COMMONWEALTH OF MASSACHUSETTS
DIVISION OF THE TRIAL COURT

HAMPDEN, SS.

SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO. 2179CV

21 0559

SARA MIROLLI
Plaintiff,

v.

HEATHER LOVE, M.D,,KIMBERLY MARAKOVITS, M.D., NADA KAWAR, M.D., NICOLE THOMPSON, M.D., DONALD KIRTON, M.D. , LAURIE A. FRIEDMAN, CNM & LAUREN JAMMALLO, M.D.
Defendants.

COMPLAINT & DEMAND FOR JURY TRIAL

HAMPDEN COUNTY
SUPERIOR COURT
FILED
OCT 27 2021
CLERK OF COURTS

The foregoing is a complaint for damages arising from the negligent medical management of Plaintiff Sara Mirolli in regard to OB/GYN care she received from November 16, 2018 forward which has resulted in the loss of her reproductive capacity.

PARTIES AND JURISDICTION

1. The Plaintiff, Sara Mirolli, is a Massachusetts resident with an address of 67 Wilder Terrace, West Springfield, Massachusetts.

2. The Defendant, Heather Love, M.D., is a natural person with a business address of 759 Chestnut Street, Springfield, Massachusetts.

3. The Defendant, Kimberly Marakovits, M.D., is a natural person with a business address of 83 South Street, Suite 11, Ware, Massachusetts 01082.

4. The Defendant, Nada Kawar, M.D., is a natural person with a business address of 271 Carew Street, Springfield, Massachusetts.

5. The Defendant, Nicole Thompson, M.D., is a natural person with a business address of 3550 Main Street, Suite 302, Springfield, Massachusetts.

6. The Defendant, Donald Kirton, M.D., is a natural person with a business address of 759 Chestnut Street, Springfield, Massachusetts.

7. The Defendant, Laurie A. Friedman, CNM., is a natural person with a business address of 3300 Main Street, Springfield, Massachusetts.

8. The Defendant, Lauren Jammallo, M.D., is a natural person with a last known address of 53 Blodgett avenue, Swampscott, MA 01907.

9. At all relevant times hereto, Plaintiff as complied with G.L. c. 231, section 60L or such is exempt from serving such notice in accordance with G.L. c. 231, section 60L (j).

FACTS

10. At all relevant times thereto, Plaintiff Mirolli received OB/GYN care at Baystate Medical Center between November 16, 2018 through December 1, 2018.

11. Plaintiff Mirolli underwent the following procedures during the subject admissions:

a. Total abdominal hysterectomy
b. Exploratory laparotomy
c. Bilateral salpingectomy
e. Cstoscopy
f. Wound Debridement
g. Broad ligament dissection (gynecologic oncology division).

12. The Plaintiff received a primary cesarean section at 41 6/7 weeks gestation for arrest of labor in the setting of severe pre-eclampsia with oliguria.

13. The plaintiff was induced at 41 4/7 weeks (EDC November 5, 2018) with misoprostol, foley bulb (two attempts "bulb came out each time"), and pitocin. Upon admission, the cervix was 1 centimeter, 50% effaced and -4 station with a posterior and soft cervix. Membranes are noted to be intact with category one tracing. The estimated fetal weight is estimated by ultrasonography at 3620 grams. Work up is negative for gestational diabetes. Blood pressure on admission was 134/80 mm/Hg and the patient height is 168 centimeters. On November 16, 2018 at 2139 hrs., the patient is evaluated by midwife Carly Detterman. Ms. Mirolli was uncomfortable but coping well. She had one dose of misoprostol and was contracting "too much to repeat dosing". With pitocin, the patient had uterine hyperstimulation on the first and lowest setting. The plan, at this time, was to hold induction agents allowing for maternal rest. Re-evaluation was significant for the cervical dilation at 2 centimeters, 50% effacement -3 station, mid position and soft. Reassuring maternal-fetal testing is noted in the record.

14. The plan upon reevaluation was to administer stadol for discomfort and restart pitocin if the cervix had no further progress over time.

15. On November 17, at 1130 hours, the patient was examined by midwife Laurie Friedman. The cervix was 3 centimeters dilated, with 90% effacement and -2 station. During this examination, membranes spontaneously ruptured and the record states meconium-stained amniotic fluid was noted. The pitocin setting was at 8 milliunits. After three hours of

ruptured membranes, the record notes that there is reassuring maternal-fetal testing and the maternal temperature is 99.1° F. The plaintiff is comfortable with epidural anesthesia. The fetal heart rate baseline is 160 beats per minute. At 1429 hours, midwife Friedman is called to evaluate late decelerations of the fetal heart rate that are recurrent. The cervix is 5 centimeters, 90% effaced and -1 station with a baseline of 165 beats per minute and category two tracing. Supportive resuscitative measures were taken for the category two tracing. The blood pressure is 135/91 mm/Hg. The pitocin is restarted at 2 milliunits, and the patient is afebrile. Pitocin was restarted and increased as the tracing is then described as category one.

16. On November 17, at 1751 hours, the plaintiff is reassessed by midwife Friedman and it is noted that the patient has rectal pressure. Blood pressure is 132/77 mm/Hg with category one tracing. There is no pelvic exam listed. However, in the assessment it states reassuring maternal fetal status and normal labor progression. Pitocin is at 10 milliunits and the plan is to reassess in two hours. At 1850 hours, the cervical exam is 7 centimeters dilated, 90% effacement and zero station. By 1935 hours, the patient is experiencing constant rectal pressure and the cervical exam is 7 centimeters, 80% effacement, and -1 station with caput (molding) developing. The blood pressure is 149/87mm/Hg with category one fetal heart rate testing. Pelvimetry is also done with this exam. The pelvis is described to have a normal arch, a concave sacrum, average ischial spines, and a non-reachable diagonal conjugate

17. The pelvic size was determined by exam to be adequate. The patient has received epidural anesthesia. Reflexes are normal and the pitocin setting is at 12 milliunits. Meconium-stained amniotic fluid and poor urine output are noted. Preeclamptic labs are pending. By 2300 hours, the pitocin setting is 14 milliunits and the plan is for cervical exam at midnight. An intrauterine pressure catheter was also placed around this time. There is category two tracing with variables (moderate) present, and the blood pressure is 137/88 mm/Hg. There is no commentary as to whether amnioinfusion was started for variable decelerations in the fetal heart rate tracing. At midnight, blood pressure is 154/92mm/Hg and the cervix was 8 centimeters dilated, 90% effaced and -1 station. Membranes had been ruptured for 12 hours with meconium, oliguria was present, and there was category one fetal testing by report.

18. On November 18, at 0115 hours, the patient had breakthrough pain and stated, "I can't do this anymore". The blood pressure is 151/92 mm/Hg with a baseline fetal heart rate of 160 beats per minute.

19. Category one tracing is documented in the record and it was noted that the patient had ruled in for severe preeclampsia with an elevated creatinine. The record indicates that Ms. Mirolli had been anuric for approximately three hours, suggestive of acute tubular necrosis of the kidney (ATN).

20. At this time, the physician obstetrical MD team is consulted by midwifery staff. Magnesium is started with a 4-gram bolus dose. The physician of record is Dr. Lauren Jammallo. The plan at this time is to restart the pitocin, and place a foley catheter in the bladder, and reassess for cervical change at 0200 hrs

21. The Plaintiff was next evaluated by Dr. Neena Qasba. It was determined that the patient had been 8 centimeters dilated for several hours with worsening renal function, prolonged rupture of membranes, meconium, oliguria and category two tracing with fetal tachycardia. Ms. Mirolli was started on azithromycin, clindamycin, and gentamicin while being counseled for operative delivery. The patient was in labor for 39 hours and dilated to 8 centimeters with failure to progress.

22. The operative report states that epidural anesthesia was used, but the anesthesia report states that a spinal anesthetic was used.

23. The Plaintiff was then placed in the operating room at 0338 hrs. and incision is at 0413 hrs., upon review of the record, almost half an hour later. At the cesarean section, a male neonate, weighing 3161 grams, is delivered at 0415 hrs.

24. It appears that the NICU team was called due to meconium and extensive manipulation to deliver an impacted fetal head. The apgars were 2, 6, and 8 with a three-vessel cord and it states that cord blood gases were drawn. The cesarean section became STAT due to the fact that the baby's heart rate could not be identified prior to surgery.

25. The plaintiff received intravenous magnesium for 24 hours post-partum for seizure prophylaxis. Her peri-partum course was complicated by oliguria, which improved prior to discharge. The cesarean section was notable for atony which involves a weakened or tired uterine muscle and this is associated with longer more dysfunctional labors. The bladder was noted to be full and "tacked high", meaning on tension.

26. This reflects an obstetrical condition called CPD or cephalopelvic disproportion.

27. The customary bladder flap displaces the bladder downward to protect the structure during delivery of the fetal head.

28. This was not done.

29. There was a 3 to 4-centimeter hematoma along the superior margin of the uterine incision (hysterotomy). A 1-centimeter inferior hematoma was stabilized following suture compression. The fetal head was noted to be extensively molded and a hand up from the vagina was needed to push up and dislodge the head. This further introduces bacteria from the vagina into the uterine cavity. Thick meconium is again noted. GBS (Group B streptococcus) is negative. The estimated blood loss was 1,000 mL.

30. By post-operative day three, the plaintiff's temperature was 98.3° F and the patient was breast feeding, tolerating diet, passing flatus, ambulatory, and pain was well-controlled. Ms. Mirolli was asymptomatic for pre-eclampsia with a hemoglobin of 7.6 mg/dL. It is noted that her blood pressure is 142/90 mm/Hg with a 97% oxygen saturation on room air. The physical exam is stated as "unremarkable", however, there is no comment regarding any odor or uterine tenderness. The record states that the fundus is described as soft and firm. Review

of the record contains a section labeled impression. It is noted in that section that the creatinine has down trended to 1.0 mg/dL and that blood pressures would be monitored.

31. The plaintiff is discharged on post-operative day three. It is noteworthy that her hemoglobin is 7.6 g/dL with a documented presence of a uterine hematoma and the temperature elevation had appeared to resolve. The white blood cell count upon discharge is not found in review or a plan for following the hemoglobin. This is critical because a post-partum patient continues to bleed with "lochia" and 7.6 leaves little margin when blood transfusion criteria is 7.0.

32. Anemia, hematoma, central obesity, prolonged labor, and extensive surgical manipulation are associated risk factors for infection.

Second Admission

33. Ms. Sarah Mirolli was readmitted to the hospital on post-operative day six from a primary cesarean section (41 6/7 weeks) for arrest of dilation in the setting of severe preeclampsia.

34. The plaintiff presented due to malodorous vaginal discharge and discomfort with urination. The exam was significant for a temperature of 100.9° F, tachycardia to 106 beats per minute, fundal tenderness, and foul-smelling vaginal discharge with erythema at the incision. The white blood cell count was noted to be 30,000 mcL. The initial clinical impression was that of post-partum endometritis and wound cellulitis.

35. The record does not indicate pelvic imaging to rule out subfascial involvement, septic pelvic thrombophlebitis, or pelvic abscess.

36. The patient was started on gentamicin and clindamycin. The record stated that there was a penicillin allergy. On hospital day three, the incision started to drain purulent fluid and the patient became febrile to 102.9° F. The patient was brought back to the operating room were an exploratory laparotomy revealed necrotizing fasciitis and a dehisced uterine hysterotomy incision. A total abdominal hysterectomy, bilateral salpingectomy, left broad ligament dissection, ureterolysis, and cystoscopy were performed. In addition, the patient had wound debridement and wound vacuum placement.

37. On post-operative day zero, infectious disease recommended meropenem and clindamycin added to vancomycin. Intraoperative wound cultures where obtained.

38. After surgery, the patient had worsening anemia and received one unit of packed red blood cells. She received clindamycin until post-operative day two. The wound vacuum was changed on post-operative day two. Ms. Mirolli was afebrile for the remainder of her admission.

39. On post-operative day three, Ms. Mirolli developed a maculopapular erythematous rash which appeared to be an atopic dermatitis vs. hypersensitivity reaction. There was good response to benadryl® and hydrocortisone. The record states that IV antibiotics were

discontinued and the patient was then transitioned to levofloxacin and metronidazole per infectious disease recommendations.

40. The admission history and physical revealed a blood pressure of 138/95 mm/Hg. The patient had 97% oxygen saturation on room air. At 2030 hours, the plaintiff's temperature is noted to be 100.9° F. On physical exam, the uterine fundus is noted as tender and there is a malodorous milky brown discharge coming from the vaginal vault. Respiratory rate is 18 breaths per minute and the incision is intact, but a moderate amount of erythema and edema existed around the incision. The note states "no drainage incision itself healing well but concern for cellulitis.

41. The patient is started on IV antibiotics gentamicin and clindamycin. No blood cultures or pelvic imaging is found in the record. Given the extensive manipulation at delivery and the risk factors for infection there is no triple antibiotic coverage given upon second admission. On November 25, 2018, at 0155 hours, the patient is seen by Katie Maggi, RN. She was admitted to the hospital in stable condition. Repeat temperature was 99.1° F and the blood pressure 145/86 mm/Hg.

42. On November 26, 2018, at 0816 hours, the patient's temperature was 98.4° F, pulse rate of 97 beats per minute, blood pressure of 121/73 mm/Hg with a 98% oxygen saturation on room air. It is noted that the cellulitis infection had visually extended and was marked with a pen. At this time, there was a copious amount of foul-smelling brown exudate draining from the incision. The white blood cell count was 32,000 mcL with a hemoglobin of 8.1 g/dL. The platelet count was 319,000/mL.

43. On November 26, 2018 at 2139 hours, the patient is seen by resident Dr. Love and Dr. Marakovits. Ms. Mirolli states that she feels well without fever or chills but does report cramping, abdominal pain and swelling. The malodorous vaginal discharge continues. Blood pressure is 136/79 mm/Hg and the temperature is 99.3° F. The marking pen is utilized to label the margin of the cellulitis and there is no drainage noted.

44. The cellulitis is superior to the abdominal incision.

45. There is no documentation in the note that states as to why the patient has not been placed on triple or broad-spectrum antibiotic coverage pending the culture results.

46. The hemoglobin is 9 g/dL and the white blood cell count is 30.9 mcL. The platelet count is 367,000 mm3. It is noted that the patient's white blood cell count is trending up.

47. There is no mention in the note for an infectious disease consult.

48. On November 26, 2018, a note is prepared by the resident and an addendum is made by the attending physician stating that she agrees with the plan as noted. By post-operative day eight, the plan is to take the patient to the operating room for wound exploration. The antibiotics remained the same.

49. It is noted on November 26, 2018 at 0816 hrs., that Ms. Mirolli's temperature is 98.4° F. At 1240 hrs., the plaintiff's temperature is 102.9° F. The record notes that the patient has a wound vacuum while awaiting to go to the operating room. This notation is made by Brittany Hulse at 1610 hrs. The patient received surgery 12 hours after the temperature spiked to 102.9° F.

50. The date of procedure is November 27, 2018. The surgeon is Dr. Donald Kirton and the assistant surgeon is Dr. Nicole Thompson. The consulting gynecologic oncologist called after the hysterectomy is Dr. Nada Kawar. The estimated blood loss is 400 mL. The operative findings are noteworthy for copious brown fluid extruding from the superficial skin incision.

51. There is necrotic adipose tissues in the next layer, the subcuticular. There is a necrotic fascial edge. A fascial dehiscence/breakdown exists on the left fascial closure.

52. The record supports a complete dehiscence of the hysterotomy incision. This means that any purulence or pus in the uterus spilled out into the abdomen, likely causing the fever and temperature spike to 102.9° F.

53. Necrotic tissue on the left broad ligament and left pelvic sidewall is also present. There are normal ovaries bilaterally. There are bilateral ureteral jets on cystoscopy. The surgical specimen is the uterus, cervix, and bilateral fallopian tubes. The anesthesia record states that the surgery started at approximately 2103 hours on November 26, 2018. The patient is documented as leaving the operating room November 27, at 0138 hrs. The patient is in the operating room for approximately 4 1/2 hours. The consult placed by Dr. Laurie Doyon on November 27, 2018 at 0:08 hrs. is to infectious disease for advisement on post-operative antibiotic regimen and presumed necrotizing fasciitis.

54. The note states that on November 29, 2018 at 0956 hrs., she visited with Ms. Mirolli and her partner, along with Dr. Kirton and the residents who operated on her. "We expressed our sympathy and offered our support and answered any remaining questions that they had".

55. There is no documentation of what the questions were on behalf of the plaintiff.

Count One

(Negligence – Heather Love, M.D, Kimberly Marakovits, M.D., Nada Kawar, M.D., Nicole Thompson, M.D., Donald Kirton, M.D., Laurie A. Friedman, CNM & Lauren Jammallo, M.D.)

56. The Plaintiff incorporates the preceding paragraphs of his Complaint in this count, and further states:

57. The Defendants, Love, Marakovits, Kawar, Thompson, Kirton, Friedman, & Jammallo, rendered medical care to the Plaintiff in a physician-patient relationship.

58. At all times relevant to this complaint, the Defendants owed to the Plaintiff, their patient, a

duty to exercise the degree of care and skill of the average qualified physician and CNM specializing in their area of practices.

59. At all relevant times hereto, the Defendants breached the aforesaid duty owed to the Plaintiff by providing medical treatment and care that fell below the standard of care required of the average practicing physician specializing in their areas of practice.

60. As a result of said breach of duty, the Plaintiff suffered injury and harm resulting in the loss of her reproductive capacity.

61. The injuries suffered were a direct and proximate result of the Defendants' conduct.

Count Two

(Failure to Obtain Informed Consent – . Heather Love, M.D, Kimberly Marakovits, M.D., Nada Kawar, M.D., Nicole Thompson, M.D., Donald Kirton, M.D., Laurie A. Friedman, CNM & Lauren Jammallo, M.D)

62. The Plaintiff incorporates the preceding paragraphs of his Complaint in this count, and further states:

63. At all times relevant to this complaint, the Defendants, Love, Marakovits, Kawar, Thompson, Kirton, Friedman, & Jammallo rendered medical care to the Plaintiff in a physician-patient relationship.

64. At all times relevant to this complaint, the Defendants owed to the Plaintiff, their patient, a duty to disclose the risks of the surgical procedures applied to the Plaintiff.

65. At all times relevant to this complaint, the Defendants, Love, Marakovits, Kawar, Thompson, Kirton, Friedman, & Jammallo, breached the aforesaid duty owed to the Plaintiff by failing to disclose said risks.

66. A reasonable doctor would have known or should have known to disclose said risks, and that said risks were material to the Plaintiff's decision.

67. As a direct and proximate result of the Defendants failures, Defendants' breach of the duty of care, the plaintiff, the Plaintiff has suffered permanent loss of reproduction capacity, and foreseeable complications.

68. As a direct and proximate result of the Defendants' negligence, the Plaintiff suffered extreme pain and suffering.

WHEREFORE, under all counts, THE PLAINTIFF, demands judgment against the Defendants, plus interest and costs and such other relief as the Court deems just.

FOR THE PLAINTIFF
By her attorney,

SARA MIROLLI

DATED: October 27, 2021

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