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

HERMINIO COLÓN, Plaintiff, v. GRUPO HIMA SAN PABLO, INC.; DR. JAIME RODRÍGUEZ SANTIAGO; DR. MANUEL E. ABRAHAM GONZALEZ; SINDICATO DE ASEGURADORES PARA LA SUSCRIPCIÓN CONJUNTA DEL SEGURO DE RESPONSABILIDAD PROFESIONAL MÉDICO-HOSPITALARIA ("SIMED"), PUERTO RICO MEDICAL DEFENSE INSURANCE COMPANY ("PRMD"), ABC INSURANCE COMPANIES, JOHN DOE AND JAMES ROE	CIVIL NO.: 22-1535 RE: TORT ACTION FOR MEDICAL MALPRACTICE PURSUANT TO ARTS. 1536 AND 1541, 31 P. R. Laws Ann. §§ 1080 AND 10806 JURY TRIAL DEMANDED

COMPLAINT

TO THE HONORABLE COURT:

APPEARS NOW, **HERMINIO COLÓN** (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 Delaware.
3. All Defendants are either individuals who reside in Puerto Rico or corporations organized under the laws of the Commonwealth of Puerto Rico with principal place of business in P.R. or of states other than Delaware.

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 **HERMINIO COLÓN** (hereinafter "**Plaintiff**") is the common law husband of patient Zoila Amaro Delgado (hereinafter "**Zoila Amaro**", or "**the patient**"), who died at Hospital HIMA Fajardo on June 13, 2022, at only thirty-five (35) years young.
7. Co-Defendant **GRUPO HIMA SAN PABLO, INC.,** d/b/a HOSPITAL **HIMA SAN PABLO FAJARDO** (hereinafter "**HSPF**" or "**hospital**"), is a corporation duly incorporated, registered and with its principal place of business in Puerto Rico.
8. Co-Defendant **DR. JAIME RODRÍGUEZ SANTIAGO** (hereinafter "**Dr. Rodríguez Santiago**") 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 **Zoila Amaro** while admitted to Defendant **HSPF's** facility on the relevant dates.
9. Co-Defendant **DR. MANUEL E. ABRAHAM GONZÁLEZ** (hereinafter "**Dr. Abraham González**") 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 **Zoila Amaro** while admitted to Defendant **HSPF's** facility on the relevant dates.

10. Co-Defendant **SINDICATO DE ASEGURADORES PARA LA SUSCRIPCIÓN CONJUNTA DEL SEGURO DE RESPONSABILIDAD PROFESIONAL MÉDICO-HOSPITALARIA** (hereinafter "**SIMED**") is an entity organized or operating under the laws of the Commonwealth of Puerto Rico, with its principal place of business in Puerto Rico, which issued insurance policies on behalf of one or more of the Co-Defendants, known and unknown Joint Tortfeasors in this case, for the acts and/or omissions described herein, encompassing the relevant period of time.
11. Co-Defendant **PUERTO RICO MEDICAL DEFENSE** (hereinafter, "**PRMD**") is an insurance company organized, existing, and with its principal place of business in Puerto Rico which issued insurance policies for medical malpractice on behalf of one or more of the Co-Defendants, known and unknown Joint Tortfeasors in this case, for the acts and/or omissions described herein, encompassing the relevant period of time.
12. Co-Defendant **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 California, which issued insurance policies on behalf of one or more co-defendants for the acts or omissions described herein, encompassing the relevant period of time.

Co-Defendants unknown joint 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

13. **Plaintiff** is the common law husband of **Zoila Amaro**, who lived with her as her husband for the past nine years.

14. **Zoila Amaro** was born on June 10, 1987 and was thirty-five (35) old at the time of the events and death on June 13, 2022.

15. **Zoila Amaro** went to CDT Humacao, also known as HIMA San Pablo Humacao, on June 10, 2022 at approximately 7 pm by herself, since she was feeling dizzy and was experiencing headaches.

16. At the CDT Humacao she was diagnosed with high blood sugar and was given an IV and medication to lower her sugar.

17. **Zoila Amaro** was discharged from CDT Humacao at around 10 pm on June 10, 2022.

18. On Saturday, June 11, 2022 **Zoila Amaro** was still feeling dizzy, and her headaches turned into migraines.

19. On Sunday June 12, 2022, the **Plaintiff** was concerned for **Zoila Amaro's** health and told her that she needed hospital care.

20. On June 12, 2022, the **Plaintiff** and **Zoila Amaro** arrived at CDT Humacao at approximately 8 am and within a half hour of arriving they were told that they could not treat **Zoila Amaro** and that they needed to transfer her to **HSPF**.

21. At approximately 11:00 am of June 12, 2022, **Zoila Amaro** arrived at **HSPF**.

22. At approximately 11:30 am the ER doctor **Dr. Abraham González,** arrived with her lab results and explained that **Zoila Amaro's** hemoglobin and platelets were dangerously low.

23. **Dr. Abraham González** stated to **Plaintiff** and **Zoila Amaro**, that she needed a blood transfusion immediately.
24. Both **Zoila Amaro** and the **Plaintiff** immediately consented to the blood transfusion.
25. No signing of consent was carried out by the **HSPF** personnel, until the following afternoon, after **Zoila Amaro** had become unresponsive.
26. **Dr. Abraham González** had the option to request the blood "STAT" (immediately) but did not.
27. **Dr. Abraham González** treated **Zoila Amaro** during her stay while in the emergency ward as well as while she was hospitalized at the intensive care unit ("ICU").
28. **Dr. Abraham González** spoke to the **Plaintiff** throughout **Zoila Amaro's** stay, even after she had been transferred out of the emergency ward and was at the ICU.
29. **Dr. Abraham González** had explained to the **Plaintiff** what would be the stages of deterioration of the patient if **Zoila Amaro** did not receive the blood transfusion.
30. **Dr. Abraham González** never gave or recorded in the medical record any reasons why the blood was delayed.
31. **Dr. Abraham González** never said nor recorded in the medical record that he was doing anything to secure the blood for **Zoila Amaro's** desperately needed transfusion.
32. **Zoila Amaro** was transferred to the ICU, under the care of **Dr. Rodríguez Santiago**.
33. During her stay, **Dr. Rodríguez Santiago** assured **Zoila Amaro** and the **Plaintiff** that the blood would arrive soon, but it did not.
34. The **Plaintiff** asked for the blood multiple times, and he was given the same response by both doctors.

35. **Dr. Rodríguez Santiago** never gave any reasons why the blood was delayed, nor did he say he was doing anything to secure the blood for **Zoila Amaro's** needed transfusion.
36. **Dr. Rodríguez Santiago** never discussed transferring **Zoila Amaro** to another institution or other alternatives to prevent her catastrophic outcome.
37. At approximately 6 am of June 13, 2022, the **Plaintiff** decided to pick up Ivette Delgado, **Zoila Amaro's** mother, so she could go and see her daughter.
38. Once they got to the hospital, and Ivette was not allowed to see **Zoila Amaro** by hospital personnel.
39. After insisting due to **Zoila Amaro's** deteriorating condition, eventually Ivette was permitted to see **the patient**, who had become unresponsive.
40. At approximately 2:50 pm, **Zoila Amaro** received a platelet transfusion.
41. At approximately 8:30 pm, **Zoila Amaro** developed worsening mental status and tachypnea and was intubated.
42. The **Plaintiff** was told by **Dr. Rodríguez Santiago** that the blood arrived at 9:00 pm and was in the hospital's supervisor's hands.
43. **Zoila Amaro's** first blood transfusion began at approximately 10:55 pm of June 13, 2022, more than 35 hours after the initial transfusion order.
44. At 10:59 pm, **Zoila Amaro** suffered a myocardial infarction, and could not be revived, and she was declared dead at 11:17 pm.

FIRST CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLE 1536 & 1541 OF THE PUERTO RICO CIVIL CODE AGAINST HSPF AND ITS PERSONNEL

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

46. At the relevant times of this complaint, **HSPF** operated or contracted to operate nursing, emergency, ICU, hospital, telemetry, radiology, cardiology, intensive care, and surgery departments within its premises.
47. The **HSPF** sets up policies, procedures and/or requirements for the treatment of the nursing, emergency, hospital, telemetry, intensive care, radiology, cardiology, and surgery departments within its premises.
48. **HSPF** through its policies, procedures and/or requirements provided privileges to **Dr. Rodríguez Santiago** and **Dr. Abraham González**, to operate patients in its facilities and provide follow up care.
49. **HSPF** is liable for the negligent acts or omissions of **Dr. Rodríguez Santiago** and **Dr. Abraham González** that caused damage to **Plaintiff** for failure to provide, disclose, or enforce proper protocols to ensure proper care, adequate medicine, and blood products to attain hemodynamic stability, monitoring and immediate intervention by doctors of patients, such as **Zoila Amaro**.
50. **HSPF** is liable for the negligent acts or omissions of **Dr. Rodríguez Santiago**, **Dr. Abraham González,** and other personnel in charge of securing adequate medicine and blood products and immediately transfuse the blood to **Zoila Amaro** to attain hemodynamic stability.
51. **HSPF** is liable for the negligent acts or omissions of **Dr. Rodríguez Santiago, Dr. Abraham González,** and the hospital personnel in charge of transferring **Zoila Amaro** to another institution with adequate medicine and blood products to attain hemodynamic stability.

52. **HSPF** is liable for failing to adequately supervise or monitor **Dr. Rodríguez Santiago** and **Dr. Abraham González** in order to prevent negligence in the treatment provided by them to **Zoila Amaro** while under their care at **HSPF**.
53. **HSPF** supplies blood and its products as well as medical, nursing, clerical, administrative, and technical personnel to the emergency, ICU, hospital, telemetry, intensive care, radiology, cardiology and surgery departments within its premises.
54. **HSPF** derives revenue from the services provided to patients at these departments within its premises.
55. **HSPF** is liable for medical malpractice occurring at the previously mentioned hospital departments located on its premises.
56. The treatment offered by **HSPF** to patient **Zoila Amaro**, 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 his beloved **Zoila Amaro**, and the injuries, as described herein.
57. **HSPF**'s personnel failed to exercise the care and precautions required under the circumstances to prevent the loss of **Zoila Amaro's** life, lacked the knowledge and medical skill required to treat a patient in their care, and failed to timely have available the blood and actually have its personnel promptly transfuse **Zoila Amaro** before it was too late.

58. **HSPF's** medical and hospital personnel negligently failed to provide patient **Zoila Amaro** with competent nursing and medical personnel to monitor, treat and follow up in a timely and adequate manner.

59. **HSPF's** medical personnel, including defendants named herein, negligently failed to adequately follow an appropriate course of treatment such as immediate blood transfusion, since **Zoila Amaro** did not receive any blood transfusions on June 12 and blood typing and crossmatching were only performed on June 13 in the afternoon, more than 24 hours after her presentation.

60. **HSPF's** medical personnel, including defendants, failed to order a blood typing and cross matching. These tests are critical for the treatment of acute hospitalized patients like **Zoila Amaro**, and this service must be available in the acute care setting 24/7.

61. **HSPF's** medical personnel, including defendants, failed to order a STAT hematology consult.

62. **HSPF's** medical personnel, including Co-Defendants named herein, negligently allowed valuable time without providing blood transfusion and thus the patient to be subjected to the foreseeable catastrophic chain of events, of patient's disorientation, falling into a coma, requiring intubation, and eventual suffering a myocardial infarction and death.

63. **HSPF's** medical personnel, including Co-Defendants named herein, failed to prevent **Zoila Amaro's** acute respiratory failure, acute kidney injury, myocardial infarction, cardiac arrythmias, and cardiopulmonary arrest by ensuring timely red blood cell transfusions.

64. **HSPF's** nursing and medical personnel negligently failed to recognize or otherwise ignored the signs and symptoms that patient **Zoila Amaro** developed during her hematologic instability and impending death.

65. **HSPF's** nursing personnel negligently failed to make all efforts to alert the pertinent doctors of **Zoila Amaro's** deteriorating health due to lack of blood transfusion.

66. **HSPF's** nursing personnel negligently failed to report the patient's complaints and deterioration.

67. **HSPF's** nursing and medical personnel negligently failed to adequately examine and follow up on patient and failed to notice or recognize significant deterioration and dire need for the blood transfusion.

68. Patient **Zoila Amaro** was neglected and mistreated by **HSPF**'s nursing personnel, causing further pain and suffering to the **Plaintiff**.

69. **HSPF's** nursing staff was not familiar with common and possible complications of a required blood transfusion and as such failed to gather all relevant data and report it to the physicians on time.

70. **HSPF's** nursing staff negligently failed to perform a neurological assessment upon unit arrival and at scheduled time intervals throughout her stay.

71. **HSPF's** nursing staff negligently failed to perform a cranial assessment upon unit arrival and at scheduled time intervals throughout her stay.

72. **HSPF's** nursing staff negligently failed to perform an assessment of the patient upon unit arrival and at scheduled time intervals throughout her stay.

73. **HSPF's** nursing staff failed to establish an affirmative care plan that directly correlated with patient's significant conditions.

74. **HSPF's** nursing staff failed to provide close and effective patient monitoring to diminish the damages to the patient.

75. **HSPF's** nursing staff notes were repetitive and lacked meaningful information.

76. **HSPF's** nursing staff notes fail to show signs of objective clinical judgment with regards to significant changes in patient.

77. **HSPF's** nursing staff's interventions failed to address a physical examination of patient.

78. **HSPF's** nursing care fell below the standards of reasonable and prudent nursing care and practice; particularly, the across-the-board nursing failure of basic monitoring, assessment, and interventions with the patient.

79. **HSPF's** nursing care failed to follow nursing protocols initiating appropriate and timely treatment and referring patients for direct evaluation by physicians.

80. **HSPF's** failed to implement, provide, disclosure and or enforce proper nursing protocols to ensure proper care and monitoring of patients that require blood transfusions.

81. **HSPF's** failed to ensure that informed consent documents were timely executed by the patient while she was able to do so, or in preparation for the transfusions by timely requesting **Plaintiff**, and failed to display the grade of reasonableness that a prudent and reasonable person would exhibit, thus breaching its continuous obligation to be vigilant for the health of **the patient** while at their facilities.

82. Patient **Zoila Amaro** required closer nursing and medical supervision but instead was afforded delayed and inadequate treatment at **HSPF**.

83. **HSPF** failed to institute and maintain a blood bank that can crossmatch, supply the blood and blood products and allow blood transfusions to occur 24/7 in an acute care hospital setting.

84. At all times herein pertinent, Co-Defendant **HSPF**, its directors, officers, and employees and physicians with privileges were negligent in receiving **Zoila Amaro** at **HSPF** which was not equipped or had the proper blood supply or could not get it in a timely fashion or failed to timely transfer the patient to another institution as well as failing to provide the proper medical attention, timely obtain and transfuse proper blood products to patient **Zoila Amaro**, in failing to provide competent medical doctors, the proper supervision of co-Defendants **Dr. Rodríguez Santiago** and **Dr. Abraham González** and other unknown physicians and residents employed by and/or practicing at **HSPF,** and by otherwise failing to exercise due care and caution to prevent the tortious conduct, injuries, and suffering to Plaintiff and to patient **Zoila Amaro**.
85. **HSPF** not only failed to adequately select, monitor, intercede or supervise co-Defendants **Dr. Rodríguez Santiago** and **Dr. Abraham González** 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 **Zoila Amaro**, proximately and directly causing her death as well as Plaintiff's injuries.
86. **HSPF** failed in its corporate duty to look out for the health of **Zoila Amaro** and guarantee her safety and well-being while hospitalized, including but not limited to providing the timely transfusion of blood to **Zoila Amaro** and to carefully select the physicians that are granted privileges to practice at its institution, requiring that such physicians take courses and are current, monitoring the work of such physicians and intervening when they commit acts of malpractice, discontinuing their privileges for

repeated or crass negligence and ensuring they are up to date with technological advances.

87. As such **HSPF** is vicariously and directly liable for the medical and nursing malpractice that occurred to **Zoila Amaro** while at its hospital facilities.

88. As a direct and proximate result of **HSPF's** lack of supervision, lack of equipment, lack of blood supply and blood products, and failure to staff its emergency ward, hospital ward, telemetry unit, ICU unit, cardiology department and surgery departments with the medical personnel and other personnel in charge of coordinating and communicating vital information necessary to appropriately treat situations such as **Zoila Amaro's**, **HSPF** and its personnel negligently caused **Plaintiff** the untimely death of his beloved wife **Zoila Amaro** and his injuries, as described herein.

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

SECOND CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLE 1536 & 1541 OF THE PUERTO RICO CIVIL CODE AGAINST PHYSICIAN DR. RODRÍGUEZ SANTIAGO

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

91. The interventions of **Dr. Rodríguez Santiago,** with patient **Zoila Amaro** while she was at **HSPF**, 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 damages and premature

death of patient **Zoila Amaro** and, thus, her pain and suffering as well as that of Plaintiff, as described herein.

92. **Dr. Rodríguez Santiago** 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 he failed to ensure **Zoila Amaro** was timely transfused, thus preventing her death.

93. **Dr. Rodríguez Santiago** 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 he failed to transfer **Zoila Amaro** to another facility that had the capability to obtain and promptly transfuse her.

94. **Dr. Rodríguez Santiago** failed to promptly consult with a hematologist in order to deal with **Zoila Amaro's** hematological instability.

95. **Dr. Rodríguez Santiago** failed to follow-up the delays in the crossmatch and transfusion process from the time of ordering the blood and throughout June 13, 2022.

96. **Dr. Rodríguez Santiago** failed to order blood crossmatch and transfusions as an "Emergency".

97. **Dr. Rodríguez Santiago** failed to prevent **Zoila Amaro** acute respiratory failure, acute kidney injury, myocardial infarction, cardiac arrythmias, and cardiopulmonary arrest by ensuring timely red blood cell transfusions.

98. **Dr. Rodríguez Santiago** 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 he failed to be diligent, exacting and timely make all

efforts to obtain and transfuse **Zoila Amaro** especially as she exhibited obvious symptoms of a hematologic catastrophe.

99. **Dr. Rodríguez Santiago** subjected the patient to a slow and painful death and recorded no efforts to obtain the timely transfusion of his patient.

100. As a direct and proximate cause of co-Defendant **Dr. Rodríguez Santiago's** actions and omissions, **Zoila Amaro** 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 his wife was deprived of her happiness, love and support.

101. In so doing, co-Defendant **Dr. Rodríguez Santiago** committed professional negligence, including lack of expertise, fault, and malpractice, which directly and proximately caused the suffering and death of patient **Zoila Amaro** and the damages to **Plaintiff**, as detailed herein.

SECOND CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLE 1536 & 1541 OF THE PUERTO RICO CIVIL CODE AGAINST PHYSICIAN DR. ABRAHAM GONZALEZ

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

103. **Dr. Abraham González** had the option to request the blood "stat" or immediately but did not.

104. **Dr. Abraham González** treated **Zoila Amaro** during her stay while in the emergency ward as well as while she was hospitalized at ICU.

105. **Dr. Abraham González** spoke to **Plaintiff** throughout **Zoila Amaro´s** stay, even after she had been transferred out of the emergency ward and was in the ICU.

106. **Dr. Abraham González** had explained to the **Plaintiff** what would be the stages of deterioration of the patient if **Zoila Amaro** did not receive the blood transfusion.

107. **Dr. Abraham González** never gave or recorded in the medical record any reasons why the blood was delayed.

108. **Dr. Abraham González** never said or recorded in the medical record that he was doing anything to secure the blood for **Zoila Amaro's** desperately needed transfusion.

109. The interventions of co-Defendant **Dr. Abraham González** with patient **Zoila Amaro** while she was at **HSPF**, 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 damages and premature death of patient **Zoila Amaro** and, thus, her pain and suffering as well as that of Plaintiff, as described herein.

110. **Dr. Abraham González´s** caring for this 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 he failed to ensure his patient was timely transfused, thus preventing her death.

111. **Dr. Abraham González** 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 he failed transfer **Zoila Amaro** to another facility that had the capability to obtain and promptly transfuse her.

112. **Dr. Abraham González** 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 he failed to be diligent, exacting and timely make all

efforts to obtain and transfuse **Zoila Amaro** especially as she exhibited obvious symptoms of a hematologic catastrophe.

113. **Dr. Abraham González** failed to follow-up the delays in the crossmatch and transfusion process.

114. **Dr. Abraham González** failed to order a STAT hematology consult.

115. **Dr. Abraham González** failed to initiate any treatment for the hemolytic anemia

116. Co-defendant **Dr. Abraham González** subjected the patient to a slow and painful death and recorded no efforts to obtain the timely transfusion of his patient.

117. As a direct and proximate cause of co-Defendant **Dr. Abraham González** actions and omissions **Zoila Amaro** 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 his wife was deprived of her happiness, love and support.

118. In so doing, co-Defendant **Dr. Abraham González** committed professional negligence, including lack of expertise, fault, and malpractice, which directly and proximately caused the suffering and death of patient **Zoila Amaro** and the damages to Plaintiff, as detailed herein.

FOURTH CAUSE OF ACTION AGAINST SIMED

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

120. Co-Defendant **SIMED** was at all times herein pertinent an insurance company authorized to do business in the Commonwealth of Puerto Rico and which issued a public liability and/or malpractice insurance policy and/or other applicable insurance on behalf of one or more Defendants and/or other unknown joint tortfeasors.

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

122. 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.

FIFTH CAUSE OF ACTION AGAINST PRMD

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

124. Defendant **PRMD** was, at all times herein pertinent, an insurance company authorized to do business as such in the Commonwealth of Puerto Rico which issued a public liability and/or malpractice insurance policy and/or other applicable insurance on behalf of one or more Defendants and/or other unknown joint tortfeasors.

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.

SIXTH CAUSE OF ACTION AGAINST ABC INSURANCE COMPANIES

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

128. Co-Defendants **ABC INSURANCE COMPANIES** are fictitiously named insurance companies so designated for lack of knowledge at this point in the proceedings.

129. Co-Defendants **ABC INSURANCE COMPANIES** were, at all times herein pertinent, insurance companies authorized to do business as such in the Commonwealth of Puerto Rico

which issued a public liability and/or malpractice insurance policy and/or other applicable insurance on behalf of Defendants and/or other unknown joint tortfeasors.

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

131. 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.

SEVENTH CAUSE OF ACTION FOR NEGLIGENCE UNDER ARTICLES 1536 & 1541 OF THE PUERTO RICO CIVIL CODE AGAINST JOHN DOE AND JAMES ROE UNKNOWN JOINT TORTFEASORS

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

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

134. Co-Defendants John Doe and James Roe's negligent participation in the securing and provision and delivery of the blood supply urgently needed for treatment of **Zoila Amaro** in all areas, including nursing, technical or medical care of **Zoila Amaro** while at Co-Defendant **HSPF** 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 **Zoila Amaro's** death and, thus, the pain and suffering of Plaintiff upon her premature death, as described herein.

135. 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 medical examination of **Zoila Amaro**, commensurate with her condition as such, directly caused and/or contributed to causing her premature death and the emotional pain and suffering such death caused upon the **Plaintiff**.

136. 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 evaluation and treatment.

137. Co-Defendants John Doe and James Roe negligently and carelessly failed to promptly examine, evaluate and treat **Zoila Amaro's** symptoms, thus denying her the provision of essential and life-saving treatment.

138. Co-Defendants John Doe and James Roe 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 **Zoila Amaro** with appropriate treatment.

139. 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 **Zoila Amaro's** condition and with her clinical signs, **Zoila Amaro** was deprived of the opportunity to be promptly treated when time was of the essence and the **Plaintiff**, through the premature death of **Zoila Amaro** was deprived of her companionship, camaraderie, support and love.

140. 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 **Zoila Amaro**, as detailed herein.

141. As a direct and proximate cause of Co-Defendants John Doe and James Roe's negligence in failing to properly treat **Zoila Amaro**, **Plaintiff** sustained severe pain and suffering upon the loss of his beloved wife.

DAMAGES

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

143. Co-Defendants' actions or omissions resulted in patient's suffering while hospitalized, which were witnessed by **Plaintiff**.

144. Patient **Zoila Amaro** was everything to **Plaintiff,** whom he loved dearly.

145. **Plaintiff** had lived with and loved **Zoila Amaro** as a husband, for the past nine years before her death.

146. **Plaintiff** suffered intense pain and anxiety when medical and nursing staff at **HSPF** failed to address the deterioration of his wife and failed to adequately intervene in her care.

147. **Plaintiff** suffered intense pain and suffering when some of the nursing staff at **HSPF** failed to care for **Zoila Amaro**, instead inflicting unnecessary pain upon the patient.

148. **Plaintiff** suffered intense pain and suffering when he observed as **Zoila Amaro** entered the different phases towards her death that he had been warned would happen to her if she did not receive the blood transfusion.

149. As a result of the professional negligence, lack of expertise, fault, and malpractice of all co-Defendants, **Plaintiff** unnecessarily and prematurely lost his beloved wife **Zoila Amaro**.

150. **Plaintiff** has suffered dearly the unnecessary loss of his wife, with whom he will not be able to share any more special moments of his life.

151. **Plaintiff's** quality of life has been severely and permanently eviscerated as a result of his wife's death.

152. **Plaintiff** was very close to his wife and has lost her consortium, counsel, and love for the rest of his life.

153. As a direct and proximate result of the negligence of all Defendants, **Plaintiff** will continue to suffer the irreparable loss of his wife, his family life and his quality of life will continue to be severely affected for the rest of his life.

154. As a direct and proximate result of the negligence of all Defendants, **Plaintiff** has suffered and will continue to suffer an intense sense of frustration and guilt not having been able to ensure that his wife obtained proper medical care.

155. 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 him daily, knowing that **Zoila Amaro's** death was preventable.

156. The acts and omissions of the Defendants have caused **Plaintiff** a terrible loss, intense, emotional pain and suffering, frustration, and a grave sense of injustice equal to a sum not less than **ONE MILLION FIVE HUNDRED THOUSAND DOLLARS ($1,500,000)**.

a. TRIAL BY JURY DEMANDED

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

PRAYER FOR RELIEF

158. **WHEREFORE**, **Plaintiff** demands judgment against all Defendants jointly and severally, in an amount not less than **ONE MILLION FIVE HUNDRED THOUSAND DOLLARS ($1,500,000)**, 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 11th day of November 2022.

CERTIFICATE OF SERVICE: I certify that on this same that I electronically filed the foregoing with the Clerk of the Court using CM/ECF system, which will automatically send notice of such filing to all attorneys of record.

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