SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

CONFIDENTIAL, individually, as Personal Representative of the ESTATE OF CONFIDENTIAL, deceased, and as guardian of <MINOR CHILD>, a minor child; CONFIDENTIAL, individually, Plaintiffs, vs. <DENTIST #1>, DDS, a licensed physician and healthcare provider; <DENTIST #2>, DDS, a licensed physician and healthcare provider; SEATTLE CHILDREN'S HOSPITAL, a Washington corporation and licensed healthcare provider; <PHARMACIST #2>, a licensed pharmacist; <PHARMACIST #1>, a licensed pharmacist, Defendants.	NO. 09-2-34248-2 SEA SECOND AMENDED COMPLAINT FOR DAMAGES

COMES NOW the Plaintiffs <PLAINTIFF>, individually, and in her capacity as Personal Representative of the <ESTATE OF PLAINTIFF>**,** and as guardian of <MINOR CHILD>, a minor child, and for cause of action against the above-named defendants, state and allege as follows:

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I. PARTIES

1.1 At all times material hereto, <Plaintiff> was a resident of King County Washington. Plaintiff is the Personal Representative of the <Estate of Plaintiff>, her deceased minor child, by order of the court in King County Superior Court Cause No. 09-4-02700-2 KNT. <Plaintiff> brings this cause of action in her individual capacity, and in her capacity as parent and legal guardian of her minor child <Deceased> (deceased) pursuant to RCW 4.24.010, and as the legal guardian of <Minor Child>, a minor child. Plaintiff also brings this action on behalf of the Estate and the Estate's beneficiaries for the wrongful death of <Deceased> pursuant to RCW 4.20 *et seq.*

1.2 Defendant <Dentist #1>, DDS, is a resident of King County, state of Washington. At all times material hereto, Defendant <Dentist #1>, DDS, was acting as a licensed dentist and healthcare provider and as an employee and/or agent of Seattle Children's Hospital. Based upon further information and belief, Defendant <Dentist #1>, DDS, provided negligent health care to <Deceased> (deceased). At all times material hereto, Defendant <Dentist #1>, DDS, was acting within the scope of her employment and/or agency with Seattle Children's Hospital.

1.3 Defendant <Dentist #2>, DDS, is believed to be a resident outside the state of Washington. At all times material hereto, Defendant <Dentist #2>, DDS, was acting as a licensed dentist and healthcare provider. At all times material hereto, this defendant was acting as an employee and/or agent of Seattle Children's Hospital and/or <Dentist #1>, DDS. At all times material hereto, this defendant was acting under the direct supervision of Defendant Sheller. Based upon further information and belief, Defendant <Dentist #2>, DDS, provided negligent health care to <Deceased> (deceased). At all times material hereto, Defendant

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<Dentist #2>, DDS, was acting within the scope of her employment and/or agency with Seattle Children's Hospital and/or <Dentist #1>, DDS.

1.4 Defendant Seattle Children's Hospital ("Seattle Children's" or "Hospital") is a healthcare provider and business entity incorporated under the laws of the State of Washington. Said defendant is licensed by the State of Washington to provide health care services, with its principal place of business located at 4800 Sand Point Way NE, Seattle, King County, Washington. Employees and/or agents of Seattle Children's Hospital provided medical care to <Deceased> on or about <Date>.

1.5 Defendant <Pharmacist #2> is believed to be a resident of King County, state of Washington. At all times material hereto, Defendant <Pharmacist #2> was acting as a licensed pharmacist and/or healthcare provider, and as an employee and/or agent of Seattle Children's Hospital. Based upon further information and belief, Defendant <Pharmacist #2> negligently and recklessly filled a prescription medication to <Deceased> (deceased). At all times material hereto, Defendant <Pharmacist #2> was acting within the scope of her employment and/or agency with Seattle Children's Hospital.

1.6 Defendant <Pharmacist #1> is believed to be a resident of King County, state of Washington. At all times material hereto, Defendant <Pharmacist #1> was acting as a licensed pharmacist and/or healthcare provider, and as an employee and/or agent of Seattle Children's Hospital. Based upon further information and belief, Defendant <Pharmacist #1> negligently and recklessly filled a prescription medication to <Deceased> (deceased). At all times material hereto, Defendant <Pharmacist #1> was acting within the scope of her employment and/or agency with Seattle Children's Hospital.

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II. JURISDICTION AND VENUE

2.1 The Court has subject matter jurisdiction over this matter pursuant to RCW 2.08.010.

2.2 All acts and omissions described herein took place in King County, Washington.

2.3 Venue is proper in King County pursuant to RCW 4.12.020.

2.4 Plaintiffs have complied with RCW 4.96.020 where applicable by properly serving their Claim for Damages on the defendants. More than sixty (60) days have elapsed since the date of service on the appropriate defendants.

2.5 Defendants Seattle Children's Hospital and <Dentist #1>, DDS have acknowledged, accepted and consented to proper service of process of the plaintiffs' summons and second amended complaint by service of same on their agent and attorney <Attorney> of the law firm Williams Kastner, PLLC, Tacoma, Washington. These defendants have therefore consented to personal jurisdiction in the above-entitled court.

2.6 Defendant <Dentist #2>, DDS has acknowledged, accepted and consented to proper service of process of the plaintiffs' summons and second amended complaint by service of same on their agent and attorney Tom Fain of the law firm Fain Sheldon Anderson and Vanderhoef, Seattle, Washington. This defendant has therefore consented to personal jurisdiction in the above-entitled court.

2.7 Defendant <Pharmacist #1> has acknowledged, accepted and consented to proper service of process of the plaintiffs' summons and second amended complaint by service of same on her agent and attorney Rando Wick of the law firm <Law Firm>, in Seattle, Washington. This defendant has therefore consented to personal jurisdiction in the above-entitled court.

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III. COMPLIANCE WITH LAWS PECULIAR TO HEALTH CARE LAWSUITS

3.1 The plaintiffs have already complied with RCW 7.70.100 by properly serving the defendants and/or the Hospital's Chief Executive Officer with their Notice of Intent to Sue. More than ninety (90) days have elapsed since the service of said Notice on the defendants.

3.2 The plaintiffs have already complied with RCW 7.70A.020(2) by properly serving the defendants with their Declaration of Voluntary Arbitration stating that the plaintiffs have elected to opt out of voluntary arbitration and seek a jury trial.

IV. FACTS

4.1 On <Date>, <Deceased>, a fifteen-year-old boy, was admitted to the dental clinic at Seattle Children's Hospital for dental treatment and/or oral surgery. The attending doctor and oral surgeon was Defendant <Dentist #1>, DDS. Also assisting <Dentist #1>was a resident doctor named <Dentist #2>, DDS.

4.2 <Deceased> was affected by the behavioral disorder known as Autism, but his condition and prior medical history were well known, or should have been well known, to the defendants and the rest of the staff at Seattle Children's.

4.2 <Deceased> received dental care at the Hospital and from <Dentist #1>and other Hospital staff members on other prior occasions for routine and non-routine dental work.

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4.3 Because of his behavior disorder, <Deceased> was unable or unwilling to take or ingest oral medication. This fact was known to Hospital staff and also recorded in <Deceased>'s chart note prior to the time of surgery.

4.4 Upon discharge following <Deceased>'s dental procedure on <Date>, <Dentist #1>authorized a prescription for a Duragesic pain patch, also known as a Fentanyl patch, to treat <Deceased>'s acute and/or intermittent pain attributed to the earlier surgical procedure. <Dentist #2>signed the prescription order at the direction of her attending doctor <Dentist #1>, DDS.

4.5 <Dentist #1>and/or <Dentist #2>had never before written or issued a prescription of a Fentanyl pain patch to any other patient.

4.6 <Dentist #1>and/or <Dentist #2>were unfamiliar with Duragesic medication and/or a Fentanyl pain patch, and/or were unfamiliar with the proper circumstances under which this medication should or should not be prescribed to dental surgery patients.

4.7 The Fentanyl dosage prescribed by <Dentist #1>and/or <Dentist #2>was a 100 microgram patch, the highest or most concentrated dosage of Fentanyl in the form of a patch that is sold by the manufacturer.

4.8 <Dentist #1>and/or <Dentist #2>were unfamiliar with the correct or proper dosage of Duragesic medication and/or a Fentanyl pain patch that should be prescribed to any one patient.

4.9 <Dentist #2>improperly chose the dosage of Fentanyl based on <Deceased>'s weight, and not based on whether <Deceased> was opioid-tolerant as required by the medication label.

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4.10 <Dentist #2>consulted the hospital's drug formulary when deciding upon the dosage of Fentanyl for <Deceased>. The hospital's formulary stated that <Deceased> was to receive no more than a 25 microgram patch, and that the prescribing doctor should also consult the drug label for more information before prescribing Fentanyl to a minor child who is considered opioid intolerant.

4.11 <Dentist #1>did not read or review the Hospital's formulary information for Fentanyl before deciding to authorize a prescription for this drug to <Deceased>.

4.12 <Dentist #1>and <Dentist #2>did not consult a reliable reference resource, like the *Physician's Desk Reference*, and did not communicate with <Deceased>'s pediatric anesthesiologist concerning whether the Fentanyl prescription and its dosage was appropriate and safe for <Deceased>.

4.13 The Hospital's formulary was an inadequate and unreliable source for determining whether the Fentanyl prescription was safe and appropriate for <Deceased>, and this fact was known, or should have been known, to the defendants.

4.14 The Hospital's formulary specifically instructed a doctor prescribing Fentanyl to review the manufacturer's drug label concerning whether the drug should be prescribed to a minor child and also on the appropriate dosage.

4.15 <Dentist #1>and <Dentist #2>chose not to review the Fentanyl drug label as instructed by the Hospital's formulary before deciding to issue a prescription to <Deceased> for this drug.

4.16 The *Physician's Desk Reference* is a reliable and authoritative treatise or reference guide for physicians when determining whether a particular medication, including a Duragesic or Fentanyl pain patch, is safe and appropriate for a particular patient.

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4.17 The doctors, pharmacists and/or hospital staff had access to the *Physcian's Desk Reference*, or some other similar reliable resource, for determining whether the Fentanyl prescription given to <Deceased> was safe and appropriate.

4.18 The doctors, pharmacists and/or hospital staff had access to the manufacturer's drug label for Fentanyl before determining whether this drug was safe and appropriate for <Deceased>.

4.19 <Deceased> was considered a non-opioid tolerant patient and this fact was known, or should have been known, to the defendants at the time of his discharge on <Date>.

4.20 Duragesic medication, including Fentanyl, is contraindicated, or should not usually be prescribed, in the following situations:

a. in patients who are not opioid tolerant;

b. in the management of acute pain or in patients who require opioid analgesia for a short period of time;

c. in the management of post-operative pain, including use after out-patient or day surgeries;

d. in the management of mild pain;

e. in the management of intermittent pain (e.g., use on an as-needed basis (prn)).

4.21 The defendants ignored, or failed to inquire, whether any of the contraindications for prescribing Fentanyl existed when this drug was prescribed for <Deceased>.

4.22 The defendants ordered and filled the prescription Fentanyl for <Deceased> when there were at least four (4) out of the five (5) contraindications present, further showing that this drug was not appropriate or safe for <Deceased> to treat his post-surgery pain.

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4.23 According to <Dentist #1's>testimony, she was informed by the hospital's pharmacists <Pharmacist #2> and/or <Pharmacist #1> that the 100 mcg Fentanyl patch prescription was safe and appropriate for <Deceased> when in fact it was not.

4.24 Upon receipt of the 100 mcg Fentanyl patch prescription, <Plaintiff> sought and received oral verification from the defendants, the discharge nurse and other staff members at Seattle Children's that the 100 mcg/hr Fentanyl patch and dosage was accurate and safe for <Deceased>.

4.25 When Shayne Buckley and <Plaintiff> filled <Deceased>'s prescription at the Hospital's pharmacy, they were again incorrectly informed by the hospital staff pharmacists, Defendants <Pharmacist #2> and <Pharmacist #1>, that the 100 mcg/hr Fentanyl patch was appropriate and safe for <Deceased>.

4.26 Later that evening, <Plaintiff> applied the 100 mcg Fentanyl patch to <Deceased> as she was instructed to do by the defendants and staff at Seattle Children's Hospital.

4.27 The following morning on <Date> <Deceased> was found unresponsive, but semi-conscious. Paramedics were immediately called to the scene to perform life-saving resuscitation efforts. Those efforts failed and <Deceased> was pronounced dead.

4.28 <Minor Child>, age 12 at the time, was <Deceased>'s younger brother. <Brother of Deceased> was present in the family home and he was cognizant of <Deceased>'s condition when <Deceased> was discovered in his room on the morning he died. <Brother of Deceased> was also present when the resuscitative efforts on <Deceased> failed, and when <Deceased> was pronounced dead in the family home by paramedics and other EMT person<Pharmacist #1>.

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4.29 <Deceased> died from a fatal overdose of Fentanyl intoxication. Ketamine was also found in <Deceased>'s system.

4.30 The concomitant use of Fentanyl with Ketamine increases the risk of respiratory depression, hypotension, and profound sedation that could lead to death. The defendants were not aware of these increased risks, and/or ignored these risks, when they decided to prescribe Fentanyl to <Deceased> while the drug Ketamine was in his system.

4.31 The amount of Fentanyl in <Deceased>'s system at or near the time of death was 19.1 ng/mL as determined by the State Toxicologist. This level of Fentanyl in <Deceased>'s system at the time of death was toxic and/or lethal for a patient that is opioid-intolerant.

4.32 The medical director and agent for Seattle Children's Hospital, <Hospital Official>, orally stated to <Plaintiff> that the Hospital and its staff failed <Deceased> and that <Deceased>'s death never should have occurred had the Hospital maintained and/or followed appropriate safeguards for the proper and accurate prescription of pain medication, including the Fentanyl patch.

4.33 Dr. Fisher further stated to <Plaintiff> and to <Deceased>'s pediatrician that the defendants were liable and/or responsible for negligently causing <Deceased>'s death by improperly prescribing the 100 mcg Fentanyl patch for acute pain following <Deceased>'s surgery.

V. COUNT ONE - NEGLIGENT CONDUCT OF DEFENDANTS

5.1 Plaintiffs re-allege the allegations set forth in paragraphs 1.1 through 4.33, and incorporate them as though fully set forth herein.

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5.2 The medical care and Fentanyl prescription provided to <Deceased> <Confidential> by the defendants fell below the expected standard of care in the State of Washington and therefore the defendants violated RCW 7.70.010 *et seq.*

5.3 The defendants were negligent for breaching a duty of care owed to plaintiffs, including <Deceased>, by among other things, needlessly endangering <Deceased> and by prescribing him the 100 mcg Fentanyl patch.

5.4 The defendants' negligent conduct and/or omissions proximately caused <Deceased>'s death and the plaintiffs' injuries, both physical and mental, and other damages.

5.5 The defendants are liable to plaintiffs under the common laws and statutory laws of Washington under the legal theories of failing to comply with the standard of care, lack of informed consent, negligence, negligent supervision, corporate negligence, vicarious liability and respondeat superior.

VI. COUNT TWO - DAMAGES FOR WRONGFUL DEATH

6.1 Plaintiffs re-allege the allegations set forth in paragraphs 1.1 through 5.5, and incorporate them as though fully set forth herein.

6.2 The defendants' acts and/or omissions constitute common law, medical and corporate negligence, and said negligence proximately caused the wrongful death of <Deceased>.

6.3 As a proximate cause of the defendants' common law, medical and corporate negligence, the plaintiffs have sustained economic and non-economic damages, including those allowed by RCW 4.24 *et seq.* and RCW 4.20 *et seq.*, and which include without limitation, past and future medical expense, past and future lost income or earning capacity,

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loss of consortium, emotional distress, grief, loss of enjoyment of life, inconvenience, mental anguish, the destruction of the parent-child relationship, and pain and suffering and in amounts to be proven at trial.

6.4 As a proximate cause of the defendants' medical and corporate negligence and/or tortious conduct, the <Estate of Plaintiff> has sustained damages including the loss of the accumulation of income and incurred medical, funeral, and burial expenses, and the conscious pain, suffering, anxiety and fear of impending death experienced by the decedent, in such amounts as will be proven at the time of trial together with interest thereon at the statutory rate from the date of death or the date the expenses were incurred.

VII. COUNT THREE - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

7.1 Plaintiffs re-allege the allegations set forth in paragraphs 1.1 through 6.4, and incorporate them as though fully set forth herein.

7.2 The defendants' negligent acts and/or omissions as described herein were egregious and constituted gross negligence and/or reckless conduct.

7.3 The plaintiffs were present and observed <Deceased> at and near the time of his death. The plaintiffs also observed <Deceased> being removed from the family home in a body bag.

7.4 As a result of the defendants' negligent and/or reckless conduct, the plaintiffs have experienced, and will continue to experience, severe emotional distress.

VIII. COUNT FOUR - TORT OF OUTRAGE

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8.1 Plaintiffs re-allege the allegations set forth in paragraphs 1.1 through 7.4, and incorporate them as though fully set forth herein.

8.2 The defendants' conduct of ordering and filling the Fentanyl prescription given to an opioid-intolerant 15-year-old disabled patient in violation of the drug manufacturer's clearly worded black box warnings was extreme and outrageous.

8.3 As a result of the defendants' reckless conduct, the plaintiffs suffered, and continue to suffer, extreme and severe emotional distress.

IX. PHYSICIAN-PATIENT PRIVILEGE

Plaintiffs assert the physician-patient privilege for 89 days following the filing of this complaint. On the 90th day following the filing of this complaint, the plaintiffs waive the physician-patient privilege pursuant to RCW 5.60.060(4)(b). The waiver is conditioned and limited as follows: The Plaintiffs (1) do not waive their constitutional right to privacy; (2) do not authorize contact with their health care providers of any kind except by judicial proceedings authorized by the Rules of Civil Procedure; and (3) defendants' representative are specifically instructed not to attempt *ex-parte* contact with any of the plaintiffs' health care providers.

X. PRAYER FOR RELIEF

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WHEREFORE, the Plaintiffs pray for judgment against the Defendants, jointly and severally, as follows:

1. For all damages sustained by the plaintiffs in an amount proven at trial, including without limitation, all past and future economic and non-economic damages allowed by RCW 4.20 *et seq.*, RCW 4.24 *et seq.*, and the common law, including the loss of the accumulation of income, incurred medical, funeral, and burial expenses, loss of consortium, destruction of the parent-child relationship, and the conscious pain, suffering, anxiety and fear of impending death experienced by the decedent;

2. Interest calculated at the maximum amount allowable by law, including pre- and post-judgment interest;

3. A reasonable attorney's fee as allowed by law;

4. Costs and disbursements pursuant to statute; and

5. Other and further relief as this Court may deem just and equitable.

DATED this <Date>.

DAVIS LAW GROUP, P.S.

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By: Christopher M. Davis, WSBA #23234
Attorneys for Plaintiffs

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