COMMONWEALTH OF MASSACHUSETTS
THE TRIAL COURT

SUFFOLK, ss.

SUPERIOR COURT DEPARTMENT
Docket No.: 18-03984G

KATERYN PAREDES, individually, and as the Administrator of THE ESTATE OF JAYREN PAREDES

Plaintiff,

v.

DR. LUCY Y. CHIE, DR. SANDRA MASON, and BETH ISREAL DEACONESS MEDICAL CENTER, INC.

Defendants.

COMPLAINT AND DEMAND FOR JURY TRIAL

STATEMENT OF THE CASE

1. This cause of action is brought by Kateryn Paredes, individually and as the Administrator of the Estate of Jayren Paredes, as Plaintiff in the above captioned action and hereby files this Complaint seeking damages for wrongful death and conscious pain and suffering pursuant to M.G.L. 229 §2 caused directly and proximately by the careless, reckless, willful, wanton, gross negligent, as well as the negligent conduct and medical malpractice of the above-named Defendants. As a direct and proximate result of the careless, reckless, willful, wanton, reckless, gross negligent, as well as the negligent conduct and medical malpractice of the above-named Defendants, Jayren Paredes (an infant) died surrounded by his family on January 11, 2016 at six (6) hours of life, giving rise to great compensatory damages. The Plaintiff further brings claims for statutory and punitive damages, costs, and attorney's fees against the Defendants related to their reckless, willful, wanton, and grossly negligent conduct in this matter pursuant to M.G.L. 229 §2 as indicated herein.

THE PARTIES

2. Ms. Kateryn Paredes (hereinafter "Plaintiff"), is the mother of Jayren Paredes (hereinafter "Decedent") and is an individual who now resides at 5 Yarmouth Place, Boston, County of Suffolk, Massachusetts, and is also the duly appointed and qualified Administrator of the Estate of Jayren Paredes. The Decedent was

born on January 10, 2016 and died on January 11, 2016 at Beth Israel Deaconess Medical Center, after 6 hours of life.

3. Dr. Lucy Y. Chie, (hereinafter "Dr. Chie"), is a physician licensed to practice medicine within the Commonwealth of Massachusetts and specializes in the practice of Obstetrics and Gynecology, and at all times relevant herein, held herself out as a physician and rendered care and treatment to the Plaintiff and/or Decedent on or about January 9, 2016 and January 10, 2016. At all relevant times herein, she maintained a professional office and provided services at Beth Israel Deaconess Medical Center, which has a principal place of business located at 330 Brookline Avenue, Boston, County of Suffolk, Massachusetts. Dr. Chie has a current business address at South Cove Community Health Center, Inc., 145 South Street, Boston, County of Suffolk, Massachusetts.

4. Dr. Sandra Mason, (hereinafter "Dr. Mason"), is a physician licensed to practice medicine within the Commonwealth of Massachusetts and specializes in the practice of Obstetrics and Gynecology, and at all times relevant herein, held herself out as a physician and rendered care and treatment to the Plaintiff and/or the Decedent on January 10, 2016. At all relevant times herein, she maintained a professional office and provided services at Beth Israel Deaconess Medical Center, which has a principal place of business located at 330 Brookline Avenue, Boston, County of Suffolk, Massachusetts.

5. Beth Israel Deaconess Medical Center, Inc. (hereinafter "Beth Israel Deaconess Medical Center") has a principal place of business located at 330 Brookline Avenue, Boston, County of Suffolk, Massachusetts and which by its employees, agents, or servants, rendered medical care and other services to the Plaintiff and Decedent and was responsible for the care of the Plaintiff and Decedent from on or about January 9, 2016, until the Decedent's death on or about January 11, 2016 and thereafter until the Plaintiff's discharge.

FACTS COMMON TO ALL COUNTS

6. In or around May 2015, the Plaintiff was a then twenty-seven (27) year old female when she learned she was pregnant with her first child, Jayren Paredes (the Decedent).

7. The Plaintiff's antepartum course was essentially uncomplicated and her prenatal care started in the first trimester at The Dimock Center, in Boston, Massachusetts. The Plaintiff attended all of the appropriate appointments and ultrasounds through to the time of labor, which was expected to occur in January 2016.

8. During her pregnancy, the Plaintiff exhibited normal testing, and underwent an ultrasound on January 5, 2016 at 39 3/7 weeks which showed an 8/8 biophysical profile and no abnormalities.

9. The Plaintiff was 39 6/7 weeks pregnant with the Decedent when, on January 9, 2016, she presented to Beth Israel Deaconess Medical Center for labor and

delivery.

10. Upon arrival to the Beth Israel Deaconess Medical Center, Labor and Delivery Unit, on January 9, 2016, Jayren Paredes (the decedent) was in a healthy condition.

11. Upon admission to Beth Israel Deaconess Medical Center, Labor and Delivery Unit, the Plaintiff complained of painful contractions. The Plaintiff was then noted to be four (4) centimeters dilated and she had bulging membranes.

12. The Plaintiff's treatment providers at Beth Israel Deaconess Medical Center first utilized electronic fetal monitoring on the Plaintiff on January 9, 2016 at 3:55PM. The fetal monitor revealed a category 1 strip and a healthy baby.

13. The Plaintiff's labor progressed to 5 to 6 cm dilation on January 9, 2016 at 6:05PM. The Plaintiff started to have Category 2 fetal monitoring strips with persistent abnormalities in the fetal monitoring tracings including late decelerations around 6:57PM with moderate variability. These late decelerations persisted until around 7:43PM and then began again from around 8:07PM until around 8:30PM when the Plaintiff was noted to now be 6 to 7cm dilated and in active labor.

14. Between 10:30PM on January 9, 2016 until at least 8:25AM on January 10, 2016 the chief resident on duty Dr. Sara Won, and the attending physician Dr. Lucy Chie, rendered medical care and treatment to the Plaintiff and continued to monitor and treat the Plaintiff during this time.

15. The Plaintiff continued to have Category 2 fetal monitoring strips with persistent abnormalities in the fetal monitoring tracings and continued to have periods of late decelerations which were noted to be continuing at 11:45PM on January 9, 2016.

16. At 11:45PM on January 9, 2016, the Plaintiff was noted to be 8cm dilated.

17. At or around 11:45PM on January 9, 2016, the Plaintiff's bag of water was broken (artificial rupture of membranes) and thick meconium was also noted.

18. Shortly thereafter, the Plaintiff developed a fever and maternal tachycardia and was diagnosed with chorioamnionitis and started on ampicillin, gentamicin, and acetaminophen, which was ordered by Dr. Won.

19. Pitocin was started on January 10, 2016 at 1:40AM per Dr. Won's order as the Plaintiff's cervix had not further dilated beyond 8cm in 2 hours and the Plaintiff had been in active labor for over 5 hours.

20. The Plaintiff continued to have Category 2 fetal monitoring strips during this time and the persistent abnormalities in the fetal monitoring tracings continued with intermittent and recurrent late decelerations continuing until beyond 3:45AM on

January 10, 2016.

21. At around 3:45AM on January 10, 2016, and despite Pitocin being titrated, it was noted that the Plaintiff had not made any further progress in cervical dilation whatsoever as the Plaintiff remained at 8 cm dilated over the past four (4) hours from the time she was noted to be 8cm dilated at 11:45 PM on January 9, 2016.

22. At or around 3:45AM on January 10, 2016, resident Dr. Jessica Kuperstock examined the Plaintiff and noted that she was concerned for arrested labor and failure to progress as the Plaintiff had been in active labor for over 7 hours and had remained at 8 cm dilation without any advancement in 4 hours despite Pitocin being titrated.

23. At or around 3:45AM on January 10, 2016, resident Dr. Kuperstock also notes that she counseled the Plaintiff regarding the need for cesarean section being performed if the arrest of labor continued, as there had not been any cervical change. The Plaintiff indicated that she was ready for a cesarean section to occur at any time, as she was worried about her protracted labor course and the effects it would have on her baby.

24. Resident Dr. Kuperstock further noted that she would re-evaluate the Plaintiff in two (2) hours or sooner as needed. Dr. Kuperstock also noted that she discussed her concerns and plan for a cesarean section with chief resident Dr. Sara Won and the attending physician Dr. Lucy Chie at that time. The decision was made to continue Pitocin and recheck the Plaintiff's cervix at 5:00AM.

25. The Plaintiff did not undergo a Sterile Vaginal Exam at or around 5:00AM on January 10, 2016 and the Plaintiff's cervix was not rechecked during that time.

26. On January 10, 2016 between 5:15AM and at least 7:45AM the Plaintiff was rendered nursing care by Nurse Higgins and Nurse Teves who continued to monitor and note the Plaintiff's lack of labor progress, arrested labor, and the persistent abnormalities in the fetal monitoring tracings that continued with the Plaintiff continuing to have Category 2 fetal monitoring strips during this time.

27. By or around 6:00AM on January 10, 2016, the Plaintiff's cervix had not further dilated whatsoever and she remained at 8cm. By this time, the Plaintiff had been in active labor for over 9.5 hours and had remained at 8 cm dilation without any advancement whatsoever in over 6 hours despite Pitocin being titrated, and the persistent abnormalities in the fetal monitoring tracings continued with the Plaintiff continuing to have Category 2 fetal monitoring strips during this time.

28. On January 10, 2016 at 6:00AM, the Plaintiff had a fetal deceleration to 60 bpm, which took 6 minutes to recover. At 6:10AM, resident Dr. Kuperstock was called in by the nurses for concerns regarding the continued persistent abnormalities in the fetal monitoring tracings and the category 2 tracings that continued. Pitocin was turned off at this time, the Plaintiff was repositioned, and oxygen was administered.

29. On January 10, 2016 at or around 6:10AM, resident Dr. Kuperstock performed a sterile vaginal exam which continued to show that the Plaintiff was not adequately progressing, that her labor had completely arrested, and that there was still no cervical change over the past over six (6) hours whatsoever, as the Plaintiff was still 8cm dilated where she had remained since 11:45PM on January 9, 2016 despite the administration of Pitocin.

30. At or around 6:10AM on January 10, 2016, resident Dr. Kuperstock noted that she would continue to monitor the Plaintiff closely. Dr. Kuperstock also noted that she had a discussion with chief resident Dr. Won, and the attending physician Dr. Lucy Chie, regarding the Plaintiff's lack of labor progress, arrested labor, and the persistent abnormalities in the fetal monitoring tracings that continued with the Plaintiff continuing to have Category 2 fetal monitoring strips.

31. At 6:40AM on January 10, 2016, and with the Plaintiff now being in active labor for over 10 hours, the Plaintiff was found to still be at 8cm dilated with still no cervical change whatsoever in 7 hours. The Plaintiff was clearly suffering from fetal intolerance to labor, fetal intolerance to Pitocin, arrested labor, failure to progress and the persistent ominous abnormalities in the fetal monitoring tracings continued with the Plaintiff continuing to have Category 2 fetal monitoring strips.

32. At or around 6:40AM on January 10, 2016, an IUPC was placed by chief resident Dr. Won and an amnioinfusion was started.

33. At 7:00AM on January 10, 2016, chief resident Dr. Won noted that the Plaintiff had developed chorioamnionitis, was experiencing persistent maternal tachycardia, and was having a protracted labor course without adequate contractions. Dr. Won further noted that Ms. Paredes had remained at 8cm dilated with no cervical change in 7 hours since the artificial rupture of membranes occurred and thick meconium was noted at 11:45PM on January 9, 2016. In addition, Dr. Won noted that the Plaintiff continued to experience Category 2 tracings with variable and late decelerations. Dr. Won further noted that she was concerned for arrest in labor and the inability to augment Pitocin due to the continuing category 2 fetal heart tracings with continued persistent abnormalities in the fetal monitoring tracings.

34. Dr. Won concluded her 7:00AM note by recording a plan to proceed with a cesarean section to occur in 1 hour (8:00AM), which Dr. Won noted she discussed with the attending physician, Dr. Chie. Dr. Won further noted that she discussed with the Plaintiff the plan to proceed with a cesarean section at 8:00AM, as well as the risks and benefits of a cesarean section, and the Plaintiff was amenable to the plan.

35. By 7:00AM on January 10, 2016, the Plaintiff had been allowed to stay in active labor for 10.5 hours although there had been no cervical change beyond 8cm dilated for over 7 hours. Throughout this time the Plaintiff questioned her plan of care and asked that a cesarean section be performed as she did over the course of

the next many hours. The Plaintiff was told at or around 7:00AM on January 10, 2016 that a cesarean section would be performed at or around 8:00AM.

36. At or around 8:00AM on January 10, 2016, the Plaintiff had still not progressed, she had now been in active labor for 11.5 hours, and she remained at 8cm dilated for over 8 hours. During this time, the Plaintiff continued to have persistent maternal tachycardia, chorioamnionitis, failure to progress, persistent abnormalities in the fetal monitoring tracings that continued with the Plaintiff continuing to have Category 2 fetal monitoring strips, fetal intolerance to labor, fetal intolerance to Pitocin, and her cervical dilation had completely arrested.

37. Despite the Plaintiff's and Decedent's condition and the plan to proceed with a cesarean section at or around 8:00AM on January 10, 2016, the attending physicians in charge of the Plaintiff's and Decedent's care, Dr. Chie and Dr. Mason who assumed care of the Plaintiff, wholly failed to intervene and initiate a caesarean section during this time or any time thereafter.

38. Thereafter, at around 8:30AM on January 10, 2016, resident Dr. Zoe McKee also began to render care to the Plaintiff and noted Plaintiff's continued protracted course of labor with Chorioamnionitis and fetal intolerance to labor with Pitocin. Despite the continued persistent abnormalities in the fetal monitoring tracings that continued with the Plaintiff continuing to have Category 2 fetal monitoring strips, chorioamnionitis, maternal tachycardia, and the Plaintiff now being in active labor for 12 hours with arrested labor and without any cervical change whatsoever in the past almost 9 hours as the Plaintiff remained 8 cm dilated, incredibly and fatally, the plan noted was to now increase the Pitocin and continue the trial of vaginal delivery instead of the attending physicians intervening and performing a cesarean section that was previously planned and noted, and that was required by the standard of care during that time.

39. At 8:53AM on January 10, 2016, the Plaintiff continued to have persistent maternal tachycardia, chorioamnionitis, failure to progress, persistent abnormalities in the fetal monitoring tracings that continued with the Plaintiff continuing to have Category 2 fetal monitoring strips with bradycardia being noted into the 100's with persistent repetitive late decelerations, fetal intolerance to labor, fetal intolerance to Pitocin, and the Plaintiff's labor remained completely arrested.

40. From 8:00AM through 10:00AM on January 10, 2016, there was no progression in labor or cervical dilation. The Plaintiff continued to show persistent abnormalities in the fetal monitoring tracings with ominous Category 2 fetal monitoring strips including persistent repetitive and prolonged late decelerations and tachycardia. The Plaintiff continued to have fetal intolerance to labor, fetal intolerance to Pitocin, and chorioamnionitis. The Plaintiff was now in active labor for 17 hours and in arrested labor for over 10 hours. Despite the noted plan to perform a cesarean section at 8:00AM, a cesarean section was not performed and the attending physicians in charge of the Plaintiff's and Decedent's care, Dr. Chie

and Dr. Mason, wholly, incredibly, and fatally, failed to intervene and initiate a caesarean section during this time or at any time thereafter and instead allowed the Plaintiff to remain at 8cm dilated and in active labor, thereby allowing the Decedent to become compromised and to decompensate which ultimately led to the Decedent's fetal demise.

41. Had a cesarean section been performed between around 8:00AM to 10:00AM on January 10, 2016 in accordance with the standard of care, the persistent abnormalities in the fetal heart rate, including late and variable decelerations, prolonged decelerations, bradycardia, tachycardia and worsening of the variability, as well as the brief shoulder dystocia and cardiopulmonary decompensation that occurred nearly 8 to 10 hours later would have been avoided and within a reasonable degree of medical certainty the Decedent would not have been allowed to become compromised and decompensate and would have been born healthy.

42. By 11:00AM on January 10, 2016 the Plaintiff had only progressed one-half centimeter in over more than 11 hours and had been allowed to remain in active labor for over 14.5 hours. Despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including the persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged decelerations, tachycardia and bradycardia, chorioamnionitis, failure to progress, and arrested labor, the attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 failed to intervene and initiate and perform a cesarean section, which was clearly and indisputably within the standard of care, and this failure to intervene and failure to perform a cesarean section was fatal to the Decedent.

43. At around 1:18PM on January 10, 2016 the decision was made to remove he IUPC as it was not working properly and instead an external monitor was placed and Pitocin was again resumed despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including the persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged decelerations, tachycardia and bradycardia, chorioamnionitis, failure to progress, and arrested labor. The attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 failed to intervene and initiate and perform a cesarean section, which was clearly and indisputably within the standard of care, and this failure to intervene and failure to perform a cesarean section was fatal to the Decedent.

44. Throughout this time, the Plaintiff repeatedly asked her medical providers to perform a cesarean section. Dr. McKee noted this as the Plaintiff being frustrated with her protracted labor course.

45. At 1:30PM on January 10, 2016 resident Dr. McKee noted the fetal heart tracings as category 2 with moderate variability, prolonged decelerations, variable decelerations, and late decelerations, which was discussed with Dr. Sandra

Mason, the attending physician. Despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including the persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged decelerations, tachycardia and bradycardia, chorioamnionitis, failure to progress, and arrested labor, the attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 failed to intervene and initiate and perform a cesarean section, which was clearly and indisputably within the standard of care and this failure to intervene and failure to perform a cesarean section was fatal to the Decedent.

46. The Plaintiff was noted to be completely dilated at 3:00PM on January 10, 2016 after being allowed to remain in active labor for an incredible 18.5 hours, and during which time she was disturbingly allowed to remain at 8cm dilated for over 11 hours. Despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including the persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged decelerations, tachycardia and bradycardia, chorioamnionitis, failure to progress, and arrested labor, the attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 failed to intervene and initiate and perform a cesarean section, which was clearly and indisputably within the standard of care and this failure to intervene and failure to perform a cesarean section was fatal to the Decedent.

47. The Plaintiff began pushing at 15:10 with resident Dr. McKee, attending physician Dr. Mason, and Nurse Higgins at her bedside.

48. During the time of the second phase of active labor which lasted 3 hours, the Plaintiff was only able to push on and off, and the Plaintiff's category 2 fetal monitoring strips continued to demonstrate persistent abnormalities in the fetal heart rate including ominous prolonged periods of decelerations, low baseline, late decelerations, and variable decelerations.

49. Despite a plan to perform a cesarean section numerous hours earlier and despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, tachycardia, chorioamnionitis, failure to progress, and arrested labor, the attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 allowed the Plaintiff to remain in active labor for 19 hours with arrested labor and failed to intervene and initiate and perform a cesarean section, which was clearly and indisputably within the standard of care and this failure to intervene and failure to perform a cesarean section was fatal to Jayren Paredes.

50. At 6:10PM on January 10, 2016, abnormalities in the fetal heart rate including ominous tracings continued, and there was an abrupt decrease in variability to absent or minimal with fetal tachycardia to the 210's and late decelerations.

51. The Decedent was born vaginally almost 22 hours after active labor began and after a short duration shoulder dystocia of 30 seconds was encountered. Dr. Mason notes that the anterior shoulder was delivered relatively easily and without difficulty after a small change in position.

52. Jayren Parades was born at 6:18PM on January 10, 2016 and was completely limp at delivery, the Apgars were 0/0/0, and his weight was 9 pounds, 8 ounces.

53. As a direct result of the Plaintiff's health care providers failing to intervene and perform a cesarean section as dictated by the standard of care many hours prior, Jayren Paredes at birth was noted to have no respiratory effort, no movement, no audible heartbeat, and he was diffusely pale. Jayren was intubated at 2 minutes of life and was given epinephrine without improvement. Full resuscitation efforts were initiated. Chest compressions were preformed for approximately 20 minutes. Jayren was placed on ventilatory support and Ms. Paredes was shown Jayren for the first time as she repeatedly asked why he was not crying and what was wrong with her son as Jayren was clearly in grave condition struggling to survive.

54. Directly thereafter, the Decedent was brought to the NICU unit for management of his severe neonatal depression. Upon examination, Jayren was severely hypotonic with no spontaneous movements noted in his extremities. Jayren's eyes opened briefly with deep stimulation. There was no corneal reflexes present, no gag reflex, and deep tendon reflexes were not present. Cerebral function monitoring was initiated and the readings were consistent with severe encephalopathy, a severe hypoxic brain injury.

55. Over the course of the next few hours, and despite all efforts available to the NICU team, Jayren's condition progressively worsened with bradycardia and desaturations into the 60's. Resuscitation efforts including chest compressions gave no significant improvement. Ms. Paredes is noted to have been at Jayren's bedside throughout the NICU course.

56. Discussions over the next few hours of Jayren's life included Jayren's extremely poor prognosis. When Jayren's condition further worsened with persistent bradycardia into the 40's to 50's range despite 5 doses of epinephrine and repetitive chest compressions, Ms. Parades was informed that Jayren was dying despite all efforts to save him. Based on the irreversible and permanent damage to Jayren, which was a direct result of the breaches in the standard of care by the Defendants, Ms. Parades was told that any further resuscitative efforts would not save him. Thereafter, she held Jayren while he was still intubated knowing he was going to die. Jayren, surrounded by his family, was baptized by a catholic priest prior to his final decompensation. Multiple family members were present and Jayren was removed from the ventilator. Jayren passed away at 1:02AM on January 11, 2016 at 6 hours of life.

57. The Beth Israel Deaconess Medical Center's final diagnosis of Jayren was Severe Perinatal Depression, Severe Hypoxic Ischemic Encephalopathy, Anemia,

Disseminated Intravascular Coagulation, Presumed Sepsis, Presumed Abdominal Hemorrhage and Severe Metabolic Acidosis.

58. Jayren Paredes' Commonwealth of Massachusetts Death Certificate lists his cause of death as Cardiorespiratory failure due to or as a consequence of Severe Perinatal Depression with Hypoxic Ischemic Encephalopathy.

59. Ms. Paredes's baby was healthy at the time of admission for labor on January 9, 2016 and at the time of delivery on January 10, 2016, the infant was compromised with severe perinatal depression and severe hypoxic ischemic encephalopathy which ultimately led to Jayren's death at six (6) hours of life. It was the responsibility of the physicians caring for the Plaintiff to deliver a healthy infant on January 10, 2016.

60. Jayren should have been delivered by cesarean section prior to decompensation and the infant becoming compromised.

61. There were no significant acute occurrences that could have led to Jayren's condition at birth such as amniotic fluid embolism, pulmonary embolism, abruption, eclampsia, or a cord prolapse.

62. Had Jayren been delivered on January 10, 2016 at around 8:00AM until around 10:00AM as the standard of care dictated, the persistent abnormalities in the fetal heart rate tracings, including late and variable decelerations, bradycardia, worsening of the variability, as well as the shoulder dystocia and cardiopulmonary decompensation that occurred near delivery 8 to 10 hours later would have been avoided and Jayren would have been born healthy and alive. Despite a plan to perform a Cesarean Section many hours prior and despite the obvious and apparent fetal intolerance to labor, fetal intolerance to Pitocin, category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate that included ominous late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, tachycardia, and minimal to absent variability, chorioamnionitis, failure to progress, and arrested labor, the attending physicians, Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 allowed the Plaintiff to remain in total active labor for almost 22 hours with long periods of arrested labor and failed to intervene and initiate and perform a cesarean section which was clearly and indisputably within the standard of care and this failure to intervene and failure to perform a cesarean section was fatal to Jayren Paredes. Had Dr. Chie and Dr. Mason, who cared for the Plaintiff on January 10, 2016 intervened and initiated and performed a cesarean section which was clearly and indisputably within the standard of care, Jayren Paredes would have been born healthy and alive.

63. Each of the Defendants named in this instant action had a medical provider/patient relationship with the Plaintiff and/or Decedent.

64. Each of the Defendants breached the standard of care when providing medical

care to the Plaintiff and/or Decedent, and each Defendant caused and/or contributed to the condition and death of the Decedent.

65. As a direct and proximate result of each Defendant's breach(es) in the standard of care, the Plaintiff and Plaintiff's Estate suffered great damages and the Decedent died.

COUNT ONE – NEGLIGENCE
(As to Defendant Dr. Lucy Y. Chie)

66. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through sixty-five (65) of this Complaint.

67. Plaintiff and Defendant Chie established a doctor/patient relationship when Defendant Chie rendered care and treatment to the Plaintiff and Decedent on or about January 9, 2016 and January 10, 2016 at the Beth Israel Deaconess Medical Center. As such, Defendant owed a duty of care to Plaintiff and Decedent to provide medical care and treatment in accordance with the applicable medical standards of care.

68. In providing care, treatment, consultation, supervision, advice and other medical services to Plaintiff and Decedent, Defendant Chie was careless, reckless, willful, wanton, reckless, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and in failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical practice at a professional level at which Defendant was then engaged, thereby breaching various standards of care as described herein. Specifically, but not exclusively, Defendant Chie failed to properly and timely intervene in the Plaintiff's/Decedent's care or treatment regarding the necessity of an emergency cesarean section and failed to properly evaluate for and to perform a cesarean section when the standard of care dictated as the Plaintiff's labor failed to adequately progress on January 10, 2016 and the Plaintiff was allowed to have a prolonged first stage active phase of labor of 18.5 hours to progress from six (6) centimeters to ten (10) centimeters dilated, and the Plaintiff was allowed to remain at 8 centimeters without adequate progression from 11:45PM on January 9, 2016 and for the next at least 11.5 hours in light of maternal tachycardia, ominous category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate including late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, fetal tachycardia, minimal to absent variability, fetal intolerance to labor, fetal intolerance to Pitocin, chorioamnionitis, failure to progress, and arrested labor. Defendant Chie also breached the standard of care when she failed to intervene, and perform a cesarean section despite a plan to do so from 8:00AM to 10:00 AM or at any time thereafter until vaginal delivery occurred around 8 to 10 hours later at 6:18PM on Janaury 10, 2016 as the infant was allowed to decompensate and become compromised with tachycardia, minimal variability, and ominous fetal 2 heart

tracings throughout. Dr. Chie allowed the Plaintiff to remain at 8 cm dilated for 11.5 hours and in total active labor for over 21.5 hours allowing Jayren to decompensate and become compromised which untimely led to his death. Had a cesarean section been performed between around 8:00AM to 10:00AM on January 10, 2016, the persistent abnormalities in the fetal heart rate, including late and variable decelerations, bradycardia, tachycardia and worsening of the variability, as well as the brief shoulder dystocia and cardiopulmonary decompensation that occurred nearly 8 to 10 hours later would have been avoided and within a reasonable degree of medical certainty Jayren would not have been allowed to become compromised and decompensate and would have been born healthy and alive. Dr. Chie also breached the standard of care when she failed to properly monitor the Plaintiff and Decedent throughout the course of the Plaintiff's labor and delivery, and failed to render adequate medical and diagnostic care and treatment to the Plaintiff and Decedent throughout the course of labor and delivery until the time of the Decedent's birth. Defendant Chie also failed to properly treat and accurately diagnose the Plaintiff and Decedent's condition(s) or to accelerate the treatment thereof. Dr. Chie further failed to act in a timely manner and negligently failed to provide proper care, treatment, and/or to provide proper supervision of said care and treatment during and throughout the Plaintiff's labor and delivery including but not limited to failing to initiate a cesarean section in light of the Plaintiff and Decedent's condition, when the standard of care so dictated. Had Defendant Chie rendered proper care within the applicable standards of care, Jayren Paredes would have been born between 8:00AM and 10:00AM on January 10, 2016 and more likely than not and within a reasonable degree of medical certainty, Jayren Paredes would have been born healthy.

69. As a direct and proximate result of Defendant Chie's careless, reckless, willful, wanton, reckless, gross negligent and negligent conduct, as well as the medical malpractice committed by Defendant Chie by breaching various standards of care as described herein, Defendant Chie caused the Plaintiff to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and great loss related to the preventable death of Jayren Paredes as he died surrounded by his family at 6 hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal.

<u>COUNT TWO – WRONGFUL DEATH</u>
<u>(As to Defendant Dr. Lucy Y. Chie)</u>

70. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through sixty-nine (69) of this Complaint.

71. Plaintiff and Defendant Chie established a doctor/patient relationship when Defendant Chie rendered care and treatment to the Plaintiff and Decedent on or

about January 9, 2016 and January 10, 2016 at the Beth Israel Deaconess Medical Center. As such, Defendant owed a duty of care to Plaintiff and Decedent to provide medical care and treatment in accordance with the applicable medical standards.

72. In providing care, treatment, consultation, supervision, advice and other medical services to Plaintiff and Decedent, Defendant Chie was careless, reckless, willful, wanton, reckless, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and in failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical practice at a professional level at which Defendant was then engaged, thereby breaching various standards of care as described herein. Specifically, but not exclusively, Defendant Chie failed to properly and timely intervene in the Plaintiff's/Decedent's care or treatment regarding the necessity of an emergency cesarean section and failed to properly evaluate for and to perform a cesarean section when the standard of care dictated as the Plaintiff's labor failed to adequately progress on January 10, 2016 and the Plaintiff was allowed to have a prolonged first stage active phase of labor of 18.5 hours to progress from six (6) centimeters to ten (10) centimeters dilated, and the Plaintiff was allowed to remain at 8 centimeters without adequate progression from 11:45PM on January 9, 2016 and for the next at least 11.5 hours in light of maternal tachycardia, ominous category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate including late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, fetal tachycardia, minimal to absent variability, fetal intolerance to labor, fetal intolerance to Pitocin, chorioamnionitis, failure to progress, and arrested labor. Defendant Chie also breached the standard of care when she failed to intervene, and perform a cesarean section despite a plan to do so from 8:00AM to 10:00 AM or at any time thereafter until vaginal delivery that occurred 8 to 10 hours later at 6:18PM on January 10, 2016 as the infant was allowed to decompensate and become compromised with tachycardia, minimal variability, and ominous fetal 2 heart tracings throughout. Dr. Chie allowed the Plaintiff to remain at 8 cm dilated for 11.5 hours and in total active labor for over 21.5 hours allowing Jayren to decompensate and become compromised which untimely led to his death. Had a cesarean section been performed between around 8:00AM to 10:00AM on January 10, 2016, the persistent abnormalities in the fetal heart rate, including late and variable decelerations, bradycardia, tachycardia and worsening of the variability, as well as the brief shoulder dystocia and cardiopulmonary decompensation that occurred nearly 8 to 10 hours later would have been avoided and within a reasonable degree of medical certainty Jayren would not have been allowed to become compromised and decompensate and would have been born healthy and alive. Dr. Chie also breached the standard of care when she failed to properly monitor the Plaintiff and Decedent throughout the course of the Plaintiff's labor and delivery, and failed to render adequate medical and diagnostic care and treatment to the Plaintiff and Decedent throughout the course

of labor and delivery until the time of the Decedent's birth. Defendant Chie also failed to properly treat and accurately diagnose the Plaintiff and Decedent's condition(s) or to accelerate the treatment thereof. Dr. Chie further failed to act in a timely manner and negligently failed to provide proper care, treatment, and/or to provide proper supervision of said care and treatment during and throughout the Plaintiff's labor and delivery including but not limited to failing to initiate a cesarean section in light of the Plaintiff and Decedent's condition, when the standard of care so dictated. Had Defendant Chie rendered proper care within the applicable standards of care, Jayren Paredes would have been born between 8:00AM and 10:00AM on January 10, 2016 and more likely than not and within a reasonable degree of medical certainty, Jayren Paredes would have been born healthy.

73. As a direct and proximate result of Defendant Chie's careless, reckless, willful, wanton, reckless, gross negligent and negligent conduct, as well as the medical malpractice committed by Defendant Chie by breaching various standards of care as described herein, Defendant Chie caused the Plaintiff to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and great loss related to the preventable death of Jayren Paredes as he died surrounded by his family at 6 hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal the damages from which the Plaintiff and the Estate of Decedent now brings this count of wrongful death and conscious pain and suffering for the use of next of kin and beneficiaries of the Estate, including punitive damages, attorneys fees and cost associated with this action.

COUNT THREE – NEGLIGENCE
(As to Defendant Dr. Sandra Mason)

74. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through seventy-three (73) of this Complaint.

75. Plaintiff and Defendant Mason established a doctor/patient relationship when Defendant Mason rendered care and treatment to the Plaintiff and/or Decedent on or about January 10, 2016 at the Beth Israel Deaconess Medical Center. As such, Defendant owed a duty of care to Plaintiff and Decedent to provide medical care and treatment in accordance with the applicable medical standards.

76. In providing care, treatment, consultation, supervision, advice and other medical services to Plaintiff and Decedent, Defendant Mason was careless, reckless, willful, wanton, reckless, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and in failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical

practice at a professional level at which Defendant was then engaged, thereby breaching various standards of care as described herein. Specifically, but not exclusively, Defendant Mason failed to properly and timely intervene in the Plaintiff's/Decedent's care or treatment regarding the necessity of an emergency cesarean section and failed to properly evaluate for and to perform a cesarean section when the standard of care dictated as the Plaintiff's labor failed to adequately progress on January 10, 2016 and the Plaintiff was allowed to have a prolonged first stage active phase of labor of 18.5 hours to progress from six (6) centimeters to ten (10) centimeters dilated, and the Plaintiff was allowed to remain at 8 centimeters without adequate progression from 11:45PM on January 9, 2016 and for the next at least 11.5 hours in light of maternal tachycardia, ominous category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, fetal tachycardia, minimal to absent variability, fetal intolerance to labor, fetal intolerance to Pitocin, chorioamnionitis, failure to progress, and arrested labor. Defendant Mason also breached the standard of care when she failed to intervene, and perform a cesarean section despite a plan to do so from 8:00AM to 10:00 AM or at any time thereafter until vaginal delivery at around 8 to 10 hours later at 6:18PM on January 10, 2016 as the infant was allowed to decompensate and become compromised with tachycardia, minimal variability, and ominous fetal 2 heart tracings throughout. Dr. Mason allowed the Plaintiff to remain at 8 cm dilated for 11.5 hours and in total active labor for over 21.5 hours allowing Jayren to decompensate and become compromised which untimely led to his death. Had a cesarean section been performed between around 8:00AM to 10:00AM on January 10, 2016, the persistent abnormalities in the fetal heart rate, including late and variable decelerations, bradycardia, tachycardia and worsening of the variability, as well as the brief shoulder dystocia and cardiopulmonary decompensation that occurred nearly 8 to 10 hours later would have been avoided and within a reasonable degree of medical certainty Jayren would not have been allowed to become compromised and decompensate and would have been born healthy and alive. Dr. Mason also breached the standard of care when she failed to properly monitor the Plaintiff and Decedent throughout the course of the Plaintiff's labor and delivery, and failed to render adequate medical and diagnostic care and treatment to the Plaintiff and Decedent throughout the course of labor and delivery until the time of the Decedent's birth. Defendant Mason also failed to properly treat and accurately diagnose the Plaintiff and Decedent's condition(s) or to accelerate the treatment thereof. Dr. Mason further failed to act in a timely manner and negligently failed to provide proper care, treatment, and/or to provide proper supervision of said care and treatment during and throughout the Plaintiff's labor and delivery including but not limited to failing to initiate a cesarean section in light of the Plaintiff and Decedent's condition, when the standard of care so dictated. Had Defendant Mason rendered proper care within the applicable standards of care, Jayren Paredes would have been born between 8:00AM and 10:00AM on January 10, 2016 and more likely than not and within a reasonable degree of medical certainty, Jayren Paredes would have been born

healthy.

77. As a direct and proximate result of Defendant Mason's careless, reckless, willful, wanton, reckless, gross negligent and negligent conduct, as well as the medical malpractice committed by Defendant Mason by breaching various standards of care as described herein, Defendant Mason caused the Plaintiff to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and great loss related to the preventable death of Jayren Paredes as he died surrounded by his family at 6 hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal.

COUNT FOUR - WRONGFUL DEATH
(As to Defendant Dr. Sandra Mason)

78. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through seventy-seven (77) of this Complaint.

79. Plaintiff and Defendant Mason established a doctor/patient relationship when Defendant Mason rendered care and treatment to the Plaintiff and/or Decedent on or about January 10, 2016 at the Beth Israel Deaconess Medical Center. As such, Defendant owed a duty of care to Plaintiff and Decedent to provide medical care and treatment in accordance with the applicable medical standards.

80. In providing care, treatment, consultation, supervision, advice and other medical services to Plaintiff and Decedent, Defendant Mason was careless, reckless, willful, wanton, reckless, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and in failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical practice at a professional level at which Defendant was then engaged, thereby breaching various standards of care as described herein. Specifically, but not exclusively, Defendant Mason failed to properly and timely intervene in the Plaintiff's/Decedent's care or treatment regarding the necessity of an emergency cesarean section and failed to properly evaluate for and to perform a cesarean section when the standard of care dictated as the Plaintiff's labor failed to adequately progress on January 10, 2016 and the Plaintiff was allowed to have a prolonged first stage active phase of labor of 18.5 hours to progress from six (6) centimeters to ten (10) centimeters dilated, and the Plaintiff was allowed to remain at 8 centimeters without adequate progression from 11:45PM on January 9, 2016 and for the next at least 11.5 hours in light of maternal tachycardia, ominous category 2 fetal monitoring strips including persistent abnormalities in the fetal heart rate including ominous late and variable decelerations, prolonged periods of decelerations, low baseline, bradycardia, fetal tachycardia, minimal to

absent variability, fetal intolerance to labor, fetal intolerance to Pitocin, chorioamnionitis, failure to progress, and arrested labor. Defendant Mason also breached the standard of care when she failed to intervene, and perform a cesarean section despite a plan to do so from 8:00AM to 10:00 AM or at any time thereafter until vaginal delivery at around 8 to 10 hours later at 6:18PM on January 10, 2016 as the infant was allowed to decompensate and become compromised with tachycardia, minimal variability, and ominous fetal 2 heart tracings throughout. Dr. Mason allowed the Plaintiff to remain at 8 cm dilated for 11.5 hours and in total active labor for over 21.5 hours allowing Jayren to decompensate and become compromised which untimely led to his death. Had a cesarean section been performed between around 8:00AM to 10:00AM on January 10, 2016, the persistent abnormalities in the fetal heart rate, including late and variable decelerations, bradycardia, tachycardia and worsening of the variability, as well as the brief shoulder dystocia and cardiopulmonary decompensation that occurred nearly 8 to 10 hours later would have been avoided and within a reasonable degree of medical certainty Jayren would not have been allowed to become compromised and decompensate and would have been born healthy and alive. Dr. Mason also breached the standard of care when she failed to properly monitor the Plaintiff and Decedent throughout the course of the Plaintiff's labor and delivery, and failed to render adequate medical and diagnostic care and treatment to the Plaintiff and Decedent throughout the course of labor and delivery until the time of the Decedent's birth. Defendant Mason also failed to properly treat and accurately diagnose the Plaintiff and Decedent's condition(s) or to accelerate the treatment thereof. Dr. Mason further failed to act in a timely manner and negligently failed to provide proper care, treatment, and/or to provide proper supervision of said care and treatment during and throughout the Plaintiff's labor and delivery including but not limited to failing to initiate a cesarean section in light of the Plaintiff and Decedent's condition, when the standard of care so dictated. Had Defendant Mason rendered proper care within the applicable standards of care, Jayren Paredes would have been born between 8:00AM and 10:00AM on January 10, 2016 and more likely than not and within a reasonable degree of medical certainty, Jayren Paredes would have been born healthy.

81. As a direct and proximate result of Defendant Mason's careless, reckless, willful, wanton, reckless, gross negligent and negligent conduct, as well as the medical malpractice committed by Defendant Mason by breaching various standards of care as described herein, Defendant Mason caused the Plaintiff to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and great loss related to the preventable death of Jayren Paredes as he died surrounded by his family at 6 hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal the damages from which the Plaintiff and the Estate of Decedent now brings this count of wrongful death and conscious pain and suffering for the use

of next of kin and beneficiaries of the Estate, including punitive damages, attorneys fees and cost associated with this action.

COUNT FIVE– NEGLIGENCE
(As to The Beth Israel Deaconess Medical Center, Inc.)

82. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through eighty-one (81) of this Complaint.

83. Plaintiff and Defendants Lucy Y. Chie and Dr. Sandra Mason established a medical provider/patient relationship when the Defendants rendered care, treatment, consultation, supervision and/or advice regarding the Plaintiff's and/or Decedent's care and treatment from on or about January 9, 2016 through on or about January 11, 2016, and until the Plaintiff was discharged at the Beth Israel Deaconess Medical Center. As such, Defendant Beth Israel Deaconess Medical Center, Inc. through its employees, agents, and/or servants owed a duty of care to Plaintiff and Decedent to provide medical care in accordance with the applicable medical standards and to otherwise act in a non-negligent manner.

84. In providing care, treatment, diagnostic services, supervision, advice, and other medical services to Plaintiff and Decedent at the Beth Israel Deaconess Medical Center, their employees, agents, and/or servants were careless, reckless, willful, wanton, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and were negligent in failing to provide acceptable care and failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical practice at a professional level at which Defendants were then engaged. Specifically, but not exclusively, Defendant is vicariously liable through the theory of respondent superior as Lucy Y. Chie and Sandra Mason, and/or Defendant's other employees, doctors, agents, or assigns failed to properly perform and provide proper obstetric care, treatment, and diagnostic services during and throughout the course of Plaintiff's labor and delivery, and/or were otherwise negligent in failing to properly supervise, train, oversee, hire or fire the healthcare providers who rendered substandard care, treatment, supervision, and/or diagnostic services to the Plaintiff and Decedent which breached the standard of care and which led to the death of the Decedent and damages to the Plaintiff and Decedent as described in this Complaint.

85. As a direct and proximate result of Defendant Lucy Y. Chie and Defendant Sandra Mason and/or Defendant's other employees, doctors, agents, or assigns failing to properly perform and provide proper obstetric care, treatment, supervision and diagnostic services within the standard of care during and throughout the course of Plaintiff's labor and delivery, and/or they were otherwise negligent or grossly negligent in failing to properly supervise, train, oversee, hire or fire the healthcare providers who rendered substandard care, treatment, and/or diagnostic services to the Plaintiff and Decedent which breached the standard of care and which led to the death of the Decedent and damages to the Plaintiff and

Decedent as described in this Complaint, the Plaintiff was caused to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and loss related to the preventable death of Jayren Paredes as he died surrounded by his family at six (6) hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal.

COUNT SIX - WRONGFUL DEATH
(As to The Beth Israel Deaconess Medical Center, Inc.)

86. Plaintiff hereby incorporates and repeats by reference Paragraphs one (1) through eighty-five (85) of this Complaint.

87. Plaintiff and Defendants Lucy Y. Chie and Dr. Sandra Mason established a medical provider/patient relationship when the Defendants rendered care, treatment, consultation, supervision and/or advice regarding the Plaintiff's and/or Decedent's care and treatment from on or about January 9, 2016 through on or about January 11, 2016, and until the Plaintiff was discharged at the Beth Israel Deaconess Medical Center. As such, Defendant Beth Israel Deaconess Medical Center, Inc. through its employees, agents, and/or servants owed a duty of care to Plaintiff and Decedent to provide medical care in accordance with the applicable medical standards and to otherwise act in a non-negligent and non-grossly negligent manner.

88. In providing care, treatment, diagnostic services, supervision, advice, and other medical services to Plaintiff and Decedent at the Beth Israel Deaconess Medical Center, their employees, agents, and/or servants were careless, reckless, willful, wanton, grossly negligent, negligent and committed medical malpractice in failing to provide acceptable care, treatment, supervision, consultation and/or advice and were negligent in failing to provide acceptable care and failing to exercise the degree of skill, care, and diligence exercised by the average qualified practitioner engaged in the medical practice at a professional level at which Defendants were then engaged. Specifically, but not exclusively, Defendant is vicariously liable through the theory of respondent superior as Lucy Y. Chie and Sandra Mason, and/or Defendant's other employees, doctors, agents, or assigns failed to properly perform and provide proper obstetric care, treatment, and diagnostic services during and throughout the course of Plaintiff's labor and delivery, and/or were otherwise negligent in failing to properly supervise, train, oversee, hire or fire the healthcare providers who rendered substandard care, treatment, supervision, and/or diagnostic services to the Plaintiff and Decedent which breached the standard of care and which led to the death of the Decedent and damages to the Plaintiff and Decedent as described in this Complaint.

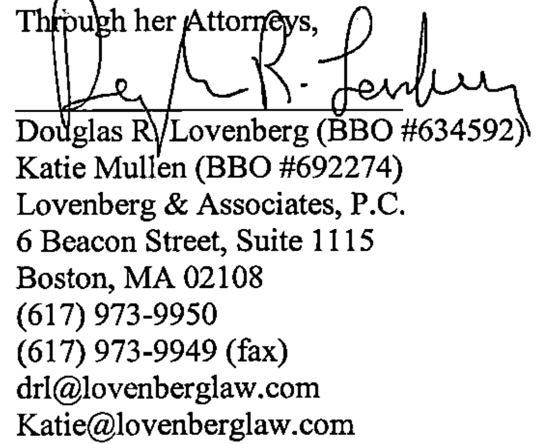
89. As a direct and proximate result of Defendant Lucy Y. Chie and Defendant Sandra Mason and/or Defendant's other employees, doctors, agents, or assigns failing to properly perform and provide proper obstetric care, treatment, supervision and diagnostic services within the standard of care during and throughout the course of Plaintiff's labor and delivery, and/or they were otherwise negligent or grossly negligent in failing to properly supervise, train, oversee, hire or fire the healthcare providers who rendered substandard care, treatment, and/or diagnostic services to the Plaintiff and Decedent which breached the standard of care and which led to the death of the Decedent and damages to the Plaintiff and Decedent as described in this Complaint, the Plaintiff was caused to suffer great damages including but not limited to the loss of consortium, physical and emotional pain and suffering, severe and permanent emotional distress and loss related to the preventable death of Jayren Paredes as he died surrounded by his family at six (6) hours of life. The Decedent suffered significant injury and damage to his brain and the loss of opportunity of life, conscious pain and suffering, wrongful death, and each has suffered other actual, consequential and incidental damages, as well as other and additional damages which proof at the time of trial will reveal the damages from which the Plaintiff and the Estate of Decedent now brings this count of wrongful death and conscious pain and suffering for the use of next of kin and beneficiaries of the Estate, including punitive damages, attorneys fees and cost associated with this action.

WHEREFORE, Plaintiff, individually and as administrator of the Estate of Jayren Paredes, demands judgment against the Defendants in an amount to be shown at trial to fully and completely compensate her and the Estate for the Decedent's wrongful death, including but not limited to, compensation for the loss of reasonably expected income, physical and mental pain and suffering, conscious pain and suffering, all actual, consequential, and incidental damages, services, protection, care, loss of consortium, assistance, society, companionship, comfort, guidance, counsel, and advice of the Decedent to persons entitled to the damages recovered, including his own loss of enjoyment of life, as well as all associated costs, including but not limited to medical expenses, funeral expenses, and the injuries and death of Jayren Paredes sustained as a result of the medical malpractice, negligent, careless, reckless, willful and wonton, and grossly negligent conduct of Defendants, jointly and severally, plus punitive damages, interest, costs, and reasonable attorney's fees as described herein.

PLAINTIFF DEMANDS A TRIAL BY JURY ON ALL ISSUES SO TRIABLE

Dated: December 30, 2018

Respectfully submitted,
KATERYN PAREDES, individually and as Administrator of the Estate of JAYREN PAREDES,
Through her Attorneys,



Douglas R. Lovenberg (BBO #634592)
Katie Mullen (BBO #692274)
Lovenberg & Associates, P.C.
6 Beacon Street, Suite 1115
Boston, MA 02108
(617) 973-9950
(617) 973-9949 (fax)
drl@lovenberglaw.com
Katie@lovenberglaw.com