IN THE SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA

REINA LOZA,
Personal Representative
of the Estate of IRIS Y. LOZA,
Deceased,
3900 70th Ave.
Hyattsville, MD 20784

Plaintiff,

v.

THE HOWARD UNIVERSITY d/b/a
HOWARD UNIVERSITY HOSPITAL
2041 Georgia Avenue, N.W.
Washington, DC 20060
SERVE:
John J. Gloster, Jr.
Registered Agent
2400 6th Street, N.W., Suite 321
Washington, DC 20059

and

OLUWAFUNMILOLA BADA, M.D.
c/o Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

and

MARIAM GOMAA, M.D.
c/o Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

and

MICHAEL WASHINGTON, M.D.
c/o Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

and

Civil Action No. _____
JURY TRIAL DEMANDED

SEYEDEH ALAIE, M.D.)
c/o Howard University Hospital
2041 Georgia Avenue, N.W.)
Washington, DC 20060
)
Defendants.
)

COMPLAINT

COMES NOW, the Plaintiff, by and through her counsel, and files this Complaint against the Defendants The Howard University d/b/a Howard University Hospital, Dr. Bada, Dr. Goma, Dr. Washington, and Dr. Alaie on the grounds and in the amount set forth below.

INTRODUCTION

1. On November 20, 2019, Iris Loza, 32, entered Howard University Hospital ("HUH") for a same-day ablation procedure to reduce menstrual flow. Discharged to home a few hours after the surgery, Ms. Loza returned to HUH the same day complaining of intense pain. She was sent home. That night would be the last time she would ever meaningfully talk to her six children. Several hours later, Ms. Loza was rushed back to HUH where she would remain, suffering tremendously, until her death on January 26, 2020. Defendants would later learn that during the laser ablation, they burned holes in Ms. Loza's bowel, bladder, and uterus. She died from the injuries caused during the ablation and from the subsequent mismanagement of her condition.

JURISDICTION AND VENUE

2. Jurisdiction is founded on D.C. Code § 11-921 as the events and damages set forth herein occurred in the District of Columbia.

3. Plaintiff Reina Loza gave written notice of the allegations to the Defendants more than 90 days prior to the filing of this Complaint.

PARTIES

4. Plaintiff Reina Loza is the adult sister of Iris Loza, deceased.

5. Reina Loza is the Personal Representative of Iris Loza's estate.

6. Iris Loza was 32 years old at the time of her death. She was a longtime resident of the District of Columbia.

7. Iris Loza left five minor children and one adult child.

8. Defendant HUH is a corporation with its principal place of business located in Washington, D.C.

9. At all times relevant, HUH held itself out to the public and to Iris Loza as a health care organization that institutionally possessed, and whose actual and/or apparent agents, servants, and employees individually possessed, that degree of skill, expertise, knowledge, and ability ordinarily possessed by reasonably prudent and competent heath care providers in the District of Columbia.

10. HUH is an organization that includes health care providers who are employees and/or agents, including attending physicians, resident physicians, fellows, and nurses all of whom are licensed to provide medical and nursing services in the District of Columbia. At all times relevant to this Complaint, HUH acted through its actual and/or apparent agents, servants, and employees, including all the individually-named defendants, all of whom acted within the scope of their authority and/or agency or employments in providing services to Iris Loza.

11. At all times relevant, Defendant Dr. Bada was a gynecologist who was licensed in the District of Columbia to provide health care services to persons in need thereof, including the decedent, Iris Loza.

12. At all times relevant, Defendant Dr. Gomaa was a gynecology resident who was licensed in the District of Columbia to provide health care services to persons in need thereof, including the decedent, Iris Loza.

13. At all times relevant, Defendant Dr. Washington was an emergency medicine physician who was licensed in the District of Columbia to provide health care services to persons in need thereof, including the decedent, Iris Loza.

14. At all times relevant, Defendant Dr. Alaie was an emergency medicine resident who was licensed in the District of Columbia to provide health care services to persons in need thereof, including the decedent, Iris Loza.

FACTS

15. Prior to November 17, 2019, Iris Loza was a healthy, happy 32-year-old woman.

16. Ms. Loza was a loving mother to her six children and maintained a fulltime job.

17. Since a prior procedure to remove her fallopian tubes, Ms. Loza experienced heavy uterine bleeding.

18. Ms. Loza met with Dr. Bada and Dr. Bada's medical resident, Dr. Gomaa, to discuss this issue.

19. Dr. Bada recommended that Ms. Loza undergo endometrial ablation.

20. Endometrial ablation is a same-day procedure in which a laser is used to destroy (thermally ablate) uterine lining, which reduces menstrual flow.

21. Prior to the procedure, Drs. Bada and Gomaa were aware from imaging that Ms. Loza had a retroverted uterus. This is a relatively common condition in which the uterus is tipped backwards toward the rectum.

22. On November 20, 2019, Drs. Bada and Gomaa performed the endometrial ablation at HUH.

23. According to their procedure note, Drs. Bada and Gomaa experienced no complications, and the ablation was successful.

24. After a few hours, Drs. Bada and Gomaa discharged Ms. Loza to home.

25. After attempting to rest at home for a few hours, Ms. Loza awoke in tremendous pain. The pain became so severe that she asked a family member to call 911.

26. While being transported back to HUH (the same day of the surgery), the EMS providers noted that Ms. Loza's oxygen saturation level had dropped, her pulse had increased, and she was complaining of difficulty breathing.

27. When she arrived at HUH's Emergency Department, Dr. Washington was the emergency medicine doctor primarily responsible for her care.

28. Dr. Washington noted that Ms. Loza had vomited four times and had not had a bowel movement since the ablation procedure. Aware of the same-day ablation, Dr. Washington requested a gynecology consult.

29. Dr. Alaie, a gynecology resident, evaluated Ms. Loza.

30. Dr. Alaie noted that Ms. Loza had 10/10 abdominal pain, and physical examination confirmed tenderness to palpation in the left and right lower quadrants. In addition, Ms. Loza's white blood cell count was elevated.

31. A pelvic ultrasound demonstrated that there was a complex fluid collection in the cul-de-sac, which had not been seen on a study performed just before the ablation. The radiologist noted that this finding likely represented hemorrhage.

32. Despite the finding of likely hemorrhage hours after an ablation procedure, a high white blood cell count, and 10/10 abdominal pain, neither Dr. Alaie nor Dr. Washington called for a general surgical consult.

33. Instead, Dr. Alaie concluded that Ms. Loza was suffering from an unspecified "food-borne illness."

34. Dr. Alaie recommended discharge and Dr. Washington agreed to send Ms. Loza home despite Ms. Loza requesting to be admitted.

35. Dr. Bada, who co-signed Dr. Alaie's record, was aware of Ms. Loza's condition and also allowed her to be sent home.

36. No general surgeon evaluated Ms. Loza on November 20, 2019.

37. The Defendants sent Ms. Loza home thinking she had food poisoning.

38. At home, Ms. Loza continued to decompensate.

39. Her family rushed Ms. Loza back to HUH approximately 12 hours later.

40. Ms. Loza was admitted for observation as a patient of Dr. Bada, who had performed the ablation.

41. In a note written on November 21, 2019, at 2:28 p.m., Ms. Loza's vital signs were markedly abnormal with a blood pressure of 75/43, and 10/10 pain.

42. The Defendants ordered no radiological testing.

43. The record does not indicate that Dr. Bada evaluated Ms. Loza.

44. At 9:59 p.m. on November 21, 2019, a nurse notified a resident that Ms. Loza's blood pressure was 77/33 and her heart rate 149 bpm.

45. The resident finally ordered a CT Scan of the abdomen and pelvis and noted she would discuss her plan with Dr. Bada.

46. At 12:51 a.m. on November 22nd, resident Dr. Alaie evaluated Ms. Loza. She noted that Ms. Loza's pain remained uncontrolled despite narcotic pain medication, that she continued to vomit, that she had chills, and that her pulse was 148 bpm.

47. While Dr. Alaie was evaluating Ms. Loza, a preliminary report of the CT Scan became available. It demonstrated postoperative free air, diffuse mesenteric edema, ascites with likely associated peritonitis, and small bowel distention likely representing a postoperative ileus.

48. Despite these emergent findings, Dr. Alaie planned to continue to perform serial abdominal exams and noted she would discuss her plan with Dr. Bada. Neither called for a surgical consult.

49. At approximately 3:40 a.m., a rapid response was called when Ms. Loza's blood pressure dropped significantly again and her heart rate increased to 140 bpm.

50. Yet another resident responded. The resident's plan included, for the first time, a surgical consult.

51. Dr. Bada would co-sign the resident's record two days later.

52. Dr. Tran performed a surgical consult, which he documented at 4:10 a.m. on November 22, 2019. Recognizing that Ms. Loza was in critical condition, Dr. Tran emergently took Ms. Loza to the operating room.

53. At surgery, Dr. Tran documented finding a small bowel perforation of more than 50% circumference, a thermal injury at the mesentery next to the damaged bowel, a seromuscular thermal injury to the dome of the bladder, and a thermal injury with perforation to the dome of the uterus.

54. Specifically, Dr. Tran documented the following: a 2cm in diameter thermal perforation of the bowel; a 3cm in diameter thermal perforation of the bladder; a 4cm in diameter "full thickness burn" of the uterus resulting in perforation.

55. During the surgery, Dr. Tran called Dr. Bada into the operating room. Dr. Bada also noted the uterus perforation, and a blanched area, which she resected.

56. Ms. Loza emerged from the surgery intubated and in critical condition.

57. Due to thermal perforations that Dr. Bada and Dr. Gomaa caused during the November 20, 2019 ablation, and the subsequent failure of the Defendants to timely recognize the injuries, Ms. Loza entered septic shock.

58. On November 23, 2019, a surgical resident bluntly explained Ms. Loza's situation: status post "endometrial ablation with subsequent thermal injury to small bowel, bladder, and uterus. Sepsis, hemodynamically unstable."

59. From November 2019 until her death on January 26, 2019, Ms. Loza's condition waxed and waned, and ultimately deteriorated.

60. Throughout this time, her close-knit family kept vigil over her in the hospital.

61. Ms. Loza came in and out of consciousness throughout this period. When conscious, Ms. Loza recognized her condition, and the suffering she was experiencing.

62. On November 26, 2019, Ms. Loza underwent another surgery to perform an abdominal washout, small bowel resection, and re-anastomosis. The procedure had to be terminated due to Ms. Loza's critical condition.

63. Upon return to intensive care, Ms. Loza was placed on a ventilator.

64. On November 29, 2019, Ms. Loza was returned to the operating room for another surgery. During this surgery, doctors performed another abdominal washout, small bowel resection, anastomosis, and placed a wound vacuum.

65. On November 30, 2019, doctors noted concern for Ms. Loza's neurological status. Further gynecology consultations were postponed.

66. Ms. Loza returned to surgery on December 2, 2019, for continued abdominal washouts to try to staunch infection.

67. By December 5, 2019, doctors noted that Ms. Loza's neurological status had improved. She was noted to be following commands.

68. Another surgical abdominal washout was performed on December 6, 2019, and again on December 13, 2019.

69. On December 14, 2019, doctors inserted a chest tube.

70. Ms. Loza progressed to acute respiratory distress syndrome and acute respiratory failure. Ms. Loza was placed on extracorporeal membrane oxygenation.

71. During this time, Ms. Loza also developed a decubitus ulcer.

72. On December 20, 2019, a new chest tube was placed.

73. During her admission, Ms. Loza developed a gastrointestinal (GI) bleed, which necessitated multiple GI procedures. It was determined that Ms. Loza had an active arterial bleed from a duodenal artery.

74. Ms. Loza's condition continued to deteriorate with doctors noting that she was suffering from "massive GI bleeding" that required more than 30 units (approximately 30 pints) of packed red blood cells in 4 days.

75. Ms. Loza underwent multiple embolization procedures to treat the GI bleed.

76. As of January 4, 2020, Ms. Loza was noted to be following commands, with spontaneous eye opening and a GCS score of 11 out of 15. (GCS measures a person's level of consciousness).

77. On January 7, 2020, Ms. Loza suffered a grand mal seizure. She continued to suffer from these seizures intermittently.

78. On day 57 of her ICU admission, Ms. Loza was noted to still be suffering from septic shock.

79. On January 20, 2019, Ms. Loza went into respiratory failure, which required the bedside placement of a tracheostomy.

80. Yet, on ICU day 61, Ms. Loza was noted to be "awake and alert, complains of pain and anxiety."

81. Similarly on ICU day 63, Ms. Loza was "awake and alert," however she was "less responsive than prior examinations and more lethargic."

82. By January 26, 2020, Ms. Loza had gone into multi-organ failure and was noted to have bleeding from the tracheostomy site.

83. Ms. Loza suffered renal failure and metabolic acidosis.

84. At 11:50 a.m. on January 26, 2020, Ms. Loza lost her pulses. By 12:12 p.m., she was in pulseless electrical activity.

85. On January 26, 2020 at 12:12 p.m., after 65 days in the ICU, Ms. Loza was pronounced dead.

86. Dr. Floyd Wilks, who was present at the pronouncement, succinctly wrote: "Ms. Iris Loza is a 33 year-old woman with a medical history significant for hysteroscopy with

endometrial ablation that was complicated by small bowel perforation with fecal peritonitis, perforation of the uterus, and serosal thermal injury to the urinary bladder."

87. Ms. Loza's death certificate, prepared by the Defendants, identifies a cause of death as "Complications of endometrial ablation."

COUNT I
(Survival Action Claim)

88. Plaintiff incorporates all prior paragraphs.

89. Defendants Dr. Bada, Dr. Gomaa, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Perforating Ms. Loza's small bowel during endometrial ablation;

b. Perforating Ms. Loza's uterus during endometrial ablation;

c. Perforating Ms. Loza's bladder during endometrial ablation;

d. Failing to be aware at all times of the location of all medical devices and surgical tools during endometrial ablation;

e. Failing to recognize and identify during endometrial ablation that they had perforated Ms. Loza's small bowel, uterus, and bladder;

f. Failing to properly plan for endometrial ablation knowing that Ms. Loza had a retroverted uterus;

g. Failing to abort the ablation once they caused the initial perforation;

h. Failing to repair the small bowel, uterine, and bladder perforations prior to finishing the ablation;

i. Failing to request surgical assistance to repair the injuries they caused;

j. To the extent Dr. Bada allowed her resident, Dr. Gomaa, to perform parts of the procedure, Dr. Bada failed to properly supervise the resident's actions;

k. As to Dr. Bada, failing to timely respond when Ms. Loza presented to HUH the same day of her ablation procedure;

l. As to Dr. Bada, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2019; and

m. Were otherwise negligent.

90. Defendants Dr. Washington, Dr. Alaie, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Failing to correctly diagnose Ms. Loza's condition on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

b. Failing to obtain a surgical consult for Ms. Loza on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

c. Concluding that Ms. Loza's symptoms were being caused by a food-borne illness;

d. Failing to act on the findings of an ultrasound that showed likely hemorrhage;

e. Failing to admit Ms. Loza on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

f. Discharging Ms. Loza on November 20, 2019;

g. As to Dr. Alaie, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2019;

h. As to Dr. Alaie, failing to timely obtain a surgical consult when the November 21, 2019 CT Scan showed post-operative free air and other worrisome findings;

i. Admitting Ms. Loza for observation on November 21, 2019 without obtaining a surgical consult;

j. Delaying obtaining a surgical consult for many hours until Ms. Loza required a rapid response; and

k. Were otherwise negligent.

91. As a direct and proximate result of Defendants' negligence, Iris Y. Loza suffered over 65 days of extreme conscious pain and suffering prior to her death.

92. As a direct and proximate result of Defendants' negligence, Iris Y. Loza spent over 65 days in the ICU during which time she underwent multiple surgeries, procedures, and bedside interventions, was intubated, ventilated, had chest tubes placed and removed, had wound vacuums placed and removed, had tubes for feeding placed, had tubes for breathing placed, had seizures, suffered massive blood loss, suffered a decubitus ulcer, and became aware that she was likely dying and would never see her six children again.

93. As a direct and proximate result of Defendants' negligence, the Estate suffered economic damages including, but not limited to, extraordinary medical bills and wage loss.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly and severally, in the amount of no less than Thirty Million Dollars ($30,000,000), plus costs and interest.

COUNT II
(Wrongful Death)

94. Plaintiff incorporates all prior paragraphs.

95. Defendants Dr. Bada, Dr. Gomaa, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Perforating Ms. Loza's small bowel during endometrial ablation;

b. Perforating Ms. Loza's uterus during endometrial ablation;

c. Perforating Ms. Loza's bladder during endometrial ablation;

d. Failing to be aware at all times of the location of all medical devices and surgical tools during endometrial ablation;

e. Failing to recognize and identify during endometrial ablation that they had perforated Ms. Loza's small bowel, uterus, and bladder;

f. Failing to properly plan for endometrial ablation knowing that Ms. Loza had a retroverted uterus;

g. Failing to abort the ablation once they caused the initial perforation;

h. Failing to repair the small bowel, uterine, and bladder perforations prior to finishing the ablation;

i. Failing to request surgical assistance to repair the injuries they caused;

j. To the extent Dr. Bada allowed her resident, Dr. Gomaa, to perform parts of the procedure, Dr. Bada failed to properly supervise the resident's actions;

k. As to Dr. Bada, failing to timely respond when Ms. Loza presented to HUH the same day of her ablation procedure;

l. As to Dr. Bada, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2020; and

m. Were otherwise negligent.

96. Defendants Dr. Washington, Dr. Alaie, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Failing to correctly diagnose Ms. Loza's condition on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

b. Failing to obtain a surgical consult for Ms. Loza on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

c. Concluding that Ms. Loza's symptoms were being caused by a food-borne illness;

d. Failing to act on the findings of an ultrasound that showed likely hemorrhage;

e. Failing to admit Ms. Loza on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

f. Discharging Ms. Loza on November 20, 2020;

g. As to Dr. Alaie, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2020;

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i. Admitting Ms. Loza for observation on November 21, 2020 without obtaining a surgical consult;

j. Delaying obtaining a surgical consult for many hours until Ms. Loza required a rapid response; and

k. Were otherwise negligent.

97. As a direct and proximate result of Defendants' negligence, Ms. Loza's beneficiaries, which include her six children (ages 1 to 18), have suffered and will continue to suffer loss of care, support, services, and guidance, and all other damages allowed by law that is recoverable by the beneficiaries for the Defendants' negligence.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly and severally, in the amount of no less than Thirty Million Dollars ($30,000,000), plus costs and interest.

Plaintiff demands a trial by jury.

Respectfully submitted,

PERRY CHARNOFF PLLC

/s/ Scott M. Perry
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Mikhael D. Charnoff (#476583)
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INTRODUCTION

1. On November 20, 2019, Iris Loza, 32, entered Howard University Hospital ("HUH") for a same-day ablation procedure to reduce menstrual flow. Discharged to home a few hours after the surgery, Ms. Loza returned to HUH the same day complaining of intense pain. She was sent home. That night would be the last time she would ever meaningfully talk to her six children. Several hours later, Ms. Loza was rushed back to HUH where she would remain, suffering tremendously, until her death on January 26, 2020. Defendants would later learn that during the laser ablation, they burned holes in Ms. Loza's bowel, bladder, and uterus. She died from the injuries caused during the ablation and from the subsequent mismanagement of her condition.

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51. Dr. Bada would co-sign the resident's record two days later.

52. Dr. Tran performed a surgical consult, which he documented at 4:10 a.m. on November 22, 2019. Recognizing that Ms. Loza was in critical condition, Dr. Tran emergently took Ms. Loza to the operating room.

53. At surgery, Dr. Tran documented finding a small bowel perforation of more than 50% circumference, a thermal injury at the mesentery next to the damaged bowel, a seromuscular thermal injury to the dome of the bladder, and a thermal injury with perforation to the dome of the uterus.

54. Specifically, Dr. Tran documented the following: a 2cm in diameter thermal perforation of the bowel; a 3cm in diameter thermal perforation of the bladder; a 4cm in diameter "full thickness burn" of the uterus resulting in perforation.

55. During the surgery, Dr. Tran called Dr. Bada into the operating room. Dr. Bada also noted the uterus perforation, and a blanched area, which she resected.

56. Ms. Loza emerged from the surgery intubated and in critical condition.

57. Due to thermal perforations that Dr. Bada and Dr. Gomaa caused during the November 20, 2019 ablation, and the subsequent failure of the Defendants to timely recognize the injuries, Ms. Loza entered septic shock.

58. On November 23, 2019, a surgical resident bluntly explained Ms. Loza's situation: status post "endometrial ablation with subsequent thermal injury to small bowel, bladder, and uterus. Sepsis, hemodynamically unstable."

59. From November 2019 until her death on January 26, 2019, Ms. Loza's condition waxed and waned, and ultimately deteriorated.

60. Throughout this time, her close-knit family kept vigil over her in the hospital.

61. Ms. Loza came in and out of consciousness throughout this period. When conscious, Ms. Loza recognized her condition, and the suffering she was experiencing.

62. On November 26, 2019, Ms. Loza underwent another surgery to perform an abdominal washout, small bowel resection, and re-anastomosis. The procedure had to be terminated due to Ms. Loza's critical condition.

63. Upon return to intensive care, Ms. Loza was placed on a ventilator.

64. On November 29, 2019, Ms. Loza was returned to the operating room for another surgery. During this surgery, doctors performed another abdominal washout, small bowel resection, anastomosis, and placed a wound vacuum.

65. On November 30, 2019, doctors noted concern for Ms. Loza's neurological status. Further gynecology consultations were postponed.

66. Ms. Loza returned to surgery on December 2, 2019, for continued abdominal washouts to try to staunch infection.

67. By December 5, 2019, doctors noted that Ms. Loza's neurological status had improved. She was noted to be following commands.

68. Another surgical abdominal washout was performed on December 6, 2019, and again on December 13, 2019.

69. On December 14, 2019, doctors inserted a chest tube.

70. Ms. Loza progressed to acute respiratory distress syndrome and acute respiratory failure. Ms. Loza was placed on extracorporeal membrane oxygenation.

71. During this time, Ms. Loza also developed a decubitus ulcer.

72. On December 20, 2019, a new chest tube was placed.

73. During her admission, Ms. Loza developed a gastrointestinal (GI) bleed, which necessitated multiple GI procedures. It was determined that Ms. Loza had an active arterial bleed from a duodenal artery.

74. Ms. Loza's condition continued to deteriorate with doctors noting that she was suffering from "massive GI bleeding" that required more than 30 units (approximately 30 pints) of packed red blood cells in 4 days.

75. Ms. Loza underwent multiple embolization procedures to treat the GI bleed.

76. As of January 4, 2020, Ms. Loza was noted to be following commands, with spontaneous eye opening and a GCS score of 11 out of 15. (GCS measures a person's level of consciousness).

77. On January 7, 2020, Ms. Loza suffered a grand mal seizure. She continued to suffer from these seizures intermittently.

78. On day 57 of her ICU admission, Ms. Loza was noted to still be suffering from septic shock.

79. On January 20, 2019, Ms. Loza went into respiratory failure, which required the bedside placement of a tracheostomy.

80. Yet, on ICU day 61, Ms. Loza was noted to be "awake and alert, complains of pain and anxiety."

81. Similarly on ICU day 63, Ms. Loza was "awake and alert," however she was "less responsive than prior examinations and more lethargic."

82. By January 26, 2020, Ms. Loza had gone into multi-organ failure and was noted to have bleeding from the tracheostomy site.

83. Ms. Loza suffered renal failure and metabolic acidosis.

84. At 11:50 a.m. on January 26, 2020, Ms. Loza lost her pulses. By 12:12 p.m., she was in pulseless electrical activity.

85. On January 26, 2020 at 12:12 p.m., after 65 days in the ICU, Ms. Loza was pronounced dead.

86. Dr. Floyd Wilks, who was present at the pronouncement, succinctly wrote: "Ms. Iris Loza is a 33 year-old woman with a medical history significant for hysteroscopy with

endometrial ablation that was complicated by small bowel perforation with fecal peritonitis, perforation of the uterus, and serosal thermal injury to the urinary bladder."

87. Ms. Loza's death certificate, prepared by the Defendants, identifies a cause of death as "Complications of endometrial ablation."

COUNT I
(Survival Action Claim)

88. Plaintiff incorporates all prior paragraphs.

89. Defendants Dr. Bada, Dr. Gomaa, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Perforating Ms. Loza's small bowel during endometrial ablation;

b. Perforating Ms. Loza's uterus during endometrial ablation;

c. Perforating Ms. Loza's bladder during endometrial ablation;

d. Failing to be aware at all times of the location of all medical devices and surgical tools during endometrial ablation;

e. Failing to recognize and identify during endometrial ablation that they had perforated Ms. Loza's small bowel, uterus, and bladder;

f. Failing to properly plan for endometrial ablation knowing that Ms. Loza had a retroverted uterus;

g. Failing to abort the ablation once they caused the initial perforation;

h. Failing to repair the small bowel, uterine, and bladder perforations prior to finishing the ablation;

i. Failing to request surgical assistance to repair the injuries they caused;

j. To the extent Dr. Bada allowed her resident, Dr. Gomaa, to perform parts of the procedure, Dr. Bada failed to properly supervise the resident's actions;

k. As to Dr. Bada, failing to timely respond when Ms. Loza presented to HUH the same day of her ablation procedure;

l. As to Dr. Bada, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2019; and

m. Were otherwise negligent.

90. Defendants Dr. Washington, Dr. Alaie, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Failing to correctly diagnose Ms. Loza's condition on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

b. Failing to obtain a surgical consult for Ms. Loza on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

c. Concluding that Ms. Loza's symptoms were being caused by a food-borne illness;

d. Failing to act on the findings of an ultrasound that showed likely hemorrhage;

e. Failing to admit Ms. Loza on November 20, 2019, when she returned to HUH shortly after discharge from her ablation procedure;

f. Discharging Ms. Loza on November 20, 2019;

g. As to Dr. Alaie, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2019;

h. As to Dr. Alaie, failing to timely obtain a surgical consult when the November 21, 2019 CT Scan showed post-operative free air and other worrisome findings;

i. Admitting Ms. Loza for observation on November 21, 2019 without obtaining a surgical consult;

j. Delaying obtaining a surgical consult for many hours until Ms. Loza required a rapid response; and

k. Were otherwise negligent.

91. As a direct and proximate result of Defendants' negligence, Iris Y. Loza suffered over 65 days of extreme conscious pain and suffering prior to her death.

92. As a direct and proximate result of Defendants' negligence, Iris Y. Loza spent over 65 days in the ICU during which time she underwent multiple surgeries, procedures, and bedside interventions, was intubated, ventilated, had chest tubes placed and removed, had wound vacuums placed and removed, had tubes for feeding placed, had tubes for breathing placed, had seizures, suffered massive blood loss, suffered a decubitus ulcer, and became aware that she was likely dying and would never see her six children again.

93. As a direct and proximate result of Defendants' negligence, the Estate suffered economic damages including, but not limited to, extraordinary medical bills and wage loss.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly and severally, in the amount of no less than Thirty Million Dollars ($30,000,000), plus costs and interest.

COUNT II
(Wrongful Death)

94. Plaintiff incorporates all prior paragraphs.

95. Defendants Dr. Bada, Dr. Gomaa, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Perforating Ms. Loza's small bowel during endometrial ablation;

b. Perforating Ms. Loza's uterus during endometrial ablation;

c. Perforating Ms. Loza's bladder during endometrial ablation;

d. Failing to be aware at all times of the location of all medical devices and surgical tools during endometrial ablation;

e. Failing to recognize and identify during endometrial ablation that they had perforated Ms. Loza's small bowel, uterus, and bladder;

f. Failing to properly plan for endometrial ablation knowing that Ms. Loza had a retroverted uterus;

g. Failing to abort the ablation once they caused the initial perforation;

h. Failing to repair the small bowel, uterine, and bladder perforations prior to finishing the ablation;

i. Failing to request surgical assistance to repair the injuries they caused;

j. To the extent Dr. Bada allowed her resident, Dr. Gomaa, to perform parts of the procedure, Dr. Bada failed to properly supervise the resident's actions;

k. As to Dr. Bada, failing to timely respond when Ms. Loza presented to HUH the same day of her ablation procedure;

l. As to Dr. Bada, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2020; and

m. Were otherwise negligent.

96. Defendants Dr. Washington, Dr. Alaie, and HUH, acting through its employees and agents, were negligent in their care and treatment of Iris Y. Loza as follows:

a. Failing to correctly diagnose Ms. Loza's condition on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

b. Failing to obtain a surgical consult for Ms. Loza on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

c. Concluding that Ms. Loza's symptoms were being caused by a food-borne illness;

d. Failing to act on the findings of an ultrasound that showed likely hemorrhage;

e. Failing to admit Ms. Loza on November 20, 2020, when she returned to HUH shortly after discharge from her ablation procedure;

f. Discharging Ms. Loza on November 20, 2020;

g. As to Dr. Alaie, failing to timely obtain a surgical consult for Ms. Loza when she re-presented on November 21, 2020;

h. As to Dr. Alaie, failing to timely obtain a surgical consult when the November 21, 2020 CT Scan showed post-operative free air and other worrisome findings;

i. Admitting Ms. Loza for observation on November 21, 2020 without obtaining a surgical consult;

j. Delaying obtaining a surgical consult for many hours until Ms. Loza required a rapid response; and

k. Were otherwise negligent.

97. As a direct and proximate result of Defendants' negligence, Ms. Loza's beneficiaries, which include her six children (ages 1 to 18), have suffered and will continue to suffer loss of care, support, services, and guidance, and all other damages allowed by law that is recoverable by the beneficiaries for the Defendants' negligence.

WHEREFORE, Plaintiff demands judgment against the Defendants, jointly and severally, in the amount of no less than Thirty Million Dollars ($30,000,000), plus costs and interest.

Plaintiff demands a trial by jury.

Respectfully submitted,

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CIVIL DIVISION Civil Actions Branch
500 Indiana Avenue, N.W., Suite 5000, Washington, D.C. 20001
Telephone: (202) 879-1133 • Website: www.dccourts.gov

REINA LOZA
Vs.
THE HOWARD UNIVERSITY et al

C.A. No. 2020 CA 004596 M

INITIAL ORDER AND ADDENDUM

Pursuant to D.C. Code § 11-906 and District of Columbia Superior Court Rule of Civil Procedure ("Super. Ct. Civ. R.") 40-I, it is hereby **ORDERED** as follows:

(1) This case is assigned to the judge and calendar designated below. All future filings in this case shall bear the calendar number and the judge's name beneath the case number in the caption.

(2) Within 60 days of the filing of the complaint, plaintiff must file proof of service on each defendant of copies of (a) the summons, (b) the complaint, and (c) this Initial Order and Addendum. The court will dismiss the claims against any defendant for whom such proof of service has not been filed by this deadline, unless the court extended the time for service under Rule 4(m).

(3) Within 21 days of service (unless otherwise provided in Rule 12), each defendant must respond to the complaint by filing an answer or other responsive pleading. The court may enter a default and a default judgment against any defendant who does not meet this deadline, unless the court extended the deadline under Rule 55(a).

(4) At the time stated below, all counsel and unrepresented parties shall participate in a remote hearing to establish a schedule and discuss the possibilities of settlement. Counsel shall discuss with their clients **before** the hearing whether the clients are agreeable to binding or non-binding arbitration. **This order is the only notice that parties and counsel will receive concerning this hearing.**

(5) If the date or time is inconvenient for any party or counsel, the Civil Actions Branch may continue the Conference **once**, with the consent of all parties, to either of the two succeeding Fridays. To reschedule the hearing, a party or lawyer may call the Branch at (202) 879-1133. Any such request must be made at least seven business days before the scheduled date.

No other continuance of the conference will be granted except upon motion for good cause shown.

(6) Parties are responsible for obtaining and complying with all requirements of the General Order for Civil cases, each judge's Supplement to the General Order and the General Mediation Order. Copies of these orders are available in the Courtroom and on the Court's website http://www.dccourts.gov/.

Chief Judge Anita M. Josey-Herring

Case Assigned to: Judge HIRAM E PUIG-LUGO
Date: November 4, 2020
Initial Conference: **REMOTE HEARING - DO NOT COME TO COURTHOUSE**
SEE REMOTE HEARING INSTRUCTIONS ATTACHED TO INITIAL ORDER

9:30 am, Friday, February 05, 2021
Location: Courtroom 318
500 Indiana Avenue N.W.
WASHINGTON, DC 20001

ADDENDUM TO INITIAL ORDER AFFECTING ALL MEDICAL MALPRACTICE CASES

D.C. Code § 16-2821, which part of the Medical Malpractice Proceedings Act of 2006, provides, "[a]fter action is filed in the court against a healthcare provider alleging medical malpractice, the court shall require the parties to enter into mediation, without discovery or, if all parties agree[,] with only limited discovery that will not interfere with the completion of mediation within 30 days of the Initial Scheduling and Settlement Conference ('ISSC'"), prior to any further litigation in an effort to reach a settlement agreement. The early mediation schedule shall be included in the Scheduling Order following the ISSC. Unless all parties agree, the stay of discovery shall not be more than 30 days after the ISSC."

To ensure compliance with this legislation, on or before the date of the ISSC, the Court will notify all attorneys and *pro se* parties of the date and time of the early mediation session and the name of the assigned mediator. Information about the early mediation date also is available over the internet at https://www:dccourts.gov/pa/. To facilitate this process, all counsel and *pro se* parties in every medical malpractice case are required to confer, jointly complete and sign an EARLY MEDIATION FORM, which must be filed no later than ten (10) calendar days prior to the ISSC. D.C. Code § 16-2825 Two separate Early Mediation Forms are available. Both forms may be obtained at www.dccourts.gov/medmalmediation. One form is to be used for early mediation with a mediator from the multi-door medical malpractice mediator roster; the second form is to be used for early mediation with a private mediator. Plaintiff's counsel is responsible for eFiling the form and is required to e-mail a courtesy copy to earlymedmal@dcsc.gov. Unrepresented plaintiffs who elect not to eFile must either mail the form to the Multi-Door Dispute Resolution Office at, Suite 2900, 410 E Street, N.W., Washington, DC 20001, or deliver if in person if the Office is open for in-person visits.

A roster of medical malpractice mediators available through the Court's Multi-Door Dispute Resolution Division, with biographical information about each mediator, can be found at www.dccourts.gov/medmalmediation/mediatorprofiles. All individuals on the roster are judges or lawyers with at least 10 years of significant experience in medical malpractice litigation. D.C. Code § 16-2823(a). If the parties cannot agree on a mediator, the Court will appoint one. D.C. Code § 16-2823(b).

The following people are required by D.C. Code § 16-2824 to attend personally the Early Mediation Conference: (1) all parties; (2) for parties that are not individuals, a representative with settlement authority; (3) in cases involving an insurance company, a representative of the company with settlement authority; and (4) attorneys representing each party with primary responsibility for the case.

No later than ten (10) days after the early mediation session has terminated, Plaintiff must eFile with the Court a report prepared by the mediator, including a private mediator, regarding: (1) attendance; (2) whether a settlement was reached; or, (3) if a settlement was not reached, any agreements to narrow the scope of the dispute, limit discovery, facilitate future settlement, hold another mediation session, or otherwise reduce the cost and time of trial preparation. D.C. Code§ 16-2826. Any Plaintiff who is unrepresented may mail the form to the Civil Actions Branch at [address] or deliver it in person if the Branch is open for in-person visits. The forms to be used for early mediation reports are available at www.dccourts.gov/medmalmediation.

Chief Judge Anita M. Josey-Herring

Civil Remote Hearing Instructions for Participants

The following instructions are for participants who are scheduled to have cases heard before a Civil Judge in a **Remote Courtroom**

Option1: (AUDIO ONLY/Dial-in by Phone):

Toll 1 (844) 992-4762 or (202) 860-2110, enter the Meeting ID from the attachment followed by #, press again to enter session.

- *Please call in no sooner than 5 minutes before your scheduled hearing time. Once you have joined the session, please place your phone on mute until directed otherwise. If you should happen to get disconnected from the call, please call back in using the phone number and access number provided and the courtroom clerk will mute your call until the appropriate time.*

If you select **Option 2** or **Option 3** use the **Audio Alternative**

Option 2: (LAPTOP/ DESKTOP USERS 1):

Open Web Browser in Google Chrome and copy and paste following address from the next page:
https://dccourts.webex.com/meet/XXXXXXXXX

Option 3: (LAPTOP/ DESKTOP USERS 2):

Open Web Browser in Google Chrome and copy and paste following address
https://dccourts.webex.com Select **Join**, enter the Meeting ID from the next page

AUDIO ALTERNATIVE: Instead of automatically using **USE COMPUTER FOR AUDIO**, select **CALL-IN** and follow the **CALL-IN** prompt window. Use a cell phone or desk phone. You will be heard clearer if you **do not** place your phone on SPEAKER. It is very important that you enter the **ACCESS ID #** so that your audio is matched with your video.

Option 4: (Ipad/SMART PHONE/TABLET):

- Go to App Store, Download WebEx App (Cisco WebEx Meetings)
- Sign into the App with your Name and Email Address
- Select Join Meeting
- Enter address from the next page: https://dccourts.webex.com/meet/XXXXXXXXX
- Click join and make sure your microphone is muted and your video is unmuted (if you need to be
- seen). If you only need to speak and do not need to be seen, use the audio only option.
- When you are ready click "Join Meeting". If the host has not yet started the meeting, you will be placed in the lobby until the meeting begins.

For Technical Questions or issues Call: (202) 879-1928, Option #2

Superior Court of the District of Columbia
Public Access for Remote Court Hearings
(Effective August 24, 2020)

The current telephone numbers for all remote hearings are: 202-860-2110 (local) or 844-992-4726 (toll free). After dialing the number, enter the WebEx Meeting ID as shown below for the courtroom. Please click a WebEx Direct URL link below to join the hearing online.

Audio and video recording; taking pictures of remote hearings; and sharing the live or recorded remote hearing by rebroadcasting, live-streaming or otherwise are not allowed

Division	Courtroom	Types of Hearings Scheduled in Courtroom	Public Access via WebEx	
			WebEx Direct URL	WebEx Meeting ID
Auditor Master	206	Auditor Master Hearings	https://dccourts.webex.com/meet/ctbaudmaster	129 648 5606
Civil	100	Civil 2 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb100	129 846 4145
	205	Foreclosure Matters	https://dccourts.webex.com/meet/ctb205	129 814 7399
	212	Civil 2 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb212	129 440 9070
	214	Title 47 Tax Liens; and Foreclosure Hearings	https://dccourts.webex.com/meet/ctb214	129 942 2620
	219	Civil 2 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb219	129 315 2924
	221	Civil 1 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb221	129 493 5162
	318	Civil 2 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb318	129 801 7169
	320		https://dccourts.webex.com/meet/ctb320	129 226 9879

	400	Judge in Chambers Matters including Temporary Restraining Orders, Preliminary Injunctions and Name Changes	https://dccourts.webex.com/meet/ctb400	129 339 7379
	415	Civil 2 Scheduling Conferences; Status, Motion and Evidentiary Hearings including Bench Trials	https://dccourts.webex.com/meet/ctb415	129 314 3475
	516		https://dccourts.webex.com/meet/ctb516	129 776 4396
	517		https://dccourts.webex.com/meet/ctb517	129 911 6415
	518		https://dccourts.webex.com/meet/ctb518	129 685 3445
	519		https://dccourts.webex.com/meet/ctb519	129 705 0412
	JM-4		https://dccourts.webex.com/meet/ctbjm4	129 797 7557
	A-47	Housing Conditions Matters	https://dccourts.webex.com/meet/ctba47	129 906 2065
	B-52	Debt Collection and Landlord and Tenant Trials	https://dccourts.webex.com/meet/ctbb52	129 793 4102
	B-53	Landlord and Tenant Matters including Lease Violation Hearings and Post Judgment Motions	https://dccourts.webex.com/meet/ctbb53	129 913 3728
	B-109	Landlord and Tenant Matters	https://dccourts.webex.com/meet/ctbb109	129 127 9276
	B-119	Small Claims Hearings and Trials	https://dccourts.webex.com/meet/ctbb119	129 230 4882