Docket #0696 Date Filed: 10/29/2018

Attorney or Party Name, Address, Telephone & FAX Nos., State Bar No. & Email Address

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☐ *Individual appearing without attorney*
☒ *Attorney for:* Movant

FOR COURT USE ONLY

UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re:

VERITY HEALTH SERVICES OF CALIFORNIA, INC.

Debtor(s).

CASE NO.: 2:18-bk-20151-ER

CHAPTER: 11

NOTICE OF MOTION AND MOTION FOR RELIEF FROM THE AUTOMATIC STAY UNDER 11 U.S.C. § 362 (with supporting declarations) (ACTION IN NONBANKRUPTCY FORUM)

DATE: 11/19/2018
TIME: 10:00 am
COURTROOM: 1568

Movant: JOSEFINA ROBLES, by and through her Conservator, SERGIO ROBLES

1. **Hearing Location**:
   - ☒ 255 East Temple Street, Los Angeles, CA 90012
   - ☐ 21041 Burbank Boulevard, Woodland Hills, CA 91367
   - ☐ 3420 Twelfth Street, Riverside, CA 92501
   - ☐ 411 West Fourth Street, Santa Ana, CA 92701
   - ☐ 1415 State Street, Santa Barbara, CA 93101

2. Notice is given to the Debtor and trustee (*if any*)(Responding Parties), their attorneys (*if any*), and other interested parties that on the date and time and in the courtroom stated above, Movant will request that this court enter an order granting relief from the automatic stay as to Debtor and Debtor's bankruptcy estate on the grounds set forth in the attached Motion.

3. To file a response to the motion, you may obtain an approved court form at www.cacb.uscourts.gov/forms for use in preparing your response (optional LBR form F 4001-1.RFS.RESPONSE), or you may prepare your response using the format required by LBR 9004-1 and the Court Manual.

4. When serving a response to the motion, serve a copy of it upon the Movant's attorney (or upon Movant, if the motion was filed by an unrepresented individual) at the address set forth above.

5. If you fail to timely file and serve a written response to the motion, or fail to appear at the hearing, the court may deem such failure as consent to granting of the motion.

6. ☒ This motion is being heard on REGULAR NOTICE pursuant to LBR 9013-1(d). If you wish to oppose this motion, you must file and serve a written response to this motion no later than 14 days before the hearing and appear at the hearing.

7. ☐ This motion is being heard on SHORTENED NOTICE pursuant to LBR 9075-1(b). If you wish to oppose this motion, you must file and serve a response no later than (*date*) _____ and (*time*) _____; and, you may appear at the hearing.

   a. ☐ An application for order setting hearing on shortened notice was not required (according to the calendaring procedures of the assigned judge).

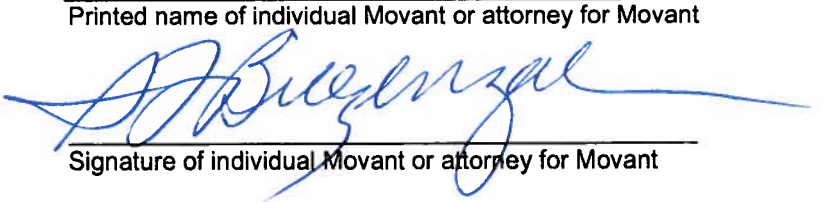
   b. ☐ An application for order setting hearing on shortened notice was filed and was granted by the court and such motion and order have been or are being served upon the Debtor and upon the trustee (if any).

   c. ☐ An application for order setting hearing on shortened notice was filed and remains pending. After the court rules on that application, you will be served with another notice or an order that specifies the date, time and place of the hearing on the attached motion and the deadline for filing and serving a written opposition to the motion.

Date: 10/29/2018

MIRMAN, BUBMAN & NAHMIAS, LLP
Printed name of law firm (if applicable)

STEPHEN F. BIEGENZAHN
Printed name of individual Movant or attorney for Movant



Signature of individual Movant or attorney for Movant

MOTION FOR RELIEF FROM THE AUTOMATIC STAY AS TO NONBANKRUPTCY ACTION

1. **In the Nonbankruptcy Action, Movant is:**
   a. ☒ Plaintiff
   b. ☐ Defendant
   c. ☐ Other (*specify):*

2. **The Nonbankruptcy Action:** There is a pending lawsuit or administrative proceeding (Nonbankruptcy Action) involving the Debtor or the Debtor's bankruptcy estate:
   a. *Name of Nonbankruptcy Action*: Robles v. St. Francis Medical Center, et al.
   b. *Docket number*: BC697012
   c. *Nonbankruptcy forum where Nonbankruptcy Action is pending*:
      Los Angeles Superior Court, Central District
   d. Causes of action or claims for relief (Claims):
      Medical Malpractice; Negligent Concealment/Negligent Misrepresentation Negligent Infliction of Emotional Distress; Fraudulent Concealment; Consumer Legal Remedies

3. **Bankruptcy Case History:**
   a. ☒ A voluntary ☐ An involuntary petition under chapter ☐ 7 ☒ 11 ☐ 12 ☐ 13 was filed on (*date*) 08/31/2018.
   b. ☐ An order to convert this case to chapter ☐ 7 ☐ 11 ☐ 12 ☐ 13 was entered on (*date*) _____.
   c. ☐ A plan was confirmed on (*date*) _____.

4. **Grounds for Relief from Stay:** Pursuant to 11 U.S.C. § 362(d)(1), cause exists to grant Movant relief from stay to proceed with the Nonbankruptcy Action to final judgment in the nonbankruptcy forum for the following reasons:
   a. ☐ Movant seeks recovery only from applicable insurance, if any, and waives any deficiency or other claim against the Debtor or property of the Debtor's bankruptcy estate.
   b. ☐ Movant seeks recovery primarily from third parties and agrees that the stay will remain in effect as to enforcement of any resulting judgment against the Debtor or bankruptcy estate, except that Movant will retain the right to file a proof of claim under 11 U.S.C. § 501 and/or an adversary complaint under 11 U.S.C. § 523 or § 727 in this bankruptcy case.
   c. ☐ Mandatory abstention applies under 28 U.S.C. § 1334(c)(2), and Movant agrees that the stay will remain in effect as to enforcement of any resulting judgment against the Debtor or bankruptcy estate, except that Movant will retain the right to file a proof of claim under 11 U.S.C. § 501 and/or an adversary complaint under 11 U.S.C. § 523 or § 727 in this bankruptcy case.
   d. ☐ The Claims are nondischargeable in nature and can be most expeditiously resolved in the nonbankruptcy forum.
   e. ☒ The Claims arise under nonbankruptcy law and can be most expeditiously resolved in the nonbankruptcy forum.

f. ☐ The bankruptcy case was filed in bad faith.

(1) ☐ Movant is the only creditor, or one of very few creditors, listed or scheduled in the Debtor's case commencement documents.

(2) ☐ The timing of the filing of the bankruptcy petition indicates that it was intended to delay or interfere with the Nonbankruptcy Action.

(3) ☐ Multiple bankruptcy cases affect the Nonbankruptcy Action.

(4) ☐ The Debtor filed only a few case commencement documents. No schedules or statement of financial affairs (or chapter 13 plan, if appropriate) has been filed.

g. ☐ Other (*specify*):

5. **Grounds for Annulment of Stay.** Movant took postpetition actions against the Debtor.

a. ☐ The actions were taken before Movant knew that the bankruptcy case had been filed, and Movant would have been entitled to relief from stay to proceed with these actions.

b. ☐ Although Movant knew the bankruptcy case was filed, Movant previously obtained relief from stay to proceed in the Nonbankruptcy Action in prior bankruptcy cases affecting the Nonbankruptcy Action as set forth in Exhibit. _____.

c. ☐ Other (*specify*):

6. **Evidence in Support of Motion: (*Important Note: declaration(s) in support of the Motion MUST be signed under penalty of perjury and attached to this motion.*)**

a. ☒ The DECLARATION RE ACTION IN NONBANKRUPTCY FORUM on page 6.

b. ☐ Supplemental declaration(s).

c. ☐ The statements made by Debtor under penalty of perjury concerning Movant's claims as set forth in Debtor's case commencement documents. Authenticated copies of the relevant portions of the Debtor's case commencement documents are attached as Exhibit. _____.

d. ☐ Other evidence (*specify*):

7. ☐ **An optional Memorandum of Points and Authorities is attached to this Motion.**

Movant requests the following relief:

1. Relief from the stay pursuant to 11 U.S.C. § 362(d)(1).

2. ☒ Movant may proceed under applicable nonbankruptcy law to enforce its remedies to proceed to final judgment in the nonbankruptcy forum, provided that the stay remains in effect with respect to enforcement of any judgment against the Debtor or property of the Debtor's bankruptcy estate.

3. ☐ The stay is annulled retroactively to the bankruptcy petition date. Any postpetition acts taken by Movant in the Nonbankruptcy Action shall not constitute a violation of the stay.

4. ☐ The co-debtor stay of 11 U.S.C. § 1201(a) or § 1301(a) is terminated, modified, or annulled as to the co-debtor, on the same terms and condition as to the Debtor.

5. ☒ The 14-day stay prescribed by FRBP 4001(a)(3) is waived.

6. ☐ The order is binding and effective in any bankruptcy case commenced by or against the Debtor for a period of 180 days, so that no further automatic stay shall arise in that case as to the Nonbankruptcy Action.

7. ☐ The order is binding and effective in any future bankruptcy case, no matter who the debtor may be, without further notice

8. ☐ Other relief requested.

Date: 10/29/2018

MIRMAN, BUBMAN & NAHMIAS, LLP
Printed name of law firm (*if applicable*)

STEPHEN F. BIEGENZAHN
Printed name of individual Movant or attorney for Movant

Signature of individual Movant or attorney for Movant

DECLARATION RE ACTION IN NONBANKRUPTCY FORUM

I, (*name of Declarant*) STUART M. WEISSMAN, declare as follows:

1. I have personal knowledge of the matters set forth in this declaration and, if called upon to testify, I could and would competently testify thereto. I am over 18 years of age. I have knowledge regarding (Nonbankruptcy Action) because:

   ☐ I am the Movant.
   ☒ I am Movant's attorney of record in the Nonbankruptcy Action.
   ☐ I am employed by Movant as (*title and capacity*):
   ☐ Other (*specify*):

2. I am one of the custodians of the books, records and files of Movant as to those books, records and files that pertain to the Nonbankruptcy Action. I have personally worked on books, records and files, and as to the following facts, I know them to be true of my own knowledge or I have gained knowledge of them from the business records of Movant on behalf of Movant, which were made at or about the time of the events recorded, and which are maintained in the ordinary course of Movant's business at or near the time of the acts, conditions or events to which they relate. Any such document was prepared in the ordinary course of business of Movant by a person who had personal knowledge of the event being recorded and had or has a business duty to record accurately such event. The business records are available for inspection and copies can be submitted to the court if required.

3. In the Nonbankruptcy Action, Movant is:

   ☒ Plaintiff
   ☐ Defendant
   ☐ Other (*specify*):

4. The Nonbankruptcy Action is pending as:

   a. *Name of Nonbankruptcy Action*: Robles v. St. Francis Medical Center, et al.
   b. *Docket number*: BC697012
   c. *Nonbankruptcy court or agency where Nonbankruptcy Action is pending*: Los Angeles Superior Court, Central District

5. **Procedural Status of Nonbankruptcy Action**:

   a. The Claims are:
   Medical Malpractice; Negligent Concealment/Negligent Misrepresentation Negligent Infliction of Emotional Distress; Fraudulent Concealment; Consumer Legal Remedies

   b. True and correct copies of the documents filed in the Nonbankruptcy Action are attached as Exhibit A.

   c. The Nonbankruptcy Action was filed on (*date*) 03/05/2018.

   d. Trial or hearing began/is scheduled to begin on (*date*) n/a.

   e. The trial or hearing is estimated to require _____ days (*specify*). (unknown)

   f. Other plaintiffs in the Nonbankruptcy Action are (*specify*):
   None.

g. Other defendants in the Nonbankruptcy Action are (*specify*):

(See Attachment 5.g.)

6. **Grounds for relief from stay:**

a. ☐ Movant seeks recovery primarily from third parties and agrees that the stay will remain in effect as to enforcement of any resulting judgment against the Debtor or the Debtor's bankruptcy estate, except that Movant will retain the right to file a proof of claim under 11 U.S.C. § 501 and/or an adversary complaint under 11 U.S.C. § 523 or § 727 in this bankruptcy case.

b. ☐ Mandatory abstention applies under 28 U.S.C. § 1334(c)(2), and Movant agrees that the stay will remain in effect as to enforcement of any resulting judgment against the Debtor or the Debtor's bankruptcy estate, except that Movant will retain the right to file a proof of claim under 11 U.S.C. § 501 and/or an adversary complaint under 11 U.S.C. § 523 or § 727 in this bankruptcy case.

c. ☐ Movant seeks recovery only from applicable insurance, if any, and waives any deficiency or other claim against the Debtor or property of the Debtor's bankruptcy estate. The insurance carrier and policy number are (*specify*):

d. ☒ The Nonbankruptcy Action can be tried more expeditiously in the nonbankruptcy forum.

(1) ☐ It is currently set for trial on (*date*) _____.

(2) ☐ It is in advanced stages of discovery and Movant believes that it will be set for trial by (*date*) _____. The basis for this belief is (*specify*):

(3) ☐ The Nonbankruptcy Action involves non-debtor parties and a single trial in the nonbankruptcy forum is the most efficient use of judicial resources.

e. ☐ The bankruptcy case was filed in bad faith specifically to delay or interfere with the prosecution of the Nonbankruptcy Action.

(1) ☐ Movant is the only creditor, or one of very few creditors, listed or scheduled in the Debtor's case commencement documents.

(2) ☐ The timing of the filing of the bankruptcy petition indicates it was intended to delay or interfere with the Nonbankruptcy Action based upon the following facts (*specify*):

(3) ☐ Multiple bankruptcy cases affecting the Property include:

(A) Case name:
Case number: Chapter:
Date filed: Date discharged: Date dismissed:
Relief from stay regarding this Nonbankruptcy Action ☐ was ☐ was not granted.

(B) Case name:
Case number: Chapter:
Date filed: Date discharged: Date dismissed:
Relief from stay regarding this Nonbankruptcy Action ☐ was ☐ was not granted.

(C) Case name:
Case number: Chapter:
Date filed: Date discharged: Date dismissed:
Relief from stay regarding this Nonbankruptcy Action ☐ was ☐ was not granted.

☐ See attached continuation page for information about other bankruptcy cases affecting the Nonbankruptcy Action.

☐ See attached continuation page for additional facts establishing that this case was filed in bad faith.

f. ☒ See attached continuation page for other facts justifying relief from stay.

6. ☐ Actions taken in the Nonbankruptcy Action after the bankruptcy petition was filed are specified in the attached supplemental declaration(s).

a. ☐ These actions were taken before Movant knew the bankruptcy petition had been filed, and Movant would have been entitled to relief from stay to proceed with these actions.

b. ☐ Movant knew the bankruptcy case had been filed, but Movant previously obtained relief from stay to proceed with the Nonbankruptcy Action enforcement actions in prior bankruptcy cases affecting the Property as set forth in Exhibit ____

c. ☐ For other facts justifying annulment, see attached continuation page.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

10/29/18 STUART J. WEISSMAN
Date *Printed name* *Signature*

VERITY HEALTH SERVICES OF CALIFORNIA, INC., Debtor
Case No. 2:18-bk-20151-ER

Attachments to:
DECLARATION OF STUART J. WEISSMAN
IN SUPPORT OF
NOTICE OF MOTION AND MOTION FOR RELIEF FROM THE AUTOMATIC STAY
(ACTION IN NONBANKRUPTCY FORUM)

Attachment 5.g. – Other defendants in the Nonbankruptcy Action are:

St. Francis Medical Center Gas, Inc., a medical corporation;
Hanh Nguyen-Clark, M.D.;
Landmark Anesthesia Medical Group, a medical corporation;
Sabri Malek, M.D.
Interventional Anesthesia & Pain Management Clinic, Inc., a medical corporation;
Massoud Shahidi, M.D.;
Gwen M Allen, M.D.;
Gwen M. Allen, M. D., Inc. a medical corporation; d/b/a/ Gardena Women's Center, Inc.;
Wilburn Durousseau, M.D.;
Pediatric and Family Medical Center, Inc., a medical corporation, d/b/a/ Eisner Pediatric and Family Medical Center; and
DOES 1 through 200, inclusive

Attachment 6.f. – Continuation page for other facts justifying relief from stay:

Ms. Josefina Robles is a 25-year-old woman who suffered an anoxic brain injury due to lack of oxygen during the delivery of her son at St. Francis Medical Center. As a result of a significant lack of oxygen, Ms. Robles has sustained devastating and catastrophic injuries. Ms. Robles has been diagnosed with quadriparesis with ataxia and spasticity with extreme weakness and only a minimal ability to move her extremities, and not in any meaningful way. Ms. Robles has bilateral deformities with claw toes. Ms. Robles also suffers from incontinence. Ms. Robles has diminished communication skills and extensive cognitive impairment affecting her memory, speech, motor control, and coordination which are essential for independent activities of daily living.

As a result of her catastrophic injuries, Ms. Robles required and continues to require further surgical procedures including tendon lengthening surgery. Additionally, she undergoes speech, physical, and occupational therapy. Ms. Robles also requires and will likely continue to require full attendant care for the rest of her life. In addition, Ms. Robles' family has had to create home modifications and modalities to assist with movement and other activities of daily living. It is likely that further home modalities and other medical, therapeutic, and assistive equipment will be required.

It is likely that these physical, mental, and cognitive impairments are permanent in nature and will continue for the rest of her life. Furthermore, Ms. Robles' physical, mental, and cognitive impairments have affected and will continue to affect her ability to conduct activities of daily living for the rest of her life.

In addition, it is likely that Ms. Robles will be unable to obtain gainful employment in the future.

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Attorneys for Plaintiff

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

JOSEFINA ROBLES, by and through her conservator, SERGIO ROBLES,

Plaintiff,

vs.

ST. FRANCIS MEDICAL CENTER, a medical corporation; ST. FRANCIS MEDICAL CENTER GAS, INC., a medical corporation; HANH NGUYEN-CLARK, M.D.; LANDMARK ANESTHESIA MEDICAL GROUP, a medical corporation; SABRI MALEK, M.D.; INTERVENTIONAL ANESTHESIA & PAIN MANAGEMENT CLINIC, INC., a medical corporation; MASSOUD SHAHIDI, M.D.; GWEN M. ALLEN, M.D.; GWEN M. ALLEN, M.D., INC., a medical corporation, d/b/a GARDENA WOMEN'S CENTER, INC.; WILBURN DUROUSSEAU, M.D.; PEDIATRIC AND FAMILY MEDICAL CENTER, INC., a medical corporation, d/b/a EISNER PEDIATRIC AND FAMILY MEDICAL CENTER; and DOES 1 through 200, inclusive,

Defendants.

Case No.: BC697012

Assigned for All purposes to:
Hon. Judge Dennis J. Landin
Dept. 4

FIRST AMENDED COMPLAINT FOR DAMAGES

1. Medical Malpractice

2. Negligent Concealment / Negligent Misrepresentation

3. Negligent Infliction of Emotional Distress

4. Fraudulent Concealment

5. Consumer Legal Remedies Act

DEMAND FOR JURY TRIAL

/ / /

/ / /

The Plaintiff, JOSEFINA ROBLES, by and through her conservator, SERGIO ROBLES, hereby sues the Defendants, ST. FRANCIS MEDICAL CENTER, a medical corporation; ST. FRANCIS MEDICAL CENTER GAS, INC., a medical corporation; HANH NGUYEN-CLARK, M.D.; LANDMARK ANESTHESIA MEDICAL GROUP, a medical corporation; SABRI MALEK, M.D.; INTERVENTIONAL ANESTHESIA & PAIN MANAGEMENT CLINIC, INC., a medical corporation; MASSOUD SHAHIDI, M.D.; GWEN M. ALLEN, M.D.; GWEN M. ALLEN, M.D., INC., a medical corporation, d/b/a GARDENA WOMEN'S CENTER, INC.; WILBURN DUROUSSEAU, M.D.; PEDIATRIC AND FAMILY MEDICAL CENTER, INC., a medical corporation, d/b/a EISNER PEDIATRIC AND FAMILY MEDICAL CENTER; and DOES 1 through 200, inclusive:

I. PARTIES

1. Plaintiff JOSEFINA ROBLES ("Ms. Robles") appears in this action by and through her conservator, SERGIO ROBLES, who is the father of Ms. Robles. Ms. Robles and SERGIO ROBLES were, and are at all times relevant to this complaint, residents of Los Angeles County, California.

2. Defendant ST. FRANCIS MEDICAL CENTER ("Defendant Hospital") is a medical corporation operating a healthcare facility in Los Angeles County, California.

3. Defendant ST. FRANCIS MEDICAL CENTER GAS, INC. ("Defendant SFMC Gas") is a medical, for-profit corporation operating in Los Angeles County, California.

4. Defendant HANH NGUYEN-CLARK, M.D. ("Defendant Dr. Nguyen-Clark") is a physician, practicing the specialty of anesthesiology in Los Angeles County, California, and was, at all times pertinent hereto, one of the physicians responsible for the care and treatment of Ms. Robles on or around March of 2017. Also, at all times pertinent hereto, Defendant Dr. Nguyen-Clark was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital, Defendant SFMC Gas and Defendant Landmark Anesthesia Medical Group.

5. Defendant LANDMARK ANESTHESIA MEDICAL GROUP ("Defendant Landmark Anesthesia") is a medical, for-profit corporation operating in Los Angeles County, California.

6. Defendant SABRI MALEK, M.D. ("Defendant Dr. Malek") is a physician, practicing the specialty of anesthesiology in Los Angeles County, California, and was, at all times pertinent hereto, one

of the physicians responsible for the care and treatment of Ms. Robles on or around March of 2017. Also, at all times pertinent hereto, Defendant Dr. Malek was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital, Defendant SFMC Gas and Defendant Interventional Anesthesia & Pain Management Clinic, Inc.

7. Defendant INTERVENTIONAL ANESTHESIA & PAIN MANAGEMENT CLINIC, INC. ("Defendant Interventional Anesthesia") is a for-profit corporation and medical healthcare facility operating in Los Angeles County, California.

8. Defendant MASSOUD SHAHIDI, M.D. ("Defendant Dr. Shahidi") is a physician, practicing the specialty of anesthesiology in Los Angeles County, California, and was, at all times pertinent hereto, one of the physicians responsible for the care and treatment of Ms. Robles on or around March of 2017. Also, at all times pertinent hereto, Defendant Dr. Shahidi was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital and Defendant SFMC Gas.

9. Defendant GWEN M. ALLEN, M.D. ("Defendant Dr. Allen") is a physician, practicing the specialty of obstetrics and gynecology in Los Angeles County, California, and was, at all times pertinent hereto, one of the physicians responsible for the care and treatment of Ms. Robles during her pregnancy on or around July of 2016 through March of 2017. Also, at all times pertinent hereto, Defendant Dr. Allen was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital and Defendant Gardena Women's Center.

10. Defendant GWEN ALLEN, M.D., INC. d/b/a GARDENA WOMEN'S CENTER, INC. ("Defendant Gardena Women's Center") is a for-profit corporation and medical healthcare facility operating in Los Angeles County, California.

11. Defendant WILBURN DUROUSSEAU, M.D. ("Defendant Dr. Durousseau") is a physician, practicing the specialty of obstetrics and gynecology in Los Angeles County, California, and was, at all times pertinent hereto, one of the physicians responsible for the care and treatment of Ms. Robles on or around March of 2017. Also, at all times pertinent hereto, Defendant Dr. Durousseau was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital and Defendant Eisner Pediatric.

12. Defendant PEDIATRIC AND FAMILY MEDICAL CENTER, INC. d/b/a EISNER PEDIATRIC AND FAMILY MEDICAL CENTER ("Defendant Eisner Pediatric") is a for-profit medical corporation and medical healthcare facility operating in Los Angeles County, California.

13. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 1 through 100, inclusive, are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this Complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 1 through 25 are unknown corporate entities that own and operate healthcare facilities. DOES 26 through 50, are physicians, obstetricians, surgeons and/or anesthesiologist involved in the care of Plaintiff and DOES 51 through 100 are other licensed or non-licensed persons involved in the care and treatment of Plaintiff. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 101 through 200, inclusive, are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this Complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 101 through 125 are unknown corporate entities. DOES 126 through 150, are physicians employed by the Defendant Hospital or other corporate entities and DOES 151 through 200 are other licensed or non-licensed persons.

II. NOTICE OF INTENT TO SUE HEALTHCARE PROVIDERS

14. Between or about June 16, 2017 and November 16, 2017, Plaintiff served all named Defendants herein with a notice of intent to sue pursuant to California Code of Civil Procedure § 364.

III. FACTUAL ALLEGATIONS RELEVANT TO FIRST CAUSE OF ACTION — MEDICAL MALPRACTICE

15. In 2016, Josephina Robles was pregnant with her first child, and Defendant Dr. Allen was her treating obstetrician.

16. Ms. Robles was due to deliver her baby by the end of February 2017, but she exceeded the 40-week term of her pregnancy.

17. On March 11, 2017 at 1:00 p.m., Defendant Dr. Allen admitted Ms. Robles to the Defendant Hospital for post-due date induction and fetal macrosomia. Fetal macrosomia means that the baby is significantly larger in size than average, weighing over 8 pounds, 13 ounces (or 4,000 grams).

18. At the time of her admission, Ms. Robles' pregnancy term was 40 weeks and 6 days.

19. On March 12, 2017 at 1:00 a.m., while being induced for delivery at the Defendant Hospital, Ms. Robles complained that she was in pain. Defendant Dr. Allen noted that Ms. Robles was in "poor pain control" and administered intravenous pain medication Stadol. Dr. Allen also noted that she would order the epidural anesthesia once Ms. Robles was 3 to 4 centimeters dilated.

20. On March 12, 2017 at 3:46 a.m., Defendant Dr. Nguyen-Clark started Ms. Robles on spinal epidural anesthesia via a catheter. When inserted properly, the catheter, through which the anesthetic medication is administered, is inserted into the epidural space of the spinal cord canal.

21. Defendant Dr. Nguyen-Clark negligently placed the catheter in the wrong location (i.e., outside the epidural spinal cord canal), resulting in the anesthesia medication going directly into the patient Josefina Robles' vascular system as opposed to being contained in Ms. Robles' epidural space. Alternatively, an overdose of anesthesia was administered causing a negative reaction in the patient, Josefina Robles. The Defendant Hospital has withheld certain medical records from the Plaintiff, lost certain medical records, or certain medical records that should exist do not exist. The absence of these records has necessitated Plaintiff pleading in the alternative.

22. The Defendants, specifically Defendants Dr. Nguyen-Clark, Dr. Allen and the Hospital's nursing staff, should have known that Defendant Dr. Nguyen-Clark placed the epidural catheter in the wrong location or that the administration of the anesthesia was malfunctioning in some manner because Ms. Robles complained of severe, persistent labor pain on at least five separate occasions *after* the epidural had been given.

23. Ms. Robles continued to feel labor pain because the anesthesia medication was not working; the anesthesia medication was not working because the epidural catheter was placed in the wrong location or because the administration of the anesthesia was having a paradoxical reaction in some other manner.

24. At 2:49 p.m., 11 hours or more after the administration of the epidural anesthesia, the nurses and doctors again noted the patient was still feeling labor pains. The charge nurse and Defendant Dr. Allen called Defendant Dr. Malek to examine Ms. Robles. Dr. Malek did so but chose not to examine the condition of the catheter and/or misapprehended the fact that the catheter had been inserted improperly by Defendant Dr. Nguyen-Clark. Dr. Malek left the epidural catheter in the wrong position and continued to improperly monitor the administration of Ms. Robles' anesthesia. Dr. Allen likewise chose not to examine the condition of the catheter and/or misapprehended the fact that the catheter was inserted improperly, made no adjustment to the catheter, and improperly monitored the administration of the anesthesia in her patient, Ms. Robles. At this point, Ms. Robles was already 9 centimeters dilated.

25. Sometime later, Ms. Robles again complained of increased labor pains. The charge nurse called Defendant Dr. Malek and he examined Ms. Robles again. He incorrectly noted in the medical record that the epidural was working properly. Defendant Dr. Malek continued administering the epidural anesthesia which continued to flow into Ms. Robles' blood stream because the epidural catheter was not in the correct location. Alternatively, even if the catheter was positioned properly, Defendants Dr. Malek and Dr. Allen chose not to perform a proper assessment of the anesthesia dosage being applied to their patient and chose to ignore the fact that she was being overdosed and/or that she was having a paradoxical reaction to the anesthesia.

26. At 5:40 p.m., at least 13 hours after the epidural catheter had been incorrectly placed, the nurses and doctors again received Ms. Robles' complaints of excruciating labor pains. Now the epidural anesthesia bags were empty, meaning all of the anesthetic was drained into Ms. Robles, yet her pain persisted. The charge nurse called Defendant Dr. Malek. Dr. Malek examined Ms. Robles again, replaced the empty epidural bags and gave her a new infusion of anesthesia. Again, Dr. Malek chose not to examine the condition of the catheter and/or misapprehended the fact that the catheter had been inserted

improperly by Defendant Dr. Nguyen-Clark; Dr. Malek also left the epidural catheter in the wrong position; and Dr. Malek continued to improperly monitor the administration of Ms. Robles' anesthesia.

27. At 7:19 p.m., Ms. Robles complained to the nurse again that she was having severe labor pains. At this time, her pain level was 8 out of 10. The epidural anesthesia was clearly not working, yet the Defendants continued administering the epidural anesthesia without adjusting or understanding the situation.

28. By 8:00 p.m., Ms. Robles was 9 to 10 centimeters dilated, but the baby was not descending. The nurses noted their patient's persistent pain level of 5 out of 10 despite the continued administration of epidural anesthesia.

29. At approximately 9:00 p.m., after being in labor since 4:00 a.m. and pushing for about 2 hours, Defendant Dr. Allen finally decided it was time for a C-section delivery. Ms. Robles' epidural catheter was removed in preparation for the surgery.

30. At 9:30 p.m., Defendant Dr. Allen cleared Ms. Robles for a C-section delivery.

31. At 9:40 p.m., Ms. Robles was taken to the operating room.

32. Between 9:45 p.m. and 10:02 p.m., in preparation for the C-section delivery, Defendant Dr. Malek removed the epidural anesthesia. According to Dr. Nalin Mallik, a critical care doctor, the epidural anesthesia was removed "[g]iven poor pain control and questioning whether functioning correctly. Decision made to give spinal anesthesia for C-section." In place of the epidural, Defendant Dr. Malek administered spinal anesthesia (Bupivacaine and Morphine) in Ms. Robles' spinal cord at L 4-5. Immediately after giving the patient Ms. Robles the spinal anesthetic, she became unresponsive requiring airway assistance.

33. At 10:11 p.m., only nine minutes after receiving the spinal anesthesia, Ms. Robles went into cardiopulmonary arrest and a code blue was called. According to the records, Ms. Robles "coded twice in the operating room."

34. CPR was in progress when a code blue was called over the Hospital's public-address system.

35. Defendant Dr. Shahidi heard the code blue and came to the operating room to assist Defendant Dr. Malek. Despite having called a code blue, no code blue team was available or responded to the call.

36. Dr. Malek and/or Dr. Shahidi did not secure the patient's airway and malintubated her by placing the breathing tube down into the esophagus and not the trachea. Defendant Dr. Malek did not properly secure his patient Ms. Robles' airway at a time when her brain was insufficiently oxygenated due to her cardiac arrest due to her anesthesia overdose.

37. Defendants Dr. Shahidi and Dr. Malek continued giving Ms. Robles spinal anesthesia.

38. At 10:12 p.m., Defendants Dr. Allen and Dr. Durousseau made the C-section incision.

39. Defendants Dr. Shahidi and Dr. Malek continued giving Ms. Robles spinal anesthesia.

40. On March 12, 2017, at 10:13 p.m., Ms. Robles' son, Humberto Garcia, was born.

41. Defendants Dr. Shahidi and Dr. Malek continued giving Ms. Robles spinal anesthesia.

42. At 11:00 p.m., Ms. Robles was moved from the operating room to the intensive care unit.

43. Due to the anesthesia overdose, the improperly monitored reaction to the anesthetic, and the improper resuscitation of the patient's cardiac arrest response to the anesthesia, Ms. Robles suffered a catastrophic brain injury, leaving her permanently and significantly damaged for the rest of her life.

44. A post-operative note by Nurse Marie G. Tanglao explained that the epidural anesthesia did not work. Similarly, Dr. Nalin Mallik, a critical care doctor who cared for Ms. Robles in the ICU, noted that "patient's hospital course [was] complicated by poor pain control despite epidural requiring multiple boluses of IV lidocaine into epidural throughout the day." The epidural was removed "[g]iven poor pain control and questioning whether [epidural] was functioning properly." Dr. Mallik documented in the medical record that Ms. Robles' cardiac arrest was "likely . . . from high spinal anesthesia. Contribution may also be from malfunctioning epidural that was given multiple boluses of lidocaine throughout the day."

45. Ms. Robles' catastrophic brain injury was completely preventable had the Defendants followed the applicable patient safety rules for the administration of epidural anesthesia, response to medication overdose, response to anesthetic reactions, airway protection, and the delivery of babies.

IV. FIRST CAUSE OF ACTION — MEDICAL MALPRACTICE

Plaintiff JOSEPHINA ROBLES, by and through her conservator, SERGIO ROBLES,

vs. All Defendants and DOES 1 through 100, inclusive.

COUNT 1

Medical Malpractice of Defendant Hospital and DOES 1 through 25

46. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

47. At all times material, Defendant Hospital and DOES 1 through 25, had a duty to provide, through its employees, actual agents, ostensible agents, servants, representatives and/or others for whom it was legally responsible, including, but not limited to, residents, physicians, nurses, physician assistants, technicians and ancillary staff, proper medical care and treatment in accordance with the prevailing standard of care to Ms. Robles, including, but not limited to, a safe facility, proper policies and procedures, supplies, and qualified personnel reasonably necessary for the treatment of their patients, including Ms. Robles.

48. Defendant Hospital and its employees, actual agents, ostensible agents, servants, representatives and/or others for whom it was legally responsible, including, but not limited to, residents, physicians, nurses, physician assistants, technicians and ancillary staff, and DOES 1 through 25 breached that duty in at least the following ways:

a. improperly administering the epidural, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

b. improperly inserting the epidural needle, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

c. choosing to administer an overdose level of anesthesia medication to Ms. Robles;

d. choosing to not appreciate the complications that could arise from administering an overdose level of anesthesia medication;

e. choosing to give an overdose of anesthesia medication into the spinal cavity;

f. failing to properly manage anesthesia medication in a surgical patient;

g. failing to adequately monitor Ms. Robles while administering overdose levels of anesthesia medication during labor;

h. choosing to ignore warning signs and symptoms that the epidural catheter had been incorrectly placed;

i. choosing not to appreciate warning signs and symptoms that the epidural catheter had been incorrectly placed;

j. not appreciating warning signs and symptoms that the epidural catheter had been incorrectly placed;

k. choosing not to recognize signs, symptoms, and complications from administering anesthesia medications as they were developing;

l. not recognizing complications from administering anesthesia medications as they were developing;

m. not appreciating or recognizing that the overdose level of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

n. choosing not to perform a C-section delivery earlier;

o. choosing not to timely, safely and appropriately communicate the prolonged anesthesia medication levels to the surgical team;

p. malintubating Ms. Robles once the decision was made to perform a C-section;

q. malintubating Ms. Robles before and/or after she coded;

r. choosing not to have a code blue team available to respond to a code blue call;

s. choosing not to provide safe care and treatment upon the administration of anesthesia medication over a prolonged period of time, including throughout the labor process;

t. choosing not to appropriately communicate and collaborate amongst the treating healthcare providers, including but not limited to physicians, consultants, nurses, physician assistants, and others, to determine why Ms. Robles' epidural anesthesia was not working properly;

u. choosing not to timely consult with additional, appropriate physicians consultants to assist with the care and treatment of Ms. Robles once the epidural anesthesia was not working properly;

v. choosing not to timely prompt additional physician evaluation, care and treatment;

w. choosing not to advocate for timely and appropriate care and treatment;

x. choosing not to invoke the chain of command for timely and appropriate care and treatment;

y. not having proper policies and procedures for invoking the chain of command when clinicians are not responding properly to signs and symptoms of improper anesthesia administration and/or anesthesia overdose;

z. not properly training the nursing, medical and ancillary staff in the policies and procedures for invoking the chain of command when clinicians are not responding properly to signs and symptoms of improper anesthesia administration and/or anesthesia overdose;

aa. choosing not to have an appropriate and safe system for the care of an individual at risk for saturation of overdose levels of anesthesia medication from the incorrect placement of an epidural catheter;

bb. choosing not to adopt or follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the administration of overdose levels of anesthesia medication;

cc. choosing not to adopt or follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the placement of epidurals and intubation;

dd. choosing not to adequately and properly train nursing and medical staff regarding the placement of epidurals and recognition of the signs and symptoms that an epidural catheter has been incorrectly placed;

ee. choosing not to adequately and properly train nursing and medical staff regarding the administration of anesthesia medication;

ff. choosing not to adequately and properly train nursing and medical staff regarding intubation;

gg. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients receiving epidurals and intubation;

hh. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients so that they do not receive overdose levels of anesthesia medication; and

ii. choosing not to adopt or follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to C-section deliveries.

49. As a direct and proximate result of Defendant Hospital and DOES 1 through 25's negligence and breaches of duty, Ms. Robles suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 2

Corporate Negligence of Defendant Hospital and DOES 1 through 25

50. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

51. At all times material, Defendant Hospital and DOES 1 through 25, had a duty to ensure the competence of its medical staff, including each of the physicians and other healthcare providers who provided medical care to Ms. Robles, through the medical staff's careful selection, screening and continuing periodic reviews.

52. At all times material, Defendant Hospital and DOES 1 through 25, had a duty to be accountable for the quality of medical care rendered by its medical staff, including each of the physicians and other healthcare providers who provided medical care to Ms. Robles, and for the competency of the medical staff by implementing policies and procedures for the selection, reappointment and ongoing, continuing evaluation of its medical staff in accordance with applicable standards, including the investigation of competency for the initial appointment and for periodic review of competency before reappointment and continued retention. The Defendant Hospital had a duty to establish controls and policies and procedures designed to ensure the achievement and maintenance of high standards of professional ethical practices including the requirement that, periodically, all physicians are required to demonstrate their ability to perform medical procedures competently and to the satisfaction of an appropriate committee or staff.

53. The Defendant Hospital and DOES 1 through 25 breached these duties, for example, by failing to ensure the initial and continued competency of Dr. Nguyen-Clark through careful periodic screenings and periodic reviews, which would have revealed that Dr. Nguyen-Clark was unfit to provide anesthesiology services to patients and had been reported for patient safety violations prior to treating Ms. Robles. This failure of the Defendant Hospital and DOES 1 through 25, created an unreasonable risk of harm to the Hospital's patients, specifically Ms. Robles. The Defendant Hospital failed to adequately, properly and non-negligently investigate, including, but not limited to, through its policies and procedures, the competency of Dr. Nguyen-Clark: 1) at the time of her initial appointment to the medical staff; 2) again at subsequent times when she was reappointed; and 3) at other times when her competency should have been questioned, which created an unreasonable risk of harm to the Hospital's patients, specifically Ms. Robles. Had the Defendant Hospital and DOES 1 through 25 investigated the competency of Dr. Nguyen-Clark at these times, that investigation would have revealed patient safety violations, including reported patient safety violations by other colleagues. The Defendant Hospital and DOES 1 through 25, failed to ensure that Dr. Nguyen-Clark demonstrated an ability to perform her medical specialty competently, which created an unreasonable risk of harm to the Hospital's patients, specifically Ms. Robles.

54. As a direct and proximate result of Defendant Hospital and DOES 1 through 25's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 3

Vicarious Liability of Defendant ST. FRANCIS MEDICAL CENTER GAS, INC.

55. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

56. Defendant Dr. Nguyen-Clark was at all times material the actual agent, ostensible agent, servant, owner, director, president and/or employee of Defendant SFMC Gas and was acting in such capacity.

57. Defendant SFMC Gas, through its acts and/or omissions, represented that Defendant Dr. Nguyen-Clark would act for it.

58. Plaintiff reasonably believed that Defendant Dr. Nguyen-Clark was acting on behalf of Defendant SFMC Gas.

59. Accordingly, pursuant to the principles of vicarious liability, Defendant SFMC Gas is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Nguyen-Clark as described in Count 4 and the damages described below in paragraph 121.

60. Defendant Dr. Malek was at all times material the actual agent, ostensible agent, servant, owner, director, president and/or employee of Defendant SFMC Gas and was acting in such capacity.

61. Defendant SFMC Gas, through its acts and/or omissions, represented that Defendant Dr. Malek would act for it.

62. Plaintiff reasonably believed that Defendant Dr. Malek was acting on behalf of Defendant SFMC Gas.

63. Accordingly, pursuant to the principles of vicarious liability, Defendant SFMC Gas is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Malek as described in Count 6 and the damages described below in paragraph 121.

64. Defendant Dr. Shahidi was at all times material the actual agent, ostensible agent, servant, owner, director, president and/or employee of Defendant SFMC Gas and was acting in such capacity.

65. Defendant SFMC Gas, through its acts and/or omissions, represented that Defendant Dr. Shahidi would act for it.

66. Plaintiff reasonably believed that Defendant Dr. Shahidi was acting on behalf of Defendant SFMC Gas.

67. Accordingly, pursuant to the principles of vicarious liability, Defendant SFMC Gas is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Shahidi as described in Count 8 and as set forth in the Prayer for Damages described in paragraph 121.

COUNT 4

Medical Malpractice of Defendant Dr. Nguyen-Clark and DOES 26 through 50

68. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

69. At all times material, Defendant Dr. Nguyen-Clark and DOES 26 through 50 had a duty to use such skill, knowledge, and care in diagnosing and treating JOSEPHINA ROBLES that other reasonably careful anesthesiologists would use in the same or similar circumstances.

70. At all times material, Defendant Dr. Nguyen-Clark and DOES 26 through 50 fell below the standard of care and breached their duty to provide non-negligent care to JOSEPHINA ROBLES in at least the following ways:

a. improperly administering the epidural, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

b. improperly inserting the epidural needle, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

c. choosing to administer overdose levels of anesthesia medication to Ms. Robles;

d. choosing to not appreciate the complications that could arise from administering overdose levels of anesthesia medication;

e. failing to adequately monitor Ms. Robles while administering overdose levels of anesthesia medication during labor;

f. choosing to ignore warning signs and symptoms that the epidural catheter had been incorrectly placed;

g. choosing not to appreciate warning signs and symptoms that the epidural catheter had been incorrectly placed;

h. not recognizing complications from administering anesthesia medications as they were developing;

i. not appreciating or recognizing that the overdose levels of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

j. choosing not to provide safe care and treatment upon the administration of anesthesia medication over a prolonged period of time, including throughout the labor process;

k. choosing not to appropriately communicate and collaborate amongst the treating healthcare providers, including but not limited to physicians, consultants, nurses, physician assistants, and others, to determine why Ms. Robles' epidural anesthesia was not working properly;

l. choosing not to timely consult with additional, appropriate physicians consultants to assist with the care and treatment of Josefina Robles once the epidural anesthesia was not working properly;

m. choosing not to timely prompt additional physician evaluation, care and treatment;

n. choosing not to advocate for timely and appropriate care and treatment;

o. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the placement of epidurals and recognition of the signs and symptoms that an epidural catheter has been incorrectly placed;

p. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients receiving epidurals; and

q. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients so that they do not receive overdose levels of anesthesia medication.

71. The actions and omissions of Defendant Dr. Nguyen-Clark and DOES 26 through 50 described above were negligent and below the applicable standards of care for physicians practicing anesthesiology.

72. As a direct and proximate result of Defendant Dr. Nguyen-Clark and DOES 26 through 50's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 5

Vicarious Liability of Defendant LANDMARK ANESTHESIA MEDICAL GROUP

73. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

74. Defendant Dr. Nguyen-Clark was at all times material the actual agent, ostensible agent, servant, owner, director, president and/or employee of Defendant Landmark Anesthesia and was acting in such capacity.

75. Defendant Landmark Anesthesia, through its acts and/or omissions, represented that Defendant Dr. Nguyen-Clark would act for it.

76. Plaintiff reasonably believed that Defendant Dr. Nguyen-Clark was acting on behalf of Defendant Landmark Anesthesia.

77. Accordingly, pursuant to the principles of vicarious liability, Defendant Landmark Anesthesia is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Nguyen-Clark as described in Count 4 and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 6

Medical Malpractice of Defendant Dr. Malek and DOES 26 through 50

78. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

79. At all times material, Defendant Dr. Malek and DOES 26 through 50 had a duty to use such skill, knowledge, and care in diagnosing and treating JOSEPHINA ROBLES that other reasonably careful anesthesiologists would use in the same or similar circumstances.

80. At all times material, Defendant Dr. Malek and DOES 26 through 50 fell below the standard of care and breached their duty to provide non-negligent care to JOSEPHINA ROBLES in at least the following ways:

a. improperly administering the epidural, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

b. improperly inserting the epidural needle, such that the anesthesia medication went directly into Ms. Robles' blood stream instead of being contained in the epidural spinal cavity;

c. choosing to administer overdose levels of anesthesia medication to Ms. Robles;

d. choosing to not appreciate the complications that could arise from administering overdose levels of anesthesia medication;

e. choosing to give an overdose of anesthesia medication into the spinal cavity;

f. failing to properly manage anesthesia medication in a surgical patient;

g. failing to adequately monitor Ms. Robles while administering overdose levels of anesthesia medication during labor;

h. choosing to ignore warning signs and symptoms that the epidural catheter had been incorrectly placed;

i. choosing not to appreciate warning signs and symptoms that the epidural catheter had been incorrectly placed;

j. choosing not to recognize complications from administering anesthesia medications as they were developing;

k. not recognizing complications from administering anesthesia medications as they were developing;

l. not appreciating or recognizing that overdose levels of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

m. choosing not to timely, safely and appropriately communicate the prolonged anesthesia medication levels to the surgical team;

n. malintubating Ms. Robles before or after she coded;

o. malintubating Ms. Robles once the decision was made to perform a C-Section delivery;

p. choosing not to provide safe care and treatment upon the administration of anesthesia medication over a prolonged period of time, including throughout the labor process;

q. choosing not to appropriately communicate and collaborate amongst the treating healthcare providers, including but not limited to physicians, consultants, nurses, physician assistants, and others, to determine why Ms. Robles' epidural anesthesia was not working properly;

r. choosing not to timely consult with additional, appropriate physicians consultants to assist with the care and treatment of Ms. Robles once the epidural anesthesia was not working properly;

s. choosing not to timely prompt additional physician evaluation, care and treatment;

t. choosing not to advocate for timely and appropriate care and treatment;

u. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the administration of overdose levels of anesthesia medication;

v. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the placement of epidurals;

w. choosing not to adequately and properly train nursing and medical staff regarding the placement of epidurals and recognition of the signs and symptoms that an epidural catheter has been incorrectly placed;

x. choosing not to adequately and properly train nursing and medical staff regarding the administration of anesthesia medication;

y. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients receiving epidurals; and

z. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients so that they do not receive overdose levels of anesthesia medication.

81. The actions and omissions of Defendant Dr. Malek and DOES 26 through 50 described above were negligent and below the applicable standards of care for physicians practicing anesthesiology.

82. As a direct and proximate result of Defendant Dr. Malek and DOES 26 through 50's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 7

Vicarious Liability of Defendant INTERVENTIONAL ANESTHESIA & PAIN MANAGEMENT CLINIC, INC.

83. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

84. Defendant Dr. Malek was at all times material the actual agent, ostensible agent, servant, owner, president, officer, director and/or employee of Defendant Interventional Anesthesia and was acting in such capacity.

85. Defendant Interventional Anesthesia, through its acts and/or omissions, represented that Defendant Dr. Malek would act for it.

86. Plaintiff reasonably believed that Defendant Dr. Malek was acting on behalf of Defendant Interventional Anesthesia.

87. Accordingly, pursuant to the principles of vicarious liability, Defendant Interventional Anesthesia is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Malek as described in Count 6 and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 8

Medical Malpractice of Defendant Dr. Shahidi and DOES 26 through 50

88. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

89. At all times material, Defendant Dr. Shahidi and DOES 26 through 50 had a duty to use such skill, knowledge, and care in diagnosing and treating JOSEPHINA ROBLES that other reasonably careful anesthesiologists would use in the same or similar circumstances.

90. At all times material, Defendant Dr. Shahidi and DOES 26 through 50 fell below the standard of care and breached their duty to provide non-negligent care to JOSEPHINA ROBLES in at least the following ways:

a. choosing to administer overdose levels of anesthesia medication to Ms. Robles;

b. choosing to not appreciate the complications that could arise from administering overdose levels of anesthesia medication;

c. choosing to overdose of anesthesia medication;

d. failing to properly manage anesthesia medication in a surgical patient;

e. malintubating Ms. Robles before or after she coded;

f. malintubating Ms. Robles once the decision was made to perform a C-Section delivery;

g. failing to adequately monitor Ms. Robles while administering overdose levels of anesthesia medication during surgery;

h. choosing to ignore warning signs and symptoms that Ms. Robles had been overdosed on anesthesia;

i. failing to recognize complications from administering anesthesia medications as they were developing;

j. not recognizing complications from administering anesthesia medications as they were developing;

k. choosing not to appreciate and failing to recognize that the overdose levels of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

l. choosing not to timely, safely and appropriately communicate the prolonged anesthesia medication levels to the surgical team;

m. choosing not to timely prompt additional physician evaluation, care and treatment;

n. choosing not to advocate for timely and appropriate care and treatment;

o. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the administration of overdose levels of anesthesia medication and its recognition; and

p. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients receiving anesthesia.

91. The actions and omissions of Defendant Dr. Shahidi and DOES 26 through 50 described above were negligent and below the applicable standards of care for physicians practicing anesthesiology.

92. As a direct and proximate result of Defendant Dr. Shahidi and DOES 26 through 50's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 9

Medical Malpractice of Defendant Dr. Allen and DOES 26 through 50

93. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

94. At all times material, Defendant Dr. Allen and DOES 26 through 50 had a duty to use such skill, knowledge, and care in diagnosing and treating JOSEPHINA ROBLES that other reasonably careful obstetricians would use in the same or similar circumstances.

95. At all times material, Defendant Dr. Allen and DOES 26 through 50 fell below the standard of care and breached their duty to provide non-negligent care to JOSEPHINA ROBLES in at least the following ways:

a. choosing to ignore warning signs and symptoms that the epidural catheter had been incorrectly placed;

b. not appreciating warning signs and symptoms that the epidural catheter had been incorrectly placed;

c. choosing not to recognize complications from administering anesthesia medications as they were developing;

d. choosing not to recognize complications from administering anesthesia medications as they were developing;

e. not appreciating or recognizing that the overdose levels of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

f. choosing to call for a C-section delivery too late;

g. choosing not to call for a C-section delivery earlier when it became clear that Ms. Robles' epidural anesthesia was not working properly;

h. choosing not to timely, safely and appropriately communicate the prolonged anesthesia medication levels to the rest of the surgical team;

i. choosing not to provide safe care and treatment upon the administration of anesthesia medication over a prolonged period of time, including throughout the labor process;

j. choosing not to appropriately communicate and collaborate amongst the treating healthcare providers, including but not limited to physicians, consultants, nurses, physician assistants, and others, to determine why Ms. Robles' epidural anesthesia was not working properly;

k. choosing not to timely consult with additional, appropriate physicians consultants to assist with the care and treatment of Ms. Robles once the epidural anesthesia was not working properly;

l. choosing not to timely prompt additional physician evaluation, care and treatment;

m. choosing not to advocate for timely and appropriate care and treatment;

n. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the recognition of the signs and symptoms that an epidural catheter has been incorrectly placed;

o. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the correct time to plan for and decide to perform a C-section delivery;

p. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients receiving epidurals;

q. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients who may require a C-section; and

r. choosing not to adequately and properly supervise nursing and medical staff to make sure appropriate care is provided to patients so that they do not receive overdose levels of anesthesia medication.

96. The actions and omissions of Defendant Dr. Allen and DOES 26 through 50 described above were negligent and below the applicable standards of care for physicians practicing obstetrics and gynecology.

97. As a direct and proximate result of Defendant Dr. Allen and DOES 26 through 50's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 10

Vicarious Liability of Defendant GWEN M. ALLEN, M.D., INC.

d/b/a GARDENA WOMEN'S CENTER, INC.

98. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

99. Defendant Dr. Allen was at all times material the actual agent, ostensible agent, servant, owner, director, president and/or employee of Defendant Gardena Women's Center and was acting in such capacity.

100. Defendant Gardena Women's Center, through its acts and/or omissions, represented that Defendant Dr. Allen would act for it.

101. Plaintiff reasonably believed that Defendant Dr. Allen was acting on behalf of Defendant Gardena Women's Center.

102. Accordingly, pursuant to the principles of vicarious liability, Defendant Gardena Women's Center is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Allen as described in Count 9 and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 11

Medical Malpractice of Defendant Dr. Durousseau and DOES 26 through 50

103. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

104. At all times material, Defendant Dr. Durousseau and DOES 26 through 50 had a duty to use such skill, knowledge, and care in diagnosing and treating JOSEPHINA ROBLES that other reasonably careful obstetricians would use in the same or similar circumstances.

105. At all times material, Defendant Dr. Durousseau and DOES 26 through 50 fell below the standard of care and breached their duty to provide non-negligent care to JOSEPHINA ROBLES in at least the following ways:

a. not appreciating or recognizing that the overdose levels of anesthesia medication administered to Ms. Robles over a prolonged period of time could cause serious complications, including a catastrophic brain injury;

b. choosing not to timely, safely and appropriately communicate the prolonged anesthesia medication levels to the rest of the surgical team;

c. choosing not to provide safe care and treatment upon the administration of anesthesia medication over a prolonged period of time, including throughout the surgical process;

d. choosing not to appropriately communicate and collaborate amongst the treating healthcare providers, including but not limited to physicians, consultants, nurses, physician assistants, and others, to determine why Ms. Robles coded;

e. choosing not to timely prompt additional physician evaluation, care and treatment;

f. choosing not to advocate for timely and appropriate care and treatment; and

g. choosing not to follow adequate, reliable, and recognized policies, procedures, protocols, or rules pertaining to the recognition of the signs and symptoms that an epidural catheter has been incorrectly placed.

106. The actions and omissions of Defendant Dr. Durousseau and DOES 26 through 50 described above were negligent and below the applicable standards of care for physicians practicing obstetrics and gynecology.

107. As a direct and proximate result of Defendant Dr. Durousseau and DOES 26 through 50's negligence and breaches of duty, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 12

Vicarious Liability of Defendant EISNER PEDIATRIC & FAMILY MEDICAL CENTER, INC.

108. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

109. Defendant Dr. Durousseau was at all times material the actual agent, ostensible agent, servant and/or employee of Defendant Eisner Pediatric and was acting in such capacity.

110. Defendant Eisner Pediatric, through its acts and/or omissions, represented that Defendant Dr. Durousseau would act for it.

111. Plaintiff reasonably believed that Defendant Dr. Doursseau was acting on behalf of Defendant Eisner Pediatric.

112. Accordingly, pursuant to the principles of vicarious liability, Defendant Eisner Pediatric is legally responsible for the negligence, breaches of duty, and medical malpractice of Defendant Dr. Doursseau as described in Count 11 and the damages as set forth in the Prayer for Damages described in paragraph 121.

COUNT 13

Vicarious Liability of Defendant Hospital for Medical Malpractice and DOES 26 through 100

113. Plaintiff realleges and reaffirms all the allegations set forth in paragraphs 1 through 45 and further alleges as follows.

114. Defendant Hospital's physicians, nurses, physicians' assistants, technicians, and ancillary staff, including, but not limited to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi, Dr. Allen, Dr. Doursseau and DOES 26 through 100 were the ostensible agents, actual agents, servants, and/or

employees of Defendant Hospital and were acting in such capacity in their care and treatment of Ms. Robles.

115. Defendant Hospital, through its actions and/or omissions, represented to Ms. Robles that its physicians, nurses, physician's assistants, technicians, and ancillary staff, including, but not limited to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi Dr. Allen, Dr. Doursseau, and DOES 26 through 100, would act for it. Defendant Hospital, through its actions, represented to Ms. Robles that its physicians, nurses, physician's assistants, technicians, and ancillary staff, including, but not limited to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi Dr. Allen, Dr. Doursseau were the ostensible agents, actual agents, servants, and/or employees of the Defendant Hospital and were acting in such capacity when they treated her at the Hospital. The Defendant Hospital also held itself out to the public as being able to provide labor and delivery medical services by representing to Ms. Robles and the public that: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby."

116. Ms. Robles looked to the Defendant Hospital to provide her with labor and delivery medical services, including obstetrical nursing care and obstetrical and anesthesia medical services. Based on the Defendant Hospital's representations and the Defendant Hospital holding itself out as a provider of labor, delivery and anesthesia services, Ms. Robles sought medical treatment at the Defendant Hospital. While at the Defendant Hospital, Ms. Robles reasonably believed that the physicians, nurses, physicians' assistants, technicians, and ancillary staff at Defendant Hospital, including, but not limited to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi, Dr. Allen, Dr. Doursseau, and DOES 26 through 100, were acting on behalf of Defendant Hospital, and the Defendant Hospital and DOES 1 through 100 are vicariously liable for the negligence of the aforementioned healthcare providers.

117. Defendant Hospital also owed Plaintiff a non-delegable duty to render proper and non-negligent medical care and treatment to Plaintiff during her admission at Defendant Hospital which duty was breached.

118. The physicians, nurses, physicians' assistants, technicians, and ancillary staff who provided medical care and treatment to Ms. Robles at the Defendant Hospital, including, but not limited

to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi, Dr. Allen, Dr. Doursseau and DOES 26 through 100, were the actual agents of Defendant Hospital and were representing the Defendant Hospital and acting within the scope of their actual agency and/or employment relationship with the Defendant Hospital during their care and treatment of Ms. Robles.

119. The Defendant Hospital, through its policies, procedures, by-laws, rules, regulations, contracts, and agreements with its healthcare providers, controlled and/or supervised the actions of its physicians, nurses, physicians' assistants, technicians, and ancillary staff, including, but not limited to, Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi, Dr. Allen, Dr. Doursseau and DOES 26 through 100, or at least had the legal right to exercise control over and/or supervise their activities

120. Accordingly, pursuant to the principles of vicarious liability, Defendant Hospital is legally responsible for the negligence, breaches of duty, and medical malpractice of its physicians, nurses, physicians' assistants, technicians, and ancillary staff who treated Ms. Robles at Defendant Hospital, including, but not limited to Defendants Dr. Nguyen-Clark, Dr. Malek, Dr. Shahidi, Dr. Allen, Dr. Doursseau, and DOES 26 through 100 as described in Counts 4, 6, 8, 9 and 11 and in the damages as set forth in the Prayer for Damages described in paragraph 121.

PRAYER FOR DAMAGES FOR CAUSE OF ACTION FOR MEDICAL MALPRACTICE

121. **WHEREFORE** as to the **FIRST CAUSE OF ACTION** — Medical Malpractice, Plaintiff prays for judgment against all named Defendants in that action and DOES 1 through 100, inclusive:

a. For noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, humiliation, disfigurement, mental anguish, diminished quality of life, emotional distress and other nonpecuniary damages in the past and in the future;

b. For past and future medical, hospital, custodial, nursing and rehabilitation expenses and costs, the cost of obtaining substitute domestic services and loss of ability to provide household services;

c. For the loss of income, lost earnings, loss of earning capacity, loss of employment, loss of business or employment opportunities, loss of ability to earn income in the future, past and future loss of wages and employment benefits;

d. For the reasonable value of services to care for and provide for Plaintiff's special needs;

e. For other general and special damages according to proof;

f. For any other compensatory damages according to proof;

g. For interest thereon at the legal rate;

h. For costs of the suit incurred herein, including expert costs; and

i. For such other and further relief as the Court deems appropriate.

V. CAUSES OF ACTION UNCONNECTED TO PROFESSIONAL SERVICES

Plaintiff JOSEPHINA ROBLES by and through her conservator SERGIO ROBLES vs. ST. FRANCIS MEDICAL CENTER and DOES 101 through 200, inclusive.

SECOND CAUSE OF ACTION — NEGLIGENT CONCEALMENT/MISREPRESENTATION

JOSEFINA ROBLES by and through her conservator SERGIO ROBLES against Defendant Hospital and DOES 101 through 200

122. Plaintiff JOSEFINA ROBLES ("Ms. Robles") appears in this action by and through her conservator, SERGIO ROBLES, who is the father of Ms. Robles. Ms. Robles and SERGIO ROBLES were, and are at all times relevant to this complaint, residents of Los Angeles County, California.

123. Defendant ST. FRANCIS MEDICAL CENTER ("Defendant Hospital") is a medical corporation operating a healthcare facility in Los Angeles County, California.

124. At all times pertinent hereto, Dr. Hahn Nguyen-Clark was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. At all times pertinent hereto, Dr. Sabri Malek was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. Defendant Hospital represented to Ms. Robles that Defendants Dr. Nguyen-Clark and Dr. Malek would act for it and that Defendants Dr. Nguyen-Clark and Dr. Malek were the ostensible agents, actual agents, servants, and/or

employees of Defendant Hospital and were acting in such capacity. Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery and represented to Ms. Robles that: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

125. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 101 through 200, inclusive, are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 101 through 125 are unknown corporate entities. DOES 126 through 150, are physicians employed by the Defendant Hospital or other corporate entities and DOES 151 through 200 are other licensed or non-licensed persons.

126. In 2016, Josephina Robles was pregnant with her first child. As many newly expectant mothers do, Ms. Robles began considering her options regarding where to give birth.

127. Ms. Robles was familiar with the Defendant Hospital's reputation in the community and, in particular, the reputation of its maternity ward.

128. Ms. Robles knew that the Defendant Hospital held itself out to the public as a premier hospital that provided excellent medical services through the physicians on its medical staff. The Defendant Hospital held itself out as being "committed to providing the highest quality care and service to our patients and their families." In fact, the Defendant Hospital claimed that its "comprehensive obstetrics program, located close to home in southeast Los Angeles County, is here to meet your every need. At St. Francis, our obstetrics specialists offer complete obstetrical care for expectant and new mothers. In fact, we deliver more than 5,000 babies every year, ensuring that you and your family receive the expert care you need when welcoming a new baby into your home."

129. The Defendant Hospital also represented that "St. Francis Medical Center strives to assure the highest level of patient care, comfort and safety."

130. With respect to its anesthesiologists, the Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

131. With respect to decisions regarding medical treatment, the Defendant Hospital explained that "[a]s a patient of St. Francis Medical Center, our goal is to provide care that is considerate and respectful of your rights and needs as a patient. If a concern should develop while you are in our medical center, we will make every effort to help resolve it in a timely manner." Specifically, the Defendant Hospital represented that "[y]ou are responsible for and have the right to . . . [h]ave effective communication for critical information [and] [m]ake decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment."

132. As a result of the Defendant Hospital's representations about the quality of its obstetrical services, Ms. Robles decided to have her baby at the Defendant Hospital. The Defendant Hospital had a fiduciary duty to its patient, Ms. Robles, to give her correct, accurate information about the quality of the medical services being offered to expectant mothers; specifically, accurate information regarding the anesthesiology department which was responsible for administering epidurals during labor and anesthesia during C-sections.

133. Unbeknownst to Ms. Robles, the anesthesiology department at the Defendant Hospital was in disarray in that there was dissention between at least some of the anesthesiologists on staff. The Hospital administration received reports that Dr. Hanh Nguyen-Clark had violated certain patient safety rules, thereby endangering patients. Specifically, before Ms. Robles was admitted to the Defendant Hospital to have her baby, Dr. Sabri Malek reported Dr. Hanh Nguyen-Clark to the Defendant Hospital's administration for patient safety violations, causing tension between them and the inability to communicate with one another on a professional basis. Therefore, serious dissention existed among, at least some of, the anesthesiologists on staff at the Defendant Hospital such that patient safety was compromised. Dr. Malek and Dr. Nguyen-Clark then became the anesthesiologists tasked with caring for

Ms. Robles during the course of her labor and delivery which went horribly awry resulting in Ms. Robles sustaining a permanent, catastrophic brain injury. Ms. Robles' injury was caused, at least in part, by Dr. Malek and Dr. Hanh Nguyen-Clark's inability to professionally communicate with one another.

134. The Defendant Hospital knew of the dissention and patient safety violations that existed in its anesthesiology department, including the serious tension between Dr. Malek and Dr. Nguyen-Clark. The Defendant Hospital knew that Dr. Hanh Nguyen-Clark was providing substandard care to patients and knew she was unfit to perform anesthesiology services. Ms. Robles did not know this information and had no way to learn this information. The Defendant Hospital, having a fiduciary duty to Ms. Robles, had a duty to disclose this information to Ms. Robles so that she, in turn, could decide whether to seek care elsewhere. The Defendant Hospital gave Ms. Robles a false sense of security in the Hospital's ability to provide her competent, non-negligent anesthesia services which is an important part of the total care rendered in connection with labor and delivery. Ms. Robles was completely unaware of the issues with patient safety and substandard care in the Defendant Hospital's anesthesiology department and the fact that it was adversely affecting patient safety.

135. Following the birth of Ms. Robles' baby, Ms. Robles' family learned that she sustained a significant brain injury during labor and delivery. Shortly after the birth of Ms. Robles' baby, Dr. Malek reached out to the Robles family. Dr. Malek spoke to the family at the Hospital and apologized for the injury Ms. Robles sustained. Dr. Malek gave the family his cell phone number and they spoke with them on the phone several times. The Robles family learned from Dr. Malek that the Hospital placed Dr. Malek on administrative leave. Thereafter, Dr. Malek arranged for a meeting with the Robles family.

136. On or about March 17, 2017, Dr. Malek met with the Robles family at a local Starbucks. Sergio Robles, Ms. Robles' father; Aida Barco, Mr. Robles' girlfriend; and Humberto Garcia, Ms. Robles' boyfriend and the father of the baby, were present at the meeting ("the Robles Family"). At this meeting, Dr. Malek told the Robles Family that he had reported Dr. Nguyen-Clark for prior patient safety violations prior to Ms. Robles giving birth at Defendant Hospital. Dr. Malek also advised the Robles Family about the dissention in the Hospital's anesthesiology department, which also existed prior to Ms. Robles giving birth at the Defendant Hospital. This was the first time that the Robles Family learned that

the Defendant Dr. Nguyen-Clark had been reported for patient safety violations prior to her providing treatment to Ms. Robles. The Defendant Hospital's anesthesiology department was in such disarray that it was affecting patient safety as it did in Ms. Robles' case.

137. Dr. Malek further advised the Robles Family that Dr. Nguyen-Clark was at fault for causing Ms. Robles' brain injury and that the obstetrician waited too long to order the C-section. Dr. Malek also advised the Robles Family that the Defendant Hospital and Dr. Nguyen-Clark were blaming him for what occurred which is why he was placed on administrative leave for what occurred to Ms. Robles.

138. The conduct of the Defendant Hospital and its administration, in misrepresenting the quality and condition of its anesthesiology department to Ms. Robles, was fraudulent and malicious. The Defendant Hospital willfully and consciously disregarded Ms. Robles' safety by concealing material facts from Ms. Robles regarding the quality and condition of its anesthesiology department.

139. The Defendant Hospital, through its officers, directors and/or managing agents was guilty of oppression, fraud and/or malice by willfully and consciously misrepresenting the quality and condition of the Hospital's anesthesiology department to Ms. Robles such that it consciously disregarded Ms. Robles' safety.[1]

140. The Defendant Hospital, through its officers, directors and/or managing agents, made false representations of material fact regarding the quality of the obstetrical services provided by the Hospital, which included anesthesiology services, when it represented to the public and Ms. Robles that it was "committed to providing the highest quality care and service to our patients and their families[;]" "we are here to provide you with superior care[;]" the Hospital "strives to assure the highest level of patient care, comfort and safety[;]" and that "[y]ou are responsible for and have the right to . . . [h]ave effective

[1]Plaintiff is pleading a claim for punitive damages against the Defendant Hospital without leave of court because the Plaintiff's causes of action, contained in paragraphs 122 through 220, do not arise out of professional negligence nor do they arise out of the rendition of professional services as defined in Cal.C.C.P. § 425.13. Therefore, the provisions of Cal.C.C.P. § 425.13, prohibiting punitive damages in medical malpractice actions without first seeking leave of court, do not apply to those causes of action. By this Amended Complaint, Plaintiff is not seeking punitive damages for its cause of action titled "First Cause of Action – Medical Malpractice" as will properly seek leave of court under Cal.C.C.P. § 425.13 to plead punitive damages for her medical malpractice claim.

communication for critical information [and] [m]ake decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment."

141. The Defendant Hospital's representations in that regard were false and untrue in that its anesthesiology department was in complete disarray, endangering patient safety and serious dissention existed between Dr. Malek and Dr. Nguyen-Clark to the point that patient safety was being adversely impacted because of their inability to communicate with one another in a professional manner. This inability to communicate professionally endangered Ms. Robles in that Dr. Malek and Dr. Nguyen-Clark were assigned by the Hospital to be her treating anesthesiologists.

142. At some point in time, the Defendant Hospital knew that its representations regarding the quality of the obstetrical services it provided, specifically including the anesthesiology services, were no longer true and, thus, the Defendant Hospital had no reasonable grounds to believe that the representations were still true.

143. The Defendant Hospital, through its officers, directors and/or managing agents, withheld and concealed the truth about the dissention and disarray in its anesthesiology department from the public and from expectant mothers, like Ms. Robles, who were considering giving birth at the Hospital, to induce those mothers to choose the Hospital as the place to give birth. Ms. Robles relied on these false representations in choosing to give birth at the Defendant Hospital.

144. Ms. Robles was completely unaware that the Defendant Hospital's anesthesiology department was experiencing severe problems with patient safety. Ms. Robles was also completely unaware that the Defendant Hospital's anesthesiology department was in disarray and that serious dissention existed between the anesthesiologists who ultimately rendered her care. Ms. Robles had no way to learn this information before she became a patient at the Defendant Hospital, and the Defendant Hospital had a duty to correct the problems in its anesthesiology department so that its representations regarding the quality of the medical care rendered by the department would be accurate.

145. Having no access to the information known by the Defendant Hospital regarding the dissention in its anesthesiology department and thus, the patient safety issues affecting its anesthesiology

department, Ms. Robles was justified in relying on the representation that the Defendant Hospital made to the public about the quality of its obstetrical services, including its anesthesiology services.

146. As a direct and proximate result of her reliance, Ms. Robles sustained the damages as set forth in the Prayer for Damages described in paragraph 221.

147. As a direct and proximate result of Defendant Hospital, through its officers, directors and/or managing agents, and DOES 101 through 200's, negligence and breaches of duty, Ms. Robles suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 221.

THIRD CAUSE OF ACTION — NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

JOSEFINA ROBLES by and through her conservator SERGIO ROBLES against Defendant Hospital and DOES 101 through 200

148. Plaintiff JOSEFINA ROBLES ("Ms. Robles") appears in this action by and through her conservator, SERGIO ROBLES, who is the father of Ms. Robles. Ms. Robles and SERGIO ROBLES were, and are at all times relevant to this complaint, residents of Los Angeles County, California.

149. Defendant ST. FRANCIS MEDICAL CENTER ("Defendant Hospital") is a medical corporation operating a healthcare facility in Los Angeles County, California.

150. At all times pertinent hereto, Dr. Hahn Nguyen-Clark was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. At all times pertinent hereto, Dr. Sabri Malek was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. Defendant Hospital represented to Ms. Robles that Defendants Dr. Nguyen-Clark and Dr. Malek would act for it and that Defendants Dr. Nguyen-Clark and Dr. Malek were the ostensible agents, actual agents, servants, and/or employees of Defendant Hospital and were acting in such capacity. Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery and represented to Ms. Robles that: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

151. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 101 through 200, inclusive, are unknown to Plaintiff, who therefore sues said

Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this Complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 101 through 125 are unknown corporate entities. DOES 126 through 150, are physicians employed by the Defendant Hospital or other corporate entities and DOES 151 through 200 are other licensed or non-licensed persons.

152. In 2016, Josephina Robles was pregnant with her first child. As many newly expectant mothers do, Ms. Robles began considering her options regarding where to give birth.

153. Ms. Robles was familiar with the Defendant Hospital's reputation in the community and, in particular, the reputation of its maternity ward.

154. Ms. Robles knew that the Defendant Hospital held itself out to the public as a premier hospital that provided excellent medical services through the physicians on its medical staff. The Defendant Hospital held itself out as being "committed to providing the highest quality care and service to our patients and their families." In fact, the Defendant Hospital claimed that its "comprehensive obstetrics program, located close to home in southeast Los Angeles County, is here to meet your every need. At St. Francis, our obstetrics specialists offer complete obstetrical care for expectant and new mothers. In fact, we deliver more than 5,000 babies every year, ensuring that you and your family receive the expert care you need when welcoming a new baby into your home."

155. The Defendant Hospital also represented that "St. Francis Medical Center strives to assure the highest level of patient care, comfort and safety."

156. With respect to its anesthesiologists, the Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

157. With respect to decisions regarding medical treatment, the Defendant Hospital explained that "[a]s a patient of St. Francis Medical Center, our goal is to provide care that is considerate and

respectful of your rights and needs as a patient. If a concern should develop while you are in our medical center, we will make every effort to help resolve it in a timely manner." Specifically, the Defendant Hospital represented that "[y]ou are responsible for and have the right to . . . [h]ave effective communication for critical information [and] [m]ake decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment."

158. As a result of the Defendant Hospital's representations about the quality of its obstetrical services, Ms. Robles decided to have her baby at the Defendant Hospital. The Defendant Hospital had a fiduciary duty to its patient, Ms. Robles, to give her correct, accurate information about the quality of the medical services being offered to expectant mothers; specifically, accurate information regarding the anesthesiology department which was responsible for administering epidurals during labor and anesthesia during C-sections.

159. Unbeknownst to Ms. Robles, the anesthesiology department at the Defendant Hospital was in disarray in that there was dissention between at least some of the anesthesiologists on staff. The Hospital administration received reports that Dr. Hanh Nguyen-Clark had violated certain patient safety rules, thereby endangering patients. Specifically, before Ms. Robles was admitted to the Defendant Hospital to have her baby, Dr. Sabri Malek reported Dr. Hanh Nguyen-Clark to the Defendant Hospital's administration for patient safety violations, causing tension between them and the inability to communicate with one another on a professional basis. Therefore, serious dissention existed among, at least some of, the anesthesiologists on staff at the Defendant Hospital such that patient safety was compromised. Dr. Malek and Dr. Nguyen-Clark then became the anesthesiologists tasked with caring for Ms. Robles during the course of her labor and delivery which went horribly awry resulting in Ms. Robles sustaining a permanent, catastrophic brain injury. Ms. Robles' injury was caused, at least in part, by Dr. Malek and Dr. Hanh Nguyen-Clark's inability to professionally communicate with one another.

160. The Defendant Hospital knew of the dissention and patient safety violations that existed in its anesthesiology department, including the serious tension between Dr. Malek and Dr. Nguyen-Clark. The Defendant Hospital knew that Dr. Hanh Nguyen-Clark was providing substandard care to patients

and knew she was unfit to perform anesthesiology services. Ms. Robles did not know this information and had no way to learn this information. The Defendant Hospital, having a fiduciary duty to Ms. Robles, had a duty to disclose this information to Ms. Robles so that she, in turn, could decide whether to seek care elsewhere. The Defendant Hospital gave Ms. Robles a false sense of security in the Hospital's ability to provide her competent, non-negligent anesthesia services which is an important part of the total care rendered in connection with labor and delivery. Ms. Robles was completely unaware of the issues with patient safety and substandard care in the Defendant Hospital's anesthesiology department and the fact that it was adversely affecting patient safety.

161. Following the birth of Ms. Robles' baby, Ms. Robles' family learned that she sustained a significant brain injury during labor and delivery. Shortly after the birth of Ms. Robles' baby, Dr. Malek reached out to the Robles family. Dr. Malek spoke to the family at the Hospital and apologized for the injury Ms. Robles sustained. Dr. Malek gave the family his cell phone number and they spoke with them on the phone several times. The Robles family learned from Dr. Malek that the Hospital placed Dr. Malek on administrative leave. Thereafter, Dr. Malek arranged for a meeting with the Robles family.

162. On or about March 17, 2017, Dr. Malek met with the Robles family at a local Starbucks. Sergio Robles, Ms. Robles' father; Aida Barco, Mr. Robles' girlfriend; and Humberto Garcia, Ms. Robles' boyfriend and the father of the baby, were present at the meeting ("the Robles Family"). At this meeting, Dr. Malek told the Robles Family that he had reported Dr. Nguyen-Clark for prior patient safety violations prior to Ms. Robles giving birth at Defendant Hospital. Dr. Malek also advised the Robles Family about the dissention in the Hospital's anesthesiology department, which also existed prior to Ms. Robles giving birth at the Defendant Hospital. This was the first time that the Robles Family learned that the Defendant Dr. Nguyen-Clark had been reported for patient safety violations prior to her providing treatment to Ms. Robles. The Defendant Hospital's anesthesiology department was in such disarray that it was affecting patient safety as it did in Ms. Robles' case.

163. Dr. Malek further advised the Robles Family that Dr. Nguyen-Clark was at fault for causing Ms. Robles' brain injury and that the obstetrician waited too long to order the C-section. Dr. Malek also

advised the Robles Family that the Defendant Hospital and Dr. Nguyen-Clark were blaming him for what occurred which is why he was placed on administrative leave for what occurred to Ms. Robles.

164. The conduct of the Defendant Hospital and its administration, in misrepresenting the quality and condition of its anesthesiology department to Ms. Robles, was fraudulent and malicious. The Defendant Hospital willfully and consciously disregarded Ms. Robles' safety by concealing material facts from Ms. Robles regarding the quality and condition of its anesthesiology department.

165. The Defendant Hospital, through its officers, directors and/or managing agents was guilty of oppression, fraud and/or malice by willfully and consciously misrepresenting the quality and condition of the Hospital's anesthesiology department to Ms. Robles such that it consciously disregarded Ms. Robles' safety.[2]

166. The Defendant Hospital owed a fiduciary duty of care to Ms. Robles as a patient receiving medical services at the Hospital.

167. The Defendant Hospital owed Ms. Robles a duty to provide her correct information regarding the quality of the medical services performed by its anesthesiology department, particularly where Ms. Robles had no means to know the truth about the patient safety violations that were adversely affecting patients at the Defendant Hospital's anesthesiology department. The Defendant Hospital had a fiduciary duty to disclose accurate information to Ms. Robles regarding the quality of medical services provided by its anesthesiology department.

168. At some point in time, the Defendant Hospital knew or should have known that its representations regarding the quality of its medical services, specifically including the anesthesiology services, were no longer true and that patients had the right to know that their medical care could be compromised by the dissention and disarray in the department, specifically, the dissention between Dr. Malek and Dr. Nguyen-Clark.

169. The Defendant Hospital, through its officers, directors and/or managing agents, breached its duty to Ms. Robles by making inaccurate representations regarding the quality of the obstetrical

[2]See footnote 1.

services it provided, specifically including the anesthesiology services, and by failing to disclose that information when it should have done so.

170. As a result of the Defendant Hospital's negligence, through its officers, directors and/or managing agents, Ms. Robles suffered serious emotional distress, including, but not limited to, suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation and shame, such that a reasonable person would be unable to cope with such emotional stress, as a result of learning of the patient safety problems at Defendant Hospital's anesthesiology department.

171. The Defendant Hospital's negligence was a substantial factor in causing Ms. Robles serious emotional distress.

172. As a direct and proximate result of the Defendant Hospital, through its officers, directors and/or managing agents, and DOES 101 through 200's negligence, Ms. Robles suffered serious emotional distress and the damages as set forth in the Prayer for Damages described in paragraph 222.

FOURTH CAUSE OF ACTION — FRAUDULENT CONCEALMENT

JOSEFINA ROBLES, by and through her conservator, SERGIO ROBLES against Defendant Hospital and DOES 101 through 200

173. Plaintiff JOSEFINA ROBLES ("Ms. Robles") appears in this action by and through her conservator, SERGIO ROBLES, who is the father of Ms. Robles. Ms. Robles and SERGIO ROBLES were, and are at all times relevant to this complaint, residents of Los Angeles County, California.

174. Defendant ST. FRANCIS MEDICAL CENTER ("Defendant Hospital") is a medical corporation operating a healthcare facility in Los Angeles County, California.

175. At all times pertinent hereto, Dr. Hahn Nguyen-Clark was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. At all times pertinent hereto, Dr. Sabri Malek was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. Defendant Hospital represented to Ms. Robles that Defendants Dr. Nguyen-Clark and Dr. Malek would act for it and that Defendants Dr. Nguyen-Clark and Dr. Malek were the ostensible agents, actual agents, servants, and/or employees of Defendant Hospital and were acting in such capacity. Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery and represented to Ms. Robles that: "[o]ur

obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

176. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 101 through 200, inclusive, are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this Complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 101 through 125 are unknown corporate entities. DOES 126 through 150, are physicians employed by the Defendant Hospital or other corporate entities and DOES 151 through 200 are other licensed or non-licensed persons.

177. In 2016, Josephina Robles was pregnant with her first child. As many newly expectant mothers do, Ms. Robles began considering her options regarding where to give birth.

178. Ms. Robles was familiar with the Defendant Hospital's reputation in the community and, in particular, the reputation of its maternity ward.

179. Ms. Robles knew that the Defendant Hospital held itself out to the public as a premier hospital that provided excellent medical services through the physicians on its medical staff. The Defendant Hospital held itself out as being "committed to providing the highest quality care and service to our patients and their families." In fact, the Defendant Hospital claimed that its "comprehensive obstetrics program, located close to home in southeast Los Angeles County, is here to meet your every need. At St. Francis, our obstetrics specialists offer complete obstetrical care for expectant and new mothers. In fact, we deliver more than 5,000 babies every year, ensuring that you and your family receive the expert care you need when welcoming a new baby into your home."

180. The Defendant Hospital also represented that "St. Francis Medical Center strives to assure the highest level of patient care, comfort and safety."

181. With respect to its anesthesiologists, the Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery: "[o]ur obstetricians, anesthesiologists and specialized

nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

182. With respect to decisions regarding medical treatment, the Defendant Hospital explained that "[a]s a patient of St. Francis Medical Center, our goal is to provide care that is considerate and respectful of your rights and needs as a patient. If a concern should develop while you are in our medical center, we will make every effort to help resolve it in a timely manner." Specifically, the Defendant Hospital represented that "[y]ou are responsible for and have the right to . . . [h]ave effective communication for critical information [and] [m]ake decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment."

183. As a result of the Defendant Hospital's representations about the quality of its obstetrical services, Ms. Robles decided to have her baby at the Defendant Hospital. The Defendant Hospital had a fiduciary duty to its patient, Ms. Robles, to give her correct, accurate information about the quality of the medical services being offered to expectant mothers; specifically, accurate information regarding the anesthesiology department which was responsible for administering epidurals during labor and anesthesia during C-sections.

184. Unbeknownst to Ms. Robles, the anesthesiology department at the Defendant Hospital was in disarray in that there was dissention between at least some of the anesthesiologists on staff. The Hospital administration received reports that Dr. Hanh Nguyen-Clark had violated certain patient safety rules, thereby endangering patients. Specifically, before Ms. Robles was admitted to the Defendant Hospital to have her baby, Dr. Sabri Malek reported Dr. Hanh Nguyen-Clark to the Defendant Hospital's administration for patient safety violations, causing tension between them and the inability to communicate with one another on a professional basis. Therefore, serious dissention existed among, at least some of, the anesthesiologists on staff at the Defendant Hospital such that patient safety was compromised. Dr. Malek and Dr. Nguyen-Clark then became the anesthesiologists tasked with caring for Ms. Robles during the course of her labor and delivery which went horribly awry resulting in Ms. Robles

sustaining a permanent, catastrophic brain injury. Ms. Robles' injury was caused, at least in part, by Dr. Malek and Dr. Hanh Nguyen-Clark's inability to professionally communicate with one another.

185. The Defendant Hospital knew of the dissention and patient safety violations that existed in its anesthesiology department, including the serious tension between Dr. Malek and Dr. Nguyen-Clark. The Defendant Hospital knew that Dr. Hanh Nguyen-Clark was providing substandard care to patients and knew she was unfit to perform anesthesiology services. Ms. Robles did not know this information and had no way to learn this information. The Defendant Hospital, having a fiduciary duty to Ms. Robles, had a duty to disclose this information to Ms. Robles so that she, in turn, could decide whether to seek care elsewhere. The Defendant Hospital gave Ms. Robles a false sense of security in the Hospital's ability to provide her competent, non-negligent anesthesia services which is an important part of the total care rendered in connection with labor and delivery. Ms. Robles was completely unaware of the issues with patient safety and substandard care in the Defendant Hospital's anesthesiology department and the fact that it was adversely affecting patient safety.

186. Following the birth of Ms. Robles' baby, Ms. Robles' family learned that she sustained a significant brain injury during labor and delivery. Shortly after the birth of Ms. Robles' baby, Dr. Malek reached out to the Robles family. Dr. Malek spoke to the family at the Hospital and apologized for the injury Ms. Robles sustained. Dr. Malek gave the family his cell phone number and they spoke with them on the phone several times. The Robles family learned from Dr. Malek that the Hospital placed Dr. Malek on administrative leave. Thereafter, Dr. Malek arranged for a meeting with the Robles family.

187. On or about March 17, 2017, Dr. Malek met with the Robles family at a local Starbucks. Sergio Robles, Ms. Robles' father; Aida Barco, Mr. Robles' girlfriend; and Humberto Garcia, Ms. Robles' boyfriend and the father of the baby, were present at the meeting ("the Robles Family"). At this meeting, Dr. Malek told the Robles Family that he had reported Dr. Nguyen-Clark for prior patient safety violations prior to Ms. Robles giving birth at Defendant Hospital. Dr. Malek also advised the Robles Family about the dissention in the Hospital's anesthesiology department, which also existed prior to Ms. Robles giving birth at the Defendant Hospital. This was the first time that the Robles Family learned that the Defendant Dr. Nguyen-Clark had been reported for patient safety violations prior to her providing

treatment to Ms. Robles. The Defendant Hospital's anesthesiology department was in such disarray that it was affecting patient safety as it did in Ms. Robles' case.

188. Dr. Malek further advised the Robles Family that Dr. Nguyen-Clark was at fault for causing Ms. Robles' brain injury and that the obstetrician waited too long to order the C-section. Dr. Malek also advised the Robles Family that the Defendant Hospital and Dr. Nguyen-Clark were blaming him for what occurred which is why he was placed on administrative leave for what occurred to Ms. Robles.

189. The conduct of the Defendant Hospital and its administration, in misrepresenting the quality and condition of its anesthesiology department to Ms. Robles, was fraudulent and malicious. The Defendant Hospital willfully and consciously disregarded Ms. Robles' safety by concealing material facts from Ms. Robles regarding the quality and condition of its anesthesiology department.

190. The Defendant Hospital, through its officers, directors and/or managing agents was guilty of oppression, fraud and/or malice by willfully and consciously misrepresenting the quality and condition of the Hospital's anesthesiology department to Ms. Robles such that it consciously disregarded Ms. Robles' safety.[3]

191. The Defendant Hospital, through its officers, directors and/or managing agents, concealed or suppressed a material fact when it failed to disclose to Ms. Robles that its anesthesiology department was experiencing severe problems with patient safety and that its department was in disarray and that serious dissention existed between Dr. Nguyen-Clark and Dr. Malek to the point that patient safety had been compromised.

192. The Defendant Hospital had a fiduciary duty to Ms. Robles and, therefore, was under a duty to disclose this information to Ms. Robles, particularly where the Defendant Hospital held itself out to expectant mothers, like Ms. Robles, as a Hospital that was well-equipped through its medical staff to provide quality obstetrical services.

[3]See footnote 1.

193. The Defendant Hospital, through its officers, directors and/or managing agents, withheld this information from Ms. Robles with intent to deceive and defraud her and specifically with the intent to induce her to choose the Hospital as the Hospital where she would deliver her baby.

194. Ms. Robles was completely unaware of the issues with patient safety, dissention between doctors and disarray in the Defendant Hospital's anesthesiology department or the fact that these issues were adversely affecting patient safety. Ms. Robles had no way of learning of this information as it was information solely in the possession of the Hospital. Ms. Robles would not have accepted medical services at the Defendant Hospital had she known this information.

195. At some point in time, the Defendant Hospital knew that its representations regarding the quality of the obstetrical services it provided, specifically including the anesthesiology services, were no longer true; yet the Defendant Hospital suppressed the facts which would have revealed that those representations were no longer true.

196. As a direct and proximate result of the Defendant Hospital, through its officers, directors and/or managing agents, and DOES 101 through 200's fraudulent concealment, Ms. Robles suffered the damages as set forth in the Prayer for Damages described in paragraph 223.

FIFTH CAUSE OF ACTION — VIOLATION OF CONSUMER LEGAL REMEDIES ACT

JOSEFINA ROBLES, by and through her conservator, SERGIO ROBLES against Defendant Hospital and DOES 101 through 200

197. Plaintiff JOSEFINA ROBLES ("Ms. Robles") appears in this action by and through her conservator, SERGIO ROBLES, who is the father of Ms. Robles. Ms. Robles and SERGIO ROBLES were, and are at all times relevant to this complaint, residents of Los Angeles County, California.

198. Defendant ST. FRANCIS MEDICAL CENTER ("Defendant Hospital") is a medical corporation operating a healthcare facility in Los Angeles County, California.

199. At all times pertinent hereto, Dr. Hahn Nguyen-Clark was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. At all times pertinent hereto, Dr. Sabri Malek was an actual agent, ostensible agent, servant, and/or employee of the Defendant Hospital. Defendant Hospital represented to Ms. Robles that Defendants Dr. Nguyen-Clark and Dr. Malek would act for it and that

Defendants Dr. Nguyen-Clark and Dr. Malek were the ostensible agents, actual agents, servants, and/or employees of Defendant Hospital and were acting in such capacity. Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery and represented to Ms. Robles that: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

200. The true names and capacities, whether individual, corporate, associate or otherwise, of Defendants DOES 101 through 200, inclusive, are unknown to Plaintiff, who therefore sues said Defendants by such fictitious names. Plaintiff will seek leave of Court to amend this Complaint to show and state the true names and capacities of the defendants designated herein as DOES when the same have been ascertained. Based on information and belief, each of the defendants designated herein as a DOE are legally responsible in some manner for the events and happenings referred to and legally caused injury and damages to Plaintiff as hereinafter set forth. DOES 101 through 125 are unknown corporate entities. DOES 126 through 150, are physicians employed by the Defendant Hospital or other corporate entities and DOES 151 through 200 are other licensed or non-licensed persons.

201. In 2016, Josephina Robles was pregnant with her first child. As many newly expectant mothers do, Ms. Robles began considering her options regarding where to give birth.

202. Ms. Robles was familiar with the Defendant Hospital's reputation in the community and, in particular, the reputation of its maternity ward.

203. Ms. Robles knew that the Defendant Hospital held itself out to the public as a premier hospital that provided excellent medical services through the physicians on its medical staff. The Defendant Hospital held itself out as being "committed to providing the highest quality care and service to our patients and their families." In fact, the Defendant Hospital claimed that its "comprehensive obstetrics program, located close to home in southeast Los Angeles County, is here to meet your every need. At St. Francis, our obstetrics specialists offer complete obstetrical care for expectant and new mothers. In fact, we deliver more than 5,000 babies every year, ensuring that you and your family receive the expert care you need when welcoming a new baby into your home."

204. The Defendant Hospital also represented that "St. Francis Medical Center strives to assure the highest level of patient care, comfort and safety."

205. With respect to its anesthesiologists, the Defendant Hospital held itself out as being able to provide the care necessary in labor and delivery: "[o]ur obstetricians, anesthesiologists and specialized nurses are available 24/7 to care for you and your baby. Even if you go into labor in the middle of the night, we are here to provide you with superior care."

206. With respect to decisions regarding medical treatment, the Defendant Hospital explained that "[a]s a patient of St. Francis Medical Center, our goal is to provide care that is considerate and respectful of your rights and needs as a patient. If a concern should develop while you are in our medical center, we will make every effort to help resolve it in a timely manner." Specifically, the Defendant Hospital represented that "[y]ou are responsible for and have the right to . . . [h]ave effective communication for critical information [and] [m]ake decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment."

207. As a result of the Defendant Hospital's representations about the quality of its obstetrical services, Ms. Robles decided to have her baby at the Defendant Hospital. The Defendant Hospital had a fiduciary duty to its patient, Ms. Robles, to give her correct, accurate information about the quality of the medical services being offered to expectant mothers; specifically, accurate information regarding the anesthesiology department which was responsible for administering epidurals during labor and anesthesia during C-sections.

208. Unbeknownst to Ms. Robles, the anesthesiology department at the Defendant Hospital was in disarray in that there was dissention between at least some of the anesthesiologists on staff. The Hospital administration received reports that Dr. Hanh Nguyen-Clark had violated certain patient safety rules, thereby endangering patients. Specifically, before Ms. Robles was admitted to the Defendant Hospital to have her baby, Dr. Sabri Malek reported Dr. Hanh Nguyen-Clark to the Defendant Hospital's administration for patient safety violations, causing tension between them and the inability to communicate with one another on a professional basis. Therefore, serious dissention existed among, at

least some of, the anesthesiologists on staff at the Defendant Hospital such that patient safety was compromised. Dr. Malek and Dr. Nguyen-Clark then became the anesthesiologists tasked with caring for Ms. Robles during the course of her labor and delivery which went horribly awry resulting in Ms. Robles sustaining a permanent, catastrophic brain injury. Ms. Robles' injury was caused, at least in part, by Dr. Malek and Dr. Hanh Nguyen-Clark's inability to professionally communicate with one another.

209. The Defendant Hospital knew of the dissention and patient safety violations that existed in its anesthesiology department, including the serious tension between Dr. Malek and Dr. Nguyen-Clark. The Defendant Hospital knew that Dr. Hanh Nguyen-Clark was providing substandard care to patients and knew she was unfit to perform anesthesiology services. Ms. Robles did not know this information and had no way to learn this information. The Defendant Hospital, having a fiduciary duty to Ms. Robles, had a duty to disclose this information to Ms. Robles so that she, in turn, could decide whether to seek care elsewhere. The Defendant Hospital gave Ms. Robles a false sense of security in the Hospital's ability to provide her competent, non-negligent anesthesia services which is an important part of the total care rendered in connection with labor and delivery. Ms. Robles was completely unaware of the issues with patient safety and substandard care in the Defendant Hospital's anesthesiology department and the fact that it was adversely affecting patient safety.

210. Following the birth of Ms. Robles' baby, Ms. Robles' family learned that she sustained a significant brain injury during labor and delivery. Shortly after the birth of Ms. Robles' baby, Dr. Malek reached out to the Robles family. Dr. Malek spoke to the family at the Hospital and apologized for the injury Ms. Robles sustained. Dr. Malek gave the family his cell phone number and they spoke with them on the phone several times. The Robles family learned from Dr. Malek that the Hospital placed Dr. Malek on administrative leave. Thereafter, Dr. Malek arranged for a meeting with the Robles family.

211. On or about March 17, 2017, Dr. Malek met with the Robles family at a local Starbucks. Sergio Robles, Ms. Robles' father; Aida Barco, Mr. Robles' girlfriend; and Humberto Garcia, Ms. Robles' boyfriend and the father of the baby, were present at the meeting ("the Robles Family"). At this meeting, Dr. Malek told the Robles Family that he had reported Dr. Nguyen-Clark for prior patient safety violations prior to Ms. Robles giving birth at Defendant Hospital. Dr. Malek also advised the Robles

Family about the dissention in the Hospital's anesthesiology department, which also existed prior to Ms. Robles giving birth at the Defendant Hospital. This was the first time that the Robles Family learned that the Defendant Dr. Nguyen-Clark had been reported for patient safety violations prior to her providing treatment to Ms. Robles. The Defendant Hospital's anesthesiology department was in such disarray that it was affecting patient safety as it did in Ms. Robles' case.

212. Dr. Malek further advised the Robles Family that Dr. Nguyen-Clark was at fault for causing Ms. Robles' brain injury and that the obstetrician waited too long to order the C-section. Dr. Malek also advised the Robles Family that the Defendant Hospital and Dr. Nguyen-Clark were blaming him for what occurred which is why he was placed on administrative leave for what occurred to Ms. Robles.

213. The conduct of the Defendant Hospital and its administration, in misrepresenting the quality and condition of its anesthesiology department to Ms. Robles, was fraudulent and malicious. The Defendant Hospital willfully and consciously disregarded Ms. Robles' safety by concealing material facts from Ms. Robles regarding the quality and condition of its anesthesiology department.

214. The Defendant Hospital, through its officers, directors and/or managing agents was guilty of oppression, fraud and/or malice by willfully and consciously misrepresenting the quality and condition of the Hospital's anesthesiology department to Ms. Robles such that it consciously disregarded Ms. Robles' safety.[4]

215. California's Consumer Legal Remedies Act (the "CLRA"), §§ 1750, *et. seq.*, prohibits unfair or deceptive acts or practices undertaken by any person or business which results in the sale of services to any consumer. Prohibited acts under the CLRA include failing to disclose material facts which a business has exclusive knowledge of and are not known by a consumer; actively concealing material facts from a consumer; and making partial representations to a consumer but also suppressing some material fact.

216. The Defendant Hospital, through its officers, directors and/or managing agents, made willful misrepresentations and actively concealed material facts regarding the quality of the obstetrical

[4]See footnote 1.

services provided by the Hospital, which included anesthesiology services. These misrepresentations were intentionally and/or consciously deceptive, untrue and misleading.

217. The Defendant Hospital's willful misrepresentations and active concealment of material facts, through its officers, directors and/or managing agents, were unfair, deceptive, untrue and misleading in that the anesthesiology department was in disarray and serious dissention existed between Dr. Malek and Dr. Nguyen-Clark to the point that patient safety was being intentionally and/or consciously disregarded.

218. At some point in time, the Defendant Hospital knew that its representations regarding the quality of the obstetrical services it provided, specifically including the anesthesiology services, were no longer true, yet it continued the business practice of making these deceptive, untrue and misleading statements and concealing material facts to the public through its advertising. The Defendant Hospital had exclusive knowledge of these material facts which were not known by consumers, including Ms. Robles. The Defendant Hospital's business practices in this regard were either fraudulent, unlawful or unfair and constituted an intentional and/or conscious disregard for the rights of patient safety.

219. The Defendant Hospital, through its officers, directors and/or managing agents, withheld and actively concealed material facts about the patient safety issues, dissention and disarray its anesthesiology department was experiencing from the public and from expectant mothers, like Ms. Robles, considering whether to give birth at the Hospital to induce those mothers to choose the Hospital. Ms. Robles and other members of the public were deceived by the Hospital's unfair, deceptive, untrue and misleading advertising, and concealment of material facts.

220. As a direct and proximate result of Defendant Hospital, through its officers, directors and/or managing agents, and DOES 101 through 200's violation of the Consumer Legal Remedies Act and intentional and/or conscious disregard for patient safety, JOSEPHINA ROBLES suffered a profound, severe and catastrophic brain injury and the damages as set forth in the Prayer for Damages described in paragraph 224.

PRAYER FOR DAMAGES FOR CAUSES OF ACTION

UNCONNECTED TO PROFESSIONAL SERVICES

221. **WHEREFORE** as the **SECOND CAUSE OF ACTION** — Negligent Concealment/Negligent Misrepresentation, Plaintiff prays for judgment against Defendant Hospital and DOES 101 through 200, inclusive,

a. For noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, humiliation, disfigurement, mental anguish, diminished quality of life, emotional distress and other nonpecuniary damages in the past and in the future;

b. For past and future medical, hospital, custodial, nursing and rehabilitation expenses and costs, the cost of obtaining substitute domestic services and loss of ability to provide household services;

c. For the loss of income, lost earnings, loss of earning capacity, loss of employment, loss of business or employment opportunities, loss of ability to earn income in the future, past and future loss of wages and employment benefits;

d. For the reasonable value of services to care for and provide for Plaintiff's special needs;

e. For punitive damages according to proof for willful, malicious and oppressive conduct or for conscious disregard of the Plaintiff's rights and safety;

f. For other general and special damages according to proof;

g. For any other compensatory damages according to proof;

h. For interest thereon at the legal rate;

i. For costs of the suit incurred herein, including expert costs; and

j. For such other and further relief as the Court deems appropriate.

222. **WHEREFORE** as the **THIRD CAUSE OF ACTION** — Negligent Infliction of Emotional Distress, Plaintiff prays for judgment against Defendant Hospital and DOES 101 through 200, inclusive,

a. For general damages for severe emotional distress;

b. For punitive damages according to proof for willful, malicious and oppressive conduct or for conscious disregard of the Plaintiff's rights and safety;

c. For other general and special damages according to proof;

d. For any other compensatory damages according to proof;

e. For interest thereon at the legal rate;

f. For costs of the suit incurred herein, including expert costs; and

g. For such other and further relief as the Court deems appropriate.

223. **WHEREFORE** as the **FOURTH CAUSE OF ACTION** — Fraudulent Concealment, Plaintiff prays for judgment against all named Defendants in that action and DOES 101 through 200, inclusive,

a. For noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, humiliation, disfigurement, mental anguish, diminished quality of life, emotional distress and other nonpecuniary damages in the past and in the future;

b. For past and future medical, hospital, custodial, nursing and rehabilitation expenses and costs, the cost of obtaining substitute domestic services and loss of ability to provide household services;

c. For the loss of income, lost earnings, loss of earning capacity, loss of employment, loss of business or employment opportunities, loss of ability to earn income in the future, past and future loss of wages and employment benefits;

d. For the reasonable value of services to care for and provide for Plaintiff's special needs;

e. For punitive damages according to proof for willful, malicious and oppressive conduct or for conscious disregard of the Plaintiff's rights and safety;

f. For other general and special damages according to proof;

g. For any other compensatory damages according to proof;

h. For interest thereon at the legal rate;

i. For costs of the suit incurred herein, including expert costs; and

j. For such other and further relief as the Court deems appropriate.

224. **WHEREFORE** as the **FIFTH CAUSE OF ACTION** — Violation of the Consumer Legal Remedies, Plaintiff prays for judgment against all named Defendants in that action and DOES 101 through 200, inclusive,

a. For noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, humiliation, disfigurement, mental anguish, diminished quality of life, emotional distress and other nonpecuniary damages in the past and in the future;

b. For past and future medical, hospital, custodial, nursing and rehabilitation expenses and costs, the cost of obtaining substitute domestic services and loss of ability to provide household services;

c. For the loss of income, lost earnings, loss of earning capacity, loss of employment, loss of business or employment opportunities, loss of ability to earn income in the future, past and future loss of wages and employment benefits;

d. For the reasonable value of services to care for and provide for Plaintiff's special needs;

e. Attorney's fees and costs pursuant to Cal. Civ. Code § 1780;

f. For punitive damages according to proof for willful, malicious and oppressive conduct or for conscious disregard of the Plaintiff's rights and safety;

g. For other general and special damages according to proof;

h. For any other compensatory damages according to proof;

i. For interest thereon at the legal rate;

j. For costs of the suit incurred herein, including expert costs; and

k. For such other and further relief as the Court deems appropriate.

Dated: June 14, 2018

ABIR COHEN TREYZON SALO, LLC

By: _____
Yolanda M. Medina
Attorneys for Plaintiff

DEMAND FOR JURY TRIAL

Plaintiff, JOSEPHINA ROBLES by and through her conservator, SERGIO ROBLES, hereby requests a trial by jury.

Dated: June 14, 2018

ABIR COHEN TREYZON SALO, LLC

By: _____
Yolanda M. Medina
Attorney for Plaintiff

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the County of Orange, State of California. I am over the age of 18 and not a party to this action. My business address is 2600 Michelson Drive, Suite 1700, Irvine, CA 92612.

On June 14, 2018, I served the foregoing documents entitled: **FIRST AMENDED COMPLAINT FOR DAMAGES,** on all interested parties to this action by placing true copies thereof enclosed in sealed envelopes addressed as follows:

See attached service list

☒ **BY MAIL**: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Santa Ana, California, in the ordinary court of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

☐ **BY ELECTRONIC MAIL:** I transmitted the document(s) listed above electronically to the e-mail addresses listed above. I am readily familiar with the firm's Microsoft Outlook e-mail system, and the transmission was reported as complete, without error.

☐ **BY PERSONAL SERVICE**: I caused such envelope(s) to be delivered by hand to the office of the addressee(s).

☐ **BY OVERNIGHT DELIVERY**: I am "readily familiar" with the firm's practice of collection and processing correspondence for overnight delivery. Under that practice it would be deposited with the express service carrier on that same day, in an envelope or package designated by the express service carrier with delivery fees provided for, at Santa Ana, California, in the ordinary course of business.

☐ **BY FAX**: I transmitted the foregoing document by facsimile transmission from (714) 716-8445 to the facsimile numbers indicated on the attached mailing list. The transmission was reported as complete and without error on the transmission report, which was properly issued by the transmitting facsimile machine. (Exhibits not faxed, are overnighted

☒ **STATE**: I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

EXECUTED on June 14, 2018, in Irvine, California.

Elsa V. Rivera
TYPE OR PRINT NAME

SIGNATURE

SERVICE LIST

Thomas R. Bradford, Esq. Peterson- Bradford- Burkwitz 100 North First Street, Suite 300 Burbank, CA 91502 T: (818)562-5800 F: (818)562-5810 TBradford@pbbllp.com	Attorneys for Defendant **SABRI MALEK, M.D., AND INTERVENTIONAL ANASTHESIA & PAIN MANAGEMENT CLINIC, INC.**
Louis H. DeHaas, Esq. Gilliam N. Pluma, Esq. David J. Ozeran, Esq. La Follette, Johnson, DeHaas, Fesler & Ames 865 South Figueroa Street, 32nd Floor Los Angeles, CA 90017 T: (213)426-3600 F: (213)426-3650	Attorneys for Defendant **ST. FRANCIS MEDICAL CENTER**
Patrick W. Mayer, Esq. Dena J. Hayden Lambirth, Esq. Schmid & Voiles 333 South Hope Street, 8th Floor Los Angeles, CA 90071 T: (213)473-8700 F: (213)473-8777 pmayer@schmidvoiules.com dlambirth@schmidvoiles.com	Attorneys for Defendant **HANH T NGUYEN-CLARK, M.D. and MASSOUD SHAHIDI, M.D.**
Robert C. Reback, Esq. Heidi L. Kjar, Esq. Reback, McAndrews & Blessey, LLP 1230 Rosecrans Avenue, Suite 450 Manhattan Beach, CA 90266 T: (310)297-9900 F: (310)297-9800 rreback@rmkws.com hkjar@rmkws.com	Attorneys for Defendant **GWEN M. ALLEN, M.D., INC., a medical corporation, d/b/a GARDENA WOMEN'S CENTER (erroneously sued and served herein as GWEN M. ALLEN, M.D., INC., a medical corporation, d/b/a GARDENA WOMEN'S CENTER, INC.)**

PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is: 21860 Burbank Boulevard, Suite 360, Woodland Hills, CA 91367

A true and correct copy of the foregoing document entitled: **NOTICE OF MOTION AND MOTION FOR RELIEF FROM THE AUTOMATIC STAY UNDER 11 U.S.C. § 362 (with supporting declarations) (ACTION IN NONBANKRUPTCY FORUM)** will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF)**: Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On (*date*) 10/29/2018, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

(Please see Attachment 1.)

☒ Service information continued on attached page

2. **SERVED BY UNITED STATES MAIL**:

On (*date*) 10/29/2018, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows. Listing the judge here constitutes a declaration that mailing to the judge will be completed no later than 24 hours after the document is filed.

Honorable Ernest M. Robles
United States Bankruptcy Court
255 E. Temple Street, Suite 1560
Los Angeles, CA 90012

☐ Service information continued on attached page

3. **SERVED BY PERSONAL DELIVERY, OVERNIGHT MAIL, FACSIMILE TRANSMISSION OR EMAIL** (state method for each person or entity served): Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on (*date*) _____, I served the following persons and/or entities by personal delivery, overnight mail service, or (for those who consented in writing to such service method), by facsimile transmission and/or email as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

☐ Service information continued on attached page

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

10/29/2018	JACQUELINE DALE	Jackie Dale
Date	*Printed Name*	*Signature*

In re: VERITY HEALTH SERVICES OF CALIFORNIA, INC.
Case No. 2:18-bk-20151-ER

Attachment to:
PROOF OF SERVICE OF DOCUMENT
to
NOTICE OF MOTION AND MOTION FOR RELIEF FROM THE AUTOMATIC STAY
(ACTION IN NON BANKRUPTCY FORUM)

Attachment 1 - To Be Served By the Court Via Notice of Electronic Filing:

Robert N Amkraut ramkraut@foxrothschild.com
Kyra E Andrassy kandrassy@swelawfirm.com,
csheets@swelawfirm.com;gcruz@swelawfirm.com;jchung@swelawfirm.com
Simon Aron saron@wrslawyers.com
Keith Patrick Banner kbanner@greenbergglusker.com,
sharper@greenbergglusker.com;calendar@greenbergglusker.com
Cristina E Bautista cristina.bautista@kattenlaw.com, ecf.lax.docket@kattenlaw.com
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