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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian Ad Litem, LATASHA NAILAH SPEARS WINKFIELD,

Plaintiffs,

vs.

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

Defendants.

COMPLAINT FOR DAMAGES FOR MEDICAL MALPRACTICE

DEMAND FOR TRIAL BY JURY

FACTUAL ALLEGATIONS

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

2. LATASHA NAILAH SPEARS WINKFIELD is the biological mother of JAHI McMATH.

3. MARVIN WINKFIELD is the husband of LATASHA NAILAH SPEARS WINKFIELD and the step-father of JAHI McMATH and was living with LATASHA

NAILAH SPEARS WINKFIELD and JAHI McMATH as a family unit for 2 years prior to January 9, 2013, and contributed to raising and caring for JAHI McMATH.

4. SANDRA CHATMAN (hereinafter "CHATMAN") is the biological maternal grandmother of JAHI McMATH and the mother of LATASHA NAILAH SPEARS WINKFIELD and was part of the family unit helping to raise JAHI McMATH. CHATMAN and JAHI had a close and loving relationship.

5. MILTON McMATH is the biological father of JAHI McMATH and is joined in this lawsuit as a nominal defendant.

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

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

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

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

10. In 2013, defendant ROSEN diagnosed JAHI McMATH with sleep apnea. ROSEN recommended a complex and risky surgery for sleep apnea which included

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

11. On December 9, 2013, at 15:04 hours, defendant ROSEN took JAHI to the operating room at CHO to perform this extensive surgery. In ROSEN's Operative Report of his procedure, he noted that he found a "suspicion of medialized carotid on right." This meant that JAHI probably had an anatomical anomaly and that her right carotid artery was more to the center and close to the surgical site. Although this congenital and asymptomatic anomaly would otherwise have had no impact on JAHI's life, it raised a serious issue as to this extensive surgical procedure. According to the medical literature, this posed an increased risk factor for serious hemorrhaging during or after surgery. Despite this fact, ROSEN failed to note in any of his orders for the nurses, doctors and other health care practitioners who would be following JAHI postoperatively, including the post-anesthesia care unit (PACU) and pediatric intensive care unit (PICU) nurses, to put these health care workers on notice that JAHI had a congenital abnormality with her right carotid artery that would put her at a higher risk of postoperative bleeding.

12. After surgery, at approximately 7:00 p.m., JAHI was taken to the PACU then the PICU, but plaintiffs LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD were initially denied permission to visit JAHI. Approximately 30 minutes

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later, they decided to enter the PICU to visit JAHI, and they were alarmed to find their daughter coughing up blood into a plastic emesis container.

13. Plaintiffs LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD expressed their concern to the nursing staff about the amount of blood JAHI was coughing up. The nurses assured plaintiff LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD that the bleeding was "normal." A nurse then gave a suction wand to LATASHA NAILAH SPEARS WINKFIELD and instructed her as to how to suction blood out of her daughter's mouth. The nurses also gave the WINKFIELDS paper towels to help catch all of the blood. At that time, although JAHI was bleeding from the mouth, the packing and bandages in her nose were dry.

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

15. Later, the nurse that had originally instructed LATASHA NAILAH SPEARS WINKFIELD to suction the blood from her daughter's mouth returned and admonished her for not suctioning the blood from her daughter's mouth. This nurse then picked up the suctioning wand and began suctioning the blood from JAHI's mouth.

16. LATASHA NAILAH SPEARS WINKFIELD again began requesting that a doctor be called to address her daughter's ongoing and significant bleeding. As far as LATASHA NAILAH SPEARS WINKFIELD was concerned, the nursing staff at CHO did not appear to be contacting a physician since none was coming to her

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daughter's assistance. The WINKFIELDS estimated that JAHI had lost 3 pints of blood or more. At that time, one nurse said the bleeding was normal, and another nurse said she did not know if it was normal or not.

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

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

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

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2013, the Code was called. At that time CHATMAN observed a doctor finally come to the bedside of JAHI and state, "Shit, her heart stopped." The cardiopulmonary arrest and Code was documented to last until 03:08 hours, or for 2 hours and 33 minutes, an extremely long period of time. During this time, the doctors and nurses failed to timely establish an airway for JAHI and no consideration was apparently given to perform an emergency tracheotomy when it was apparent after endotracheal intubation attempts were not resulting in prompt and adequate oxygenation of JAHI in a timely manner.

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

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

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

23. On December 11, 2013, LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD were advised that EEG brain testing indicated that JAHI had sustained significant brain damage. On December 12, 2013, LATASHA NAILAH

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SPEARS WINKFIELD and MARVIN WINKFIELD were advised that a repeat EEG also revealed that JAHI had suffered severe brain damage. They were advised that JAHI had been put on the organ donor list and that they would be terminating her life support the next morning. Upset that the hospital administration was pushing them to donate JAHI's organs and terminate life support without explaining what had happened to their daughter, LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD made inquiries as to what happened. Nobody with the hospital administration explained what happened.

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

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

26. The WINKFIELDS then obtained a restraining order preventing CHO from terminating JAHI's life support. Eventually, an agreement was reached whereby JAHI was released to the WINKFIELDS. Recent evaluations by doctors, including a board certified pediatric neurologist, confirm that JAHI does not meet the definition of brain death.

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DEFENDANTS ROSEN AND CHO BREACHED THE APPLICABLE STANDARDS OF CARE

27. Plaintiffs incorporate herein by reference paragraphs 1 through 26 above as though fully set forth herein.

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

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

30. During the subject surgery, defendant ROSEN discovered that JAHI might have a medialized right carotid artery. Defendant ROSEN fell below the standard of care when he failed to mention this condition in any of his postoperative orders which he knew would have been read and relied upon by the nurses and doctors who would have been responsible to care for JAHI postoperatively in the PACU and in the PICU. By failing to note JAHI's possible medialized right carotid artery and the significance of that condition that she was at a higher risk of life-threatening bleeding, the medical staff at CHO were not provided the important medical information which ROSEN should have provided them.

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

32. The nurses and medical doctors at CHO, including the fellows, residents and attending physicians, fell below the applicable standard of care by allowing

JAHI to bleed for hours without insisting that the surgeon, ROSEN, return to bedside and address the source of the bleed. In the event that ROSEN was not available or refused to respond, medical staff at CHO had the duty to get another surgeon involved with JAHI's care in order to identify and address the source of the significant blood loss which was getting worse and worse over time.

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

FIRST CAUSE OF ACTION

FOR PERSONAL INJURIES

ON BEHALF OF JAHI McMATH

(Against Defendants ROSEN, CHO and DOES 1 THROUGH 100)

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

35. As a result of the professional negligence of the defendants, plaintiff JAHI McMATH has been injured and has sustained a profound impact to the quality of her life.

36. As a result of the negligence of the defendants, plaintiff JAHI McMATH has incurred medical expenses and will incur medical, nursing and other related

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expenses in the future, in an amount that will be established according to proof.

37. As a result of the negligence of the defendants, plaintiff JAHI McMATH will suffer a loss of earning capacity in the future, according to proof at the time of trial.

SECOND CAUSE OF ACTION

FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

ON BEHALF OF PLAINTIFFS

LATASHA NAILAH SPEARS WINKFIELD AND CHATMAN

(As Against Defendants ROSEN, CHO AND DOES 1 THROUGH 100)

38. Plaintiffs incorporate herein by reference paragraphs 1 through 37 above as though fully set forth herein.

39. At approximately 7:00 p.m. on December 9, 2013, plaintiff LATASHA NAILAH SPEARS WINKFIELD witnessed her daughter JAHI McMATH suffering from continuous postoperative bleeding that continued to get worse. When her pleas for medical intervention to the nursing staff were ignored, she contacted her mother CHATMAN who she knew to be an experienced and trained nurse. By 10:00 p.m., CHATMAN arrived at JAHI's bedside. CHATMAN realized immediately that her grandchild was suffering from excessive bleeding and that continued blood loss could result in serious personal injury or death. Plaintiff CHATMAN then began insisting that doctors be called to the bedside to address the complication of bleeding.

40. Plaintiff CHATMAN advised LATASHA NAILAH SPEARS WINKFIELD that the prolonged bleeding was not normal and that JAHI McMATH was suffering from complications of surgery which were not being properly addressed medically. From that point on, both plaintiffs LATASHA NAILAH SPEARS WINKFIELD and CHATMAN were aware that JAHI was being harmed by the inadequate and substandard nursing care she was receiving at CHO, by her surgeon who had not

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checked on the status of his patient or by the other medical staff at CHO.

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

42. LATASHA NAILAH SPEARS WINKFIELD became so emotionally distraught and overcome that she was admitted into CHO for observation.

THIRD CAUSE OF ACTION

FOR WRONGFUL DEATH ON BEHALF OF PLAINTIFFS

LATASHA NAILAH SPEARS WINKFIELD AND MARVIN WINKFIELD

(Against Defendants ROSEN, CHO, MILTON McMATH and DOES 1 THROUGH 100)

43. Plaintiffs incorporate herein by reference paragraphs 1 through 42 above as though fully set forth herein.

44. In the event that it is determined JAHI McMATH succumbed to the injuries caused by the negligence of the defendants, plaintiffs LATASHA NAILAH SPEARS WINKFIELD and MARVIN WINKFIELD have lost love, companionship, comfort, care, affection, society and moral and financial support of their daughter, according to proof at the time of trial.

WHEREFORE, plaintiffs pray as follows:

AS TO THE FIRST CAUSE OF ACTION, PLAINTIFF SEEKS:

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

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AS TO THE SECOND CAUSE OF ACTION, PLAINTIFFS SEEK:

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

AS TO THE THIRD CAUSE OF ACTION, PLAINTIFFS SEEK:

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

DATED: March 2, 2015

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