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IN THE FIFTHTEENTH CIRCUIT COURT, IN AND FOR
PALM BEACH COUNTY, FLORIDA

Barbara Dziedzic; Paul Dziedzic, Sr.; Stacey Wilson; and Paul Dziedzic, Jr.; each in their individual capacities; and Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic,

Plaintiffs,

v.

Palms West Hospital Limited Partnership, a Florida limited partnership doing business as Palms West Hospital; Columbia Palm Beach GP, LLC, a Delaware limited liability company; and Linda Truempy, R.N.

Defendants.
_____/

Case No.: 502018CA007015XXXXMB

JURY TRIAL DEMANDED

FIRST AMENDED COMPLAINT

Plaintiffs, Barbara Dziedzic and Paul Dziedzic, individually; and Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic; sue the Defendants, Palms West Hospital Limited Partnership, a Florida limited partnership; Columbia Palm Beach GP, LLC, a Delaware limited liability company; and Linda Truempy, R.N.; and for their causes of action state as follows:

Introduction

1. This case arises out of gross malpractice that caused the death of Joshua Dziedzic, a 25-year old college student, while he was a patient in Palms West Hospital.

2. The case also arises from the intentional concealment of the malpractice from the patient's parents, despite an obligation to disclose the event to the parents pursuant to statutory and fiduciary duties.

3. This case seeks damages in excess of the $15,000 minimum jurisdictional limits of this court.

4. Venue is appropriate in Palm Beach County because the cause of action arose here.

5. All conditions precedent to filing this action, if any, have occurred or have been waived.

6. Where applicable, Plaintiffs have fully complied with the provisions of Chapter 766, Florida Statutes regarding presuit notice and discovery.

7. Joshua Dziedzic died in Palms West Hospital on August 22, 2016. The Plaintiffs include:

a. Barbara Dziedzic, who is Joshua's mother;
b. Paul Dziedzic, Sr., who is Joshua's father;
c. Barbara Dziedzic, as the Personal Representative of the Estate of Joshua Dziedzic.

8. A copy of the Order of Appointment of Barbara Dziedzic is attached to this Complaint as Exhibit A.

The Defendants

9. Defendant Palms West Hospital Limited Partnership is a Florida limited partnership which, at all times material, owned and operated a hospital in Palm Beach County known to the public as "Palms West Hospital."

10. Defendant Columbia Palm Beach GP, LLC is a Delaware limited liability company which, at all times material, was the general and managing partner of Palms West Hospital Limited Partnership.

11. Palms West Hospital Limited Partnership, Columbia Palm Beach GP, LLC, and the hospital itself will collectively be referred to throughout as "Palms West Hospital."

12. Defendant Linda Truempy, R.N. ("Nurse Truempy") is a Florida Registered Nurse.

13. At all times material, Nurse Truempy was working as a Registered Nurse in the Intensive Care Unit ("ICU") of Palms West Hospital, and was an employee of Palms West Hospital, acting within the course and scope of her employment.

Common Facts

14. Joshua Dziedzic struggled with drug addiction, which arose from prescription opioid use following surgery on both of his feet from a car accident.

15. Prior to the malpractice which caused his death, Joshua had been attending Palm Beach State College and working as a personal trainer at a local gym.

16. On or about August of 2016, Joshua had a relapse of his addiction problems, resulting in a life-threatening unintentional drug overdose for which he was admitted to Palms West Hospital's ICU on August 8, 2016.

17. During the first few days of his hospitalization, Joshua was unconscious and, on a ventilator, and it appeared that he might not survive. However, by August 15, he had significantly recovered and was able to be weaned off the ventilator.

18. By August 18, Joshua was alert, talking and walking. On that date, in anticipation of Joshua being discharged from the ICU, Nurse Truempy came into Joshua's room to remove a central line catheter in Joshua's neck, while Joshua was sitting upright in a chair talking with his mother.

19. A "central line catheter," or "central line," is a catheter placed in a large vein, usually in the internal jugular vein in the neck.

20. Central lines are used to administer medications or fluids that cannot be taken by mouth or that would harm a smaller peripheral vein, and/or to obtain blood for certain tests, and/or to measure central venous pressure.

21. Central lines are extremely common among critically ill hospital patients and they are in daily use in hospitals across the country and around the world. According to the United States Center for Disease Control, in the United States alone there are over 15 million central line catheter-days/year recorded in intensive care

units.[1]

22. Joshua Dziedzic's central line was on the left side of his neck, extending about 17 to 20 centimeters into his internal jugular vein, with the tip of the catheter resting in the right atrium of his heart.

23. It is very common knowledge among healthcare providers who work in intensive care units in the United States that pulling a central line catheter out of a patient's internal jugular vein improperly would be dangerous and could seriously jeopardize the patient's health and safety.

24. It is very common knowledge among healthcare providers who work in intensive care units that improper removal of a central line can allow air to be sucked into the patient's vein, leading to what is known as a venous air embolism.

25. It is very common knowledge among healthcare providers who work in intensive care units that a venous air embolism can cause significant damage to a patient's heart and lungs and can be fatal.

26. It is very common knowledge among healthcare providers who work in intensive care units that in order to prevent a venous air embolism from occurring when a central line is removed, the patient must be placed in a Trendelenburg position (*i.e.*, with the head 15 to 20 degrees lower than the feet) for the removal, and that if the Trendelenburg position is contraindicated for any reason, the patient must at least be

[1] http://stacks.cdc.gov/view/cdc/5916/.

lying flat when the line is removed.

27. It is very common knowledge among healthcare providers who work in intensive care units that when the patient is in an upright position when a central line is removed it reduces the patient's central venous pressure to below normal atmospheric pressure and places the patient at particular high risk for entraining air very rapidly into the venous circulation.

28. It is very common knowledge among healthcare providers who work in intensive care units that in addition to making sure the patient is lying flat, the safe removal of a central line also requires asking the patient to slowly exhale while the line is being pulled out, or to hold their breath and bear down (*i.e.*, perform the Valsalva maneuver), to further alter the pressure gradient.

29. It is very common knowledge among healthcare providers who work in intensive care units that the final important step in the safe removal of a central line includes quickly applying pressure to the site when the line is out and then sealing the neck opening with an occlusive dressing. An occlusive dressing is a medical dressing which seals the wound off from outside air.

30. At the time she removed Joshua Dziedzic's central line Nurse Truempy had over 30 years of ICU nursing experience, including supervision and teaching of other ICU nurses.

31. Nurse Truempy at all times material was aware of the proper and safe way

to remove a central line catheter from a jugular vein of a patient.

32. Nurse Truempy ignored every one of the safety precautions when she pulled Joshua's central line out of his internal jugular vein.

33. Nurse Truempy pulled Joshua's central line out while Joshua was sitting upright in the chair talking with his mother.

34. Nurse Truempy did not instruct Joshua to get into the Trendelenburg position or even to lie flat when she pulled the line out.

35. Nurse Truempy did not instruct Joshua to slowly exhale or alternatively perform the Valsalva maneuver while she was pulling the line out.

36. Nurse Truempy did not apply pressure to the large opening in Joshua's neck when the line was out.

37. Nurse Truempy did not promptly cover the large opening in Joshua's neck with an occlusive dressing when the line was out.

38. Nurse Truempy just pulled out Joshua's central line while he was sitting upright and talking to this mother, and then she walked away.

39. Nurse Truempy's conduct in removing the central line was gross negligence, meaning it was so reckless or wanting in care that it constituted a conscious disregard or indifference to Joshua's life, safety and rights.

40. Additionally, or alternatively, Nurse Truempy's actions were "intentional misconduct," meaning that she had actual knowledge of the wrongfulness of her

conduct and the high probability that injury would occur, yet despite that knowledge, she intentionally pulled out Joshua's central line in an improper and dangerous manner.

41. As a result of the improper removal of his central line, Joshua Dziedzic suffered a catastrophic, and ultimately lethal, venous air embolism.

42. Within moments after the line was out, Joshua began complaining to his mother of chest pain and difficulty breathing, while clutching his mother's arm.

43. Shortly thereafter Joshua collapsed, and his mother had to physically support the weight of his collapsing body to keep him from falling to the floor.

44. While supporting Joshua's body, his mother cried out for help to support Joshua and to place him back into the ICU bed.

45. Joshua lost consciousness as his oxygenation level quickly dropped from the high 90s down to the low 70s, which is considered severely hypoxic.

46. Joshua was initially placed on a non-rebreather mask with 100% oxygen, until he could be intubated again and then kept on a mechanical ventilator.

47. Joshua remained unconscious in the ICU at Palms West Hospital from the time Nurse Truempy pulled out his central line until four days later, when, on August 22, 2016, Joshua was declared brain dead and disconnected from the ventilator, with his mother sitting by his side.

48. Barbara Dziedzic suffered severe psychological and emotional distress and mental anguish arising from her being present and witnessing her son's severe

hypoxic event and collapse. Her severe emotional distress over this incident has been manifested by depression, nightmares, inability to concentrate, bouts of crying significant weight gain, and both chest pains and hypertension developing shortly after the event. These conditions have also all been exacerbated by the coverup by the hospital described herein.

49. At all times material Palms West Hospital had in place a written hospital-wide policy regarding the proper way to manage and remove a central line catheter. This written policy (hereafter "Central Line Policy") states on its face that it applies to all physicians and registered nurses.

50. At all times material, all physicians and nurses working in the ICU were required to be aware of, and follow, the Central Line Policy.

51. The Central Line Policy stated the patient was to be placed in the Trendelenburg position before a central line is removed.

52. After Nurse Truempy removed the central line from Joshua's neck, she made a nurse's note in his chart stating that she removed his central line while he was sitting in the chair and that after she had done that Joshua started complaining of burning in the middle of his chest with shortness of breath, and his oxygen saturations then dropped down to the seventies.

53. Every doctor and nurse who thereafter read Nurse Truempy's notes over the next four days became aware that Nurse Truempy violated the hospital-wide

Central Line Policy by removing Joshua's central line while he was sitting upright in a chair. They also knew that following that improper line removal Joshua immediately suffered a major hypoxic event and collapsed, had to be immediately reintubated, and he that never regained consciousness.

54. After the event, several physicians made notations in the progress note section of the chart that Joshua had been doing very well and recovery right up until the time Nurse Truempy removed his central line catheter, following which he promptly suffered a major hypoxic event.

55. Every nurse and physician reading those progress notes over the next four days was aware that following Nurse Truempy's improper removal of the central line Joshua suffered a major hypoxic event from which he did not recover.

56. At all times material it was widely known throughout the ICU that Joshua's collapse was related to the improper removal of his central line by Nurse Truempy.

"Never Events" – Shocking and Preventable Injuries

57. Causing an air embolism by improperly removing a central line is widely known as a hospital "Never Event."

58. The term "Never Event" was first introduced to medicine in 2001 by the National Quality Forum, which is a large not-for-profit organization created to develop and implement a national strategy for health care quality measurement and reporting.

59. According to the National Quality Forum, the term "Never Event" was developed to describe "particularly shocking medical errors" that should never occur in a hospital.[2]

60. In 2007, Medicare regulations approved of and adopted the National Quality Forum's "Never Event" list, and Medicare made it known to all participating hospitals that it would stop reimbursing hospitals for charges arising from the treatment of patient injuries caused by Never Events.

61. The Medicare "Never Event" regulations also preclude hospitals from billing patients for care arising from "Never Events."

62. Following the publication of Medicare's "Never Event" regulations, most major health insurance companies in the United States announced they, too, would stop paying hospitals for medical care related to injuries caused by a Never Event.

63. As a result of Medicare's Never Event regulations and the actions of the major health insurers, long before Joshua's medical care the "Never Event" list of "particularly shocking" and easily preventable medical errors had been widely circulated among hospitals around the United States, including without limitation to hospital governing boards, hospital administrators, hospital risk managers, hospital patient safety officers, hospital patient safety committees, hospital quality assurance committees, utilization review committees, and medical bill coding departments.

[2] https://psnet.ahrq.gov/primers/primer/3/never-events

64. At all times material Palms West Hospital was and is a participating hospital member of The National Quality Forum and was and is aware of the development and publication of the "Never Events" list of particularly shocking and easily preventable errors, including specifically the prevention of venous air embolism in patients.

65. At all times material Palms West Hospital was and is a Medicare participating hospital and was and is aware of Medicare's publication of the Never Event list and its Never Event regulations.

66. At all times material Palms West Hospital was and is under health care reimbursement contracts with major health insurance companies and third-party payors and was and is aware of the prohibition in those insurance contracts which prohibit the hospital from seeking reimbursement from those health insurers and third-party payors for treatment or care arising from "Never Events."

67. At all times material Palms West Hospital, through its governing board, hospital administration, risk managers, hospital patient safety officers, hospital patient safety committees, quality assurance department, utilization review committee, billing department, coding department and medical staff and nursing personnel, was and is aware of the list of easily preventable Never Events, including the introduction of venous air occurring in connection with placement, management or removal of central line catheters.

68. Although the list of "Never Events" has grown over the years, failing to prevent venous air embolism in connection with central lines was on the list from the beginning and was one of the original eight Never Events.

The Coverup – Death from a "Broken Heart"

69. At all times material, the hospital, doctors and nurses involved in Joshua's care at Palms West Hospital considered Barbara Dziedzic and Paul Dziedzic, Sr. as Joshua's healthcare surrogates for daily treatment decisions and "informed consent" when Joshua was unable to give consent himself.

70. Following the improper removal of Joshua's central line, Joshua's doctors, nurses and other hospital personnel knew that Joshua had suffered a venous air embolism from Nurse Truempy's improper removal of the central line, but they never told Joshua's parents that is what had happened.

71. After Joshua lost consciousness and was placed back on the ventilator, Joshua's parents and family were lied to and told that Joshua had sustained a sudden, massive heart attack caused by a condition they called "broken heart syndrome."[3]

72. Joshua's parents and other family members were told that Joshua had

[3] "Broken Heart Syndrome refers to a temporary heart condition brought on by a stressful situation, such as the death of a loved one. People with broken heart syndrome may have sudden chest pain and think they are having a heart attack. These symptoms are treatable and the condition usually reverses itself in days or weeks. https://www.mayoclinic.org/diseases-conditions/broken-heart-syndrome/symptoms-causes/syc-20354617

suffered sadness and embarrassment over the hurt he had caused to his family due to his drug relapse and overdose, and that Joshua's sadness had stressed his heart so much that he had a heart attack because of it.

73. To Joshua's grieving parents, this meant that Joshua had collapsed, and then died four days later, partly because of them. Joshua's parents and other family members had been trying every day since Joshua first regained consciousness following the initial drug overdose to reassure Joshua how much they loved him, that they were not angry or disappointed in him, and that they were eager to help him start over as soon as he came home from the hospital.

74. To Joshua's parents, dying from a broken heart meant that they had not done enough to reassure Joshua of their love for him, and their grief and natural feelings of guilt over his death were multiplied because of this false and deliberately misleading diagnosis.

75. "Broken heart syndromes" to the extent they do occur, do not come on suddenly at the time of having a central line removed, and broken heart syndrome has never been reported in the medical literature to be associated in any way with central line removal.

76. "Broken heart syndrome" does not result in the type of catastrophic hypoxic event like the event that occurred when Joshua's central line was removed.

77. Joshua Dziedzic did not have "broken heart syndrome."

78. In addition to what has been described above, Palms West Hospital took several other actions and omissions in order to conceal the Never Event. These actions and omissions included, but were not limited to:

a. The hospital failed to require any of the doctors, nurses or other personnel who had knowledge of the incident to submit mandatory incident reports, which were a requirement under the hospital's own internal policies and required by Florida Statutes and state hospital regulations;

b. The hospital failed to report the Never Event incident to the Florida Agency for Health Care Administration within fifteen days of the occurrence (called Code 15 Reports) which was required under the hospital's own internal policies and by Florida Statutes and state hospital regulations;

c. The hospital omitted the Never Event from its 2016 Annual Code 15 Report to the Florida Agency for Health Care Administration, which report was required under the hospital's own internal policies and required by Florida Statutes and state hospital regulations;

d. The hospital failed to conduct an internal root cause analysis[4] to determine why the incident occurred, and failed to take any steps to prevent it from happening again to other patients, which was required under the hospital's own internal policies and was required by Florida Statutes and state hospital regulations;

e. At some point in time after the Never Event occurred the Director of the ICU confronted Nurse Truempy and advised her that she probably caused Joshua to sustain a venous air embolism by improperly removing his central line. In spite of that discussion, the Director of the ICU participated in a coverup by failing to file an incident report herself as required by hospital policy, failing to instruct Nurse Truempy to file an incident report as required by hospital policy, failing to ensure that the hospital reported the event to the parents of Joshua Dziedzic, as required by law and hospital policy, and failing to ensure

[4] A root cause analysis ("RCA") is a structured method used to analyze serious adverse events that is widely deployed as an error analysis tool in health care. The ultimate goal of RCA is to prevent future harm by eliminating the latent errors that underlie adverse events.

that the hospital reported the event to the Agency for Health Care Administration;

f. At some point in time after the Never Event occurred, the Chief Nursing Officer of the hospital became aware of the Never Event. Along with other hospital administrative and clinical personnel, she participated in an internal decision to keep the Never Event concealed and not to file any incident reports, not to do a root cause analysis, not to notify the family, and not to notify the Agency for Healthcare Administration;

g. After Joshua died, the hospital sent an electronic death report to the Office of the Palm Beach County Medical Examiner. The cause of death on the electronic death record described the cause of death as resulting from "anoxic brain encephalopathy due to a drug overdose, with contributing factors of acute respiratory failure and acute renal failure." The cause of death was classified as "natural" and intentionally omitted any reference to the venous air embolism. This intentionally misleading death report made it seem as if Joshua Dziedzic died directly from his drug overdose rather than the gross malpractice committed during the removal of Joshua's central line.

Truth came from the Medical Examiner

79. Following Joshua's death, his body was moved from the hospital to a funeral home in Fort Myers, where Joshua's family held a funeral service for Joshua. His body was embalmed in Ft. Myers and awaited cremation.

80. For reasons unknown to the family, the Office of the District Medical Examiner for Palm Beach County became suspicious about the cause of Joshua's death, and one of its investigators requested certain information from Joshua's medical records from Palms West Hospital. Such requests are customarily complied with, and digital copies of the specific records requested are sent. However, on this occasion, rather than provide the specific pages requested in digital format, the hospital printed

paper copies of all one thousand seven hundred eighty-eight (1,788) pages of hospital records and sent them to the Medical Examiner's office in order to make the investigator's job of reviewing and understanding the sequence of what had happened much more difficult and time consuming.

81. After a review of the medical records, Dr. Michael Bell, the Chief Medical Examiner for the District, took jurisdiction of the case and requested that Joshua's body be returned from Lee County to Palm Beach County for examination by his office.

82. The body was returned to Palm Beach County and the Medical Examiner performed an autopsy and reviewed relevant hospital records.

83. More than three months after Joshua's death, a new death certificate was issued, this time by the Medical Examiner, changing the cause of Joshua's death to "probable air embolism following removal of central venous catheter," and changing the manner of death from "natural" to "accident."

84. The Medical Examiner advised Joshua's mother over the telephone that the real cause of Joshua's death was not "broken heart syndrome" or his drug overdose but was instead a venous air embolism following improper removal of Joshua's central line by Nurse Truempy. The Medical Examiner also recommended to Joshua's mother that she and her family obtain legal counsel.

Agency For Health Care Administration

85. After the coverup was revealed by the medical examiner, the Florida Agency for Healthcare Administration ("AHCA"), began its own investigation of Joshua's medical care.

86. During the investigation of Joshua's care and in a direct admission against interest, Nurse Truempy stated;

a. That she removed Joshua's central line while he was sitting upright in a chair;

b. That removing the line while Joshua was sitting up in the chair was not the proper way to do it;

c. That the proper way to do it was to have Joshua lie flat and hold his breath;

d. That right after she removed the line Joshua all of a sudden grabbed his chest and said he was having a lot of pain and that she needed the help of another nurse to get Joshua back into bed, and the intensivist, Dr. Hossain, had to come in and re-intubate Joshua.

87. During the investigation of Joshua's care and in a direct admission against interest, the Director of the Intensive Care Unit of the hospital stated:

a. That Nurse Truempy's removal of Joshua's central line while he was sitting upright was very surprising to her;

b. That she had spoken to Nurse Truempy about it after the event, and advised her that Joshua may have sustained an air embolism due to Nurse Truempy's improper removal of the central line;

c. That Nurse Truempy admitted to her that she had removed the line while Joshua was sitting upright in a chair;

d. That the appropriate way to remove a central line, and according to hospital policy at the time, was that Joshua should have been in a Trendelenburg position, not sitting up; and

e. That she (the Director of the Intensive Care Unit) chose not to file the required incident report upon learning of the event.

88. During the investigation of Joshua's care and in a direct admission against interest, the Chief Nursing Officer of the hospital stated:

a. That she could not recall who told her initially about the incident; and

b. That besides herself, she could not recall who, or how many other people were involved in the decision that was made not to initiate the required incident report.

89. During the investigation of Joshua's care and in a direct admission against interest, the hospital's Director of Patient Safety and Risk Management stated:

a. That the policy of Palms West Hospital was that an incident report should be initiated when something happens outside of the normal, customary routine happens;

b. That an incident report should have been submitted when Joshua had to be re-intubated following the removal of his central line while he was sitting upright in a chair;

c. That this event that occurred to Joshua should have been reported as an adverse event, Code 15 serious event;

d. That the hospital should have performed a Root Cause Analysis of this event;

e. That when "the hospital" looked at the nursing notes "they" knew what the cause was and "they" decided not to generate an incident report or otherwise report the incident.

COUNT I –Breach of Statutory Duty to Disclose

Plaintiffs, Barbara Dziedzic, individually, Paul Dziedzic, Sr., individually, and Barbara Dziedzic as Personal Representative of the Estate of Joshua Dziedzic, reallege paragraphs 1 through 89, and further state as follows:

90. This is a cause of action against Palms West Hospital and Nurse Truempy for breach of their statutory duties to disclose the Never Event to Joshua Dziedzic's mother and father.

91. At all times material while Joshua was a patient in Palms West Hospital, Joshua's medical condition was frequently such that he was not capable of making his own informed treatment decisions. This was particularly true during the first several days of his admission, and then again from when he collapsed from the venous air embolism on August 18, 2016 and became unconscious, until he was removed from life support and died on August 22, 2016.

92. At all times material, Joshua's parents were present and communicating regularly with the hospital, its nurses, its medical staff, and other hospital personnel, regarding Joshua's condition and care.

93. Joshua had not formally designated a health care surrogate in writing and at all times material Joshua's parents individually and together were acting as Joshua's health care surrogates regarding his medical and hospital care pursuant an implied agreement with the hospital.

94. At all times material, the hospital, its nurses, its medical staff and other hospital personnel accepted both of Joshua's parents, individually and collectively, as Joshua's health care surrogates regarding his medical and hospital care.

95. On some occasions during the admission the hospital asked Joshua's mother to sign consent forms for Joshua, and she did, and on other occasions the hospital asked Joshua's father to sign consent forms for Joshua, and he did.

96. At all times material Section 395.0197, Florida Statutes required Palms West Hospital to have in place a comprehensive risk management program.

97. One of the statutory requirements of the risk management program was that the hospital have in place a system for notifying patients of adverse incidents. Section 395.0197(1)(d) describes the required notification system as:

> A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury. [emphasis supplied]

98. An "adverse incident" is defined in 395.0197(5) as:

> "… an event over which health care personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:
> (a) Results in one of the following injuries:
> 1. Death;
> 2. Brain or spinal damage;
> 3. Permanent disfigurement;
> 4. Fracture or dislocation of bones or joints;

> 5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

99. Joshua's venous air embolism (the Never Event) met the definition of an "adverse incident" pursuant to the forgoing statute and thus was required to be reported under the hospital's mandatory system of reporting. [5]

100. Not only must the hospital have a reporting system in place, but a related statute mandates that the reporting of adverse incidents to the patient and family actually be done. Section 395.1051, Florida Statues additionally provides:

> **Duty to notify patients**. —An appropriately trained person designated by each licensed facility **shall** inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient [emphasis added].

101. When §395.0197(1)(d) and §395.1051 refer to informing the patient "or an individual identified pursuant to s. 765.401(1)," those sections are incorporating a requirement that the hospital follow a statutory hierarchy of reporting the adverse incident to the patient's family members in the event the patient is incapacitated.

102. Section 765.401(1) provides that when a patient is incapacitated and has not previously executed an advanced directive or designated a health care surrogate, health care decisions may be made for the patient by the following individuals, in the

[5] All "Never Events" would necessarily also meet the definition of an "adverse incident," although not all adverse incidents rise to the level of a Never Event.

following order of priority, which is being paraphrased:

a. A court appointed guardian;

b. The patient's spouse;

c. An adult child of the patient;

d. A parent of the patient;

e. A majority of the patient's adult siblings. [other lower categories of preference omitted].

103. While hospitalized at Palms West Hospital, Joshua Dziedzic did not have a court appointed guardian, or an advance directive or previously designated health care surrogate. He also was not married, and he had no children. Consequently, Joshua's parents were at the top of the statutory hierarchy to serve as his healthcare decision-makers pursuant to 766.401(1), and they were also the person's the hospital was required by law to promptly notify of any adverse incident involving Joshua.

104. More specifically, when Joshua became incapacitated following the improper removal of his central line, it was the statutory duty of the hospital to disclose the adverse event to Joshua's mother and father pursuant to §395.1051.

105. A statutory duty to disclose this event to Joshua's parents was also separately owed by every physician and every nurse in the hospital who became aware of the event, including without limitation, Nurse Truempy. Section 456.0575(1), Florida Statutes states:

Every licensed health care practitioner shall inform each patient, or an

> individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient (emphasis added).

106. Section 456.001(4), Florida Statutes, defines "licensed health care practitioners" to include without limitation, all medical doctors licensed under Chapter 458, all osteopathic physicians licensed under Chapter 459, and all nurses licensed under Chapter 464.

107. As licensed health care practitioners, Nurse Truempy and all of Joshua's physicians and nurses during the admission each had their own independent statutory duty to notify Joshua's parents of this event. The language of 456.0575(1) does not in any way limit the reporting obligation to healthcare practitioners who were at fault for causing the adverse event. The plain meaning of the words, "Every licensed health care practitioner shall inform" clearly means that <u>all</u> of Joshua's physicians and nurses with knowledge of the event had a statutory obligation to disclose it to Joshua, and during his period of incapacity, to his parents. None one of them did.

108. Section 766.110, Florida Statutes, creates a private cause of action against a hospital when the hospital's failure to initiate and diligently administer the required risk management program causes injury to a patient. More specifically, that statute provides, in part:

> (1) **All health care facilities**, including hospitals and ambulatory surgical centers, as defined in chapter 395, **have a duty to assure comprehensive risk management … and are liable for a failure to exercise due care in fulfilling these duties.** These duties shall include, but not be limited to:

….

> (b) **The adoption of a comprehensive risk management program which fully complies with the substantive requirements of s. 395.0197**….
>
> (c) **The initiation and diligent administration of … risk management processes established in paragraphs (a) and (b)….**
>
> **Each such facility shall be liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient** (emphasis supplied).

109. At all times material, Palms West Hospital failed to have in place the required risk management system for notifying patients.

110. At all times material, Palms West Hospital failed to diligently administer the required risk management processes, including the mandatory system for promptly notifying patients or their families of adverse incidents.

111. At all times material, Joshua Dziedzic had a right to have the adverse incident timely disclosed directly to him, and during his period of incapacity, directly to his parents who were lawfully making healthcare decisions on Joshua's behalf. This right held by Joshua includes the right not to have his health care surrogates making life and death medical decisions for him based on inaccurate or incomplete information.

112. At all times material, Joshua's parents, acting as healthcare surrogates and decision-makers for their son pursuant to 765.401(1), had the right to be promptly

notified that the adverse incident had occurred, which included being told specifically about Joshua's real (or even suspected) diagnosis and cause of his condition. These rights in the parents include the right not to have to make life and death medical decisions for their son based on inaccurate or incomplete information.

113. Barbara Dziedzic and Paul Dziedzic, Sr. were requested by the hospital and its medical staff to agree to terminate Joshua from life support, and ultimately, the parents did agree to removal of his life support on August 22, 2016, four days after the event. Making such a decision for their son is certainly one of the most horrible and difficult decisions any parent could ever be asked to make.

114. If Joshua's parents had been told about the Never Event they would, more likely than not, have made different healthcare decisions for their son, including, but not necessarily limited to:

a. They would have sought consultations from different physicians;

b. They would have sought the transfer of their son to a different hospital;

c. They would have demanded that Nurse Truempy not be allowed to return to Joshua's room;

d. They would have been more skeptical about the recommendation to terminate life support coming from people who committed gross malpractice and committed a Never Event that caused his condition;

e. Being skeptical about the recommendations to terminate life support, they would have given their son more time to see if he would recover, prior to removing life support.

115. Most parents forced to make a decision to remove their child from life support would likely have moments of regret and second guessing over such a decision after it had been made. Because of the concealment of Joshua's Never Event from the parents until after his death, the emotional distress, mental anguish and second guessing of Barbara Dziedzic and Paul Dziedzic, Sr. has been made considerably worse by the actions of the defendants described herein.

WHEREFORE, Plaintiffs, Barbara Dziedzic and Paul Dziedzic, Sr. individually sue Palms West Hospital and Nurse Truempy for all damages to which they are entitled, and Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic, sues Palms West Hospital and Nurse Truempy for all damages sustained by Joshua Dziedzic arising from the violation of his statutory rights to have his health care surrogates fully informed prior about his condition prior to their making health care decisions on his behalf. Collectively plaintiffs also sue for costs of this action and hereby demand trial by jury.

COUNT II –Breach of Fiduciary Duty

Plaintiffs, Barbara Dziedzic, individually, Paul Dziedzic, Sr. individually, and Barbara Dziedzic as Personal Representative of the Estate of Joshua Dziedzic, reallege paragraphs 1 through 115, with the exception of paragraph 90, and further state as follows:

116. This is a cause of action against Palms West Hospital, for breach of a fiduciary duty owed to Joshua Dziedzic and to his parents, to provide accurate and timely medical information to them, including without limitation to disclose the Never Event and the ultimate cause of Joshua's injury and death.

117. The Florida Supreme Court has described the term "fiduciary relationship" as being very broad under common law, and that "[s]tripped of all embellishing verbiage, it may be confidently asserted that every instance in which a confidential or fiduciary relation in fact is shown to exist will be interpreted as such." *Quinn v Phipps*, 113 S. 419, 421 (Fla. 1927). The Court in *Quinn* also stated:

> The relation and duties involved need not be legal; they may be moral, social, domestic or personal. If a relation of trust and confidence exists between the parties (that is to say, where confidence is reposed by one party and a trust accepted by the other, or where confidence has been acquired and abused), that is sufficient as a predicate for relief. The origin of the confidence is immaterial. *at* 421.

118. The Florida Supreme Court has also stated that a fiduciary relationship may be implied by law, and such relationships are "premised upon the specific factual situation surrounding the transaction and the relationship of the parties." *Doe v Evans*, 814 So.2d 370, 374 (Fla 2002), citing *Capital Bank v MVB, Inc.*, 644 So.2d 515, 518 (Fla 3d DCA 1994).

119. Citing to the Restatement (Second) of Torts, the Supreme Court stated:

> … "[o]ne standing in a fiduciary relation with another is subject to liability to the other for harm resulting from a breach of duty imposed by the relation."

> Thus, "[a] fiduciary who commits a breach of his duty as a fiduciary is guilty of tortious conduct to the person for whom he should act.... **[T]he liability is not dependent solely upon an agreement or contractual relation between the fiduciary and the beneficiary but results from the relation**." Restatement (Second) of Torts § 874 cmt. b (1979). **Moreover, "[a] fiduciary relation exists between two persons when one of them is under a duty to act for or to give advice for the benefit of another upon matters within the scope of that relation.**" *Evans Id* at 374 [citations omitted] [emphasis supplied]

120. The elements of a cause of action for breach of fiduciary duty claim in Florida are:

a. The existence of a fiduciary duty;

b. The breach of that duty; and

c. Damages proximately caused by the breach.

Minotty v. Baudo, 42 So. 3d 824, 836 (Fla. 4th DCA 2010) (citing *Gracey v. Eaker,* 837 So. 2d 348, 353 (Fla. 2002)).

121. As a hospital and healthcare provider, Palms West Hospital was in a unique position of power and influence over the medical care provided within the hospital.

122. At all times material, the hospital, its nurses, and the other hospital staff and personnel owed to Joshua's parents that same level of honesty, fairness and candor they owed to Joshua as a patient.

123. At all times material, the hospital, its nurses, and the other hospital staff and personnel knew that Joshua's parents had very little medical knowledge, and consequently knew the parents were relying on the hospital to keep the parents

continuously and fully informed at all times regarding Joshua's medical condition.

124. Joshua's parents' desire for information was partly because the parents were extremely anxious to hear about Joshua's ongoing status, like any loving and supportive parents would be. But the parents' reliance on the hospital for information also arose from their need to know correct and complete medical information so they could provide consent and permission to the hospital for the hospital's continued treatment of their critically ill son.

125. Throughout the entire admission, the hospital, through its nurses and other staff and personnel were frequently asking the parents to give the hospital various permissions in regard to its treatment of Joshua. The requests for treatment permissions that were made by the hospital to the parents sometimes asked for written permissions and sometimes just oral permissions, and included such things as asking the parents:

a. To allow the hospital to make certain releases of Joshua's protected health information;

b. To allow the hospital to perform various testing;

c. To allow the hospital to place and manage a central line and other IV lines and catheters;

d. To allow the hospital to perform an MRI with contrast media;

e. To allow the hospital to administer to Joshua certain types of blood products;

f. To allow the hospital to perform certain hemodialysis treatments;

g. To allow the hospital to remove Joshua from life support;

h. To allow organ donations to be harvested from Joshua's body;

i. To consent to the release of Joshua's body after his death.

126. Implied in that relationship is that the hospital would always only make recommendations in Joshua's best interest as a critically ill patient, and not ever only in the self-interest of the hospital.

127. Also implied in the relationship is that the hospital would always provide important, timely and accurate information to Joshua's parents, so they would be in a position to make timely, safe and intelligent decisions regarding their critically ill son's medical and hospital care and treatment.

128. Joshua's parents had very little medical knowledge, so in order for the parents to make reasonable decisions on behalf of their son, at all times material the parents placed their trust and confidence in the hospital, its nurses, medical staff and other hospital personnel to provide them with accurate, complete, and timely information about Joshua's medical condition, his diagnoses, the cause or causes of his diagnoses, and recommendations for Joshua's treatment.

129. At all times material, the hospital, its nurses, medical staff and other hospital personnel were aware not only of the parent's limited medical knowledge and reliance, but also of the parent's considerable emotional distress due to their son's

critical condition.

130. At all times material, the hospital, its nurses, medical staff and other hospital personnel were aware that the parents were placing this reliance on them, and they accepted the parents' trust, confidence and reliance on them to provide accurate and timely information and treatment recommendations for Joshua.

131. At all times material, the hospital's acceptance of the trust and reliance placed in it by the parents, created a fiduciary duty to timely disclose to the parents all important and reasonably available medical information about their son and his medical status, including without limitation, the actual or likely cause of his collapse and hypoxic event, and four days later, his death.

132. Because of the fiduciary nature of their relationship as described herein, Palms West Hospital had a duty to fully disclose the Never Event to Joshua's parents, and this duty arises directly from the fiduciary nature of their relationship. The fiduciary duty to disclose existed completely apart from any statutory or regulatory obligation imposed on the hospital to disclose the event to the parents. However, the obligation to disclose this event as a fiduciary was further heightened by the statutory obligation to disclose imposed by Section 395.1051, Florida Statutes, and also the obligation to disclose that was imposed on the hospital by several other regulatory and accrediting requirements discussed below.

Joint Commission Accreditation Requirement of Disclosure

133. Palms West Hospital is accredited by The Joint Commission (formerly called "JCAHO," or the "Joint Commission on Accreditation of Healthcare Organizations"), and the hospital holds itself out to the public, to the State of Florida, to Medicare, and to third party health insurance carriers as being accredited by The Joint Commission.

134. In the State of Florida, complying with Joint Commission accreditation standards is a significant commitment by hospitals to consumers in Florida. Under Florida hospital regulations, by becoming maintaining its accreditation, Palms West Hospital became exempt from routine license inspections by the Florida Agency for Healthcare Administration.[6]

135. At all times material The Joint Commission had a Standard of Accreditation in place that required Palms West Hospital to inform Joshua's parents about the Never Event/Adverse Incident. Joint Commission Standard of Accreditation RI.01.02.01, deals with a patient's right to participate in all decisions about the patient's care and services. Element of Performance A-21 under that Accreditation Standard states "The hospital informs the patient or surrogate decision-maker about

[6] Accredited hospitals meeting Chapter 59A-3.253(3), Florida Administrative Code, are "deemed" to be in compliance with Florida licensure and certification requirements. Deemed hospitals are not scheduled for routine on-site licensure surveys by AHCA.

unanticipated outcomes of care, treatment, and services that relate to "Sentinel Events" as defined by the Joint Commission."

136. According to The Joint Commission, a "Sentinel Event" is a patient safety event that results in death, permanent harm, or severe temporary harm and for which intervention is required to sustain life. The Joint Commission calls them "sentinel" because they signal the need for immediate investigation and response. [7]

137. By this definition all Never Events would also be "Sentinel Events," although not all Sentinel Events would necessarily rise to the level of "shocking and completely avoidable" events on the Never Events list. Likewise, by this definition pf "Sentinel Events" all "adverse incidents" as defined by F.S. 395.0197(5) would also be "Sentinel Events" pursuant to The Joint Commission's standards of accreditation.

138. Palms West Hospital violated this mandatory Joint Commission standard by failing to disclose the Sentinel Event/Never Event/Adverse Incident to Joshua's parents.

Leapfrog Group Membership Requirement of Disclosure

139. At all times material Palms West Hospital was a member of the Leapfrog Group, which is a national patient safety organization driven by large health insurance companies that pay for healthcare.

140. At all times material on the Palms West Hospital website, and in other

[7] https://www.jointcommission.org/assets/1/6/CAMH_2012_Update2_24_SE.pdf

material ways, the hospital promoted itself to the public and to private health insurers as being a member of the Leapfrog Group.

141. The Leapfrog Group, on its own website, gives public ratings for each of its member hospitals based on their adherence to desired safety initiatives.

142. At all times material, The Leapfrog website reveals that Palms West Hospital has four "bars," the highest rating available, for its management of Never Events.

143. Leapfrog's website describes how Never Events are required to be managed by its member hospitals, stating that if a Never Event occurs, Leapfrog member hospitals have made a "promise" to their patients to do the following:

a. Apologize to the patient and/or family; and

b. Report the event to an outside agency within ten days of becoming aware that the event has occurred; and

c. Perform a root cause analysis of the event; and

d. Waive costs directly related to the Never Event; and

e. Make a copy of the Never Event policy available to patients, patients' family members, and payers upon request.

144. At all times material Palms West Hospital violated all of the Leapfrog requirements described in the preceding paragraph.

145. Beginning in 2017, Leapfrog imposed additional obligations on member hospitals regarding how they must manage Never Events, to include:

a. Interviewing family members to gather additional evidence for the root cause analysis;

b. Informing the family of the actions that the hospital will take to prevent future recurrences of similar events based on findings of the root cause analysis;

c. Putting a program in place to provide support for caregivers involved in Never Events, such as Nurse Truempy; and

d. Performing an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each Never Event that occurred.[8]

146. As of the date of filing this Amended Complaint, the hospital has still not complied with any of these additional Leapfrog mandatory requirements.

147. When a hospital completely conceals Never Events, it is easy to maintain a high Leapfrog rating for managing such events.

Financial Motivations to Conceal Never Events

148. At all times material, the concealment of the Never Event by the hospital was motivated by its own self-interest and financial gain by placing its own interests above its fiduciary duty to Joshua and his parents to disclose the event.

149. Throughout his hospitalization, Joshua Dziedzic had health insurance coverage through Blue Cross Blue Shield ("BCBS"). BCBS is one of the major health insurance providers that followed Medicare's lead for non-payment of care resulting

[8] http://www.leapfroggroup.org/influencing/never-events

from Never Events. In order to qualify to accept BCBS insurance payments, Palms West Hospital had to agree it would not bill BCBS, or the patients, for care related to Never Events.

150. If the venous air embolism had been disclosed, BCBS would not have paid the hospital for Joshua's care during the last four days in the hospital when he was in the intensive care unit on life support. By keeping the venous air embolism concealed, the hospital was able to improperly bill BCBS for the medical care required because of the Never Event, and BCBS in fact paid Palms West Hospital for that care.

151. BCBS has filed a lien against Joshua's estate seeking to be reimbursed out of any recovery in this case for the Never Event care it improperly paid to the hospital.

152. The hospital's breach of its fiduciary duty to Joshua and his parents is still ongoing since the hospital has failed to reimburse BCBS for those charges, thus allowing a lien claim against Joshua's estate and the parent's recovery in this case to continue.

153. Another incentive for the hospital to conceal the Never Event was that disclosure of such gross malpractice to the family of a deceased patient can frequently lead to a lawsuit being filed against the hospital. The risk of such a suit is completely avoided if the family is not told the true cause of their loved one's injury and death.

154. Because Never Events are considered both "particularly shocking" and

"easily preventable," they are in a special category of hospital-caused patient injuries. When they are reported to AHCA, Never Events are more likely than other types of adverse incidents to lead to an AHCA investigation and/or fines and other sanctions imposed on both the hospital and the individual medical or nursing personnel involved. By not reporting the Never Event to AHCA, the hospital placed its own interests above the interests of Joshua or his parents.

155. The hospital also placed its own interests above the interests of Joshua and his parents by not reporting the Never Event to The Joint Commission. If reported it had the potential to prompt a Joint Commission investigation. Any Joint Commission investigation could jeopardize the hospital's accreditation process. If the hospital ever lost its Joint Commission accreditation, even if temporarily, it would suffer extreme financial losses as a result.

156. The hospital also placed its own interests above the interests of Joshua and his parents by not reporting the Never Event to the Leapfrog Group. By simply not reporting the event to the Leapfrog Group, the hospital could keep its high rating and continue to promote its Leapfrog membership and high rating for hospital marketing and insurance reimbursement purposes.

157. At all times material and in the foregoing manner, the hospital put its own self-interest ahead of the interests of Joshua Dziedzic and his parents, to whom it owed a fiduciary duty of utmost good faith, honesty, and fair dealing.

WHEREFORE, Plaintiffs, Barbara Dziedzic, Paul Dziedzic, Sr., and Barbara Dziedzic as Personal Representative of the Estate of Joshua Dziedzic sue Palms West Hospital for breach of fiduciary duty, and to recover all damages to which they are entitled, to include costs of this action, and hereby demand trial by jury.

COUNT III – Intentional Infliction of Emotional Distress (The Tort of Outrage)

Plaintiffs, Barbara Dziedzic and Paul Dziedzic, Sr., individually, reallege paragraphs 1 through 157, with the exception of paragraphs 90 and 116, and further state as follows:

158. This is a cause of action against Palms West Hospital for intentional infliction of emotional distress, also known as the tort of "outrage," arising from the concealment of the venous air embolism and misrepresentation of the cause of Joshua Dziedzic's injury and death.

159. The elements of a cause of action for intentional infliction of emotional distress are:

a. The wrongdoer intended to cause severe emotional distress or acted with reckless disregard of the high probability of causing severe emotional distress; and

b. The conduct was outrageous; and

c. The conduct caused severe emotional distress to the claimant.

160. At all times material, the conduct of the hospital in failing to disclose the

cause of Joshua's collapse and subsequent death was intentional and reckless.

161. The conduct of the hospital in failing to disclose to the parents that Joshua sustained a venous air embolism or probable venous air embolism that led to his collapse and subsequent death caused extreme emotional distress and mental anguish to the parents.

162. The conduct of the hospital, its nurses, the medical staff and other hospital personnel in failing to disclose to the parents that it was Nurse Truempy's gross malpractice that caused or probably causes Joshua's venous air embolism caused extreme emotional distress and mental anguish to the parents.

163. The conduct of the hospital, its nurses, the medical staff and other hospital personnel in misrepresenting the cause of Joshua Dziedzic's injury and death as being from "broken heart syndrome" caused extreme emotional distress and mental anguish to the parents.

164. During the four days between the air embolism occurring and Joshua's death, his parents had to struggle with the unbearable decision of whether to remove Joshua from life support. While struggling with that emotional burden, they were each also struggling with the added burden that they might have been able to keep Joshua from dying of a "broken heart" if they had only done more to convince him of their love and support before he suffered his major hypoxic event and collapse.

165. When the parents learned after Joshua died that the real cause of his death

was gross nursing and hospital malpractice, which then had been intentionally covered up, their ever-present grief over their loved one's recent death was magnified several times over because of their new feelings of extreme anger and betrayal.

166. Under the facts described herein, the complete disregard for the grieving parent's suffering and fragility by the hospital and its staff is outrageous misconduct and intolerable in a civilized society.

WHEREFORE, Plaintiffs, Barbara Dziedzic and Paul Dziedzic, Sr. sue Palms West Hospital for intentional infliction of emotional distress, and to recover all damages to which they are entitled, to include costs of this action, and they hereby demand trial by jury.

COUNT IV – Civil Conspiracy to Conceal

Plaintiffs, Barbara Dziedzic, Paul Dziedzic, Sr., and Barbara Dziedzic as Personal Representative of the Estate of Joshua Dziedzic, reallege paragraphs 1 through 156, with the exception of paragraphs 90 and 116, and further state as follows:

167. This is a cause of action against Palms West Hospital for civil conspiracy, arising from the breach of fiduciary and statutory duty to disclose the venous air embolism and the misrepresentation of the cause of Joshua Dziedzic's injury and death.

168. The elements of civil conspiracy are:

a. A conspiracy between two or more parties;

b. To do an unlawful act;

c. The doing of some overt act in pursuance of the conspiracy; and

d. Damage to the plaintiff as a result of the acts performed pursuant to the conspiracy.

169. A cause of action for civil conspiracy will only exist if the basis for the conspiracy is an underlying independent wrong or tort which would constitute a cause of action if the wrong were done by one person. *See, e.g., Regan v Davis* 97 So2d 324 (Fla.2d DCA 1957); *American Diversified Ins. Services, Inc., v Union Fidelity Life Ins. Co.* 439 So..2d 904 (Fla. 2n DCA 1983).

170. The violation of a fiduciary or a statutory duty may be the underlying tort or basis for a separate cause of action for civil conspiracy. *Blatt v. Green, Rose, Kahn & Piotrkowski* 456 So.2d 949, 951 (Fla 3d DCA 1984) (holding that a civil conspiracy action may be based on an underlying fiduciary duty which was created in the Florida Probate Code).

171. At all times material Palms West Hospital contracted with Intensive Care Consortium, Inc., a Florida corporation, to provide physicians specializing in intensive care ("intensivists") to provide medical care to patients in the intensive care unit of the hospital.

172. At all times material Belayet Hossain, M.D. was one of the physicians

provided by Intensive Care Consortium, Inc. to work in the intensive care unit and provide medical care to patients at Palms West Hospital.

173. Belayet Hossain, M.D. is one of the physicians who told Joshua Dziedzic's parents that Joshua's injuries were due to "broken heart syndrome."

174. At all times material, Belayet Hossain, M.D. was an independent contractor under his contract with Intensive Care Consortium, Inc., and not working as an agent or employee of the hospital.

175. At all times material, Damaan Arden, M.D. was a hospitalist under the employ of the hospital and acting in the course and scope of his employment.

176. Damaan Arden, M.D. is another one of the physicians who told the parents that Joshua's sudden collapse and later death were caused by "broken heart syndrome."

177. Several hours after Nurse Truempy removed Joshua's central line and he collapsed, a CT angiogram (CTA) of his chest was performed. A CTA can sometimes detect a venous air embolism, but it cannot be used to rule out an air embolism because the air often rapidly dissipates after the event has occurred. The radiologist who read the CTA images stated in his report that there was no evidence of a "pulmonary embolism." A pulmonary embolism is a blood clot and is not related to a venous air embolism. The radiologist stated nothing in his report about ruling out a venous air embolism and did not mention anything about the presence or absence of a venous air

embolism.

178. After the CTA report was available, several of Joshua's doctors, including Dr. Hossain and Dr. Aden, began to assert to other healthcare providers in the hospital that an air embolism had been ruled out by the CT angiogram.

179. During the hospitalization, Belayet Hossain M.D. and Damaan Arden, M.D. conferred with each other, either directly or indirectly through their notes, and together agreed to advise the parents that Joshua had suffered a "broken heart syndrome" and not to mention that more likely than not the real diagnosis was a venous air embolism resulting from improper removal of the central line by Nurse Truempy.

180. The actions of Belayet Hossain, M.D., and Damaan Arden, M.D., and others, in misrepresenting the true cause of Joshua Dziedzic's death were done in furtherance of the plan or scheme of the hospital not to report the event and to conceal the occurrence of the gross malpractice and Never Event from Joshua's family.

181. Under Florida law, in order for a conspiracy to exist it is not necessary to prove there was a formal agreement to commit the conspiracy. The existence of a conspiracy can be implied or inferred from circumstantial evidence indicative of an overall plan. *See e.g. LaPolla v. State* 504 So.2d 1353 (Fla. 4th DCA 1987). The facts alleged herein create an inference or implication of a civil conspiracy.

182. The hospital, through its agents and employees, including through its agent Damaan Arden, M.D., was a co-conspirator with independent contractor Belayet

Hossain, M.D., causing harm, injury and damage to the parents.

WHEREFORE, Plaintiffs, Barbara Dziedzic, Paul Dziedzic, Sr., and Barbara Dziedzic as Personal Representative of the Estate of Joshua Dziedzic sue Palms West Hospital for the tort of civil conspiracy, and to recover all damages to which they are entitled, to include costs of this action, and they hereby demand trial by jury.

COUNT V – Truempy's Negligent Infliction of Emotional Distress

Plaintiff, Barbara Dziedzic, in her individual capacity, realleges paragraphs 1 through 89, and further states as follows:

183. This count is for negligent infliction of emotional distress and seeks to recover damages for Barbara Dziedzic's severe emotional distress and trauma caused by witnessing her son's hypoxic event and collapse after Nurse Truempy pulled out his central line.

184. The elements of a cause of action for negligent infliction of emotional distress are:

a. The claimant must be present and witness the event causing the negligent or intentional injury to another; and

b. The claimant must have a close personal relationship to the directly injured person; and

c. The claimant must have sustained some physical impact during the event, even if only slight; or

d. The claimant must have some discernable physical manifestation

of injury caused by the psychological trauma of witnessing the event.

See, e.g., Willis v. Gami Golden Glades, LLC, 967 So. 2d 846, 850 (Fla. 2007); *Champion v. Gray*, 478 So. 2d 17, 20 (Fla. 1985).

185. Barbara Dziedzic sustained physical impact at the time of the event, which included having her son clutching her arm as he complained of severe chest pain and being unable to breathe. She also sustained physical impact as Joshua collapsed and she had to grab his falling body to keep him from hitting the floor, and she helped move him back into the ICU bed.

186. Barbara Dziedzic suffered severe psychological and emotional distress due to witnessing her 25-year old son's sudden hypoxic event and his collapse into her arms. Her severe emotional distress was manifested by depression, nightmares, inability to concentrate, bouts of crying, significant weight gain, and elevations in her cortisol level, which is a stress hormone.

WHEREFORE, Barbara Dziedzic sues Linda Truempy, RN, for all damages to which she is entitled, to include costs of this action, and hereby demands trial by jury.

COUNT VI – Truempy's Intentional Infliction of Emotional Distress

Plaintiff, Barbara Dziedzic, in her individual capacity, realleges paragraphs 1 through 89, and further states as follows:

187. This count is for intentional infliction of emotional distress and seeks to recover damages for Barbara Dziedzic's severe emotional distress and trauma caused

by witnessing her son's sudden hypoxic event and collapse after Nurse Truempy pulled out his central line.

188. The elements of a cause of action for intentional infliction of emotional distress are:

a. The wrongdoer's conduct was intentional or reckless; and

b. The conduct was outrageous; and

c. The conduct caused emotional distress; and

d. The emotional distress was severe.

189. Nurse Truempy's misconduct, consisting of pulling out Joshua's central line while he was sitting upright in a chair and talking with his mother, and then just walking away, was intentional, reckless, and outrageous.

190. Barbara Dziedzic suffered severe psychological trauma and emotional distress due to witnessing her son's sudden hypoxic event and collapse. This emotional distress has caused depression, nightmares, inability to concentrate, bouts of crying, significant weight gain, and elevations in her cortisol level, which is a stress hormone.

WHEREFORE, Barbara Dziedzic sues Linda Truempy, RN, for all damages to which she is entitled, to include costs of this action, and hereby demands trial by jury.

COUNT VII – Hospital Vicarious Liability for Truempy's Negligent Infliction of Emotional Distress

Plaintiff, Barbara Dziedzic, in her individual capacity, realleges paragraphs 1

through 89, and paragraphs 183 through 186, and further states as follows:

191. This count sues Palms West Hospital for its vicarious liability to Barbara Dziedzic for Nurse Truempy's conduct and arising from Nurse Truempy's negligent infliction of emotional distress.

192. At all times material, Nurse Truempy was the agent or employee of Palms West Hospital, acting in the course and scope of her agency and employment.

WHEREFORE, Barbara Dziedzic, individually, sues Palms West Hospital for all damages to which she is entitled, to include costs of this action, and hereby demands trial by jury.

COUNT VIII – Hospital Vicarious Liability for Truempy's Intentional Infliction of Emotional Distress

Plaintiff, Barbara Dziedzic, in her individual capacity, realleges paragraphs 1 through 89, and paragraphs 187 through 190, and further states as follows:

193. This count sues Palms West Hospital for its vicarious liability to Barbara Dziedzic for Nurse Truempy's conduct and arising from Nurse Truempy's intentional infliction of emotional distress.

194. At all times material, Nurse Truempy was the agent or employee of Palms West Hospital, acting in the course and scope of her agency and employment.

WHEREFORE, Barbara Dziedzic, individually, sues Palms West Hospital for all damages to which she is entitled, to include costs of this action, and hereby demands

trial by jury.

COUNT IX – Wrongful Death – Truempy's Malpractice

Plaintiff, Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic, realleges paragraphs 1 through 89, and further states as follows:

195. This count seeks recovery under the Florida Wrongful Death Act for Joshua Dziedzic's death arising from Nurse Truempy's gross malpractice in pulling out Joshua's central line and walking away.

196. At the time of his death, Joshua Dziedzic was unmarried, and he had no children.

WHEREFORE, Plaintiff, Barbara Dziedzic, in her capacity as Personal Representative of the Estate, is bringing this action to recover all damages recoverable under the Florida Wrongful Death Act, to include:

a. All medical bills caused by the injury and death, either paid by Joshua's parents or which have become a charge against the estate;

b. On behalf of Joshua's parents, Barbara and Paul Dziedzic, Sr., expenses of the funeral, cremation, and any related expenses;

c. On behalf of the Estate of Joshua Dziedzic, all loss of prospective net accumulations to the estate.

COUNT X – Wrongful Death – Hospital Malpractice

Plaintiff, Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic, realleges paragraphs 1 through 89, and further states as follows:

197. This Count seeks recovery under the Florida Wrongful Death Act for

Joshua Dziedzic's death, arising from Palms West Hospital's failure to have and/or enforce a comprehensive risk management program and to ensure the competence of its medical staff and personnel.

198. Pursuant to Section 395.0197, Florida Statutes, hospitals are required to have in place a comprehensive risk management program that specifically includes, among other things:

> a. The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients.
>
> b. **The development of appropriate measures to minimize the risk of adverse incidents to patients, including, but not limited to:**
>
> 1. **Risk management and risk prevention education and training of all nonphysician personnel…**(emphasis supplied).

199. Additionally, Section 766.110, Florida Statutes provides:

> (1) All health care facilities, including hospitals …**have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties.** These duties shall include, but not be limited to:
>
> (a) The adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff;
>
> (b) **The adoption of a comprehensive risk management program which fully complies with the substantive requirements of s. 395.0197…**

> (c) **The initiation and diligent administration of the medical review and risk management processes established in paragraphs (a) and (b)** including the supervision of the medical staff and hospital personnel to the extent necessary to ensure that such medical review and risk management processes are being diligently carried out.
>
> **Each such facility shall be liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient** (emphasis supplied).

200. At all times material, Palms West Hospital failed to exercise due care in assuring the competency of its ICU nursing staff, including Nurse Truempy.

201. At all times material, Palms West Hospital failed to develop or enforce appropriate measures to minimize the risk of adverse incidents, including specifically the preventable "particularly shocking medical errors" on the Never Event list, including improper removal of a central line.

202. Palms West Hospital and its risk management program never took any steps to put systems or mechanisms in place to prevent improper removal of central lines.

203. As a direct and proximate result of the actions and omissions of Palms West Hospital described herein, Joshua Dziedzic suffered from a venous air embolism and died.

204. At the time of his death, Joshua Dziedzic was unmarried, and he had no children.

WHEREFORE, Plaintiff, Barbara Dziedzic, in her capacity as Personal Representative of the Estate, is bringing this action against Palms West Hospital to recover costs of this action together with all damages recoverable under the Florida Wrongful Death Act, to include:

a. All medical bills caused by the injury and death, either paid by Joshua's parents or which have become a charge against the estate;

b. On behalf of Joshua's parents, expenses of the funeral, cremation, and any related expenses;

c. On behalf of the Estate of Joshua Dziedzic, all loss of prospective net accumulations to the estate.

COUNT XI – Wrongful Death – Hospital Vicarious Liability for Truempy's Malpractice

Plaintiff, Barbara Dziedzic, as Personal Representative of the Estate of Joshua Dziedzic, realleges paragraphs 1 through 89, and further states as follows:

205. This Count seeks recovery under the Florida Wrongful Death Act for Joshua Dziedzic's death, based on Palms West Hospital's vicarious liability for Nurse Truempy's gross malpractice and reckless behavior.

206. At all times material, Nurse Truempy was the agent or employee of Palms West Hospital, acting in the course and scope of her agency and employment.

207. As a direct and proximate result of the actions and omissions of Nurse Truempy described herein, Joshua Dziedzic suffered from a venous air embolism and died.

208. At the time of his death, Joshua Dziedzic was unmarried, and he had no children.

WHEREFORE, Plaintiff, Barbara Dziedzic, in her capacity as Personal Representative of the Estate of Joshua Dziedzic, hereby demands a trial by jury and sues Palms West Hospital to recover costs of this action together with all damages recoverable under the Florida Wrongful Death Act, to include:

a. All medical bills caused by the injury and death, either paid by Joshua's parents or which have become a charge against the estate;

b. On behalf of Joshua's parents, expenses of the funeral, cremation, and any related expenses;

c. On behalf of the Estate of Joshua Dziedzic, all loss of prospective net accumulations to the estate.

Dated this 21st day of September, 2018.

/s/ *Scott R. McMillen*
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CERTIFICATE OF COUNSEL

The undersigned counsel hereby certifies that he has made a reasonable investigation as permitted by circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care and treatment of Joshua Dziedzic and such investigation has given rise to a good faith belief that grounds exist for an action against these defendants.

Dated this 21st day of September, 2018.

/s/*Scott R. McMillen*
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Certificate of Service

I HEREBY CERTIFY that on this 21st day of September, 2018, I electronically filed the foregoing with the Florida Courts E-filing Portal which will either serve the document by email or provide a link by email to the document on a website maintained by the clerk, to the following attorneys, at their appropriate email addresses.

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