeter is reading_____%
Respirations are.....labored, unlabored, regular, and irregular

A ASSESSMENT:

This is what I think the problem is .....
The problem seems to be cardiac, infection, neurologic, respiratory
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse, we need to do something.

R RECOMMENDATION:

I suggest or request that you:
Transfer the patient to critical care
Come see the patient at this time
Talk to the patient or family about code status
Ask for a consultant to see patient now
Speak with the attending about this patient
Are any tests needed CXR, ABG, EKG, CBC, Others?
If a change in treatment is ordered then ask:
How often do you want vital signs?
When do you want to be notified?
If a change in treatment is indicated but not ordered:
I feel that an upper level resident or the attending should be consulted. Would you like me to call them or do you want to call them?

HARRIS HEALTH - OHAKWEH - 59674

10. Harris Health System Policy & Procedure on Medical Record Documentation

Harris County Hospital District

POLICY AND REGULATIONS MANUAL

Policy No: 4410
Page Number: 1 of 9

Effective Date: 10/94
Board Motion No:

TITLE: **MEDICAL RECORD DOCUMENTATION**

PURPOSE: To establish the process for medical record documentation to be used within the Harris County Hospital District.

POLICY STATEMENTS:

A complete, legible, and accurate medical record shall be maintained for every patient who is evaluated or treated at the Harris County Hospital District (HCHD).

POLICY ELABORATIONS:

Each page of the medical record must contain accurate and complete patient identifying data, such as the medical record number, name, and patient's date of birth.

All healthcare providers shall document into the medical record when available.

I. DEFINITIONS:

A. **AUTHENTICATION:** Validation of each user's information, which requires a unique identification (ID) and password combination to login to the medical record system.

B. **ETHICIST:** Active member of the HCHD Ethics Committee with PhD or equivalent level training and credentialed or employed by the HCHD.

C. **LICENSED INDEPENDENT PRACTITIONER (LIP):** Any individual permitted by law and by the HCHD to provide care and services, without relevant direction or supervision within the scope of the individual's licensure and consistent with individually granted clinical privileges.

D. **RESIDENT/INTERN/HOUSESTAFF/FELLOW - (HOUSESTAFF):** Means an individual who, licensed as appropriate, is a graduate of a medical, dental, osteopathic, or podiatric school and who is appointed to the Hospital District's professional graduate training program and who participates in patient care under the direction of Medical Staff members who have Clinical Privileges for the services provided by the Housestaff..

E. **UNACCEPTABLE ABBREVIATION:** Standard abbreviations commonly mistaken when interpreting a medical documentation, which can lead to errors in patient care.

F. **UNLICENSED ASSISTIVE PERSONNEL (UAP):** An individual who is trained to function in an assistive role to the licensed registered nurse in the provision of patient/client care activities as delegated by the nurse. The term includes, but is not limited to nurse aides, orderlies, assistants, attendants, or technicians.

II. MEDICAL RECORD DOCUMENTATION GUIDELINES:

The guidelines that shall be used in documenting the medical record shall be found in Appendix "A" attached hereto.

III. USE OF SYMBOLS AND ABBREVIATIONS:

Medical record entries shall not contain abbreviations and symbols deemed unsafe.

A. *Prohibited Abbreviations:*

1. To ensure patient safety within the HCHD, the Joint Commission List of Prohibited Abbreviations has been adopted. Any abbreviations, acronyms, or symbols that are on the HCHD's Prohibited Abbreviations List (Appendix B) may not be used in the medical record. Items contained therein are not to be used for the handwritten, typewritten, or computer generated documentation of patient care activities; nor to request any services related to patient care.

2. If an abbreviation, acronym, or symbol has multiple meanings, its use should be avoided unless the intended meaning is clear from the content by which it is used.

3. Any documentation containing unacceptable abbreviations or questionable entries shall be referred to the author, for clarification and prior to implementation.

4. Use of "unacceptable abbreviations" shall be documented on the HCHD Adverse Drug Event Form.

5. Episodes of non-compliance shall be reported to the author's immediate supervisors for corrective action.

6. Events involving the use of "unacceptable abbreviations" shall be communicated to the HCHD Medication Use Safety Committee (MUSC), service chiefs, directors, and/or administrators as deemed appropriate.

IV. HEALTHCARE PROFESSIONALS AUTHORIZED TO MAKE ENTRIES:

Only LIPs, Housestaff, UAPs, Nursing staff and Allied Health Care professionals authorized by the HCHD shall make entries into a patient's medical record.

Nursing, Allied Health Professional Agency, and/or students are authorized to make entries in the medical record following the documentation guidelines. (See Appendix C – List of individuals authorized to make medical record entries within the scope of their licensure/certification.)

Harris County Hospital District

POLICY AND REGULATIONS MANUAL

Policy No: 4410
Page Number: 5 of 9
Effective Date: 10/94
Board Motion No:

APPENDIX "A"
GUIDELINES FOR MEDICAL RECORD ENTRIES

PAPER MEDICAL RECORDS	ELECTRONIC MEDICAL RECORDS
Documentation Timeline: Entries shall be made at the time of treatment/observation.	***Documentation Timeline*** Entries shall be made at the time of treatment/observation.
Date & Time: Every entry shall be dated and timed: a. Military time shall be used in 24-hour facilities. b. Standard time shall be used in ambulatory clinics.	**Date & Time:** Each electronic entry shall contain a system generated date and time.
Error Corrections: Utilize the Line, Initial, Date (LID) concept: a. Draw a single line through the entry or portion of entry to be corrected (the original entry must still be legible/visible); b. Initial and Date; c. State the reason for the error, as applicable; d. Document the correct information; and e. Authenticate entry.	***Error Corrections:*** a. Requires an Addendum; b. Document the reason for the error correction; d. Document the correct information; and e. Authenticate entry
Late Entries: a. Identify entry as "late entry"; b. Enter current date and time; c. Identify or refer to date and incident for which the late entry is written; d. Authenticate entry; and e. The physician identification stamp may be used in addition to physician signature but cannot substitute for the original signature.	***Late entries:*** a. All entries on all flow sheets that are entered late will be documented by adding the appropriate column of time that the care or observation was actually completed. b. All entries in notes that are added late will be documented with the correct date and time when they are entered.

HARRIS HEALTH - OHAKWEH - 59683

Harris County Hospital District

POLICY AND REGULATIONS MANUAL

Policy No: 4410
Page Number: 6 of 9
Effective Date: 10/94
Board Motion No:

PAPER MEDICAL RECORDS	ELECTRONIC MEDICAL RECORDS
Legibility: All entries must be legible. It is recommended that black or blue ink be used. A printed physician Identification Number stamp may be used in addition to the required date, time, and legal signature.	
Authentication: The author of each entry must be identified with the author's name, title /credentials (M.D., D.O., DDS, etc. and HCHD identification number (badge number). Specific guidelines for Agency and/or students are noted below.	***Authentication*** Requires a unique ID and password combination of each user to login to the medical records system.
Data integrity: Entries shall not be altered, erased or removed (use of correction fluids and/or liquid paper is prohibited)	Electronic medical record information cannot be altered after it is electronically signed.

Harris County Hospital District

POLICY AND REGULATIONS MANUAL

Policy No: 4410
Page Number: 8 of 9

Effective Date: 10/94
Board Motion No:

APPENDIX C
INDIVIDUALS AUTHORIZED TO MAKE MEDICAL RECORD ENTRIES WITHIN THE SCOPE OF THEIR LICENSURE/CERTIFICATION

Functional Role: Source HCHD Policy 4410
Attending Physician
Nurse Practitioner/Advanced Nurse Practitioner
Medical Student
Housestaff
Physician Assistant (PA)
Audiologist
Audiologist Technician
Cardiopulmonary Technician
Clinical Case Management (CCM) Program Coordinator
Certified Nurse Assistant (CNA)
Certified Nurse Anesthetist
Certified Nurse Midwife
Chaplain
Child Life Specialist
Clinical Clerical Specialist/Technician (CCT)
Clinical Nurse Case Manager (CNCM)
CSHCN Grant Social Worker II
Dietitian/Nutritionist/Technician
Genetics Counselor
Ethicist
Health Educator
Infant Feeding Counselor/Breast Feeding Counselors
Interpreter
Licensed Chemical Dependency Counselor/Insight Case Manager
Licensed Professional Counselor
Licensed Vocational Nurse (LVN)
Nursing Student
Occupational Therapist, Assistant, Student
Patient Care Technician I, II, and III (PCT)
Pharmacist
Physical Therapist, Assistant, Student
Pulmonary Function Technician, Technologist
Psychiatric Technician
Recreational Therapist
Risk Manager
Quality (QMS) Resource Manager
Quality QMS Coordinator
Quality Inpatient Director
Registered Nurse
Researcher
Respiratory Care Practitioner/Therapist
RN, Grants Implementation
Senior Clinical Nurse Case Manager
Social Worker Case Manager I, II
Speech Pathologist
T Steps Clinician

VIII. CERTIFICATION & CLOSING

Under Federal Rule of Civil Procedure 11, by signing below, Plaintiffs & Realtors – individually and/or via Counsel subscribed below – hereby certifies to the best of their knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

IX. JURY TRIAL REQUEST

Pursuant to FRCP Rule 38(b)(1), Plaintiffs hereby request a jury trial.

Respectfully Submitted,

_/s/ Ernest C. Adimora-Nweke, Jr
Ernest C. Adimora-Nweke, Jr
State Bar Number: 24082602
Adimora Law Firm
3050 Post Oak Blvd., Suite 510
Houston, TX 77056
281-940-5170 (Office)
ernest@adimoralaw.com
Attorney for Plaintiff(s) & Realtor(s)

CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the foregoing pleading was upon the below counsels on 05/11/2020 and shall be served upon a date designated by the Court post its filing in this Court, and pursuant to Federal Rules of Civil Procedure.

Respectfully Submitted,

_/s/ Ernest C. Adimora-Nweke, Jr
Ernest C. Adimora-Nweke, Jr

Ebon Swofford
Assistant County Attorney
State Bar No. 00792588
S.D. Tex. ID No. 423962
Ebon.Swofford@harrishealth.org
L. Sara Thomas
Deputy Managing Attorney
State Bar No. 24063034
S.D. Tex. ID No. 1000100
Sara.thomas2@harrishealth.org
2525 Holly Hall, Suite 190
Houston, Texas 77054
(713) 566-6559
(713) 566-6558 fax
ORIGINAL/FORMER ATTORNEYS FOR DEFENDANT HARRIS COUNTY HOSPITAL DISTRICT D/B/A HARRIS HEALTH SYSTEM D/B/A BEN TAUB HOSPITAL

JEFFREY B. MCCLURE
State Bar No. 13428200
jeffmcclure@andrewskurth.com
LAURA TRENAMAN
State Bar No. 00798553
ltrenaman@andrewskurth.com
600 Travis Street, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200
Telecopier: (713) 220-4285
ORIGINAL/FORMER ATTORNEYS FOR DEFENDANT BAYLOR COLLEGE OF MEDICINE AND ITS EMPLOYEE DEFENDANTS.

John R. Strawn Jr.
Texas Bar No. 19374100
Federal ID No. 6277
jstrawn@strawnpickens.com
Andrew L. Pickens
Texas Bar No. 15971900
Federal ID No. 14969
apickens@strawnpickens.com
Strawn Pickens LLP
Pennzoil Place, South Tower
711 Louisiana, Suite 1850
Houston, Texas 77002
713-659-9600
713-659-9601 fax
www.strawnpickens.com
ORIGINAL/FORMER ATTORNEYS FOR DEFENDANT JOHN MICHAEL HALPHEN.