FILED
4th JUDICIAL DISTRICT COURT
San Miguel County
7/26/2023 1:23 PM
CLERK OF THE COURT
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STATE OF NEW MEXICO
COUNTY OF SAN MIGUEL
FOURTH JUDICIAL DISTRICT COURT

ARTHUR BUSTOS, as Wrongful Death Personal Representative of the Estate of ALEX RAY FIERRO, Deceased,

Plaintiff,

v.

THE ARTESIA SPECIAL HOSPITAL DISTRICT, d/b/a ARTESIA GENERAL HOSPITAL, HEATHER MARSHALL VASKAS, M.D., JOHN AND JANE DOES A-F, and JOHN DOE COMPANIES G-K,

Defendants.

D-412-CV-2023-00260
Aragon, Abigail

COMPLAINT FOR WRONGFUL DEATH AND PUNITIVE DAMAGES

COMES NOW, Plaintiff Arthur Bustos, as Wrongful Death Personal Representative of the Estate of Alex Ray Fierro, Deceased, by and through his undersigned counsel of record, and states the following as his Complaint for Wrongful Death and Punitive Damages against The Artesia Special Hospital District, d/b/a Artesia General Hospital ("AGH" or "Hospital"), Heather Marshall Vaskas, M.D. ("Doctor"), John and Jane Does A through F, and John Doe Companies G through K, (hereinafter referred to by such designations, or collectively as "Defendants".):

I.

PARTIES

1. Plaintiff Arthur Bustos is a citizen of the State of New Mexico and is a resident of San Miguel County, New Mexico.
2. Arthur Bustos has previously been appointed as the Wrongful Death Representative of the Estate of Alex Ray Fierro (hereinafter sometimes referred to as "Decedent" or "Alex")

pursuant to the New Mexico Wrongful Death Act, NMSA 1978, §41-2-3 in Cause No. D-412-CV-2023-00223, Fourth Judicial District, San Miguel County, New Mexico.

3. Defendant Artesia Special Hospital District d/b/a Artesia General Hospital is authorized to do business in the State of New Mexico and is doing business in the State of New Mexico.
4. Upon information and belief, Artesia Special Hospital District was doing business as Artesia General Hospital, Eddy County, New Mexico, at all material times hereto.
5. Defendant Doctor, upon information and belief, is a medical doctor doing business in the State of New Mexico at all material times hereto.
6. The Hospital and the Doctor acted by and through their agents, partners, officers, and employees, and are responsible for their acts or omissions through the doctrines of *Respondeat Superior* or agency.
7. John and Jane Does A through F, inclusive, are unknown persons who may have treated, cared for, participated in decisions, or otherwise have contributed to the death of Decedent, or otherwise violated the rights of the Decedent and as discovery proceeds, if the names of such individuals are determined, they will be substituted for the John and Jane Doe designations.
8. John Doe Companies G through K, inclusive, are companies, partnerships, corporations, limited liability companies, or any other entity, public or private, that may have contributed to the death of Decedent, may have employed persons that contributed to the death of Decedent, or otherwise violated the rights of the Decedent and as discovery proceeds, if the names of such companies are determined, they will be substituted for the John Doe Companies designations.

II.

JURISDICTION, VENUE, AND JOINDER

9. Jurisdiction over the parties and the subject matter herein is proper within this Court pursuant to Article VI of the New Mexico Constitution.

10. Venue is proper in this Court because Plaintiff Arthur Bustos resides in San Miguel County, State of New Mexico. NMSA 1978, §38-3-1(A).

III.

FACTUAL BACKGROUND

11. On January 26, 2023, Alexee J. Trevizo (hereinafter "Alexee"), the surviving mother of the Decedent, attended Artesia High School as a student, was on the Cheer Squad, and attended Artesia High School cheer practice on January 26, 2023.

12. On January 26, 2023, at approximately 11:47 p.m., Alexee was taken to AGH Emergency Department complaining of low back pain and abdominal pain.

13. On a pain level of one (1) to ten (10), with ten (10) being the greatest, Alexee stated that she was a ten (10).

14. Alexee is a female of child-bearing age.

15. Alexee had regular menses, had used birth control (pills and condoms), worked out a minimum of two (2) hours, five (5) days per week, and had worked out on January 26, 2023, for over three (3) hours with the cheer team.

16. On January 27, 2023, at approximately 12:05 a.m., Alexee was seen in the Emergency Department at AGH, at which time the attending physician was Heather Marshall Vaskas, M.D.

17. Upon examination, Alexee complained of low back pain, and told the Doctor that she had been at cheerleading practice and felt like she needed to have a bowel movement, but was unable to do so, and further indicated that she was also experiencing abdominal pain.
18. Alexee denied pregnancy, and informed the Doctor that she was "on her period".
19. Alexee was asked if she had undergone a pelvic exam before, and she told the staff of AGH that she had not.
20. On January 27, 2023, at 12:18 a.m., medication was given to Alexee consisting of Cyclobenzaprine and Acetaminophen.
21. On January 27, 2023, at 12:28 a.m., medication was given to Alexee consisting of Sodium Chloride, Ketorolac, Ondansetron, and Morphine Sulfate.
22. A saline lock and urinalysis were completed but no specimen was received of HCG Qual Serum (a qualitative HCG blood test checks if there is a hormone called Human Chorionic Gonadotropin in a person's blood, which is produced in the body during pregnancy).
23. On January 27, 2023, at 12:28 a.m. lab tests were ordered, and such orders were entered at 12:30 a.m.
24. On January 27, 2023, at 12:28 a.m. a pregnancy serum test was ordered and collected at 12:30 a.m., received at 12:31 a.m., and reported at 12:51 a.m. by a call out [notice of results sent via computer] to Chris Sanchez, R.N., at the AGH, and the Doctor, showing positive for pregnancy.
25. The doctor and nurses admit that at 12:51 a.m. they received on their computers the notice of the results of the blood test showing that Alexee was pregnant.
26. The medications which were being given via an IV of Cyclobenzaprine, Acetaminophen, Sodium Chloride, Ketorolac, Ondansetron, and Morphine Sulfate and despite AGH, the

doctor and nurses knowing at 12:51 Alexee was pregnant, was continued after they had notice of the pregnancy.

27. The medication including morphine was not stopped after the Defendants knew at 00:51 hours Alexee was pregnant.

28. Keterolac, Ondansetron, Cyclobenzapine and Morphine all have warnings regarding use if the patient is pregnant.

29. On January 27, 2023, Alexee said she needed to use the bathroom, a nurse removed the IV at 0139 hours, and Alexee ran down the hall from her room to the public bathroom in the Emergency Room.

30. On January 27, 2023, at 1:40 a.m., Alexee's mother checked on her as she had not come out of the bathroom, and checked on her again at 1:49 a.m.

31. On January 27, 2023, at 1:56 a.m., the Emergency Department staff at AGH checked on Alexee and one of the nurses got the key to unlock the bathroom door, but before the door was unlocked, Alexee exited the bathroom.

32. On January 27, 2023, at 1:57 a.m., Alexee exited the bathroom, no one assisted her as she walked back to the room she had been in.

33. Alexee gave birth, unassisted, to a son while in the bathroom.

34. On January 27, 2023, at 2:02 a.m., the Doctor had already ordered an ultrasound to determine the status of the baby, and same was ordered before the doctors and nurses learned that Alexee had given birth.

35. On January 27, 2023, at 2:38 a.m., the infant, Alex Ray Fierro ("Decedent"), was pronounced dead by the Defendant Doctor.

36. The Hospital allowed the police into the room of Alexee, with lapel cameras on, and asked questions of Alexee and her mother, that are protected by HIPPA laws and by the New Mexico Constitution, law, rules, statutes, and regulations.
37. Medical records, lab results and videos of Alexee, her treatment or lack thereof at or by Defendants without consent of Alexee were released to the Artesia Police Department and later to the public.
38. Subsequently, the videos, without consent of Alexee, her attorneys and/or a Court were disclosed to the media, District Attorney, Artesia Police Department, and have appeared on Facebook and other social media from numerous persons in the community, along with three (3) major television networks, and have shown such confidential and private information that did not come from Alexee or her attorneys, and did not come with consent from Alexee or her attorneys.
39. The Hospital violated the HIPPA laws by allowing the taking of such videos, and the release of protected health information.
40. The Hospital, doctor and hospital employees allowed the release of protected medical records and information including reports and videos taken at the hospital.
41. The Hospital employees and doctors were aware of the pregnancy at 12:51 a.m., failed to inform Alexee that she was pregnant, and failed to take the necessary healthcare procedures and protocols for a pregnant woman who was at a term pregnancy.
42. The Decedent died from the malpractice of Defendants.
43. Alexee was nineteen (19) years old at the time, was 5' in height, and her weight was 126 pounds.

IV.

CLAIMS FOR RELIEF
COUNT I: AGAINST DEFENDANT HOSPITAL

44. All previous paragraphs are incorporated herein by reference.

45. Defendant Hospital, through administration, policies, and procedures, was negligent in failing to exercise ordinary care, treatment, and diagnosis of Alexee Trevizo, thereby leading to the death of Alex Ray Fierro.

46. Defendant Hospital breached its duties by:

    a. Failure to perform timely, complete and accurate assessment of Alexee;

    b. Failure to follow guidelines and practices that a woman of child-bearing age complaining of low back pain and/or abdominal pain is presumed pregnant until proven otherwise;

    c. Failure to follow guidelines and practices that a woman of child-bearing age who indicates she has to go to the bathroom should be examined first to make certain she is not pregnant and giving birth.

    d. Failure to follow guidelines and practices that a woman known by the hospital, doctor and caregivers to be pregnant based on hospital and doctor tests should be examined before going to the bathroom especially after muscle relaxants and morphine have been given via an IV, to make certain she is not giving birth as opposed to having to relieve herself.

    e. Failure to document accurate, factual, and complete information in the patient's permanent medical record regarding nursing care rendered;

f. Failure to develop and implement an appropriate nursing plan of care for a 19-year old female patient in the Emergency Department complaining of low back pain, abdominal pain, and necessity of going to the bathroom;

g. Failure to provide standard nursing interventions to prevent the administration of medication or contraindicated medication to be administered to patients prior to an appropriate differential diagnosis;

h. Failure to develop and implement an appropriate nursing plan of care for a person reporting with the symptoms of Alexee;

i. Failure to have at the top of the list the possibility of pregnancy;

j. Failure to provide standard nursing interventions to prevent administration of medication or contraindicated medication to a patient who is pregnant;

k. Failure to hire medical providers who are qualified and adequately trained regarding diagnosis of pregnancy;

l. Failure to hire medical providers who are qualified and adequately trained regarding the necessity for performance of pelvic exams and delivering babies;

m. Failure to have available necessary equipment to properly evaluate a woman of child bearing years to determine pregnancy and whether birth is imminent.

n. Failure to implement and operate a medical record system to communicate patient status to the attending physician in a timely and proper manner;

o. Failure to implement and operate a system in which the existence of a pregnancy is immediately provided to the attending physician;

p. Failure to implement and operate a system in which the attending physician and nurses communicate timely and in a proper manner with the patient;

q. Failure to ensure that nursing and medical staff timely and properly identify a pregnancy;

r. Failure to implement a system that prevents violation of the HIPPA laws;

s. Failure to implement and operate a system that assures privacy of its patients;

t. Failure to implement and operate a system that requires written consent prior to sharing a patient's healthcare information;

u. Failure to implement and operate a system that prevents the release of HIPPA protected information outside of the Hospital, and those directly providing care to the patient;

v. Failure to have and supply necessary machinery and equipment to test for pregnancy, especially including component parts for the ultrasound testing; and

w. By other means that will be ascertained through discovery during this litigation.

47. The treatment, care, and management of Alexee by the Hospital during the events described in this Complaint were reckless, wanton, and performed with utter disregard for the safety and welfare of Alex Ray Fierro.

48. Alex Ray Fierro's death was a direct and proximate result of the negligent acts and omissions of Defendant Hospital, doctor and health care providers of Defendant Hospital.

49. As a further direct and proximate result of the acts and omissions of the Defendant Hospital, Plaintiff is entitled to Wrongful Death damages as provided by the laws of the State of New Mexico.

50. The death of Alex Ray Fierro was due to the negligence of Defendant Hospital, doctor and healthcare providers without any contributing negligence on the part of Alex Ray Fierro.

COUNT II: NEGLIGENT HIRING, CREDENTIALING, TRAINING AND SUPERVISION AGAINST DEFENDANT HOSPITAL

51. All previous paragraphs are incorporated herein by reference.

52. The doctors, nurses, and staff who cared for Alexee, were acting at all relevant times as employees, agents, apparent agents, ostensible agents, and/or contractors over which Defendant Hospital had sufficient control.

53. Defendant Hospital knew, or should have known, that hiring and/or credentialing the doctors, nurses, and staff who cared for Alexee, would create an unreasonable risk of injury to a group or class that includes Decedent.

54. Defendant Hospital failed to use ordinary care in hiring and/or credentialing the doctors, nurses, and staff who cared for Alexee.

55. The Defendant Hospital is responsible for ensuring its healthcare providers are properly educated and trained so the patients do not suffer, and a baby is not born in a manner recited herein.

56. The Defendant Hospital should have had training programs, written policies, and procedures in place to ensure patients, such as Alexee, were provided with timely and proper medical care.

57. Defendant Hospital, through its agents and employees, were required to use the ordinary standard of care a reasonably prudent Hospital would use in hiring, training, supervising, and granting privileges to the Doctor as a professional healthcare provider.

58. The Defendant Hospital, through it agents and employees, willfully, recklessly, or negligently provided Alexee inadequate medical services and violated the rules of the standard of care through one (1) or more acts or omissions, including the following:

    a. Choosing to allow unqualified and inappropriately trained healthcare professionals to practice in its facilities;

    b. Choosing not to provide or require adequate training of agents and/or employees regarding pregnancy;

    c. Choosing not to establish or enforce adequate written procedures and guidelines for timely and proper recognition of pregnancy;

    d. Choosing not to establish or enforce adequate written procedures and guidelines for timely and proper communication between the laboratory and the doctors and nurses;

    e. Choosing not to establish or enforce adequate written procedures and guidelines for communication between the doctor and nurses with the patient in a timely and proper manner;

    f. Choosing not to have adequate written procedures and guidelines for recognition of pregnancy and timely and proper delivery of a baby;

    g. Choosing not to establish and enforce adequate written procedures regarding HIPPA violations;

h. Choosing not to establish and enforce adequate written procedures for privacy violations;

i. Choosing not to have adequate written procedures and guidelines regarding privacy and protection of HIPPA information;

j. Choosing not to have adequate skilled staff and equipment to provide competent care for its patients;

k. Choosing not to adequately supervise employees and agents practicing or working at the Hospital;

l. Choosing not to hire, credential, or grant privileges only to well-qualified physicians in the Emergency Department;

m. Choosing not to provide or require adequate training regarding thorough and accurate note-taking, dictation, and making the medical record;'

n. Choosing not to provide or require adequate training regarding communication between nursing staff, laboratory staff, and doctors;

o. Choosing not to establish or enforce policies and procedures regarding obtaining testing immediately and prior to the administration of medications;

p. Choosing not to establish or enforce policies and procedures regarding following the professional warnings for administration of dosage and types of medications to the patient; and

q. By other means ascertained through discovery during this litigation.

59. Defendant Hospital further failed to use ordinary care in training and supervising the doctors, nurses, and staff who cared for Alexee.

60. If the doctors, nurses, and staff who cared for Alexee had been properly trained and supervised, they would not have, among other things:

a. Negligently failed to provide adequate nursing interventions to prevent the death of Alex Ray Fierro;

b. Negligently failed to provide adequate nursing interventions to prevent the death of Alex Ray Fierro;

c. Negligently failed to provide adequate medical services to prevent medication, overmedication, or contraindicated medication for a pregnant female;

d. Failure to adequately and timely require testing of a female patient 19-years of age reporting with lower back pain, abdominal pain, and "feeling like she needed to go to the bathroom";

e. Failure to provide adequate doctors and nursing staff with the ability and training to recognize pregnancy, perform objective testing for pregnancy, and obtain immediate testing for pregnancy; and failure to timely and properly diagnose pregnancy;

f. Failure to timely and appropriately communicate between the laboratory, nurses, staff, and the attending Doctor, the results of the pregnancy test in a manner intended to immediately notify such persons;

g. Failure to provide adequate medical intervention to ensure timely and proper pain assessment, mental status assessment, objective hands-on examinations, and communication of same, including adequate documentation; and

h. In other matters which will be made known through discovery.

61. Defendant Hospital's negligence in hiring, credentialing, training, and supervising the doctors, nurses, and staff who cared for Alexee was a direct proximate cause of Alex Ray Fierro's ultimate death.

62. The actions, failures, and omissions were reckless, wanton, and with utter disregard for the welfare and safety of Alex Ray Fierro.

COUNT III: NEGLIGENCE THROUGH *RESPONDEAT SUPERIOR* AND VICARIOUS LIABILITY AGAINST DEFENDANT HOSPITAL

63. All previous paragraphs are incorporated herein by reference.

64. At all times relevant herein, the doctors, nurses, and staff of Defendant Hospital were acting within the course and scope of their employment with Defendant, when through the acts and omissions outlined in the preceding paragraphs, they failed to use ordinary care in providing treatment that a reasonable and prudent healthcare provider would have provided under the same or similar circumstances.

65. At all relevant times herein, the doctors, nurses, and staff were acting within the course and scope of their employment with Defendant Hospital when, through the acts and omissions outlined in the preceding paragraphs, they failed to meet the standard of care that a reasonable and prudent healthcare provider would have provided under the same or similar circumstances.

66. At all relevant times herein, the doctors, nurses, and staff who cared for Alexee were under the control of Defendant Hospital; therefore, the Hospital is liable pursuant to the doctrines of *Respondeat Superior* and vicarious liability.

67. The management, or lack of management, of Alexee's medical condition was reckless, wanton, and performed with utter disregard for Alexee's safety and welfare, and for the safety and welfare of Alex Ray Fierro.

68. As a direct and proximate result of the negligent acts and omissions of Defendant Hospital, through the doctors, nurses and staff who cared for Alexee, over whom Defendant Hospital had sufficient control, Alex Ray Fierro died.

69. As a further direct and proximate result of the negligent acts and omissions of Defendant Hospital, through the doctors, nurses and staff who cared for Alexee, over whom Defendant Hospital had sufficient control, Alex Ray Fierro is entitled to statutory Wrongful Death damages.

70. The death of Alex Ray Fierro was due to the negligence of Defendant Hospital without any contributing negligence on the part of Alex Ray Fierro.

71. John Does A – F and John Doe Companies G – K are or may be included in the performance, actions, omissions, and failures set forth above.

COUNT IV: AGAINST DOCTOR

72. All previous paragraphs are incorporated herein by reference.

73. Defendant Vaskas intentionally, willfully, recklessly, and negligently provided inadequate medical services resulting in the death of Alex Ray Fierro, in violation of the standard of care for a hospitalist in New Mexico, by committing one (1) or more of the following acts and omissions:

    a. Choosing not to be in the proper physical, mental, and emotional condition to perform medical services;

    b. Choosing not to have adequate training and knowledge of the medications and treatments to be utilized to timely and properly treat Alexee, nonetheless, she attempted to perform them anyway;

c. Choosing not to explain to Alexee her true condition and as Alexee continued to exhibit symptoms of pregnancy, deliberately, intentionally, willfully, wantonly, recklessly, and with utter disreard did not explain the truth to Alexee in a timely manner;

d. Choosing not to explain the true nature of Alexee's condition to Alexee so that she could make an informed decision about her future care;

e. Choosing not to timely, properly, and immediately become aware of testing results communicated by the laboratory;

f. Providing services to Alexee without the requisite training, skill, knowledge, experience, and expertise;

g. Improperly diagnosing and treating Alexee with medications prior to appropriate, timely, and proper testing and screening;

h. Improperly treating Alexee with incorrect medications at inappropriate intervals and administration of contraindicated medications, and failing to monitor, assess, and stay advised of Alexee's true condition;

i. Inability to diagnose or choosing to ignore the differential diagnoses of pregnancy;

j. Choosing not to have immediate testing performed to determine the true reasons for Alexee's condition;

k. Choosing not to make sure the nurses performed assessments at appropriate intervals;

l. Choosing to allow HIPPA violations regarding the medical condition of Alexee and Decedent;

m. Choosing to fail to provide Alexee with her privacy rights; and

n. Choosing to blame the death of Alex Ray Fierro upon others, rather than taking responsibility for her failures and omissions.

74. The intentional, willful, reckless, and negligent acts and/or omissions of Doctor Varkas were a direct and proximate cause of the death of Alex Ray Fierro.

V.

DAMAGES AGAINST DEFENDANTS

75. All previous paragraphs are incorporated herein by reference.

76. As a direct and proximate result of the acts and omissions of the Defendants, described above, Alex Ray Fierro died.

77. As such, Plaintiff seeks damages, including the Wrongful Death damages provided under statutory law in the State of New Mexico, pre-judgment interest, post-judgment interest, and Plaintiff's cost of suit, as allowed by law, and such other and further relief as this court deems just and proper in the premises.

COUNT V: PUNITIVE DAMAGES AGAINST DEFENDANTS

78. All previous paragraphs are incorporated herein by reference.

79. Defendants' acts and omissions complained of in the preceding paragraphs, are believed to be of an egregious nature, in reckless, wanton, and total disregard to the rights and safety of Alex Ray Fierro.

80. Among others, these intentional, malicious, willful, reckless and/or wanton acts and omissions of the Defendants, either singularly, in combination, or based on the cumulative conduct of employees of Defendants, were a cause of Alex Ray Fierro's death.

81. As such, in addition to actual damages ascertained and demonstrated in this matter, punitive damages are required to punish and deter these types of acts and omissions in the future.

82. Punitive damages should be assessed jointly and severally.

WHEREFORE, Plaintiff prays for judgment against Defendants, jointly and severally, for Wrongful Death damages, sufficient to fully compensate Plaintiff for the injuries and damages described herein, for survivorship claims, for loss of consortium claims, for intentional infliction of emotional distress, post-judgment interest, pre-judgment interest, Plaintiff's cost of suit as allowed by law and for punitive damages, and for such other relief to which Plaintiff may be entitled in the premises.

Respectfully submitted,

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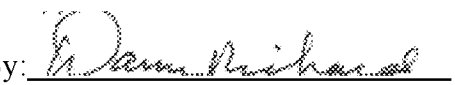
By: 
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