IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

EVELYN GARCIA as Personal Representative of the Estate of ANTHONY DURAN,

Plaintiff,

v.

PALM BEACH COUNTY FIRE RESCUE, an agency, department and subdivision of Palm Beach County,

Defendant.
_____/

Case No.:

COMPLAINT

The Plaintiff, EVELYN GARCIA, as Personal Representative of the Estate of ANTHONY DURAN, sues the Defendant, PALM BEACH FIRE RESCUE, an agency, department and subdivision of Palm Beach County, Florida, and states as follows:

1. This is an action for damages in excess of this Court's minimum jurisdictional limits, to wit: Fifteen Thousand ($15,000.00) Dollars, exclusive of interest and costs.

2. At all times material hereto, the Plaintiff, EVELYN GARCIA is and was over the age of 18, has been lawfully appointed Personal Representative of the Estate of ANTHONY DURAN, is a resident of Palm Beach County, Florida, is subject to the jurisdiction of this Honorable Court, and is otherwise sui juris.

3. At all times material hereto, Defendant, PALM BEACH COUNTY FIRE RESCUE, is and was an agency, department and subdivision of Palm Beach County, Florida, created by state

law to provide fire prevention and suppression services, and emergency medical services to the residents and visitors of Palm Beach County, Florida, with its principal and only place of business in Palm Beach County, Florida, and is subject to the jurisdiction of this Honorable Court.

4. Palm Beach County is the proper venue for this action as the parties reside here, and the cause of action accrued here.

5. Timely, lawful and proper Notice has been given pursuant to Fla. Stat. §768.28(6)(a).

6. Plaintiff is the Personal Representative of the Estate of ANTHONY DURAN and is the proper party to bring this action for the Estate and Decedent's survivors.

7. Under Florida's Wrongful Death Act, the potential beneficiaries of the recovery are the Estate of ANTHONY DURAN, Evelyn Garcia, the Decedent's mother, Jose Duran, the Decedent's natural father, and two sisters.

8. Pursuant to Florida Administrative Code §64J-1.014(6), "each licensed EMS provider is responsible for quality review for completeness and accuracy of their own patient care records."

9. Thus, each employee, agent and servant of the Defendant is responsible for ensuring the record of their care, treatment and transport of patients like ANTHONY DURAN is a truthful and accurate representation of the events that occurred.

10. Additionally, pursuant to Florida Administrative Code §64J-1.014(2), "the transporting vehicle personnel shall at a minimum provide an abbreviated patient record to the receiving hospital personnel at the time the patient is transferred…"

11. If truthful and accurate, the version of the patient care record left with the receiving hospital should be consistent with the official final version of the record.

12. For the particular interaction with ANTHONY DURAN, there are two distinctly different reports which contain inexplicable discrepancies as to the timing of nearly every event in the record and inconsistencies as to what events actually transpired.

13. These discrepancies demonstrate that the Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through its employees on the crew of Rescue Unit R33, failed to rapidly assess ANTHONY DURAN, failed to follow protocols and procedures for treating patients such as ANTHONY DURAN, failed to render emergency care and treatment and failed to promptly transport ANTHONY DURAN, which cost ANTHONY DURAN his life.

14. On June 28, 2015, Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through its employees, agents and servants on Rescue Unit R33, responded to an emergency medical call at a residence involving an asthmatic young man who was having trouble breathing. This young man turned out to be ANTHONY DURAN.

15. The two versions of the records contain inconsistent times as to when Rescue Unit R33 was dispatched to the scene, when it was en route, the time it arrived at the scene and the time Rescue Unit R33 left the scene for JFK Medical Center.

16. Rescue Unit R33 appears to have arrived at the home of the Decedent, ANTHONY DURAN, at either 14:39:00 or 14:39:55, depending upon which report is consulted.

17. ANTHONY DURAN's history of asthma was made known to the crew members of Rescue Unit R33 by his mother, EVELYN GARCIA, who was present for and observed the entire interaction.

18. Pursuant to the Regional Common EMS Protocols, which have been adopted by the Defendant PALM BEACH COUNTY FIRE RESCUE, adult patients in the midst of a respiratory emergency must be immediately assessed and vitals recorded.

19. A critical component of a patient's vital signs is that patient's blood pressure. ANTHONY DURAN's blood pressure was never taken or recorded on either report at any time.

20. On the version of the report given to the receiving hospital, JFK Medical Center, at the time ANTHONY DURAN was transferred to the hospital's care, the first set of vitals was recorded as occurring at 15:14:23*, nearly 40 minutes after Rescue Unit R33 arrived on the scene.*

21. Since such a delay in taking and recording vitals on a patient with a potentially life threatening medical condition is indefensible, in the "official" version of the report, those initial vital sign values were backdated to make them appear to have been done at 14:39:55.

22. There can be no good faith explanation for why a set of vital signs reportedly taken at 15:14:23 would be reported as occurring upon arrival on the version of the report created after the crew knew of ANTHONY DURAN's death.

23. The *only other set of vitals* recorded during the entire course of treatment and transport was timed on both reports at 15:17:46; however, in the copy left with JFK Medical Center, ANTHONY DURAN's **heart rate was recorded as being 108**. In the "official" version of the report created after the crew knew of ANTHONY DURAN's death, his **heart rate was changed to 46**. There can be no good faith explanation for why a documented heart rate in the normal range would be altered to an abnormal rate reflecting bradycardia on the "official" version of the report.

24. Another important component of a patient's vital signs is that patient's pulse rhythm.

25. In the "official" version of the report containing the vital signs which were backdated to make them appear to have been taken at 14:39:55, ANTHONY DURAN's pulse rhythm was described as "regular."

26. However, in the narrative in the "official" version of the report, Rescue Unit R33 describes ANTHONY DURAN as "pulseless upon arrival."

27. Knowing that ANTHONY DURAN had died, Rescue Unit R33 created a report which was designed to create the false impression that his condition was so severe upon their arrival that nothing they could have done would have saved ANTHONY DURAN.

28. If, however, ANTHONY DURAN was, in fact, "pulseless upon arrival", then the crew of Rescue Unit R33 inexplicably failed to perform any of the steps in the Adult Asystole/PEA Algorithm. They failed to assess and records whether ANTHONY DURAN was in a shockable rhythm, failed to attempt cardioversion, and failed to administer amiodarone.

29. For a patient having a respiratory emergency, the crew of Rescue Unit R33 failed to measure or record ANTHONY DURAN's oxygen saturation until 15:17:46, failed to assess chest wall movement, rate and depth of ventilation, presence of symmetrical rise or fall, or use of accessory muscles for breathing.

30. In the "official" version of the report, the crew of Rescue Unit R33 documented interpreting EKG results at 14:39:55, six minutes before the leads were placed on ANTHONY DURAN and at a time when the machine had not yet been turned on. There can be no good faith explanation for this.

31. The crew of Rescue unit R33 inexplicably failed to provide the first line medication for asthmatics having trouble breathing, Albuterol through a nebulizer, which is a rapidly acting bronchodilator.

32. The medication is required to be carried on all advanced life support transport vehicles, and upon information and belief, was present and available to be given. Neither version of the

report contains any justification for why the medication required to be given by protocol wasn't given.

33. Similarly, the crew of Rescue Unit R33 failed to administer any Solu-Medrol, despite Regional Common EMS Protocols dictating that this medication is the second line medication to be given.

34. Instead of delivering known, available, first or second line medications for the emergent treatment of difficulty breathing, and with no indication whatsoever of any drug use or overdose, the crew of Rescue Unit R33 administered Narcan, whose only purpose is to reverse the effects of an overdose, and which could have made no difference to saving ANTHONY DURAN's life.

35. Despite failing to give the Albuterol or Solu-Medrol, according to the "official" version of the report, at 15:05:00 a slowly infusing third line medication, Magnesium Sulfate, which was not likely to be effective working alone or given that late, was administered. *According to the version given to JFK, no reference to any Mag Sulfate is noted.*

36. Pursuant to Florida Administrative Code §64J-1.014(3), "the abbreviated patient care record [provided to the receiving hospital] **shall include** all known information listed below:… (n) Medication(s) administered including the time, medication, dose and route."

37. The absence of any reference to Mag Sulfate when it is mandatory to include reference to it, further suggests the "official" version of the report is unreliable.

38. Depending upon which version of the report is consulted, an initial dose of epinephrine was administered at either 14:50:54 or 14:52:00. Under either scenario, waiting that long before delivering epinephrine is unreasonable and violates protocols.

39. A second dose of epinephrine was recorded as having been administered at 14:58:10 on both versions of the report.

40. On the version given to JFK Medical Center upon transfer, the second dose was the last dose given. *On the "official" version of the report, three additional doses were recorded as having been given prior to arrival at JFK*. There is no good faith explanation for a discrepancy between two doses and five doses of medication given, especially in light of the requirement that medication information is mandatory to report to the receiving hospital.

42. The only logical explanation for the discrepancy between two and five doses of epinephrine is to make the "official" version of the report appear to show that what should have been done was actually done.

43. According to the "official" version of the report, the least experienced crew member, a "probationary paramedic" who only possessed BLS certification, performed manual chest compressions beginning at 14:44:00. Pursuant to the Adult Asystole/PEA Algorithm, there should be two minutes of continuous uninterrupted CPR, yet the "official" version of the report reflects that the same "probationary paramedic" applied the three lead EKG at 14:45:00, thus making it impossible to have performed CPR appropriately pursuant to protocol.

44. In their report to the JFK personnel, the crew first stated manual compressions began at 15:00, then they changed that time to 14:51, then they changed it a third time, to 14:41. It appears they could not keep that detail straight, as the "official" version of the report contains none of those times. EVELYN GARCIA did not witness any of the crew of Rescue Unit R33 perform any manual compressions.

45. According to the "official" version of the report, it took 17 minutes from time of arrival to apply the Lucas device to provide the compressions, which is not in compliance with any protocol. Before applying the device, the crew carelessly dropped it on ANTHONY DURAN's face.

46. The crew of Rescue Unit R33 attempted to transfer ANTHONY DURAN using a scoop stretcher, which was either defective or improperly used, as it bent and became unusable.

47. The crew of Rescue Unit R33 failed to have sufficient back-up equipment on board, and failed to come up with a back-up plan to address this situation such that the transport to JFK Medical Center was delayed while a backup unit, E33, delivered replacement equipment.

48. The crew of Rescue Unit R33 failed to emergently get ANTHONY DURAN out of his home and into the ambulance, and once inside, failed to emergently transport him to JFK. EVELYN GARCIA left the scene after the ambulance pulled away, yet arrived at JFK Medical Center well before the ambulance.

49. The staff of JFK Medical Center initiated a full Code upon arrival, but were unable to save ANTHONY DURAN's life.

50. Too much time had been wasted, and inadequate treatment delivered by the Defendant PALM BEACH COUNTY FIRE RESCUE by and through Rescue Unit R33.

Count I

Wrongful Death against PALM BEACH FIRE RESCUE

51. Plaintiff readopts and realleges the allegations contained in paragraphs 1 -50 as if more fully set forth herein.

52. At all times material hereto, Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through the crew of Rescue Unit R33, had a duty to quickly and efficiently assess and treat ANTHONY DURAN, as any delay in patient care would potentially threaten the life and health of ANTHINY DURAN.

53. At all times material hereto, Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through the crew of Rescue Unit R33, had a duty to provide reasonable and appropriate advanced life-saving measures, including providing medications and interventions, designed to preserve and maintain life.

54. At all times material hereto, Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through the crew of Rescue Unit R33, had a duty to emergently transport ANTHONY DURAN to the closest suitable hospital.

55. Defendant, PALM BEACH COUNTY FIRE RESCUE, by and through the crew of Rescue Unit R33, breached said duties and was negligent by:

A. Failing to properly assess ANTHONY DURAN;

B. Failing to appropriately and timely secure an airway and administering supplemental oxygen;

C. Failing to appropriately and timely monitor ANTHONY DURAN's Oxygen saturation;

D. Failing to appropriately or timely monitor ANTHONY DURAN's Vital signs;

E. Failing to monitor or record ANTHONY DURAN's blood pressure;

F. Failing to appropriately or timely monitor ANTHONY DURAN by EKG;

G. Failing to administer albuterol to ANTHONY DURAN;

H. Failing to administer Solu-Medrol to ANTHONY DURAN;

I. Failing to timely or appropriately administer epinephrine to ANTHONY DURAN;

J. Failing to appropriately or timely perform continuous uninterrupted CPR;

K. Failing to appropriately or timely follow the Adult Asystole/PEA Algorithm;

L. Failing to appropriately or timely follow Regional Common EMS Protocols for Adults experiencing respiratory difficulty;

M. Failing to appropriately or timely assess whether ANTHONY DURAN's rhythm was shockable and failing to attempt cardioversion;

N. Failing to appropriately or timely utilizing the Lucas Device;

O. Failing to have required equipment in good working order inherent in the task of transporting patients, to wit, a non-defective scoop stretcher.

P. Failing to appropriately or timely transport ANTHONY DURAN to JFK Medical Center;

Q. Failing to maintain complete and accurate records as required by Florida Administrative Code provisions;

R. Manufacturing inaccurate official records to avoid discovery of the negligence of Rescue Unit R33; and

S. Otherwise unreasonably failing to provide life sustaining care and treatment to ANTHONY DURAN.

56. As a direct and proximate result of the breaches set forth above, Defendant PALM BEACH COUNTY FIRE RESCUE, by and through the crew of Rescue Unit R33, caused or contributed to cause the death of ANTHONY DURAN, damaged his Estate and Survivors, and they are entitled to recover all damage available under Florida's Wrongful Death Act, including but not limited to: The loss of support and services in the past, with interest, and in the future; lost care, companionship, guidance, and protection, and mental pain and suffering of the

survivors from the date of death; any and all medical or funeral expenses incurred due to the death of the decedent; the loss of prospective net accumulations of the Estate of the decedent, which might reasonably have been expected, but for the wrongful death of the decedent; and all other damages allowed by law.

WHEREFORE, the Plaintiff, EVELYN GARCIA, Personal Representative of the Estate of ANTHONY DURAN demands judgment against Defendant, PALM BEACH COUNTY FIRE RESCUE, for damages in excess of Fifteen Thousand ($15,000.00) Dollars, exclusive of interest, fees and costs, prejudgment interest where applicable, costs of this suit, all other relief to which the Estate and survivors are entitled, and **demands trial by jury** of all issues triable as her right by jury.

Dated this ____27th__ day of June, 2017.

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