IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

ELVIA G. OCASIO RIVERA, Plaintiff, v. DOCTORS CENTER HOSPITAL INC.; DR. MELITSA AGUILAR MARRERO; DR. SANTIAGO ULLOA RAMIREZ; DR. ORLANDO C. GONZALEZ MORALES; A, B, C INSURANCE COMPANIES, INC.; D, E, F INSURANCE COMPANIES; JOHN DOE; JAMES ROE; Defendants	CIVIL NO.: 19-1556 RE: TORT ACTION FOR MEDICAL MALPRACTICE PURSUANT TO ARTS. 1802 AND 1803, 31 P. R. Laws Ann. §§ 5141 AND 5142. JURY TRIAL DEMANDED

COMPLAINT

TO THE HONORABLE COURT:

APPEARS NOW, **ELVIA G. OCASIO RIVERA** (hereinafter referred to as "Plaintiff", through the undersigned counsel, and hereby states, alleges, and requests as follows:

JURISDICTIONAL BASIS

1. This case is based upon diversity jurisdiction under 28 U.S.C. §1332.
2. Plaintiff is domiciled in and is a resident of the state of New York.
3. All Defendants are either individuals who reside in Puerto Rico or corporations organized under the laws of the Commonwealth of Puerto Rico with his principal place of business in P.R. or of states other than New York.

4. The matter in controversy exceeds the sum of SEVENTY FIVE THOUSAND DOLLARS ($75,000.00), exclusive of interest and costs, thus vesting jurisdiction on this Honorable Court pursuant to 28 U.S.C. § 1332.

5. Venue is proper in the District of Puerto Rico pursuant to 28 U.S.C. §1391, since the events and acts or omissions giving rise to this claim occurred in this district.

THE PARTIES

6. Plaintiff **ELVIA G. OCASIO RIVERA** (hereinafter "plaintiff") is the niece of patient Candida R. Rivera Adorno (hereinafter "Candida Rivera", or "the patient'), who died at Doctor's Center Hospital in Manati on July 27, 2018.

7. Co-Defendant DOCTORS' CENTER HOSPITAL, INC., d/b/a **DCH** (hereinafter "**DCH**" or "hospital"), is a corporation duly incorporated and registered in and with its principal place of business in Puerto Rico.

8. Co-Defendant **DCH** owns and/or operates a hospital located in Manatí, Puerto Rico, wherein it provides its patients with a gamut of hospital services and/or hospital care, including emergency, radiology, internal medicine, oncology, PACU, ICU, laboratory and other hospital care and services.

9. Co-Defendant **DR. MELITSA AGUILAR MARRERO** (hereinafter "**DR. AGUILAR**") is a physician authorized to practice medicine in Puerto Rico, who is designated in the relevant medical record as the patient's attending physician and who treated Mrs. Candida R. Rivera Adorno while admitted to Defendant **DCH** on the relevant dates.

10. Co-Defendant **DR. SANTIAGO ULLOA RAMIREZ** (hereinafter "**DR. ULLOA**") is a physician authorized to practice medicine in Puerto Rico, who is designated in the

relevant medical record as a surgeon consulted and who surgically intervened on two occasions and treated Mrs. Candida R. Rivera Adorno while admitted to Defendant **DCH** on the relevant dates.

11. Co-Defendant **DR. ORLANDO C. GONZALEZ MORALES** (hereinafter "**DR. GONZALEZ**") is a physician authorized to practice medicine in Puerto Rico, who is designated in the relevant medical record as a surgeon consulted and who surgically intervened on one occasion and treated Mrs. Candida R. Rivera Adorno while admitted to Defendant **DCH** on the relevant dates.

12. Co-Defendants **A, B, C INSURANCE COMPANIES** are entities or corporations organized or operating under the laws of the Commonwealth of Puerto Rico, with their principal place of business in Puerto Rico or in a state other than New York and/or New York, which issued insurance policies on behalf of named defendants for the acts or omissions described herein, encompassing the relevant period of time.

13. Co-Defendants **D, E, F INSURANCE** are entities or corporations organized or operating under the laws of the Commonwealth of Puerto Rico, with their principal place of business in Puerto Rico or in a state other than New York, which issued insurance policies on behalf of one or more unknown codefendants/tortfeasors for the acts or omissions described herein, encompassing the relevant period of time.

14. Co-Defendants unknown tortfeasors **JOHN DOE** and **JAMES ROE** are physicians or other health care providers fictitiously named herein, to be later replaced by their actual names which may become known through further discovery in this litigation and who may be liable to Plaintiff for the damages suffered, in whole or in part, for the actions and/or omissions herein described, encompassing the relevant period of time.

GENERAL ALLEGATIONS

15. Plaintiff is an adult niece of Candida R. Rivera Adorno, who was like a mother-like aunt to her.

16. Candida R. Rivera Adorno (herein after referred to as "Candida Rivera" or "patient") was born on June 6, 1953 and was only 65 years old at the time of the events and death on July 27, 2018.

17. On the evening of June 7, 2018, Candida Rivera arrived at the **Doctor's Center Hospital in Manati (**herein after referred to as "**DCH")** emergency ward, complaining of generalized weakness, unspecified moderate pain.

18. Patient was ordered laboratory test and evaluated by emergency room Dr. Ivan E. Garcia Cuevas, and determined that the results indicated decrease in hematocrit and hemoglobin indicative of anemia.

19. On June 8, 2018, patient was admitted and hospitalized at **DCH**.

20. **DCH** assigned **Dr. Melitsa Aguilar Marrero** (herein after referred to as "**Dr. Aguilar"**) as the attending physician for Candida Rivera.

21. **Dr. Aguilar** accepted to become treating physician for Candida Rivera.

22. Patient's preliminary work up showed a large mass in the rectum and rectal bleeding.

23. While administering potassium intravenously to the patient, the nursing personnel carelessly allowed the liquid to extravasate from the vein, thereby burning the tissue.

24. The patient and family were informed by **Dr. Aguilar** that the large tumor was suspected to be cancerous and was inoperable and that other treatment would be initiated.

25. An oncologist, Dr. Perez Casellas evaluated the patient and also told the patient and her family that the course to take was to reduce the tumor first prior to surgical extraction.

26. **Dr. Aguilar** consulted surgeon **Dr. Santiago Ulloa Ramirez (**herein after referred to as "**Dr. Ulloa**"**)** whose preoperative diagnosis was "a huge rectal mass with rectal prolapse."

27. **Dr. Ulloa**, after a physical examination of the patient Candida Rivera, also told the patient and her family that the tumor was inoperable and to surgically remove it would be to relegate her to a colostomy for the rest of her life.

28. **Dr. Ulloa** informed the patient and her family that he would request all his instruments in order to do a deep biopsy of the tumor the following day.

29. After the surgical intervention, **Dr. Ulloa** informed the patient and family that he had not limited his intervention to a biopsy, but he had extracted the tumor completely.

30. On June 18, 2018, **Dr. Ulloa** performed a protoscopy and transanal excision of rectal mass with perineal rectosigmoidectomy and levatoplasty.

31. **Dr. Ulloa's** findings in his operative report were: " a huge polypoid, sessile rectal mass, soft in general, but a spot of indurated area at the apex far away from a surgical border and rectal prolapse."

32. **Dr. Ulloa**, without doing proper preoperative work up or a proper bowel preparation proceeded to perform the colorectal surgery on the patient.

33. **Dr. Ulloa** failed to detect perforation of rectum and/or adequately correct it prior to termination of surgery.

34. Instead the patient was left with a hole in her rectum where feces was leaking into and infecting the abdominal cavity.

35. The day following the surgery, on June 19, 2018, the patient began to deteriorate and show signs and symptoms of abdominal infection.

36. On June 20, 2018, the abdomen was distended and extremely painful with recurrent vomiting.

37. Despite these signs and symptoms, neither **Dr. Aguilar**, nor **Dr. Ulloa** proceeded to timely intervene in the care of their patient.

38. Two days elapsed and the vomiting continued, distention more severe and the pain increased to the point where the patient was crying out in excruciating pain.

39. Finally, a code green was called by nursing when blood was observed seeping out of patient's mouth and **Dr. Aguilar** transferred the patient to intensive care unit.

40. On June 23, 2018, the family was informed by the doctors that a CT revealed intestinal blockage and that patient needed to be surgically intervened immediately due to a toxic condition

41. The patient had developed sepsis in the presence of an acute abdomen, requiring immediate surgical intervention.

42. It was not until June 23, 2018 that **Dr. Ulloa** intervened and performed an exploratory laparotomy.

43. **Dr. Ulloa** in the previous surgery had perforated the rectum and the abdomen was contaminated with fecal material, requiring washout and end-sigmoid colostomy.

44. At this point, Candida Rivera was in critical condition and returned to the Intensive Care Unit.

45. **Dr. Ulloa** informed the family by telephone that he would not be treating the patient who, as far as he was concerned, was stable from the surgery standpoint.

46. During the following two days, the patient's family requested to see **Dr. Aguilar**, who refused to see them.

47. Finally, on June 26, 2018, **Dr. Aguilar** met with the family and admitted she did not realize the gravity of the patient's condition despite the family's reported signs, symptoms and complaints of possible infection.

48. While at the ICU, Candida Rivera had some progress in her overall cardiovascular status and her infection was under antibiotic control and was transferred to the ward.

49. Defendants **Dr. Aguilar**, **Dr. Ulloa** and **DCH's** nursing personnel failed to properly monitor, treat and follow up on patient's healing resulting in wound dehiscence, in other words her wound became necrotic and opened.

50. On one occasion the nurse cleaning the colostomy bag negligently allowed the fecal contents to spill over onto the open wound.

51. Patient's family had to insist with the nurses on providing adequate care to patient.

52. Patient's family had to insist with nurses to repeatedly notify **Dr. Aguilar** of the patient's deterioration.

53. **Dr. Aguilar** became hostile towards patient's family because they insisted on getting adequate care for their loved one and the nurses were calling her too often.

54. Patient's family members had to point out to nurses, attending physician **Dr. Aguilar** and ultimately **Dr. Ulloa** of this development and insist on treatment.

55. Days elapsed without physical examination, evaluation or intervention of the patient by a surgeon.

56. It was not until July 20, 2018, that **Dr. Orlando Gonzalez Morales** (herein after referred to as "**Dr. Gonzalez**") intervened to do an abdominal exploration for wound dehiscence.

57. **Dr. Gonzalez'** surgery was unnecessarily delayed.

58. **Dr. Gonzalez'** surgery was inadequate since he failed to properly debride, and instead closed the abdomen and failed to place a wound VAC.

59. **Dr. Gonzalez'** inadequate surgery contributed to the ventilation and multisystem failure.

60. Despite the family request to have the critical patient cared more closely at the ICU, Dr. Gonzalez insisted on her being transferred to the ward.

61. Because the wound was closed and had no means to drain, Dr. Gonzalez had to personally drain, a very painful procedure without any sedation.

62. The patient continued to deteriorate and died on July 27, 2018.

63. The treatment of this patient by defendants was below the standard of care.

64. The patient had cancer of the rectum, which was the cause of her anemia and was very treatable.

65. On June 18, 2018, **Dr. Ulloa** took the patient into the operating room without a surgical strategy nor without the proper preoperative bowel preparation.

66. Instead in this first surgery, **Dr. Ulloa** performed an unreasonable surgical procedure, to include a rectal prolapse procedure which sentenced the patient to a bad outcome.

67. Rapid septicemia and intra-abdominal sepsis occurred shortly after **Dr. Ulloa** first surgical intervention.

68. Both, attending **Dr. Aguilar** and **Dr. Ulloa,** failed to ensure timely re-intervention thereby allowing the infection to rage within patient's abdomen for five days.

69. **Dr. Ulloa,** in his second intervention, found four-quadrant fecal contamination, but failed to do aggressive debridement and resection of infected tissue.

70. As a result of the substandard care **Dr. Ulloa** provided patient, she developed signs and symptoms of an intra-abdominal catastrophe.

71. **Dr. Gonzalez** failed to intervene promptly, allowing valuable time to elapse.

72. When **Dr. Gonzalez** finally intervened, he failed to: adequately perform debridement, leave the wound open, set up a wound VAC as well as examine, monitor and treat patient.

73. **Dr. Gonzalez** failed to place adequate drainage for the wound, thereby requiring him to physically extract it from the patient days later without any anesthetics, thereby causing further pain and suffering to her and plaintiff.

74. As a consequence of the mishandling of the case, patient's fate was sealed and she expired from progressive low-grade sepsis and multi-system organ failure.

75. Plaintiff and patient's daughters for many months sought to get the complete medical records from **DCH** of patient Candida Rivera, but time and again these were not produced by the **hospital**.

76. As a result, a complaint and legal action had to be undertaken by patient's family against **DCH** before it finally produced the full medical record.

77. There is no signed consent form for the nature of the surgery carried out by **Dr. Ulloa** and thus there was a lack of informed consent.

FIRST CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLE 1802 & 1803 OF THE PUERTO RICO CIVIL CODE AGAINST

DOCTOR CENTER HOSPITAL MANATI AND ITS PERSONNEL

78. The allegations contained above are incorporated by reference as if again fully set forth herein.

79. At the relevant times of this complaint, **DCH** operated or contracted to operate emergency, hospital, telemetry, radiology, intensive care, and surgery departments within its premises.

80. The hospital sets up policies, procedures and/or requirements for the treatment of the emergency, hospital, telemetry, intensive care, radiology and surgery departments within its premises.

81. **DCH** through its policies, procedures and/or requirements for hospital privileges admitted from its emergency department to its hospital ward and assigned **Dr. Aguilar** to become her treating physician while at **DCH**.

82. **DCH** assigned **Dr. Aguilar**, who was only a family medicine doctor and unqualified to adequately treat patient Candida Rivera's condition.

83. As such, **DCH** is liable for the negligent acts or omissions of **Dr. Aguilar** that caused damage to Plaintiff.

84. **DCH** supplies medical, nursing, clerical, administrative, and technical personnel to the emergency, hospital, telemetry, intensive care, radiology and surgery departments within its premises.

85. **DCH** derives revenue from the services provided to patients at these departments within its premises.

86. **DCH** is liable for medical malpractice occurring at the previously mentioned hospital departments located on its premises.

87. The treatment offered by **DCH** to patient Candida Rivera, through its medical, nursing, technical personnel, and/or the doctors who either are employees, or have privileges who used its facilities, was below the medical standard that satisfies the exigencies generally recognized by the medical profession in light of the modern means of communication and teaching and, as such, directly caused and/or contributed to causing Plaintiff the untimely death of her beloved aunt, patient Rivera Adorno, and the injuries, as described herein.

88. **DCH's** personnel failed to exercise the care and precautions required under the circumstances in order to prevent the loss of patient Candida Rivera's life, lacked the knowledge and medical skill required to treat a patient in their care, and failed to timely have available the personnel and equipment necessary to avoid the injuries, suffering and subsequent death of patient Candida Rivera.

89. **DCH** medical and hospital personnel negligently failed to provide patient Candida Rivera with competent nursing and medical personnel to monitor, treat and follow up in a timely and adequate manner.

90. **DCH** medical personnel, including defendants named herein, negligently failed to adequately treat the patient with a treatable rectal carcinoma, but instead died due to gross neglect.

91. **DCH** medical personnel, including defendants named herein, negligently failed to adequately follow an appropriate course of treatment such as colonoscopy with biopsy, endorectal ultrasound, await surgical pathology report, clinical staging before proceeding wit curative surgery.

92. **DCH** medical personnel, including defendants named herein, negligently allowed the patient to be subjected to a misguided operation without proper preoperative work up or bowel preparation.

93. **DCH** nursing and medical personnel negligently failed to recognize or otherwise ignored the signs and symptoms that patient Candida Rivera developed consistent with post surgical infection.

94. **DCH** nursing and medical personnel negligently failed to recognize or otherwise ignored the signs that patient Candida Rivera developed consistent with a developing infection, leading to septicemia, respiratory insufficiency, multi-organ failure and death.

95. **DCH** nursing and medical personnel negligently failed to adequately examine and follow up on patient's healing of wound and recovery, allowing the wound to become necrotic and become undone due to poor nutrition and bacterial overgrowth.

96. **DCH** nursing and medical personnel failed to use available methods to timely prevent, diagnose and treat patient Candida Rivera who was a likely candidate to develop an abdominal catastrophe after the second surgical intervention.

97. While at **DCH's** ward, patient Candida Rivera was inadequately monitored by nurses and physicians, requiring family to be intervening to alert and try to obtain timely treatment for the patient.

98. Patient Candida Rivera Adorno required closer nursing and medical supervision but instead was afforded delayed and inadequate treatment throughout her admission at **DCH**.

99. Patient Candida Rivera was neglected and mistreated by **DCH's** nursing personnel, causing further pain and suffering to plaintiff.

100. At all times herein pertinent, co-Defendant **DCH**, its directors, officers, and employees and physicians with privileges were negligent in failing to provide the proper medical attention to patient Candida Rivera, in failing to provide competent medical doctors, the proper supervision of co-Defendant **Dr. Aguilar, Dr. Ulloa, Dr. Gonzalez** and other unknown physicians and residents employed by and/or practicing at **DCH**, and by otherwise failing to exercise due care and caution to prevent the tortious conduct, injuries, and suffering to Plaintiff and to patient Candida Rivera.

101. **DCH** not only failed to adequately select, monitor, intercede or supervise the Defendant physicians and/or ensure their prompt attention to the patient, but also permitted the use of its facilities by physicians with privileges, in that way allowing, encouraging, and condoning the negligent care and improper treatment of patient Candida Rivera, proximately and directly causing her death as well as Plaintiff's injuries.

102. As a result of all of the above, **DCH** misled those who sought full hospital treatment into thinking that they would be appropriately treated.

103. **DCH** did not provide the timely services of persons capable of properly and effectively coordinating its departments and providing proper nursing care and required diagnostic studies to patient Candida Rivera.

104. As a direct and proximate result of **DCH's** lack of supervision and failure to staff its emergency, hospital ward, telemetry and ICU units, and surgery departments with the medical personnel and personnel in charge of coordinating and communicating vital

information necessary to appropriately treat emergency situations at **DCH**, **DCH** and its personnel negligently caused Plaintiff the untimely death of her aunt patient Candida Rivera and her injuries, as described herein.

105. As a direct and proximate cause of co-Defendant **DCH** and its personnel's failure to properly treat patient Candida Rivera, Plaintiff sustained severe pain and suffering and other damages, as described below.

106. There was no signed consent form in the medical record allowing **Dr. Ulloa** to perform the surgery at **DCH**, thereby constituting battery on the patient.

SECOND CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLE 1802 & 1803 OF THE PUERTO RICO CIVIL CODE AGAINST PHYSICIANS DR. MELITSA AGUILAR MARRERO, DR. SANTIAGO ULLOA RAMIREZ, ORLANDO C. GONZALEZ MORALES

107. The allegations contained above are incorporated by reference as if again fully set forth herein.

108. The interventions of Co-Defendants **Dr. Aguilar, Dr. Ulloa** and **Dr. Gonzalez**, with patient Candida Rivera while she was at **DCH**, were below the standards that satisfy the exigencies generally recognized by the medical profession in light of the modern means of communication and teaching and, as such, directly caused and/or contributed to causing the premature death of patient Candida Rivera and, thus, her pain and suffering as well as that of Plaintiff, as described herein.

109. Co-Defendant **Dr. Aguilar** and co-defendants caring for her patient, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they

failed to provide timely and proper treatment when suspected adenocarcinoma of the rectum.

110. Co-Defendant **Dr. Aguilar** and codefendants and/or medical personnel under their supervision and independently, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to provide timely and effective care to the deteriorating conditions demonstrated by the patient's signs and symptoms.

111. Co-Defendant **Dr. Aguilar,** as the attending of patient Candida Rivera, is liable for the negligent treatment provided by the physicians that were consulted, including co-defendants **Dr. Ulloa** and **Dr. Gonzalez** herein, and intervened in this patient, since they failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to provide timely, adequate and within the standard of care to treat the very treatable rectal cancer and subsequent surgeries and care.

112. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Ulloa**, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to provide patient Candida Rivera with a proper preoperative evaluation by performing a digital rectal examination, a protoscopy and/or colonoscopy and/or rectal ultrasound, CT and MRI.

113. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Ulloa**, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical

profession at that time and under like and similar circumstances when they failed to provide patient Candida Rivera with a proper bowel preparation before submitting her to surgery.

114. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Ulloa**, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to provide patient Candida Rivera with a tailored treatment to the patient and proper surgical strategy.

115. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Ulloa**, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to provide patient Candida Rivera with a tailored treatment and preserve the anal sphincter and avoidance of colostomy.

116. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Ulloa** under their supervision and independently, failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to closely observe and timely treat patient Candida Rivera after each surgery for signs of infection and the sequela of rectal perforation.

117. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Gonzalez** failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to timely examine, evaluate and intervene for exploratory surgery and wound dehiscence.

118. Co-Defendant **Dr. Aguilar** and codefendant **Dr. Gonzalez** unduly delayed the surgery until July 20, 2018 that **Dr. Gonzalez** intervened to do an abdominal exploration for wound dehiscence.

119. Co-defendant **Dr. Aguilar** and codefendant **Dr. Gonzalez** subjected the patient to an inadequate third surgery and post surgical care since **Dr. Gonzalez** failed to properly debride, and improperly closed the abdomen and failed to place a wound VAC, or draining devices.

120. Co-Defendants **Dr. Aguilar, Dr. Ulloa, Dr. Gonzalez** failed to do a appropriate preoperative evaluations, instead performed inappropriate surgical procedures failing to adequately correct the missteps, compounded by delayed treatment, failure to monitor and treat and contributing and causing patient's death.

121. As a direct and proximate cause of Co-Defendants **Dr. Aguilar, Dr. Ulloa, Dr. Gonzalez** actions and omissions upon being presented with a patient in Rivera Adorno condition and with her clinical signs, patient Rivera Adorno was deprived of an opportunity to be adequately and promptly treated when time was of the essence and the Plaintiff, through the premature death of her aunt was deprived of her happiness, love and support.

122. In so doing, Co-Defendants **Dr. Aguilar, Dr. Ulloa,** And **DR. Gonzalez** committed professional negligence, including lack of expertise, fault and malpractice, which directly and proximately caused the suffering and death of patient Candida Rivera and the damages to Plaintiff, as detailed herein.

THIRD CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLES 1802 & 1803 OF THE PUERTO RICO CIVIL CODE A, B, C INSURANCE COMPANIES

123. The allegations contained above are incorporated by reference as if again fully set forth herein.

124. Co-Defendants **A, B, C INSURANCE COMPANIES,** designated as such for not knowing their identities, were at all times herein pertinent an insurance companies authorized to do business in the Commonwealth of Puerto Rico and which issued public liability and/or malpractice insurance policies on behalf of Co-Defendant, **Doctor's Center Hospital in Manati (DCH), Dr. Aguilar, Dr. Ulloa And Dr. Gonzalez.**

125. Pursuant to 26 P.R. Laws Ann. § 2001, an insurance company is liable for the negligence or fault of its insured.

126. Pursuant to 26 P.R. Laws Ann. § 2003, an action against an insurer may be brought separately or may be joined together with an action against its insured.

127. Therefore, Co-Defendants **A, B, C INSURANCE COMPANIES** are jointly and severally liable to Plaintiff for the damages caused **DCH, Dr. Aguilar, Dr. Ulloa and Dr. Gonzalez.**

FOURTH CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLES 1802 & 1803 OF THE PUERTO RICO CIVIL CODE AGAINST JOHN DOE AND JAMES ROE UNKNOWN JOINT TORTFEASORS

128. The allegations contained above are incorporated by reference as if again fully set forth herein.

129. Co-Defendants John Doe and James Roe are so designated for lack of knowledge at this point in the proceedings.

130. Co-Defendants John Doe and James Roe's intervention in the nursing, technical or medical care of patient Rivera Adorno while at Co-Defendant **DCH** was below the nursing, technical and medical standard that satisfies the exigencies generally recognized by the medical profession in light of the modern means of communication and teaching and, as such, directly caused and/or contributed to causing patient Candida Rivera's death and, thus, the pain and suffering of patient Candida Rivera while hospitalized and of Plaintiff upon her premature death, as described herein.

131. Co-Defendants John Doe and James Roe negligently and carelessly, breaching the medical standard that satisfies the exigencies generally recognized by the medical profession in light of the modern means of communication and teaching, failed to perform a complete, thorough and adequate post fall from bed monitoring, testing and assessment of patient Candida Rivera, commensurate with her reported symptoms of neurological deterioration, and, as such, directly caused and/or contributed to causing patient Candida Rivera physical injury and emotional pain, as well as her premature death and the emotional pain and suffering such death caused upon Plaintiff.

132. Co-Defendants John Doe and James Roe negligently and carelessly failed to exercise reasonable care and skill commensurate with the standard of care practiced in the medical profession at that time and under like and similar circumstances when they failed to correctly and promptly recognize and treat the patient's symptoms and condition and, thus, failed to provide a prompt, complete, thorough and adequate medical evaluation and treatment.

133. Co-Defendants John Doe and James Roe negligently and carelessly failed to promptly test, monitor, evaluate and treat patient Candida Rivera's symptoms, thus denying him the provision of essential and life-saving treatment.

134. Co-Defendants John Doe and James Roe negligently and carelessly failed to provide proper care to their patient, patient Candida Rivera, by failing to engage in her examination, evaluation of symptoms, and care on a timely basis, so that they did not follow up on the signs and symptoms of neurological deterioration.

135. As a direct and proximate cause of Co-Defendants John Doe and James Roe's negligent actions and omissions upon being presented with a patient in patient Candida Rivera's condition and with her clinical signs, patient Candida Rivera was deprived of the opportunity to be promptly treated when time was of the essence and the Plaintiff, through the premature death of patient Candida Rivera, was deprived of her companionship, camaraderie, support and love.

136. In so doing, Co-Defendants John Doe and James Roe committed professional negligence, including lack of expertise, fault and malpractice, which directly and proximately caused the death of patient Candida Rivera, as detailed herein.

137. As a direct and proximate cause of Co-Defendants John Doe and James Roe's negligence in failing to properly treat patient Candida Rivera, Plaintiff and patient Candida Rivera sustained severe pain and suffering.

FIFTH CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLES 1802 & 1803 OF THE PUERTO RICO CIVIL CODE AGAINST D, E, F INSURANCE COMPANIES

138. The allegations contained above are incorporated by reference as if again fully set forth herein.

139. Co-Defendants **D**, **E, F INSURANCE COMPANIES** were at all times herein pertinent insurance companies authorized to do business in the Commonwealth of Puerto Rico and which issued public liability and/or malpractice insurance policies on behalf of one or more unknown tortfeasors.

140. Pursuant to 26 P.R. Laws Ann. § 2001, an insurance company is liable for the negligence or fault of its insured.

141. Pursuant to 26 P.R. Laws Ann. § 2003, an action against an insurer may be brought separately or may be joined together with an action against its insured.

142. Therefore, **E, F, G INSURANCE COMPANIES** are jointly and severally liable to Plaintiff for the damages caused to them by one or more unknown tortfeasors.

143. Therefore, Co-Defendants **D, E, F INSURANCE COMPANIES** are jointly and severally liable to Plaintiff for the damages caused to them and patient Candida Rivera by any and/or all unknown joint tortfeasors.

DAMAGES

144. The allegations contained above are incorporated herein by reference as if again fully set forth.

145. Defendants actions or omissions resulted in patient's suffering over many weeks while hospitalized, which was witnessed by plaintiff, who came to Puerto Rico and immediately went to **DCH** to see her beloved Candida Rivera.

146. Patient Candida Rivera was like a mother to Plaintiff, whom she loved dearly.

147. Plaintiff had grownup with Candida Rivera, staying at her house and pending time with her everyday after school.

148. Plaintiff, year after year since the time she could remember was cared for by Candida Rivera, thereby developing an extremely close relationship with her.

149. It was not until Plaintiff married and moved to New York that the almost daily contact ceased.

150. When plaintiff came to Puerto Rico, she always visited and spent time with Candida Rivera.

151. When Candida Rivera was hospitalized, plaintiff came to Puerto Rico and after dropping her children off, went directly to **DCH**.

152. Plaintiff accompanied Candida Rivera sometimes during the day and at others all night and witnessed the mistreatment and neglect by nursing and medical personnel all the way until the day before she died.

153. Plaintiff suffered intense pain and anxiety when medical and nursing staff at **DCH** failed to address the deterioration of her mother-like aunt or adequately intervene in her care.

154. Plaintiff suffered intense pain and anxiety when some of the nursing staff at **DCH** failed to care for Candida Rivera and treat her with care, instead inflicting unnecessary pain upon the patient when taking her blood pressure on the ulcered arm, moving her very brusquely despite the large surgical and opening wound and demonstrating total insensitivity towards the patient and the pain they were causing her.

155. Plaintiff suffered intense pain and anxiety when she experienced the extreme pain and suffering and utter deterioration of her mother-like aunt due to neglect of defendants.

156. As a result of the professional negligence, lack of expertise, fault, and malpractice of all Co-Defendants, Plaintiff unnecessarily and prematurely lost her beloved mother-like aunt Candida, who she called Titi Rosin.

157. With her mother's death, Plaintiff, at a relatively young age, lost a lifelong source of love and comfort.

158. Plaintiff has suffered dearly the unnecessary loss of her mother-like aunt, with whom she will not be able to share any more special moments of her life.

159. Plaintiff's quality of life has been severely and permanently eviscerated as a result of her mother-like aunt's death.

160. Plaintiff was very close to her mother-like and has lost her company, counsel and love for the rest of her life.

161. As a direct and proximate result of the negligence of all Defendants, Plaintiff will continue to suffer the irreparable loss of her mother-like aunt and her quality of life will continue to be severely affected for the rest of her life.

162. As a direct and proximate result of the negligence of all Defendants, Plaintiff have suffered and will continue to suffer an intense sense of frustration and guilt at not having been able to ensure that her mother–like aunt obtained proper medical care.

163. As a direct and proximate result of the negligence of all Defendants, Plaintiff has a sense of frustration, guilt and a deep pain that affects her daily, knowing that Candida's death was preventable.

164. The acts and omissions of the Defendants have caused Plaintiff **ELVIA G. OCASIO RIVERA** a terrible loss, intense, emotional pain and suffering, frustration and a grave sense of injustice equal to a sum not less than **ONE MILLION DOLLARS ($1,000,000.00)**.

TRIAL BY JURY DEMANDED

25. Plaintiff demands trial by jury on all causes of action herein raised.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment against all Defendants jointly and severally, in an amount not less than **ONE MILLION DOLLARS ($1,000,000.000)**, as well as costs incurred, reasonable attorneys' fees, and such other and further relief as this Honorable Court may deem just and proper under the law.

RESPECTFULLY SUBMITTED.

In San Juan, Puerto Rico, on this 6th day of June 2019.

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