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Superior Court of California
County of Sacramento
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By: V. Bloxson Deputy

Attorneys for Plaintiffs Emilliano Walker, Kalia Zachary, and Dalee Marez

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SACRAMENTO

EMILLIANO WALKER, an individual; KALIA ZACHARY, an individual; and DALEE MAREZ, an individual.

Plaintiffs,

v.

COMMONSPIRIT HEALTH, a nonprofit corporation; DIGNITY HEALTH, a California nonprofit corporation; MORTUARY SUPPORT SERVICES OF NORTHERN CALIFORNIA, LLC, a limited liability company; MICHAEL ROBERT LOFTON, an individual; and DOES 1 through 50, inclusive

Defendants

Case No.: 25CV009026

COMPLAINT FOR DAMAGES

1. **Intentional Infliction of Emotional Distress**
2. **Negligence**
3. **Negligent Hiring and Supervision**
4. **Gross Negligence**

DEMAND FOR JURY TRIAL

Plaintiffs Emilliano Walker ("Emilliano"), Kalia Zachery ("Kalia"), and Dalee Marez ("Dalee") (collectively the "Plaintiffs"), by and through undersigned counsel, hereby allege on information and belief as follows:

INTRODUCTION

1. Defendants CommonSpirit Health ("CommonSpirit") and Dignity Health (collectively, "Dignity") are massive health care companies that earn billions of dollars in revenue each year by operating hospitals throughout the United States. Dignity's C-Suite and high-level executives earn millions of dollars each year, including the companies' CEOs, who are each reported to earn over Twenty-Seven Million Dollars per year.

2. Over the course of at least the past five years, and likely longer, Dignity has engaged in a pattern and practice of egregiously failing to perform myriad post-death responsibilities related to patients who died in the care and custody of its hospitals. For example, Dignity has repeatedly failed to notify family members of their loved one's deaths, failed to perform their requisite actions towards preparing and registering death certificates, and contracted for funeral service companies to hold the human remains of dead patients for extremely over-long periods of time while families look for their deceased "missing" relatives. In fact, Dignity's handling of these matters has been so egregious that they have been the subject of governmental audits in both 2022 and 2024, the former of which resulted in the issuance of two corrective action plans ("Corrective Action Plans") that Mercy failed to implement despite reporting to the government that they did. Indeed, in the 2024 audit, the California Department of Public Health stated that Dignity "failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations." As a result of Dignity's actions and inactions, the family members of patients who die in Dignity's hospitals far-too-often receive no notice of the deaths at all and are left to scour the world for a "missing person" while enduring the excruciating emotional distress related thereto. Plaintiffs are also informed and believe that the Sacramento District Attorney is conducting an investigation into these exact practices.

3. Sadly, Plaintiffs' story is one more in a litany of heartbreaking stories that could have been prevented if Dignity had simply complied with the law or even its own Corrective Action Plans

that were in place as a result of the dozens of times it had already failed to follow the law leaving families to search for their loved ones for months and sometimes years after their death. Dignity callously continued not to follow the law even after multiple government warnings and a Corrective Action Plan leaving Plaintiffs to search relentlessly, along with the Sacramento Police Department, for their missing mother and beloved sister for seven months while her body decomposed in a "storage" facility that Dignity had improperly and covertly moved her to at the time of her death.

4. On November 2, 2023, Tonya Walker ("Ms. Walker"), the beloved mother and sister of Plaintiffs, died while in the custody and care of Mercy General Hospital ("Mercy General"), a Sacramento hospital owned and operated by Dignity. After Ms. Walker died, Dignity did not take any action to notify Ms. Walker's family of her death, nor did it issue a death certificate that would have triggered official notices to the police and government authorities. Dignity instead contracted with a funeral services company Defendant Mortuary Support Services of Northern California, LLC ("MSSNC"), owned by Defendant Michael Robert Lofton ("Lofton") and operated through his personal license, to "store" Ms. Walker's remains. Together, Dignity, MSSNC, and Lofton (collectively "Defendants"), all failed to take any of the legally required actions to prepare and register Ms. Walker's death certificate. They also failed to obtain a legally required permit for the movement and storage of her remains, another mechanism that would have triggered a notice of her death to government authorities and stopped the family's search for her. As a result, like dozens of others before her, Ms. Walker's body sat decomposing in improper storage for seven months while Ms. Walker's family scoured Sacramento's darkest recesses hoping to find her.

5. Plaintiffs' search for Ms. Walker included working with police, endless driving and walking throughout Sacramento, posting digital flyers to Facebook, SnapChat, and Instagram, and taking to the streets to circulate approximately two thousand flyers around Sacramento. Plaintiffs also put out a $3,500 reward for information leading to Ms. Walker's whereabouts, which resulted in daily messages from anonymous individuals providing false "tips" that Plaintiffs unknowingly went to all ends to investigate. Plaintiffs also received messages from anonymous individuals claiming to be holding Ms. Walker hostage for ransom, some of whom photoshopped photos of Ms. Walker's face in distress or in a body bag. These are only a few examples of what Plaintiffs had to endure on

a daily basis while dealing with the devastating reality of not knowing what happened to their missing mother and sister. Despite the extreme emotional distress Plaintiffs endured, they refused to give up hope and continued searching for Ms. Walker the entire seven months she was missing.

6. On May 31, 2024, the Sacramento Police Department finally learned that Ms. Walker had died and informed Plaintiffs that her body was being held at a local mortuary owned and operated by MSSNC and Lofton (collectively "MSSNC Defendants"). Kalia and Dalee immediately traveled to MSSNC's facility and were shown Ms. Walker's body, which due to improper storage was in an unrecognizable state beyond imaginability. Moreover, Kalia and Dalee were shocked to see that Ms. Walker's eyes and skin appeared to have been surgically removed from her body. To add insult to injury, Dignity appeared to have unilaterally elected to donate Ms. Walker's organs without consent from Ms. Walker who was not an organ donor and without any notice or approval from Ms. Walker's Catholic family. This final image of Ms. Walker is now engrained in Kalia and Dalee's minds as the last image of their beloved sister. It will haunt them forever.

7. Defendants' actions described herein were done intentionally or in reckless disregard to the probability of causing emotional distress to Plaintiffs. Therefore, the Defendants are liable for intentional infliction of emotional distress and the incredible damages Plaintiffs have suffered and will continue to suffer related thereto. Additionally, Defendants' actions breached a host of duties that Defendants owed to the Plaintiffs, leading to liability of the causes of action alleged herein.

PARTIES

8. Plaintiff Emilliano Walker ("Emilliano") is an individual who resides in Sacramento County, California. Emilliano is Ms. Walker's adult biological son.

9. Plaintiff Kalia Zachery ("Kalia") is an individual who resides in Sacramento County, California. Kalia is Ms. Walker's adult sister.

10. Plaintiff Dalee Marez ("Dalee") is an individual who resides in Sacramento County, California. Dalee is Ms. Walker's adult sister.

11. Defendant CommonSpirit Health is a non-profit corporation with its principal place of business in Chicago, Illinois. At all times relevant to this Complaint, CommonSpirit has conducted business in Sacramento County, California.

12. Defendant Dignity Health is a California non-profit corporation with its principal place of business in San Francisco, California. At all times relevant to this Complaint, Dignity Health has conducted business in Sacramento County, California.

13. Defendant Mortuary Support Services of Northern California, LLC is a California limited liability company with its principal place in the Sacramento County, California.

14. Defendant Michael Robert Lofton is an individual, who Plaintiffs are informed and believe resides in Sacramento County, California. Lofton personally holds Cemetery and Funeral Bureau License No. FD-2208. Plaintiffs are informed and believe that MSSNC uses Lofton's license to operate.

15. Plaintiffs are ignorant of the names and capacities of Does 1 through 50 ("Doe Defendants") and sues them as Does 1 through 50 inclusive. Plaintiffs will amend this action to allege these Doe Defendant's names and capacities when ascertained.

16. Each of the named and identified Defendants herein are responsible in some manner for the occurrences, injuries, and damages herein, and the damages were directly and proximately caused by these Defendants' acts and omissions. Plaintiffs are informed and believe and allege thereon, that at all times mentioned herein, that the Doe Defendants, each of them, were the agents and/or employees of each other, and in taking the actions herein alleged were acting in the course and scope of said agency and/or employment with advanced knowledge, consent, acquiescence, or subsequent ramification of Defendants. As a corollary, Defendants are liable for the acts and/or omissions of the other Defendants under the doctrine of respondent superior and the laws of vicarious liability.

17. Lofton is liable for his own direct and personal participation in the tortious conduct described herein and is also liable as a result of MSSNC's participation in such conduct. On information and belief, MSSNC is the alter ego for Lofton, as MSSNC is the agent of Lofton and/or MSSNC is so dominated and controlled by Lofton as to justifiably disregard the separate entity existence. Plaintiffs are informed and believe and, on that basis allege, that Lofton is the sole owner of MSSNC and Lofton is the majority owner of MSSNC or has exercised sole control of MSSNC even if he is not the majority owner, and that MSSNC is inadequately capitalized, or that Lofton

caused MSSNC's funds or other assets to be commingled with his own personal assets. Plaintiffs are informed and believe that MSSNC and Lofton use the same offices and have disregarded the corporate formalities, and that Lofton operates MSSNC through Lofton's personal license with the California Cemetery and Funeral Bureau. There is such a unity of interest and ownership that the individuality, or separateness, of MSSNC and Lofton has ceased to exist, and adherence to the separate existence of MSSNC and Lofton would sanction a fraud or promote injustice.

JURISDICTION AND VENUE

18. This Court has jurisdiction over this action pursuant to California Constitution Article VI, Section 10, which grants the Superior Courts "original jurisdiction in all other causes" except those given by statute to other courts.

19. Furthermore, the Court has personal jurisdiction over Defendants because a substantial portion of the acts or omissions alleged in this Complaint took place in California, and Plaintiffs are informed and believe that Defendants either reside in California or otherwise possess sufficient minimum contacts with California, including conducting their operations in the State of California, as to render the exercise of jurisdiction by California courts permissible under traditional notions of fair play and substantial justice.

20. Venue is proper in California Superior Court of the County of Sacramento pursuant to California Code of Civil Procedure § 395 because Sacramento County is where the subject incident and injuries occurred and where the obligation and liabilities arose for the Defendants. The Court has subject matter jurisdiction over this controversy as a court of general jurisdiction within Sacramento.

BACKGROUND ON APPLICABLE LAW

21. In 1939, the California legislature enacted the California Health and Safety Code ("Health & Safety Code") to consolidate and revise the law relating to the preservation of the public health and safety, including not only the health and safety of persons, but also the custody and disposition of dead bodies (hereafter "human remains").

California Death Certificate Laws

22. Division 102 of the Health & Safety Code establishes the laws regarding the preparation and issuance of vital records, including death certificates. Specifically, Chapter 6 of

Division 102 of the Health & Safety Code establishes the law for the preparation and issuance of death certificates, which the law requires to be completed within eight calendar days of an individual's death. (Cal. Health & Safety Code § 102775.)

23. Chapter 6 establishes that a hospital is required to complete "the medical and health section data and the time of death," which must also be "attested to by the physician and surgeon last in attendance." (Health & Safety Code § 102795.) Notably, "the medical and health section data and the physician's or coroner's certification shall be completed by the attending physician within 15 hours after the death." (Health & Safety Code § 102800.)

24. Additionally, those in custody and/or control of human remains are required to "prepare the certificate and register it with the local registrar." (Cal. Health & Safety Code §§ 102800, 102780.) To facilitate this, those in custody and/or control of human remains are required to complete other affirmative steps in preparing the death certificate including "obtain[ing] the required information other than medical and health section data from the person or source best qualified to supply the information." (Cal. Health & Safety Code § 102790.)

Law Requiring Notification to Families of Decedents

25. Division 7 of the Health & Safety Code, Sections 7000 – 8030, establishes the law regarding the notification requirements for those holding human remains prior to final disposition. As a threshold matter, the person or entity holding the remains is required to use reasonable diligence to notify the family of the decedent about the death. (Cal. Health & Safety Code § 7104.) This allows the family of the decedent to control the disposition of the remains, which they have a right to do. (Cal. Health & Safety Code § 7100.)

26. Additionally, pursuant to the American Medical Association's Principles of Ethics, "informing a patient's family that the patient has died is a duty that is fundamental to the patient-physician relationship … ordinarily, the treating physician should take responsibility for informing the family. However, it may be appropriate to delegate the task of informing the family to another physician if the other physician has a previous close relationship with the patient or family and the appropriate skill." (AMA Principles of Medical Ethics, Rule 2.3.3.) Moreover, the physician has the duty to "disclose the death in a timely manner." (*Id.*)

Law Related to the Storage Human Remains Prior to Final Disposition

27. In California, an entity holding the remains must obtain a permit for disposition from the local registrar in the district where the death occurred to hold any human remains for over eight days. (Cal. Health & Safety Code § 103070.)

28. California Health & Safety Code Division 8, Chapter 2, Article 5 governs the operation of funeral services companies in California, including the requirements for storing human remains. For example, "within two hours after a crematory licensed by the State of California takes custody of a body that has not been embalmed, it shall refrigerate the body at a temperature not greater than 50 degrees Fahrenheit unless the cremation process will begin within 24 hours of the time that crematory took custody." (Cal. Health & Safety Code § 8346.) Similarly, pursuant to the California Code of Regulations, "every licensed funeral establishment and funeral director who holds unembalmed remains for a period longer than twenty-four (24) hours shall cause the body to be refrigerated at an approved facility with sufficient capacity." (Cal. Code Regs. Tit. 16 § 1223.)

Organ Donation Laws

29. Chapter 3.5 of Division 7 of the Health & Safety Code consists of the Uniform Anatomical Gift Act, which establishes the laws for organ donation.

30. As a general matter, to become an organ donor, an individual must during his or her lifetime affirmatively establish that he or she wants to be an organ donor, for example through a driver's license, will, or the Donate Life California Organ and Tissue Donor Registry. (Cal. Health & Safety Code § 7150.20.) In the event an individual does not elect to become an organ donor, the only way in which they can posthumously become an organ donor is for that decision to be made based on a statutorily established hierarchy of individuals, in the following order: the agent of the decedent who had the right to make an anatomical gift pursuant to statute, the spouse or domestic partner of the decedent, the adult children of the decedent, the parents of the decedent, the adult siblings of the decedent, the adult grandchildren of the decedent, the grandparents of the decedent, an adult who exhibited special care and concern for the decedent during their lifetime, and persons who were acting as the guardians or conservators of the person of the decedent at the time of death." (Cal. Health & Safety Code § 7150.40(a)(1)-(9).)

31. Notably, it is the hospital's duty to establish a protocol for notifying the next of kin of potential organ donors to obtain their consent to donate the organs, and that notification must occur "at or near the time of notification of death." (Cal. Health & Safety Code § 7184.) Only after all family members and other statutorily enumerated individuals who are reasonably available have been consulted, may the hospital make the determination to donate the decedent's organs. (Cal. Health & Safety Code § 7150.40(a)(10).)

ALLEGATIONS

Background on CommonSpirit and Dignity Health

32. CommonSpirit is a national health care company that operates more than seven hundred care sites and one hundred and forty-two hospitals across twenty-one states in the United States. CommonSpirit operates hospitals in California through Dignity Health, a California based company that operates forty hospitals across California, Arizona, and Nevada.

33. In September 2024, CommonSpirit publicized that it generated Thirty Seven Billion Dollars ($37,000,000,000) in revenues for the 2024 fiscal year, which ended on June 30, 2024.[1] ProPublica reports that Dignity Health generated over Nine Billion, Nine Hundred Million Dollars ($9,900,000,000) for the 2023 fiscal year.[2] The companies' billions of dollars in revenues are then used to, *inter alia,* pay their C-Suite executives and other high-ranking executives millions of dollars in yearly compensation. For example, according the Paddock Post, CommonSpirit's CEO earned approximately Twenty Eight Million Dollars Per Year ("28,000,000) during the 2023 fiscal year.[3] Similarly, ProPublica reported that in 2023, Dignity Health's CEO earned over Twenty-Seven Million Dollars ($27,000,000) in compensation, while Dignity Health's Chief Operating Officer and Senior Chief Strategy Officer earned just over Six Million Dollars ($6,000,000) and Four Million Dollars ($4,000,000), respectively.

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[1] https://www.commonspirit.org/news-articles/commonspirit-health-releases-fy2024-year-end-results#:~:text=CommonSpirit%20Health%20reported%20revenues%20of,8.2%25%20over%20the%20prior%20year.
[2] https://projects.propublica.org/nonprofits/organizations/941196203
[3] https://paddockpost.com/2025/01/01/executive-compensation-at-commonspirit-health-2023/

34. Notwithstanding CommonSpirit and Dignity Health's massive revenues, they have engaged in a long standing pattern and practice of cutting costs by, *inter alia,* failing to institute procedures and take actions to timely notify families of patient deaths, failing to timely take requisite actions towards preparing death certificates, and failing to properly process the remains of deceased patients.

35. In 2022, the California Department of Public Health ("CDPH") conducted an audit into Dignity after receiving many complaints that their hospital(s) failed to notify families about those deaths in a timely manner. During that audit, the Chief Medical Officer for Dignity Health admitted that it was "the responsibility of the [Dignity Health] attending physician to notify family of a patients' death." In the audit report, CDPH also noted that based on reviewing Dignity Health's policies and procedures: "the Attending Physician or his or her representative is responsible for notifying the next of kin in all cases of death." As a result of the audit, CDPH determined that Dignity had failed to notify families, as well as implement procedures and train staff to do so. Accordingly, the CDPH issued the two Plans of Correction. The Plans of Correction required Dignity to provide education to their staff on the location of contact information, the requirement to notify a patient's family about a death, and the requirement to document notifications to family. The Plan of Correction also required Dignity to develop an auditing and reporting process and implement other measures to verify proper procedures were followed. In 2022 and 2023, Dignity reported to CDPH that it had completed the corrections set forth in the Plans of Correction.

36. Beginning in or around 2024, the United States Department of Health and Human Services ("DHHS") directed the CDPH to conduct another audit into Dignity after receiving many complaints that their hospital(s) still failed to properly notify families about the deaths of many patients who died in Dignity's custody and care, as well as Dignity's failure to complete their death requirements towards preparing death certificates in a timely manner. For example, CDPH's audit of Mercy San Juan Medical Center, a sister hospital of Mercy General that is owned and operated by Dignity in a suburb of Sacramento, California, CDPH concluded: "[T]he hospital failed to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures related to family notification of patient death, timely completion of death certificates, and

processing of patient remains … these failures contributed to ongoing delays in processing of death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had then potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage; on 10/14/24, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first half of 2024."

37. Additionally, in the 2024 audit, the CDHP found that Dignity "failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations."

Background Mortuary Support Services of Northern California and Lofton

38. Michael Robert Lofton holds California Cemetery and Funeral Bureau License No. FD-2208. Lofton is also the sole manager and/or member of Mortuary Support Services of Northern California, LLC ("MSSNC"). MSSNC offers mortuary transport, storage, crematory and funeral home services.

39. MSSNC regularly enters into contracts with Sacramento area hospitals, including Dignity's Mercy General, to transport and store the bodies of individuals who die while in care of Mercy General. Pursuant to this arrangement, when Mercy General has human remains that Mercy General desires the MSSNC Defendants to transport and store, in exchange for compensation, the MSSNC Defendants pick up the body from Mercy General and transports it back to MSSNC's facility located at 35 Quinta Ct., Suites C and/or D, Sacramento California. Prior to Ms. Walker's death, Dignity and the MSSNC Defendants all had repeated advanced notice that there were serious issues with their handling of human remains for individuals who died while in Mercy General's care whose remains were being stored by the MSSNC Defendants. For example, between May 2, 2023 and September 12, 2023, the MSSNC Defendants communicated to Dignity that the MSSNC Defendants were holding the bodies of at least thirty five patients who died while in the care of Mercy General, and for whom death certificates had not yet been timely prepared and families had not been properly notified to collect. As reported by MSSNC to Mercy General at that time, MSSNC had been holding some of these bodies for up to two years.

Background on Tonya Walker

40. Ms. Walker was born in 1972 in Sacramento, California, and lived in the Sacramento area her entire life. First and foremost, Ms. Walker cared about family, and she loved and was beloved by her family. Ms. Walker was raised by her family in the Catholic faith, a faith she kept her entire life. The following is a photograph of Ms. Walker:

41. Throughout Ms. Walker's life, she gave much to the Sacramento community. For example, she worked as an aid at multiple elementary schools, including with a Christian kindergarten. Walker was also creative and entrepreneurial, and channeled those energies into starting a local business selling homemade health and beauty products.

42. At the time Ms. Walker died, her address was 1044 Jean Avenue, Sacramento, California, 95839 ("Home"), which she shared with Emillio.

Ms. Walker is Admitted to Mercy General

43. On October 31, 2023, Ms. Walker was admitted to Dignity's Mercy General Hospital with what Mercy General described as "symptoms of hypoglycemia, hypertension, and hyperkalemia." As reflected in the limited records that Ms. Walker's family has been able to obtain to date, upon admission, Ms. Walker provided the Hospital with her contact information including her address. Additionally, Ms. Walker identified her ex-boyfriend Donald Ketcherside ("Ketcherside") as an emergency contact. Ms. Walker also informed the Hospital that she was Catholic. Notably, Ms. Walker did not identify as an organ donor.

After Ms. Walker Dies Alone, The Hospital Fails to Properly Memorialize Her Death and Removes Her Organs Without Permission

44. Upon Ms. Walker's death Dignity made no attempt to notify Ms. Walker's family that that she had passed. In fact, Mercy General only reached out to a single phone number during her hospitalization that they had on file for Mr. Ketcherside, which they immediately learned was "not in service," a fact that they memorialized in their internal records. In Dignity's own internal systems, it affirmatively acknowledged that Dignity needed to continue to "attempt to locate family/SDM," yet they never did. Accordingly, during Ms. Walker's last few days of life she was alone and at the time she died, she was also alone. Dignity never attempted to send anyone to the address on file or locate her family during her hospitalization or after her passing.

45. Accordingly, the events leading up to Walker's death on November 2, 2023 remain largely a mystery to Ms. Walker's family. What is known is that on November 2, 2023 at 1:19 a.m., *i.e.,* approximately ***two hours before*** Ms. Walker died, Dignity notified the "organ bank" (which Plaintiffs are informed and believe is Sierra Donor Services) of Ms. Walker's death. Dignity's records also identify Ms. Walker as a "candidate to donate [her] eyes [and] tissue," although neither Ms. Walker nor her family or next of kin ever elected to make Ms. Walker an organ donor.

46. On November 2, 2023 at 3:11 a.m., Ms. Walker was pronounced dead by attending physician Andrew Norris ("Dr. Norris"). However, in the wake of Ms. Walker's death, neither Dr. Norris nor any other physician at Dignity completed the statutorily required medical and health data section for Ms. Walker's death certificate, which Dignity was required by law to do within fifteen hours of Ms. Walker's death.

47. Furthermore, Dignity did not take any action to notify Ms. Walker's family that Ms. Walker had died. As a corollary, Dignity did not take reasonable steps to obtain Ms. Walker's family's consent to harvest Ms. Walker's organs for organ donation purposes. Notwithstanding, Plaintiffs are informed and believe that Dignity unilaterally made the decision to make Ms. Walker an organ donor, and then without any permission whatsoever, harvested Ms. Walker's eyes and tissue.

48. Dignity's records indicate that Dignity did not request an autopsy of Ms. Walker's body. Accordingly, Dignity did not relinquish custody of Ms. Walker's body to a coroner. Instead,

Dignity contacted MSSNC and contracted for the MSSNC Defendants to transport Ms. Walker's body from the hospital to the morgue for storage. To that end, Plaintiffs are informed and believe that on November 2, 2023 at 4:41 a.m., Dignity released Ms. Walker's remains to MSSNC, who in turn transported Ms. Walker's body away from the hospital and to the MSSNC for "storage." At the time of transferring custody of Ms. Walker's body to the MSSNC Defendants, Dignity did not provide any information to the MSSNC Defendants for the MSSNC Defendants to use in preparing Ms. Walker's death certificate, despite having a legal obligation to do so.

49. Thereafter, MSSNC billed Dignity on a monthly basis for the MSSNC Defendants' "storage" of Ms. Walker's body.

The Family Searches for Ms. Walker for Months

50. Because neither Dignity nor the MSSNC Defendants notified Ms. Walker's family that Ms. Walker had died, Plaintiffs searched the Sacramento area for Ms. Walker for seven months, enduring excruciating emotional distress all the while.

51. October 27, 2023 was the last day that Ms. Walker's family heard from Ms. Walker. By November 2, 2023, Plaintiffs were becoming increasingly concerned due to the lack of contact from Ms. Walker, and the fact that she was not answering their phone calls. Plaintiffs' concerns were amplified on November 4, 2023, when Ketcherside reported that he also had not seen her in days.

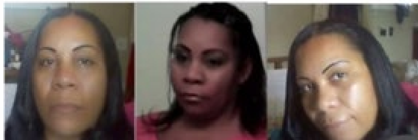
52. On or around November 10, 2023, the family filed a missing person's report with the Sacramento Police Department and began their formal search. At first, Plaintiffs posted to Facebook, hoping that someone in their network would have information about Ms. Walker's whereabouts. Plaintiffs then extended a cash reward to anyone who could identify Ms. Walker's whereabouts. An example of a digital post the family made is below:

!! MISSING !!

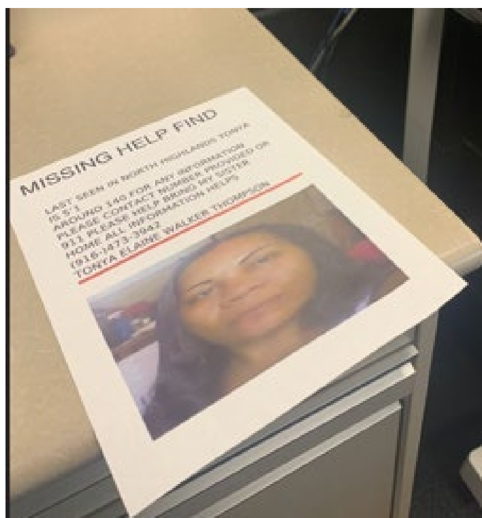
Tonya Elaine Walker Thompson Zachary
5'1" 140lbs

Last seen on 10/24 in North Highlands, CA
If you have ANY information which leads to bringing
Tonya home to her family, please call/text
(916) 473-3942 or call 911.

!! $3,500 REWARD !!
For the successful location,
which leads to the physical sight of
Tonya Elaine Walker Thompson Zachary



53. Plaintiffs also took to the streets spearheading their own search for their beloved Tonya searching in ditches, drainpipes and alleys to see if they could find her or any clue as to her whereabouts. They prepared two thousand paper flyers, which they posted in places they knew Ms. Waker to frequent and handed others out to members of the community. An example of a flyer that the family circulated around the Sacramento area is as follows:



54. On November 14, 2023, the Sacramento Police Department called Plaintiffs and informed them that they had discovered Ms. Walker's car, which had been abandoned and looted. At that juncture, Plaintiffs amplified their search and began calling local hospitals, including Mercy General, to see if any knew about her whereabouts. Dalee notified each hospital that Ms. Walker was missing, asked if Ms. Walker had been admitted, and left Dalee's contact information. Plaintiffs did

not receive a response from a single hospital, including Mercy General or any other Dignity hospital. Notwithstanding, Plaintiffs did not give up hope, and they continued searching for their missing mother and sister.

55. Between November 2023 and May 2024, Plaintiffs received many responsive messages from individuals in the Sacramento community who had seen the flyers that Plaintiffs circulated and Plaintiffs' online posts, which Plaintiffs ultimately expanded to other social media platforms including Facebook and TikTok. For example, Dalee received anonymous messages from individuals who claimed to have seen Ms. Walker's body in a ditch, drainpipe, or who had knowledge of Ms. Walker's body being buried underground. Whenever Plaintiffs received these messages, they traveled to the location based on the tip and scoured the areas for Ms. Walker's body, crawling into drainpipes or using shovels to excavate areas where people claimed Ms. Walker was buried. Of course, Plaintiffs never found anything – as Ms. Walker's remains were actually in the possession of the Defendants the entire time. For example, the following is the photo of a drainage pipe that Dalee traveled to and the family paid someone to crawl down looking for Ms. Walker's body after they received an anonymous tip that her body was located in the pipe:

56. As another example, the following is a photo of train tracks that Plaintiffs traveled to and looked for Ms. Walker after receiving an anonymous tip that Ms. Walker's body could be found by the train tracks:

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9 57. Plaintiffs also received messages from anonymous individuals claiming to have
10 kidnapped Ms. Walker, who demanded Plaintiffs pay a cash ransom in exchange for Ms. Walker.
11 The following is an excerpt from one set of messages the family received from an anonymous
12 individual claiming to have kidnapped Ms. Walker:

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22 58. Other anonymous individuals messaged Plaintiffs claiming they had possession of Ms.
23 Walker's body and would only return it for a reward. For example, the following is an excerpt from
24 messages that Dalee received from an individual who identified herself as "Denise":
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59. These are only a few examples of the many messages that Plaintiffs received during their months-long search for Ms. Walker. All of this caused Plaintiffs extreme added emotional distress dealing with a continuing vicious circle of emotions ranging from hope to fear, to dread, to despair.

Seven Months Later, the Plaintiffs are Notified of Ms. Walker's Death

60. Plaintiffs searched tirelessly for Ms. Walker for approximately seven months, fighting through severe emotional distress from not knowing what had happened to their beloved mother and sister, and all the while were in constant contact with the Sacramento Police Department for any shred of information.

61. On May 31, 2024, officers from the Sacramento Police Department called the family and conveyed that they had received notice that Ms. Walker had died. Accordingly, until May 31, 2024, Plaintiffs had no notice of the facts underlying the claims they allege in this complaint. The Sacramento Police Department notified Plaintiffs that Ms. Walker's remains were being held at a local crematorium. However, the police reported to Plaintiffs that the remains required further identification to definitively confirm Ms. Walker's identity. Accordingly, it was necessary for Plaintiffs to endure yet another devastating and shocking experience in the search for their loved one.

MSSNC Improperly Stored Walker's Body

62. On May 31, 2024, Kalia and Dalee traveled to the MSSNC Facility to view the purported remains. However, before the MSSNC Defendants allowed Kalia and Dalee to view Ms. Walker's remains, the MSSNC Defendants required them to pay $250 as a viewing fee and sign an alleged release regarding the viewing of her remains. The release pertained to a nonexistent entity called "Cremations Only" and was required prior to the identification of her body – meaning Kalia and Dalee could not have identified their sister without first signing the alleged "release" of the nonexistent entity. Moreover, the alleged release only suggested Ms. Walker would be presented "without bathing, disinfecting, dressing, cosmetology, hairdressing, or casketing," and in no way discussed the incredibly gruesome and disturbing condition of Ms. Walker's body.

63. The MSSNC staff then escorted them into the back room to view the remains, which were covered by a medical cover. When the cover was pulled back, it revealed a grotesque and disturbing sight beyond imaginability such that Ms. Walker's sisters could only identify her based on a portion of a tattoo on her arm that could barely be made out based on the state of the decomposition of Ms. Walker's body. Plaintiffs are informed and believe that the MSSNC Defendants failed to properly store Ms. Walker's remains by failing to embalm Ms. Walker's body and refrigerate it at the appropriate temperature and/or storing her remains at a facility that did not meet the appropriate standards set by law. Additionally, it appeared to Kalia and Dalee that Ms. Walker's eyes and tissue had been intentionally removed as her face appeared to be doused with battery acid corroding the area where Ms. Walker's eyes once were. These gruesome and disturbing images, which no person should ever have to see, are now engrained in Kalia and Dalee's minds forever.

64. Moreover, the MSSNC Defendants failed to properly obtain a permit to hold Ms. Walker's body. Indeed, although the MSSNC Defendants took over custody of Ms. Walker's body on November 2, 2023, the MSSNC Defendants did not apply timely for an Application and Permit for Disposition of Human Remains, which is required by law to store a body for more than eight calendar days. Instead, the MSSNC Defendants held Ms. Walker's body from November 2, 2023 through April 16, 2023, *i.e.,* five and a half months, before finally obtaining a permit.

Notwithstanding, each month, the MSSNC Defendants billed the hospital a monthly storage charge for holding Ms. Walker's remains.

The MSSNC Defendants Failed to Timely Prepare Ms. Walker's Death Certificate or Otherwise Notify the Family that the MSSNC Defendants Had Custody of Ms. Walker's Body

65. Defendants also failed to timely finalize Ms. Walker's death certificate and deliver it to the local registrar, which Defendants were required to do by law. Had Defendants properly done so, law enforcement would have been notified about Ms. Walker's death and could have in turn notified Plaintiffs. However, because Defendants failed to follow the law by taking their respective requisite steps towards preparing and delivering Ms. Walker's death certificate, Sacramento County did not find out about Ms. Walker's death until approximately over a half a year after Ms. Walker died. As a corollary to this, and also because Defendants failed to take any effort to locate and notify Ms. Walker's family about her death, they did not find out until the Sacramento Police Department finally notified Plaintiffs on May 31, 2024.

66. On June 7, 2024, more than seven months after Ms. Walker's death, her death certificate was finally issued. However, even on the tardily issued final certificate, the "physicians certification" was done by "Komaldeep Singh, MD," who was not listed as the attending physician on the hospital's notification of death documents—Dr. Norris was.

Ms. Walker's Family Suffers Lasting Emotional Distress and Trauma

67. Although on May 31, 2024 Plaintiffs finally got closure about the fact that Ms. Walker died, their emotional distress and trauma continues to this day. Moreover, the last and final image of Ms. Walker that is now engrained in Kalia and Dalee's minds is the highly disturbing image of Ms. Walker's body at MSSNC, a final image of their sister that they now have to carry with them the remainder of their lives. A hideous and traumatic end to a brutal, devastating and highly unnecessary search for their sister.

68. On December 13, 2024, Plaintiffs notified Dignity of the claims alleged herein.

FIRST CAUSE OF ACTION

Intentional Infliction of Emotional Distress

(As to Defendant CommonSpirit, Dignity Health, MSSNC, Lofton and DOES 1-50)

69. Plaintiffs re-allege and incorporate by reference herein all of the allegations contained in paragraphs 1-68.

70. Defendants, who jointly maintained custody and/or control of Ms. Walker's remains for at least seven months after her death, engaged in conduct that caused Plaintiffs to suffer severe emotional distress.

71. Defendants' conduct included:

a. Defendants failed to properly warn Ms. Walker's family about the condition of Ms. Walker's remains before allowing Kalia and Dalee to view Ms. Walker's remains. They did this after -

b. Defendants did this after Dignity procured Ms. Walker's eyes and tissue for organ donation purposes without contacting Ms. Walker's family and obtaining their consent.

c. Defendants failed to notify Ms. Walker's family that Ms. Walker had died, Defendants failed to timely prepare and deliver required documents related to Ms. Walker's death including but not limited to her death certificate.

d. Defendants also failed to timely obtain an Application and Permit for Disposition of Human Remains despite holding Ms. Walker's body for almost seven months.

e. Defendants failed to properly store Ms. Walker's remains.

72. Defendants' conduct was outrageous and exceeded the bounds of decency in a civilized community.

73. Defendants either intended to cause Plaintiffs emotional distress, or acted with reckless disregard of the probability that Plaintiffs would suffer emotional distress while knowing of their presence. Indeed, Plaintiffs first gave Defendants notice of their presence in November 2024 when

they called Dignity and informed Dignity that they were suffering from severe emotional distress while searching for Ms. Walker who was missing. Moreover, on Kalia and Dalee were present on May 31, 2024 when they finally saw Mr. Walker's remains.

74. Plaintiffs have suffered severe and permanent emotional distress, as described herein. Plaintiffs emotional distress came in many forms. For example, Kalia and Dalee suffered serious emotional distress based on seeing the condition of Ms. Walker's remains on May 31, 2024, a final image of their sister that they will have to live with for the remainder of their lives. For example, Plaintiffs suffered serious emotional distress during the nearly seven-month period that they searched the Sacramento area for Ms. Walker, all-the-while dealing with repeated false leads of anonymous messages from purported kidnappers, or individuals who claimed to have seen Ms. Walker's body. As another example, Plaintiffs suffer severe emotional distress from the knowledge about manner in which the Defendants handled Ms. Walker's remains, which is particularly traumatic due to Ms. Walker's and Plaintiffs' Catholic faith. These are only a few examples.

75. Defendants' conduct as described herein was a substantial factor in causing Plaintiffs' emotional distress.

76. Defendants' conduct as described herein was oppressive and/or malicious, in that it was despicable conduct that subjected the family to cruel and unjust hardship in conscious disregard for the Plaintiffs' rights and/or was carried out with a willful and conscious disregard to the rights of the Plaintiffs. As a corollary, Plaintiffs seek an award of punitive damages as against Defendants by way of this complaint.

SECOND CAUSE OF ACTION

Negligence

(*As to Defendants CommonSpirit, Dignity Health, MSSNC, Lofton, and DOES 1-50*)

77. Plaintiffs re-allege and incorporate by reference herein all of the allegations contained in paragraphs 1-68.

78. Defendants owed duties of care to the Plaintiffs. Those duties included:

a. Defendants' duty to handle Ms. Walker's remains with ordinary care.

b. Defendants' duty to use reasonable efforts to notify the Plaintiffs about Ms. Walker's death, in addition to Defendants' duty to prepare and/or deliver requisite documents related to Ms. Walker's death including her death certificate and an Application and Permit for Deposition of Human Remains.

c. Defendants' duty to use ordinary care related to the storage of Ms. Walker's remains.

d. MSSNC and Lofton's duty of care to give Kalia and Dalee sufficient warning about the condition of Ms. Walker's remains before allowing them to see it on May 31, 2024.

79. Defendants breached their respective duties by:

a. Defendants failed to handle Ms. Walker's remains with ordinary care.

b. Defendants failed to take reasonable efforts to notify the Plaintiffs about Ms. Walker's death. This included failing to take steps including but not limited to timely preparing and delivering Ms. Walker's death certificate and timely obtaining an Application and Permit for Disposition of Human Remains.

c. Defendants failed to properly store Ms. Walker's remains.

d. The MSSNC Defendants failed to give Kalia and Dalee sufficient warning about the condition of Ms. Walker's remains before allowing them to view the remains on May 31, 2024.

80. As a result of Defendants' aforementioned conduct, Plaintiffs suffered damages, including but not limited to the form of emotional distress.

81. Defendants' actions as described herein were the proximate cause of Plaintiffs' damages.

82. Defendants' conduct as described herein was oppressive and/or malicious, in that it was despicable conduct that subjected the family to cruel and unjust hardship in conscious disregard for the Plaintiff's rights and/or was carried out with a willful and conscious disregard to the rights of

the Plaintiffs. As a corollary, Plaintiffs seek an award of punitive damages as against Defendants by way of this complaint.

THIRD CAUSE OF ACTION

Negligent Hiring, Training, and Supervision

(As Against Defendants CommonSpirit, Dignity Health, and DOES 1-50)

83. Plaintiffs re-allege and incorporate by reference all of the allegations contained in paragraph 1 - 82.

84. Dignity had a duty to use reasonable care in hiring, training, and supervising the staff of Mercy General.

85. Dignity failed to use reasonable care in hiring, training, and supervising the staff of Mercy General to assure that:

a. Mercy General's staff were trained in their obligations required in preparing Ms. Walker's death certificate.

b. Mercy General's staff made reasonable attempts to give Ms. Walker's family notice of Ms. Walker's death.

c. Mercy General's staff performed their requisite responsibilities towards preparing Ms. Walker's death certificate and delivering it to the funeral provider.

d. Mercy General's staff created and/or followed proper protocols for organ donation.

86. As a direct result of Dignity's negligent hiring, training, and supervision of Marcy General's staff, Plaintiffs suffered damages, including emotional distress damages, in excess of the jurisdictional minimum of this Court.

87. Dignity's conduct as described herein was oppressive and/or malicious, in that it was despicable conduct that subjected the family to cruel and unjust hardship in conscious disregard for Plaintiffs rights and/or was carried out with a willful and conscious disregard to the rights of the Plaintiffs. As a corollary, Plaintiffs seek an award of punitive damages as against Defendants by way of this complaint.

FOURTH CAUSE OF ACTION

Gross Negligence

(As Against Defendants CommonSpirit, Dignity Health, and DOES 1-50)

88. Plaintiffs re-allege and incorporate by reference herein all of the allegations contained in paragraphs 1-76.

89. Upon Ms. Walker's death, Dignity owed Plaintiffs a duty of care to take reasonable efforts to contact Ms. Walker's family and notify them about the option to donate Ms. Walker's organs, and to obtain the consent of Ms. Walker's family before taking Ms. Walker's organs for donation purposes. Furthermore, at all relevant times, Dignity was required to "develop a protocol for identifying potential organ and tissue donors. The protocol shall require that any deceased individual's next of kin or other individual, as set forth in Section 7151, at or near the time of notification of death be asked whether the deceased was an organ donor or if the family is a donor family. If not, the family shall be informed of the option to donate organs and tissues pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7." To that end, California Health & Safety Code Section 7151 created a duty to create and follow a protocol for identifying organ donors and obtaining consent from an appropriate individual under Section 7151.

90. Dignity breached this duty, failing to take reasonable efforts to contact Ms. Walker's family and notify them about the option to donate Ms. Walker's organs or otherwise obtain their consent, and by either failing to develop a sufficient protocol or failing to follow a protocol that was developed. Dignity further breached this duty by taking Ms. Walker's organs without permission.

91. As a direct and proximate cause of Dignity's breach of duty, Plaintiffs suffered damages according to proof, but in excess of the jurisdictional limits of this court. For example, Plaintiffs suffered substantial emotional distress due to the mishandling of Ms. Walker's remains that occurred due to what Plaintiffs are informed and believes was Dignity's removal of Ms. Walker's eyes and tissue without notifying Ms. Walker's family of their option to donate Ms. Walker's organs or obtain their consent. The occurrence resulting in the injury was of a nature that the statute was designed to protect.

92. Plaintiffs allege that Dignity is liable for gross negligence because their actions related to failing to notify Plaintiffs and/or removing Ms. Walker's organs without permission were not in good faith and/or were in bad faith.

93. Dignity's conduct as described herein was oppressive and/or malicious, in that it was despicable conduct that subjected the family to cruel and unjust hardship in conscious disregard for Plaintiffs rights and/or was carried out with a willful and conscious disregard to the rights of the Plaintiffs. Accordingly, Plaintiffs seek punitive damages against Dignity by way of this complaint.

* * *

PRAYER FOR RELIEF

WHEREFORE, PLAINTIFFS PRAY FOR RELIEF AS FOLLOWS:

1. A judgment in favor of Plaintiffs and against Defendants;
2. General damages against Defendants according to proof;
3. Special damages against Defendants according to proof;
4. Punitive damages as against Defendants;
5. Legal interest, including pre-judgment and post-judgment interest, on judgment from the filing of the original complaint to the date of judgment;
6. Any other and further relief as this Court deems just and proper.

* * *

DEMAND FOR JURY TRIAL

Plaintiffs demand a trial by jury on all the triable issues within this Complaint.

DATED: April 15, 2025

ZWEIBACK, FISET & ZALDUENDO LLP

Rachel L. Fiset

Rachel Fiset
Ben Heller