COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
C.A.

KELLY OMU & DAVID OMU

Plaintiffs,

v.

MASS GENERAL BRIGHAM, BRIGHAM & WOMEN'S HOSPITAL, MICHELLE SICILIANO, JON C. ASTER, GEORGE LUTHER MUTTER, LAURENT DELLI-BOVI, JOHN DOE #1, JANE DOE #1

Defendants.

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COMPLAINT AND JURY DEMAND

Plaintiffs, Kelly Omu ("Kelly") and David Omu ("David) (collectively, "Plaintiffs") state as follows for their complaint in this action:

PARTIES

1. Plaintiffs Kelly Omu and David Omu have, at all times relevant to this matter, resided in Jaffrey, New Hampshire.

2. Defendant Mass General Brigham ("MGB") is, upon information and belief, a company with a principal place of business at 800 Boylston Street, Boston, Massachusetts in the county of Suffolk.

3. Defendant Brigham & Women's Hospital ("BWH") is, upon information and belief, a company with a principal place of business at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.[1]

4. Defendant Michelle Siciliano is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Technical Operations Manager, Autopsy and Decedent Affairs.

5. Defendant John C. Aster is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Interim Chair of Pathology.

6. Defendant George Luther Mutter is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Doctor of Pathology.

7. Defendant Laurent Delli Bovi is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Doctor of Obstetrics and Gynecology.

8. Defendant John Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of

[1] Defendants MGB and BWH are hereinafter collectively referred to as, "The Brigham."

employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, his position was/is Pathologist.

9. Defendant Jane Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is Social Worker.

JURISDICTION AND VENUE

10. This Court has subject matter jurisdiction over this action pursuant to G.L. c. 223A §§ 2, 3.

11. This Court has personal jurisdiction over each and every Defendant pursuant to G.L. c. 223 § 1. Defendants Mass General Brigham and Brigham and Women's Hospital transact business, trade, and commerce in Massachusetts, including in connection with the property involved in this action located at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Mass General Brigham and Brigham & Women's Hospital have their principal places of business in Massachusetts.

12. Each of the individually named Defendants has their principal place of employment at the Brigham & Women's Hospital located at 75 Francis Street in Boston, Massachusetts.

13. All the Defendants have engaged in a course of conduct which has caused harm and injury to Plaintiffs in Massachusetts.

14. Venue exists in Suffolk County pursuant to G.L. c. 223 § 1 because each of the Defendants have as their principal places of business, or principal places of employment, a location in Suffolk County.

FACTUAL BACKGROUND

15. Kelly and David Omu were married in mid-2021.

16. In September of 2021, they conceived their first child, whom they named Mariposa.

17. Approximately four months into the pregnancy, Plaintiffs learned through doctors that Mariposa would have severe, life-limiting disabilities if she were delivered to term and survived outside of the womb.

18. At the time, Plaintiff Kelly Omu was being cared for by Dr. Laurent Delli-Bovi, an obstetrics and gynecology doctor at Brigham and Women's Hospital.

19. Plaintiffs consulted with Dr. Delli-Bovi and other health care providers, and made the difficult decision to terminate the pregnancy.

20. At roughly eighteen and a half weeks into the pregnancy, Plaintiffs traveled from New Hampshire to a women's health facility in Brookline, Massachusetts to undergo the procedure to end the pregnancy.

21. Due to the gestational age of the fetus, the procedure was to take two days, requiring an overnight stay in Massachusetts.

22. On the first day, January 20, 2022, Kelly was required to fill out multiple forms consenting to the procedure as well as a "Massachusetts Consent for Burial and/or Cremation" form regarding how she and David wished to handle the disposition of Mariposa's remains; and was required to speak on the phone with a receptionist from Defendant BWH in order to establish a patient account with BWH.

23. Notably, the "Consent for Burial and/or Cremation" form is separated into two sections, requiring the parents to indicate what they wanted to happen with their child's remains in addition to whether they approved of pathology testing.

24. Kelly and David were informed by clinic staff that genetic testing would be performed on Baby Mariposa's remains at Brigham and Women's Hospital and that the clinic would ship the remains to BWH after the procedure.

25. Accordingly, because pathology studies were needed, Kelly checked the box in the first section, indicating that she wished to assume responsibility for the handling of Mariposa's remains after the genetic testing was completed.

26. She wrote into the "Consent for Burial and/or Cremation" form the name of the Smith and Heald Funeral Home in Milford, New Hampshire, as well as their phone number and address.

27. Kelly chose this funeral home because her cousin, Patrick Brooks, worked there and would be handling the arrangements.

28. On January 21, 2022, Kelly underwent the traumatic procedure to end the pregnancy.

29. Kelly was informed again that the clinic was going to send Mariposa's remains to Brigham and Women's Hospital, where pathologists would perform genetic testing.

30. Kelly was informed by the clinic that someone from BWH would contact her when Mariposa's remains were ready to be transferred to the funeral home.

31. Nobody ever informed Kelly and David how long the genetic testing would take or when they could expect Baby Mariposa's remains to be ready.

32. Kelly provided the relevant documents to Mr. Brooks at Smith and Heald Funeral Home on January 21, 2022.

33. On that same day, January 21, 2022, Smith & Heald Funeral Home sent an authorization, on behalf of Plaintiff Kelly Omu, to permit the release of Plaintiffs' daughter's remains to the Smith & Heald Funeral Home. **(see Exhibit A)**.

34. In addition to their oral representations prior to the procedures and their indications on the "Consent for Burial and/or Cremation" forms, the Plaintiffs relied upon Dr. Delli-Bovi to provide the fax authorization that was sent by Smith & Heald Funeral Home to the appropriate office and staff at the Brigham, where Dr. Delli-Bovi worked.

35. The authorization was sent via fax by Smith & Heald Funeral Home to the office of Defendant Dr. Delli-Bovi.

36. The recipient fax number was 617-227-3248.

37. This fax number belongs to the office of Dr. Laurent Delli-Bovi.

38. The fax was received by the office of Dr. Laurent Delli-Bovi.

39. The Plaintiffs then anxiously waited for the day that their daughter's remains would be ready for a proper funeral.

40. Mr. Brooks informed Plaintiffs that he would communicate with BWH about scheduling the pickup of Baby Mariposa.

41. Plaintiffs were informed by Mr. Brooks that someone at BWH told Mr. Brooks that the genetic testing would take "a few weeks."

42. Thereafter, every week, Kelly checked her online medical records portal to monitor whether there was any information regarding the results of the genetic testing.

43. Weeks went by and each time Kelly checked the portal, there was no information regarding Mariposa.

44. Kelly assumed the genetic testing was still ongoing since the hospital had not contacted her, or Mr. Brooks at the funeral home.

45. Then, approximately six weeks after sending Mariposa's remains to BWH, during one of her weekly reviews of the portal, Kelly noticed that the genetic testing results had been uploaded to her portal.

46. The testing report indicated that the testing was completed nearly a month prior, on February 7, 2022.

47. Nobody ever contacted Kelly, David, or the funeral home to inform them that the testing was completed, and Mariposa's remains were ready for transfer.

48. Upon seeing the testing results in her portal, on March 5, 2022, Kelly texted her cousin at Smith and Heald Funeral Home to tell him that it appeared the testing was completed, and that Mariposa's remains were ready to be picked up.

49. Mr. Brooks, an experienced funeral home director, was confused as to why the hospital never contacted him, when the hospital knew Smith and Heald was listed as the funeral home handling the arrangements for Baby Mariposa's remains.

50. Mr. Brooks immediately contacted Brigham and Women's Hospital on March 5, 2022, to arrange to transfer Baby Mariposa's remains.

51. Nobody from Brigham and Women's Hospital answered his calls and nobody called the funeral home back to arrange for the transfer.

52. Mr. Brooks told Kelly and David that despite repeated calls, the hospital was not giving him information, and he was getting the sense that something was wrong.

53. Mr. Brooks told Plaintiffs that the hospital was "giving him the run around" as by March 9, 2022, he had spoken to three different people at BWH and had still received no information regarding the whereabouts of Baby Mariposa's remains.

54. Mr. Brooks indicated that it was very unprofessional for the hospital to refuse to contact Kelly, David, or the funeral home immediately when Mariposa's remains were ready for transfer.

55. It was even more concerning to Mr. Brooks that the hospital was not answering their calls to transfer Mariposa's remains or to explain where her remains were.

56. Mr. Brooks was especially confused because he thought a renowned hospital like Brigham and Women's would understand how to handle the transfer of remains and would have policies in place to efficiently facilitate such transfers.

57. Shocked and confused, Plaintiffs called BWH to find an explanation for what happened to Mariposa.

58. On March 10th, 2022, Plaintiff Kelly Omu received an email from Dr. Laurent Delli-Bovi.

59. In her email, Dr. Delli-Bovi apologized for what the Plaintiffs had to endure.

60. Dr. Delli-Bovi said that the "Women's Health Services" department of Brigham & Women's Hospital acknowledged that Dr. Delli-Bovi "had indicated on the pathology requisition form that [Plaintiffs] planned [a] burial cremation."

61. This communication confirmed that the fax authorization form sent from Smith & Heald Funeral Home was received by Dr. Laurent Delli-Bovi.

62. This communication confirmed that Dr. Laurent Delli-Bovi provided the fax authorization form to the appropriate entities at BWH.

63. This communication confirmed that Brigham and Women's Hospital and the Women's Health Services Department of BWH was in possession of appropriately completed paperwork indicating that Plaintiffs would be receiving Baby Mariposa's remains for cremation at the completion of genetic testing.

64. In short, the Plaintiffs did everything in their power to make arrangements for the receipt of their daughter's remains at the completion of genetic testing.

65. Dr. Delli-Bovi said she'd spoken to a doctor in the pathology department, and identified him as Dr. George Mutter.

66. Dr. Delli-Bovi also wrote to Kelly: "I know Brigham Pathology is taking steps to prevent this from happening again."

67. This communication constituted an admission that BWH, and the Brigham Pathology Department, had mishandled the process for keeping and transferring Baby Mariposa to Plaintiffs.

68. Approximately five days after Plaintiffs discovered, on their own, that the testing had been completed a month prior, they received a call from Dr. George Mutter, the pathologist who performed the genetic testing of Mariposa.

69. Dr. Mutter told Kelly and David that Mariposa's remains were "misplaced" and apparently discarded.

70. Dr. Mutter said he never saw the form indicating how Kelly and David wished to handle Mariposa's remains.

71. Dr. Mutter apologized on behalf of BWH and admitted that it was an egregious failure to not honor Plaintiffs' wish to have a proper burial for their child.

72. Dr. Mutter's statements to Plaintiff's constituted an admission that Dr. Mutter and BWH staff failed in their obligations to the Plaintiffs by improperly disposing of the remains of their daughter, Baby Mariposa.

73. Dr. Mutter explained that the only remnant of Mariposa's remains that were still in the possession of BWH were the small tissue samples that were kept for genetic testing.

74. Dr. Mutter offered to send the small remnants of tissue samples to Plaintiffs as a consolation.

75. While Kelly and David had envisioned a beautiful memorial for their child, allowing them to visit her and remember her in a respectful manner, Dr. Mutter proposed that Kelly and David turn the tissue sample into a candle.

76. Kelly and David never received any answers regarding how or why the Brigham discarded Baby Mariposa's remains.

77. Plaintiffs have been forever deprived of any opportunity to grieve and bury their daughter.

78. After enduring the grief caused by the Brigham's inexcusable mishandling of their child's remains coupled with MGB's callous and outrageous response to the situation, Plaintiff Kelly Omu remains in therapy nearly 3 years later.

79. Baby Mariposa has never been recovered.

Baby Everleigh

80. The Brigham was aware of problems in its Pathology Department dating back more than a year.

81. In August 2020, the Brigham inexcusably discarded the remains of Baby Everleigh Ross. *See generally*, *Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022). **(See Attached as Exhibit B)**

82. In the *Everleigh* matter, the plaintiffs' daughter was born at BWH and died 12 days later on August 6, 2020.

83. When plaintiffs sent a funeral home to pick up their daughter's body at BWH four days later on August 10, 2020, they learned that Baby Everleigh was missing.

84. Baby Everleigh's remains have still never been located.

85. During the Brigham's investigation into the loss of Baby Everleigh, Pathologist John Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems.

86. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there."

87. Gryzb told investigators that the pathology department had "filed safety reports and complaints about how other departments leave their workspace."

88. Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

89. Gryzb was hardly alone; Sheila Cox, a transport employee at BWH, was interviewed by Brigham security in the Baby Everleigh matter and remembered that it was "a mess" on the day of Everleigh's disappearance.

90. Another pathologist, Jacob Plaisted, had put Brigham on notice about the conditions of the morgue prior to the loss of Baby Everleigh.

91. Unlike Gryzb, Plaisted had lodged formal complaints with hospital administrators prior to the disappearance of Baby Everleigh and informed Brigham investigators of this fact after the loss of Baby Everleigh.

92. Notably, while the Brigham touted its "transparency" in sharing information with patients' families, in the *Everleigh* matter, the Brigham has refused to disclose pertinent information regarding their investigation, including, but not limited to, complaints about the morgue levied by hospital employees and complete video surveillance of the morgue on the relevant dates.

93. Regardless of what caused the Brigham's loss of Baby Everleigh, by August of 2020 the hospital was aware of problems in its morgue and Pathology Department related to the care, handling, and transfer of infant and pre-natal remains.

Baby Oliver Bothe

94. In November 2020, three months after they lost Baby Everleigh, the Brigham discarded Baby Oliver Bothe's remains without contacting the parents. *See generally*, *Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023). **(See attached Exhibit C)**.

95. Like the Plaintiffs in the case at bar, the plaintiffs in *Bothe* underwent a traumatic, pregnancy-ending procedure because of medical complications.

96. When authorizing the procedure to end the pregnancy, Madeleine Bothe and Ed Felstead were required to sign paperwork, including forms indicating how they wished to handle Baby Oliver's remains.

97. Like the Plaintiffs in the case at bar, Madeleine and Ed checked off the box on a form indicating that they would assume the responsibility for the burial or cremation of Baby Oliver's remains.

98. They reiterated to the medical staff and social workers they interacted with, including social worker Jessica Marks, that their final wish for Oliver's remains was to perform a cremation after the completion of the visual autopsy.

99. One of the forms Madeleine and Ed were provided involved the disposition of Oliver's remains.

100. Madeleine and Ed's selection on the disposition of remains form stated:

> I will assume the responsibility for burial or cremation of the remains following any necessary examination by a pathologist, and I will make the necessary arrangements. If I have not done so within fourteen (14) days, I

> agree that Brigham and Women's Hospital will handle disposal in accordance with its hospital policy.

101. About a week after undergoing the procedure, Madeleine received a call from MGB social worker Jessica Marks.

102. While Madeleine and Ed had previously communicated their wishes for the disposal of Baby Oliver verbally, and in writing, to Marks, Marks again asked Madeleine what she intended to do with Baby Oliver's remains.

103. Madeleine confirmed her intent to have Baby Oliver cremated.

104. Marks provided Madeleine with the names of funeral homes to contact.

105. Madeleine specifically asked Marks how much time they had to decide and make arrangements.

106. Marks assured Madeleine and Ed that they had "six months, so plenty of time" to decide, and that Baby Oliver's remains would be safely kept in the hospital morgue until arrangements were made.

107. Relying on this assertion, Madeleine and Ed took a few weeks to grieve their loss, prior to making arrangements for Oliver's remains.

108. On December 7, 2020, a few weeks after her phone call with Marks, Madeleine called a funeral home to arrange to pick up Baby Oliver's remains and prepare him for cremation.

109. The funeral home called the hospital and immediately called Madeleine and Ed with horrifying news: Baby Oliver was missing.

110. According to the funeral home, Brigham informed the funeral home that Baby Oliver's remains were no longer in the morgue because the Brigham had made "other arrangements."

111. The Brigham never disclosed to Madeleine and Ed what "hospital policy" it was referring to or the firm date that Baby Oliver's remains needed to be retrieved after the completion of the genetic testing and autopsy.

112. Instead, Jessica Marks, a Brigham representative, assured Madeleine and Ed after Baby Oliver's death that his remains would be kept safely in the morgue for up to six months.

113. When Ed called the hospital and Jessica Marks to ask what happened, Marks told him she would find out and get back to them.

114. Marks never called back.

115. Neither Marks, nor the Brigham ever informed Madeleine and Ed about who made the decision to discard Baby Oliver or why it had occurred.

116. Madeleine also called BWH numerous times but received no answers.

117. Finally, Madeleine reached Lynn Blech, the Director of Patient/Family Relations at Brigham and Women's Hospital and spoke with her.

118. Blech informed Madeleine that the hospital discarded Baby Oliver's remains because more than fourteen days had passed, and the hospital followed its policy.

119. Madeleine could not believe that the hospital did not call her or Ed to verify their intent on the disposition of Baby Oliver's remains, especially where Marks stated to them that Baby Oliver would remain in the morgue for the foreseeable future.

120. Blech told Madeleine that BWH used to call parents of deceased children to verify the intended disposition of remains, but found that it "caused more harm than good," re-traumatizing people about their deceased child.

121. Rather than make a phone call to ensure that the plaintiffs' wishes were honored, and Baby Oliver's remains respected, Brigham chose to discard Baby Oliver without telling anyone.

122. Blech's communications to Bothe clearly established that the improper disposal of babies at BWH was a "policy" decision, and not an isolated incident.

Baby Katherine Noel

123. In December 2020, the Brigham threw away Baby Katherine Noel's remains without contacting the parents. *See generally*, *Jodie Skrzat & Christian Noel v. Mass General Brigham, et al.,* No. 02863 (Suffolk County Superior Court, filed December 15, 2023). **(See attached Exhibit D**).

124. On December 28, 2020, due to medical complications, Plaintiff Jodie Skrzat underwent a procedure to terminate her pregnancy at Brigham and Women's Hospital.

125. Like the Plaintiffs in the case at bar and *Bothe*, Jodie had multiple conversations with MGB medical professionals regarding how to handle Katherine's remains after the procedure.

126. The resident obstetrician told Jodie she had three options for the handling of Katherine's remains: (1) remains returned to Jodie and Christian; (2) remains donated to science; or (3) remains destroyed by the hospital.

127. Jodie is a medical doctor, and was fully aware of the concept of informed consent.

128. Jodie indicated on the forms and in conversation with the resident obstetrician assisting her that she wanted Baby Katherine to be returned to her.

129. Jodie was never informed that the hospital would dispose of Katherine's remains if they were not collected within two weeks.

130. On the contrary, Jodie was told by the resident obstetrician that before the remains can be returned, the pathology department first must complete an autopsy and genetic testing.

131. Jodie was told that these procedures would take "some time," and that the hospital would contact Jodie and Christian when Katherine's remains were ready to be picked up.

132. Jodie left BWH nervously awaiting the phone call from BWH telling her she could finally bury her daughter.

133. During that month, Jodie and Christian never received a phone call or received any information from BWH regarding Katherine's remains.

134. Once she recovered from additional surgeries due to complications from the procedure, as it had been over a month since Katherine had passed with no contact from the hospital, Jodie asked her partner, Chrisitan Noel, to call the social worker at BWH.

135. When Christian called the social worker to ask when they could pick up Katherine's remains, he was shocked and appalled at the answer: "I don't know if we can still track that down; it's usually two weeks and then no recourse."

136. Nobody had ever contacted Jodie and Christian to tell them Katherine's remains were ready to be picked up, as BWH and the resident obstetrician had promised they would.

137. Instead, BWH unilaterally disposed of Katherine's remains without ever informing Jodie and Christian or contacting them for pickup.

138. Christian told the social worker what Jodie was told by BWH and the resident obstetrician – that they would be contacted when the remains were ready to be picked up.

139. In response, the social worker said: "That's a story I've heard multiple times before. This isn't an isolated incident."

140. Jodie went looking for help. She joined support groups on social media to see if anyone else had dealt with something like this.

141. As a radiologist at UMASS Medical, Jodie also sought information in a social media group for female physicians.

142. Jodie found out that one of her high school acquaintances, Dr. Beth Harrison, worked in the pathology department at Brigham and Women's Hospital.

143. Jodie told Harrison her story and Harrison said she would investigate it and get back to her.

144. Jodie reached out the following day and Harrison told her she was working on it and relaying concerns to the appropriate people.

145. From then on, Jodie never heard from Harrison again. Jodie tried to contact her multiple times and Harrison never responded.

146. Christian continued calling the social worker who had told him that this was "not an isolated incident."

147. The two communicated a few times but once concerns started to arise, the social worker stopped returning calls from Christian.

148. As the communications from BWH ceased, Jodie sought help in one of her social media support groups – a group for people that terminated their pregnancies due to lethal diagnoses for their unborn children.

149. In that support group, Jodie met Madeleine Bothe.

150. Jodie learned from Madeleine that BWH told Madeleine and her husband, Ed, that they would be contacted when the remains of their child, Oliver, were ready for pickup – only for BWH to unilaterally discard the remains of Baby Oliver without any prior communication with Madeleine and Ed.

151. Finding out that their child's remains were discarded by BWH was devastating to Jodie and Christian. It compounded their grief and made them feel like they lost their daughter all over again.

152. Jodie and Christian's grief was exacerbated when they discovered that this tragedy was entirely preventable; BWH had done this to other families and was clearly not instituting any changes to ensure it never happened again.

Baby Kaylee Emery

153. In March of 2021, Brigham threw away Baby Kaylee Emery's remains against the wishes of her parents. *See generally*, *Lauren Emery & Michael Ward v. Mass General Brigham, et al.,* No. 00778 (Suffolk County Superior Court, filed March 21, 2024). (**See attached Exhibit E)**.

154. On March 1, 2021, Lauren Emery and Michael Ward made the difficult decision to terminate their pregnancy due to medical complications.

155. Those plaintiffs chose The Brigham to have the procedure because the Brigham held itself out and represented itself to consumers through marketing, advertising, and its online presence as "the most trusted name in women's health…a world leader in helping women live longer, healthier lives."

156. Just like the plaintiffs in *Bothe*, *Skrzat*, and the case at bar, Lauren and Michael were required to fill out multiple forms regarding their decision to terminate the

pregnancy, including forms regarding how they would like the hospital to handle Baby Kaylee's remains.

157. Lauren and Michal indicated multiple times, on the forms and in conversations with the MGB social worker assisting them, that they wished to have Baby Kaylee's remains returned to them and then cremated.

158. While Lauren and Michael completed the paperwork, hospital staff updated Lauren and Michael's contact information to ensure that they could contact them when Baby Kaylee's remains were ready to be picked up.

159. On March 2, 2021, Lauren underwent the medical procedure at BWH.

160. Hospital staff at the Brigham requested to perform an autopsy on Baby Kaylee and to perform genetic testing to research the "rare disease" that the hospital told Lauren and Michael that Baby Kaylee suffered from.

161. Lauren and Michael agreed to an autopsy to determine whether there was a connection between their prior miscarriages and the complications affecting Baby Kaylee, and to assess whether there was a genetic condition causing pregnancy complications.

162. Lauren and Michael once again made sure to officially designate that they wanted to have Baby Kaylee's remains returned to them and cremated by way of a funeral home after the hospital performed the autopsy.

163. Plaintiffs were familiar with this procedure, having previously gone through two miscarriages.

164. A social worker from the Brigham read off a list of names of funeral homes in the area and asked Lauren to indicate which funeral home the hospital should contact to arrange for the transfer of Kaylee's remains.

165. Lauren selected a funeral home in Brockton, Massachusetts.

166. The social worker informed Lauren and Michael that she would contact the funeral home and take care of everything once Baby Kaylee's remains were ready to be picked up.

167. The social worker assured Lauren and Michael that the hospital would call them after the autopsy and that the results of the autopsy would be shared with them.

168. No one from the hospital ever called and Lauren and Michael never received documentation of the autopsy results.

169. Approximately one week after leaving the Brigham, Lauren called the social worker who had promised to call her, but did not receive a reply.

170. Lauren called the funeral home but did not receive any information.

171. Lauren called the Brigham and was simply told that they would call her back with information.

172. Lauren never received a call back from anyone at the Brigham.

173. In mid-April of 2021, after calling the Brigham more than ten times without getting any answers regarding where Baby Kaylee's remains were, Lauren and Michael received a call from a doctor at BWH who identified herself as "Dr. Reimer."

174. Upon information and believe, the person calling Lauren and Michael was Dr. Rebecca Reimers, who practiced in Maternal-Fetal Medicine and was a Medical Genetics Fellow at BWH.

175. Upon information and belief, the Maternal-Fetal Medicine department is a part of the "Women's Health Services" department at BWH.

176. Dr. Reimers informed Lauren and Michael that the hospital did not have Baby Kaylee's remains because it had been more than fourteen days since Baby Kaylee

passed, and after remains have been in the morgue for more than fourteen days, it is the hospital's practice to discard them.

177. Dr. Reimers specifically indicated to Lauren and Michael that the "morgue" was the place where fetal remains are stored

178. Dr. Reimers stated that the BWH pathology department never received a call from anyone to arrange to transport Baby Kaylee's remains to a funeral home.

179. Lauren and Michael asked Dr. Reimers whether that meant the social worker failed to do her job, as they were told that everything would be taken care of by the hospital and that they should simply wait until the hospital contacted them.

180. Dr. Reimers responded that she did not have all the necessary information but that it appeared that "a communication did not get to the right people."

181. Dr. Reimers acknowledged and agreed that Lauren and Michael indicated in conversations with MGB staff and on a disposition of remains form that they wanted Baby Kaylee's remains returned to them.

182. Dr. Reimers stated that the BWH pathology department was expecting someone to contact their department within fourteen days to arrange for a funeral, but that did not happen.

183. Dr. Reimers explained that after fourteen days the hospital will "take care of the remains" and it appeared that Baby Kaylee "went down that route."

184. Lauren and Michael asked if this meant that the hospital discarded Baby Kaylee's remains in the trash.

185. Dr. Reimers responded that she didn't believe Kaylee was "thrown away" but she acknowledged that Kaylee was not respected and cremated the way Lauren and Michael wished.

186. Dr. Reimers further assured Lauren and Michael that she would find out what the hospital was doing to ensure that this mistake never happened again.

187. Dr. Reimers assured Lauren and Michael that Lauren and Michael did not input the wrong selection on the disposition of remains form, and that the Plaintiffs had consistently expressed their desire to have Kaylee cremated and buried, and the hospital did not honor that request.

188. Dr. Reimers stated that someone from BWH attempted to call Lauren and Michael, but the hospital did not have their correct contact information and were unable to reach them.

189. This was shocking to Lauren and Michael, as they specifically remembered updating their contact information at the hospital on March 1, 2021.

190. Dr. Reimers admitted that mistakes were made by MGB staff, and told Lauren and Michael that she filed a "major complaint" within the hospital and would be meeting with the department heads to find out what happened.

191. Dr. Reimers assured Lauren and Michael that she would call them with an update after her meeting with the department heads.

192. Dr. Reimers never called back.

193. Lauren and Michael never received Kaylee's remains, nor have they ever been told by MGB staff what happened to Kaylee's remains.

194. Instead, their memory of Baby Kaylee is enshrined on Michael's forearm:

A Missing Baby Problem at Brigham and Women's Hospital

195. In total, during an approximately 18-month period from August 2020 until early 2022, the Brigham threw away the remains of 5 children in violation of the expressed wishes of the parents.

196. If each of those five cases, the plaintiffs made BWH and its staff aware of their desire to receive the remains of their children either in writing, orally, or both.

197. In each of those five cases, the babies are still missing to this day.

198. By at least August of 2020, the Brigham and the Pathology Department was on notice that there was a problem within the morgue with how infant remains were stored and kept.

199. By at least the middle of December of 2020, BWH was aware that its policies and procedures for genetic testing and handling fetal and infant remains were inconsistent and misleading; led to the improper disposal of human remains; and were traumatizing the parents of deceased children.

200. In November of 2020, a social worker in *Bothe* told those plaintiffs that they had "six months, so plenty of time" to contact BWH to arrange for the pickup of their child, Baby Oliver.

201. In late December of 2020, a resident obstetrician informed plaintiff Jodie Skrzat that genetic testing procedures would take "some time," and that the hospital would contact Jodie and Christian when Baby Katherine's remains were ready to be picked up.

202. At some point in early January of 2021, a social worker at BWH speaking to plaintiff Christian Noel about the improper disposal of his daughter, Baby Katherine, disclosed: "That's a story I've heard multiple times before. This isn't an isolated incident."

203. In March of 2021, a social worker informed plaintiffs Lauren Emery and Michael Ward that she would contact the funeral home and take care of everything once Baby Kaylee's remains were ready to be picked up.

204. In December of 2020, Lynn Blech – Director of Patient/Family Relations at Brigham and Women's Hospital and a witness in the *Everleigh* matter – told Madeleine Bothe that BWH had a policy of *not* calling parents to confirm their desired intent on how their child's remains would be disposed.

205. In April of 2021, Dr. Reimers' acknowledgement that someone from BWH attempted to call Lauren and Michael in the *Baby Kaylee* matter was directly contradictory to the stated policy position of BWH from Lynn Blech, Director of Patient and Family Relations.

206. Over the relevant 18-month period, BWH staff repeatedly told families that they had no obligation to do anything in order to receive the remains of their child, and that the hospital would contact them for pickup of the remains.

207. Discovery remains open in the *Everleigh* matter.

208. In the *Everleigh* matter, the Brigham has never produced any information regarding the loss Baby Oliver, Baby Katherine, Baby Kaylee, and Baby Mariposa, even though each of those incidents is irrefutably responsive to the Baby Everleigh Plaintiffs' discovery requests.

COUNT I
(MGB & BWH - BREACH OF CONTRACT)

209. The Plaintiffs incorporate all the foregoing paragraphs of the complaint as if set forth in full below.

210. Plaintiffs and MGB/BWH signed an agreement whereby the hospital, its staff, and its employees would care for Baby Mariposa until her remains could be picked up.

211. This care included safeguarding Baby Mariposa's body and returning it to the family for burial after her passing, in accordance with the documented request of the Plaintiffs.

212. BWH assured the Plaintiffs that Baby Mariposa's remains would be safely kept in the morgue until BWH contacted the family to retrieve her body.

213. BWH and its agents, including the resident obstetrician, did not tell the Plaintiffs that the BWH morgue has a history of erroneously discarding infant remains.

214. BWH knew, as of at least August 2020, that their faulty morgue operation had caused the hospital to lose the remains of at least four other deceased children: (1) Baby Everleigh (2) Baby Oliver (3) Baby Katherine (4) Baby Kaylee. *See generally*, *Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County Superior Court, filed June 23, 2022); *Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023); *See generally*, *Jodie Skrzat &*

Christian Noel v. Mass General Brigham, et al., No. 02863 (Suffolk County Superior Court, filed December 15, 2023); *See generally*, *Lauren Emery & Michael Ward v. Mass General Brigham, et al.,* No. 00778 (Suffolk County Superior Court, filed March 21, 2024).

215. The Plaintiffs fulfilled all their obligations under the contract between the parties.

216. The Plaintiffs made arrangements with a funeral home and communicated those arrangements to their physician at BWH, who acknowledged receiving the communications.

217. The contract between Defendants BWH and MGS and the Plaintiffs was supported by valid consideration.

218. By their actions, and inaction, the Defendants have breached the contract.

219. The Defendants' breach is material and goes to the heart of the contract between the parties.

220. The Defendants' breach has caused injury, damage and harm to the Plaintiffs.

COUNT II
(MGB & BWH - BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING)

221. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

222. The contract between the Plaintiffs and Defendants MGB and BWH includes an implied covenant of good faith and fair dealing.

223. The covenant requires that neither party act to deprive the other party of the fruits and benefits of the contract.

224. MGB and BWH promise each of their patients "superior care that is patient- and family-centered, accessible, and equitable."

225. In accepting the care and treatment of Baby Mariposa, MGB and BWH accepted responsibility to live up to that promise which was supported by the consideration they received in the form of the fees they charged to the Plaintiffs and their insurance carriers.

226. By its actions, and inaction, the Defendants failed to abide by the terms of this agreement and have breached the covenant of good faith and fair dealing.

227. The Defendants' breach has caused injury, damage, and harm to the plaintiff.

COUNT III
(DEFENDANTS ASTER, SICILIANO, MUTTER, DELLI-BOVI, JOHN DOE #1, JANE DOE #1 – NEGLIGENCE)

228. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

229. Defendant Aster was the Interim Chair of the Pathology Department since at least August of 2020.

230. Upon information and belief, as Chair of the Pathology Department, Defendant Aster was responsible for creating, drafting, revising, and enforcing the policies and procedures governing the Pathology Department and the morgue.

231. Upon information and belief, the Chair of the Pathology Department would be informed of "major incidents" involving the loss, improper disposal, and failure to safeguard infant remains by his department.

232. Plaintiffs' physician, Defendant Delli-Bovi, indicated in writing to Plaintiffs that "Brigham Pathology is taking steps to prevent this from happening again."

233. A fair inference from this admission is that the Department responsible for the loss of Baby Mariposa was the Pathology Department.

234. Upon information and belief, the Chair of the Pathology Department would be aware of an investigation of the Pathology Department by the Boston Police Department when Baby Everleigh was lost in August of 2020.

235. A fair inference to draw from all of the above facts is that the Chair of the Pathology Department would be aware – as BWH admitted to impacted families – that this had happened "multiple" times before, and that losing babies at BWH was "not an isolated incident."

236. The loss of four other babies prior to Baby Mariposa was a result of a pattern and practice at BWH and the BWH Pathology Department, overseen by Defendant Aster.

237. At all relevant times, Defendant Siciliano was the Technical Operations Manager, Autopsy and Decent Affairs at BWH.

238. Defendant Siciliano worked closely with the morgue staff, pathologists, and the department of Patient and Family Services.

239. Defendant Siciliano's office was next door to the morgue cooler.

240. The families in all five missing baby cases were told, at various times by hospital staff and providers, that their loved ones were being kept in or handled by the "morgue."

241. Defendant Siciliano was aware of the loss of Baby Everleigh's remains in August of 2020 and was interviewed as part of the investigation by both BWH and the Boston Police Department.

242. Defendant Siciliano was one of the BWH staff responsible for ensuring that human remains were properly handled after death and any subsequent genetic testing, and coordinating with families for the safe return of those remains.

243. Defendant Delli-Bovi was a treating physician of Plaintiff Kelly Omu.

244. Defendant Delli-Bovi was responsible for coordinating with "Women's Health Services" and other staff at BWH to ensure that the wishes of Plaintiffs were properly conveyed to, and honored by, the Pathology Department at BWH.

245. The Defendants owed the Plaintiffs a duty of care in the handling and safeguarding of Baby Mariposa.

246. The Defendants failed to use reasonable care by mishandling Baby Mariposa and throwing her body away.

247. Defendant Aster failed to use reasonable care to ensure that the Pathology Department established and complied with policies that would actually safeguard the remains of deceased infants and fetuses at BWH and safely return them to their families.

248. Defendant Aster failed to investigate repeated failures of his staff and Department in strikingly similar situations during the 18-months leading up to the loss of Baby Mariposa.

249. Defendant Aster failed to revise or amend the policies of the Pathology Department, which could have prevented the loss of Baby Mariposa.

250. Defendant Delli-Bovi failed to ensure that the wishes of Plaintiffs were honored by the Pathology Department and failed to ensure that the Pathology Department acknowledged the wishes of Plaintiffs.

251. The Defendants' failure to use reasonable care caused injury, damage, and harm to the Plaintiffs.

COUNT IV
(MGB & BWH - VIOLATION OF M.G.L. c. 93A, § 9)

252. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

253. Plaintiffs were told that Baby Mariposa's remains would be safely kept in the morgue until they were contacted by the Brigham to retrieve them.

254. The Brigham's failure to properly care and account for the body of Baby Mariposa – knowing that Kelly, David, and their family relied upon the Brigham's promises to keep Baby Mariposa's body safely in the morgue – constitutes an unfair and deceptive practice in violation of Chapter 93A.

255. Moreover, the Brigham's employees' shocking disregard and dismissal of phone calls by grieving parents (and their agents) looking for information is a wanton behavior tantamount to a deceptive practice.

256. Neither the Brigham nor its agents informed the Plaintiffs that the Brigham morgue has a history of erroneously discarding infant remains.

257. Neither the Brigham, nor its agents, informed the Plaintiffs that the hospital and its Pathology Department had a "policy" of not calling parents of deceased children to confirm their wishes prior to disposing of infant or fetal remains.

258. BWH knew, as of at least March 2022, that their faulty morgue operation had caused the hospital to lose at least four other deceased child's remains – Baby Everleigh, Baby Oliver, Baby Katherine, and Baby Kaylee.

259. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, Brigham's morgue again discarded a deceased child's remains – Baby Mariposa.

260. The Brigham has deliberately attempted to conceal the ineptitude of its Pathology Department and morgue operations for financial gain.

261. By August of 2020, at the time Baby Everleigh Ross was thrown away by Brigham staff, the Brigham was already on notice that its Pathology Department and leadership were ill equipped to safely retain child remains in its morgue.

262. Notwithstanding this knowledge, the Brigham continued to allow its agents to falsely represent to grieving parents that their child's remains would be safely kept in the morgue until hospital staff contacted the family to retrieve the bodies.

263. The Brigham attempted to conceal the discarding of Baby Mariposa by not responding to inquiries from the Plaintiffs' designated funeral home; and not providing answers about how this happened once the Plaintiffs were finally able to speak to representatives from The Brigham.

264. No one explained to Plaintiffs who discarded Baby Mariposa, and why the family was told she would be kept safe until the Brigham contacted the Plaintiffs to retrieve her body.

265. The Brigham's refusal to provide answers can only be explained by the Brigham's hopes that no one will ever ask what happened to Baby Mariposa and why.

266. The Brigham's repeated attempts to cover-up the loss of Baby Everleigh, Baby Oliver, Baby Katherine, Baby Kaylee, and Baby Mariposa is evidence of their unfair and deceptive conduct, as they continued to represent to the public that it was the premiere hospital for women's health despite the ineptitude of its morgue operation and Pathology Department.

267. On or about October 16, 2023, the Plaintiffs, through counsel, delivered a demand letter to the Defendants containing the specific allegations of conduct by the Defendants that constituted violations of Massachusetts General Laws c. 93A, § 9. (*See* **Exhibit F**, Chapter 93A Demand Letter).

268. Plaintiffs' demand letter satisfied the required written notice of claim provision of Massachusetts General Laws c. 93A, §9.

269. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants were engaged in trade and commerce.

270. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants held themselves out as the "most trusted name in women's health," and promised to provide "superior care that is patient- and family-centered, accessible, and equitable."

271. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions were unfair and deceptive.

272. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants acted willfully and intentionally.

273. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions occurred primarily and substantially in Massachusetts.

274. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, as a result of the Defendants' unfair and deceptive actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT V
(DEFENDANTS ASTER, SICILIANO, MUTTER, DELLI-BOVI, JOHN DOE #1, JANE DOE #2 – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS)

275. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

276. The Defendants knew, or should have known, that their conduct would cause emotional distress.

277. The conduct of the Defendants was extreme and outrageous.

278. The conduct of the Defendants caused emotional distress to the Plaintiffs.

279. The emotional distress suffered by the Plaintiffs as a result of the conduct of the Defendants was severe.

280. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT VI
(DEFENDANTS ASTER, SICILIANO, MUTTER, DELLI-BOVI, JOHN DOE #1, JANE DOE #2 - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS)

281. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

282. As a direct and proximate result of the Defendants' negligence, Plaintiffs have suffered severe emotional distress and anguish, and have suffered physical

manifestations and harms as a result of the severe and profound emotional distress inflicted upon them by Defendants' negligence.

283. A reasonable person in the same position as the Plaintiffs would have suffered severe and profound emotional distress due to Defendants' negligence.

COUNT VII
(DEFENDANTS ASTER, SICILIANO, MUTTER, DELLI-BOVI, JOHN DOE #1, JANE DOE #2 - TORTIOUS INTERFERENCE WITH HUMAN REMAINS)

284. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

285. The Defendants were responsible for caring for the human remains of Baby Mariposa.

286. The Plaintiffs were entitled to a peaceful disposition of Baby Mariposa.

287. The conduct of the Defendants was intentional, reckless, and/or negligent.

288. The conduct of the Defendants prevented the proper interment or cremation of Baby Mariposa.

289. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

JURY DEMAND

The Plaintiffs demand a jury trial on all claims and issues triable by jury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that the Court enter the following relief:

I. Enter judgment for the Plaintiffs on all counts of this Complaint.

II. Order the Defendants to pay damages, legal fees, costs, and expenses as appropriate, including double or treble damages under G.L. c. 93A.

III. Award the Plaintiffs such other and further relief as is just and appropriate in the circumstances.

Respectfully Submitted
For the Plaintiffs,

/s/ Gregory D. Henning
Gregory D. Henning, Esq. (BBO #663189)
Greg.Henning@henningstrategies.com
Henning Strategies
141 Tremont Street – 3rd floor
Boston, MA 02111
Tel: (617) 293-6534

Respectfully Submitted
For the Plaintiffs,

/s/ Patrick Driscoll
Patrick Driscoll, Esq. (BBO #669560)
pdriscoll@boyleshaughnessy.com
Boyle | Shaughnessy Law, P.C.
695 Atlantic Avenue, 11th Floor
Boston, MA 02111
Tel: (617) 451-2000

Date: 1.16.25

EXHIBIT A

Massachusetts Consent for Burial and/or Cremation

Massachusetts Law, Chapter III, Section 202 provides that the disposition of fetal remains, irrespective of duration of pregnancy, may be made at the discretion of the parent in either of the following ways: (1) the parents may make arrangements for burial in an approved cemetery, or for cremation with a licensed crematorium (Women's Health Services will provide the documentation required to obtain the necessary burial permit) or (2) the remains may be released for disposition in a manner which does not create a hazard to public health.

1. **If pathology studies are indicated, fetal tissue will be sent to Brigham & Women's Hospital or ConVerge Diagnostic Services. If you are making burial/cremation arrangements please check in the appropriate space below.**

(✓) I wish to assume the responsibility for the disposition of the remains and will make the necessary arrangements. If this has not occurred within fourteen (14) days, I agree that Brigham & Women's Hospital or ConVerge Diagnostic Services will handle disposal.

Funeral arrangements at Smith and Heald (63 Elm St. Milford NH 03055 603 673 1422)

( ) I release the remains to Brigham & Women's Hospital or ConVerge Diagnostic Services for immediate disposal.

2. **If pathology studies are not indicated, if you are making burial/cremation arrangements please check in the appropriate space below.**

( ) I wish to assume the responsibility for the disposition of the remains and will make the necessary arrangements. If this has not occurred within fourteen (14) days, Women's Health Services will handle disposal.

Funeral arrangements at _____.

( ) I release the remains to Women's Health Services for immediate disposal.

Kelly L Omn
Patient Signature

1/20/22
Date

Witness

1-20-22
Date

EXHIBIT B

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT (BOSTON)
C.A. NO.: 2284CV

ALANA ROSS and, DANIEL MCCARTHY,
Plaintiffs,

v.

MASS GENERAL BRIGHAM,
BRIGHAM & WOMEN'S HOSPITAL,
HEIDI TAYLOR, JENNIFER CONRADO,
KATHERINE AMATO,
JANE DOE #1, JANE DOE #2, JOHN DOE # 1,
JOSE LOPES, JOHN GRZYB,
JACOB PLAISTED, MICHELLE SICILIANO,
JON C. ASTER, KEVIN SLATTERY,
BRENDA CAREY-MULLANEY, and
KYLA NIEDER.
Defendants.

COMPLAINT AND JURY DEMAND

Plaintiffs, Alana Ross ("Alana") and Daniel McCarthy ("Daniel") (collectively, "Plaintiffs") state as follows for their complaint in this action:

PARTIES

1. Plaintiffs Alana Ross and Daniel McCarthy have, at all times relevant to this matter, resided in Sharon, Massachusetts in the county of Norfolk.

2. Defendant Mass General Brigham ("MGB") is, upon information and belief, a company with a principal place of business at 800 Boylston Street, Boston, Massachusetts in the county of Suffolk.

3. Defendant Brigham & Women's Hospital is a company with a principal place of business at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.

4. Defendant Heidi Taylor is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Neonatal Intensive Care Unit ("NICU") Nurse.

5. Defendant Jennifer Conrado is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is NICU Nurse.

6. Defendant Katherine Amato is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Security Officer.

7. Defendant Jane Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is NICU Supervisor.

8. Defendant Jane Doe #2 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is Nurse/Social Worker.

9. Defendant John Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon

information and belief, John Doe #1 oversaw the morgue's administration, direction, financing, and/or management.

10. Defendant Jose Lopes is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Patient Transport.

11. Defendant John Grzyb is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Pathologist.

12. Defendant Jacob Plaisted is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Pathologist.

13. Defendant Michelle Siciliano is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Technical Operations Manager, Autopsy and Decedent Affairs.

14. Defendant John C. Aster is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Interim Chair of Pathology.

15. Defendant Kevin Slattery is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Director of Security.

16. Defendant Brenda Carey-Mullaney is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Investigator.

17. Defendant Kyla Nieder is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Investigator.

JURISDICTION AND VENUE

18. This Court has subject matter jurisdiction over this action pursuant to G.L. c. 223A §§ 2, 3.

19. This Court has personal jurisdiction over each and every Defendant pursuant to G.L. c. 223 § 1. Defendants Mass General Brigham and Brigham and Women's Hospital transact business, trade, and commerce in Massachusetts, including in connection with the property involved in this action located at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Mass General Brigham and Brigham & Women's Hospital have their principal places of business in Massachusetts.

20. Each of the individually named Defendants have their principal place of employment at the Brigham & Women's Hospital located at 75 Francis Street in Boston, Massachusetts.

21. All of the Defendants have engaged in a course of conduct which has caused harm and injury to Plaintiffs in Massachusetts.

22. Venue exists in Suffolk County pursuant to G.L. c. 223 § 1 because each of the Defendants have as their principal places of business, or principal places of employment, a location in Suffolk County. Plaintiffs reside in Sharon, Massachusetts. Sharon is located in Norfolk County.

FACTUAL BACKGROUND

23. Alana Ross and Daniel McCarthy ("Plaintiffs") learned they were pregnant on February 20, 2020. They named their child "Everleigh."

24. Plaintiffs chose Brigham and Women's Hospital ("BWH") to have Baby Everleigh because BWH held itself out and represented itself to consumers through marketing, advertising, and its online presence as "the most trusted name in women's health…a world leader in helping women live longer, healthier lives."

25. Alana Ross delivered Baby Everleigh at BWH on July 25, 2020. Baby Everleigh was born prematurely and suffered medical complications. She was immediately transported to the NICU.

26. On August 1, 2020, Plaintiffs were allowed to hold their daughter for the first time. They read Baby Everleigh her first book – *Little Red Riding Hood.*

27. From August 1 through August 6, 2020, Plaintiffs maintained a vigil at the hospital and hoped for a positive medical development for Baby Everleigh. They continued

to read to her, getting halfway through the third book in a series – *Judy Moody Saves the World* – by the end of the day on August 5, 2020.

28. On August 6, 2020, Plaintiffs and their parents returned to the hospital at the urging of BWH doctors and were told that further treatment options were exhausted.

29. Daniel's mother, Andrea Taber, baptized Baby Everleigh in her hospital room. Plaintiffs and their parents took turns holding Baby Everleigh.

30. Baby Everleigh died at BWH on August 6, 2021.

31. Plaintiffs handed Baby Everleigh to the BWH NICU nurses so that they could clean her body and dress her, which they did while Plaintiffs were still in the hospital room.

32. Thereafter, Jane Doe #2 approached Daniel to discuss if Plaintiffs wished to waive their right to an autopsy of Baby Everleigh's body.

33. Following a discussion with Jane Doe #2, Daniel signed a paper waiving their autopsy rights, and asked Jane Doe #2 about the timing in which Baby Everleigh's body could be picked up from BWH and prepared for burial.

34. Jane Doe #2 advised Daniel that Baby Everleigh's body would safely be transported to the morgue, at which time Daniel inquired if – given concerns over decomposition of her remains – Baby Everleigh's body would be safe in the morgue for several days while Plaintiffs made arrangements for her funeral and burial.

35. Jane Doe #2 promised and assured Daniel that Baby Everleigh's body would be safe for several days in the morgue.

36. NICU nurses collected Baby Everleigh's memory box, which contained pictures, collages, and keepsakes, such as her baptism water. Plaintiffs were allowed to say their goodbyes. It was the last time Plaintiffs ever saw Baby Everleigh.

37. On August 10, 2020, representatives from the Gillooly Funeral Home, on behalf of Plaintiffs, arrived at BWH to pick up Baby Everleigh so that she could be prepared for a funeral and burial services.

38. Baby Everleigh was not at BWH. Her body, which was supposed to be kept safe and protected by BWH and its employees, was never located.

39. Baby Everleigh is still missing to this day.

How BWH and the Defendants Lost Baby Everleigh

40. On the evening of August 6, 2020, after the Ross and McCarthy families departed BWH, Baby Everleigh was transported to the BWH morgue.

41. At all times relevant to the claims in this case, Jon C. Aster was the Interim Chair of Pathology at BWH. The BWH morgue is managed and supervised as part of the Pathology Department.

42. At all times relevant to the claims in this case, Defendant Aster was responsible for management, oversight, administration, compliance, and supervision of the BWH morgue and its employees, including pathologists.

43. At all times relevant to the claims in this case, Defendant Michelle Siciliano was the Technical Operations Manager, Autopsy and Decedent Affairs at the BWH morgue. Defendant Siciliano's job was, in part, to coordinate logistics for receiving bodies at the morgue and distributing them to the appropriate venues, including funeral homes.

44. Nurses Heidi Taylor and Jennifer Conrado were responsible for safeguarding Baby Everleigh and safely bringing her from the 6th floor of BWH to the morgue for safekeeping. At all times relevant to the claims in this case, Defendants Conrado and Taylor were supervised by Jane Doe #1, the NICU Supervisor.

45. Defendant Jane Doe #1 was responsible for the supervision of all nurses in the Neonatal Intensive Care Unit (NICU). At all times relevant to the claims in this case, Jane Doe #1 was responsible for supervising and training Defendants Conrado and Taylor, and ensuring that children who passed away in the NICU were safely transported to the morgue and their remains properly logged and stored.

46. On August 6, 2020, Defendants Conrado and Taylor were accompanied to the BWH morgue by a BWH Security Officer. On information and belief, this Security Officer was Katherine Amato.

47. At all times relevant to the claims in this case, Defendant Amato was supervised by Kevin Slattery, the Director of Security.

48. On August 6, 2020, one of Defendant Amato's responsibilities was to accompany Defendants Conrado and Taylor to ensure that Baby Everleigh was safely transported to the morgue and her remains properly logged and stored.

49. At approximately 8:55 pm on August 6, 2020, Defendants Conrado, Taylor, and Amato arrived at the BWH morgue with Baby Everleigh.

50. Defendant Amato opened the outer door to the morgue and noticed that the inner door to the morgue cooler was open. She noted that it should not be open at that time.

51. Defendant Amato noticed a male Transport employee inside of the morgue. That employee was holding a stretcher. On information and belief, that male Transport employee was Defendant Jose Lopes.

52. Defendant Amato observed Defendant Lopes – whom she knew to be a Transport employee – standing inside of the morgue in a position that blocked the location where infant remains are normally kept.

53. Defendant Conrado was holding Baby Everleigh when Defendants Conrado, Taylor, and Amato arrived at the morgue.

54. Defendant Taylor made a hand-written entry on the BWH Morgue Log Book indicating the arrival of Baby Everleigh to the morgue. Defendant Amato observed the entry of Baby Everleigh's name in the Morgue Log Book.

55. Inside the BWH morgue at the time of Baby Everleigh's arrival were at least three BWH employees: (1) Pathologist John Grzyb, (2) Pathologist Jacob Plaisted, and (3) Jose Lopes of Patient Transport.

56. While holding Baby Everleigh, Defendant Conrado asked someone inside of the morgue where Baby Everleigh's remains should be placed. Defendant Conrado believed she was speaking with an employee of the Pathology Department. In reality, she was asking Defendant Lopes, who was employed in Patient Transport.

57. Defendant Lopes replied to Defendant Conrado, "You can put it anywhere."

58. Defendant Conrado again inquired of Defendant Lopes where to place the body, noting this time that she was carrying infant remains. Defendant Lopes again replied, "You can put it anywhere."

59. The direction from Defendant Lopes to Defendant Conrado was overheard by Defendant Amato and Defendant Plaisted.

60. Despite knowing that Defendant Lopes was a Transportation employee and not a member of pathology department, Defendant Amato did not say anything, or interject, or indicate Lopes' true responsibilities to Defendant Conrado or Defendant Taylor.

61. Defendant Plaisted took no action to direct Defendant Conrado where to place the remains of Baby Everleigh.

62. Defendant Grzyb took no action to direct Defendant Conrado where to place the remains of Baby Everleigh.

63. Defendant Conrado entered the morgue and turned to the right, placing Baby Everleigh's remains down on a metal rack.

64. At the time, there were no other human remains – either infant or adult – on the metal rack.

65. The metal rack upon which Defendant Conrado placed Baby Everleigh was not the appropriate or designated place for the delivery of infant remains to the morgue.

66. Defendants Amato, Taylor, and Conrado left the morgue.

67. BWH has a bracelet scanning system to record the location of patients throughout the hospital by scanning a code on the patient's bracelet.

68. Some linens at BWH also have embedded chips that can be scanned by the linen service company.

69. There was no electronic tag system or other procedures in place at BWH to digitally record the delivery of infant remains to the morgue.

70. The only recording system in place at the BWH morgue at all times relevant to this action was a hand-written Morgue Log Book.

71. The next morning, on August 7, 2020, Defendant Grzyb was working inside of the morgue. At approximately 7:52 am, Defendant Grzyb collected linens from a morgue tray and disposed of them in a "soiled linens" receptacle.

72. Upon information and belief, Baby Everleigh was laying on top of the tray that was cleaned by Defendant Grzyb.

73. Baby Everleigh's body was thrown away with the "soiled linens" from the morgue.

74. At some point after Baby Everleigh was thrown away as "soiled linens," the linens were transported to a linen servicing company outside of BWH property.

75. No one at BWH realized that Baby Everleigh was missing on August 6, 2020.

76. No one at BWH realized that Baby Everleigh was missing on August 7, 2020.

77. No one at BWH realized that Baby Everleigh was missing on August 8, 2020.

78. No one at BWH realized that Baby Everleigh was missing on August 9, 2020.

79. On the afternoon of August 10, 2020, representatives from the Gillooly Funeral Home arrived at BWH to take custody of the body of Baby Everleigh on behalf of Plaintiffs. They met with Defendant Grzyb and Defendant Plaisted at the BWH morgue.

80. Neither the Gillooly Funeral Home employees, nor Defendants Grzyb and Plaisted, could locate Baby Everleigh anywhere in the morgue.

81. Several hours later, a representative from Gillooly Funeral Home called Plaintiffs and informed them that Baby Everleigh could not be located.

Brigham and Women's Attempts to Find Baby Everleigh

82. Four days after Baby Everleigh went missing, BWH began an investigation into her disappearance.

83. The investigation was run by the BWH Security Department, and its director, Defendant Kevin Slattery. Defendant Nieder and Defendant Carey-Mullaney conducted the investigation under the direction of Defendant Slattery.

84. Defendant Slattery spoke to Andrea Taber, Plaintiff McCarthy's mother, on the evening of August 10. He said a meeting would take place between the security department, NICU, and patient advocates and that he would update the family after the meeting.

85. At 10:15 pm on August 10, Defendants Slattery, Dr. Terrie Inder, and Niv Patterson from Patient and Family Services called Andrea Taber. They had no answers to questions asked by the Plaintiffs, but assured Plaintiffs that BWH was "doing everything in [their] power to find answers."

86. On the morning of August 11, Defendants Nieder and Carey-Mullaney spoke to Defendant Grzyb at the morgue. He offered to provide them with assistance in their investigation. Defendants Nieder and Carey-Mullaney departed the morgue without asking Defendant Grzyb any questions.

87. Around 11am that morning, Defendant Slattery and Niv Patterson called Andrea Taber and informed her that Baby Everleigh had been "put in the wrong place" when she was brought to the morgue. They told Ms. Taber that Everleigh was "wrapped in a blanket," and had been "signed in" to the morgue but was never signed out. They had no further answers to Ms. Taber's questions.

88. On the afternoon of August 11, 2020, on their own volition, Plaintiffs and their family members contacted the Boston Police Department ("BPD") to report that the body of their child was missing. Investigators from BPD arrived at BWH around 2:55pm and began their own investigation.

89. Defendant Nieder told BPD investigators that she had already reviewed video footage from the hospital and that "nothing she had reviewed on the camera footage seemed to assist BWH in locating the remains" of Baby Everleigh.

90. BPD relied upon the representations of Defendant Nieder and the BWH Security Department in determining what steps they would take to try to recover Baby Everleigh.

91. On the morning of August 11, 2020 – 5 days after Baby Everleigh's disappearance and a full day after BWH first learned that she was gone – BWH investigators spoke to NICU Nurse Director Michael Duggan to identify the nursing staff that had taken Baby Everleigh to the morgue.

92. Nursing Director Duggan told investigators that Defendant Conrado had worked the night before and ended her shift at 7am that morning; that she would be back at 7pm that evening; and that the "possibility of her being available to give a statement right away may not be feasible."

93. Nursing Director Duggan told investigators that Defendant Taylor "may" be reachable because she was not working the previous night and would be coming on shift later that evening.

94. Ultimately, Defendant Taylor was not made available to speak with BPD investigators. BPD was informed by BWH security that Defendant Taylor was "not answering calls from the hospital."

95. Despite Defendant Conrado being the last known person to hold Baby Everleigh, BWH investigators did not speak to her about the disappearance of Baby Everleigh until the afternoon of August 11, 2020 – 24 hours after BWH first realized Baby Everleigh was missing.

96. In a phone conversation with BWH investigators, Defendant Conrado confirmed that an employee of BWH working inside of the morgue had told her "you can put that anywhere" when she asked about the placement of Baby Everleigh inside of the morgue. Defendant Conrado confirmed that she placed Baby Everleigh on a tray in the morgue area.

97. Defendant Conrado was never made available to speak with BPD investigators who were working to find Baby Everleigh. Instead, they were informed of her "initial statement" to BWH investigators.

98. BPD investigators began to review clips of the hospital footage around the area of the morgue from August 6, 2020. They inspected the BWH morgue itself, and then reviewed additional video provided by BWH.

99. BPD investigators interviewed Defendant Grzyb on the afternoon of August 11, 2020. At the time of the interview, Defendant Grzyb was well aware that Baby Everleigh was missing.

100. In his interview with BPD investigators, Grzyb said that pathologists were "very careful" about handling hazardous waste and soiled linens in the morgue. He was adamant to BPD detectives that he did not observe, nor remove any soiled linens when he entered the morgue cooler for work on Friday, August 7, 2020.

101. BPD investigators traced the soiled linen containers from BWH and identified the likely location of the soiled linens from BWH.

102. BPD investigators also contacted the trash company that collected medical waste and trash from the linen company servicing BWH, as well as the transfer company that collected medical waste that was separated from linens used at BWH.

103. BPD investigators spent eight hours on the morning of August 12, 2020 digging through blood soaked clothing, feces covered linens, and other medical waste at a transfer station searching for Baby Everleigh. No BWH employees or staff participated in this search.

104. On the afternoon of August 12, 2020, BPD investigators were notified by BWH Chief of Police William Barrett that Defendant Grzyb had eventually admitted seeing some linens on a stainless steel tray inside the morgue and disposed of it in the soiled linens container.

105. After this disclosure by BWH, Defendant Nieder provided video to BPD investigators showing Grzyb throwing out linens from the morgue on the morning of August 7, 2020. Upon information and belief, the linens contained Baby Everleigh.

106. After being informed of Grzyb's confession to BWH security, BPD investigators spoke to the linen servicing company and the company that transported waste from the linen company.

107. Detectives from BPD determined that because of the volume of linen coming from BWH and the soiled linen that still remained in the BWH hallways before pickup, it was possible that the linen containing Baby Everleigh might still be able to be recovered.

108. On the evening of August 12, 2020, BPD investigators and employees from the waste transfer company dug through hundreds of pounds of medical waste, desperately searching for Baby Everleigh. After several hours the search was concluded, and Baby Everleigh was not found.

109. No BWH employees or staff participated in this search.

110. On the morning of August 12, 2020 – five days after Baby Everleigh's disappearance and almost two days after BWH first learned she was missing – BWH investigators interviewed Defendant Grzyb.

111. Defendant Grzyb told investigators that on the morning of August 7, 2020, he had not cleaned up any soiled linens and did not clean up the morgue cooler because he "wanted to get all the office work done."

112. Defendant Nieder informed Mr. Grzyb that he was observed on video on the morning of August 7, 2020 leaving the morgue cooler with "something in his right hand, a bundle of sorts." Defendant Gryzb became "more distraught," and told investigators from BWH that he "should have known that those blankets were a baby inside, but that he was moving so fast and thought he was cleaning up after [the pickup of another body]."

113. Defendant Grzyb told investigators that he throws trash and linens away from inside of the morgue cooler "almost every day," that "sheets and blankets are usually left under decedents or pillows under their heads," and that "chucks or paperwork are also left behind on the floors too."

114. Defendant Nieder asked Grzyb how likely it was that he threw away Baby Everleigh in the soiled linen container; Defendant Grzyb said "that seems like the likely scenario." Defendant Grzyb said that because the prenatal remains were "not left in the right location," he "knows he threw the blanket away" and must have thought it was a "left-over blanket."

115. Defendant Grzyb told investigators that "mistakes of other people who have access to the morgue set [off] a chain of events that were unavoidable." He told investigators that because Baby Everleigh was "wrapped in a blanket" and had "no identifying makers on the outside of the blanket," he likely threw it away in the soiled linen container.

116. Defendant Grzyb expressed concern to investigators that this incident was going to cause his face to be "plastered on the news." Defendant Nieder told Defendant Grzyb that news coverage was unlikely, but that the incident would likely lead to "good changes to processes and procedures for the morgue."

Sloppy Conditions and Poor Management of the BWH Morgue Were Known Risks Prior to the Loss of Baby Everleigh

117. BWH was aware of problems with the management and conditions of its morgue prior to BWH losing Baby Everleigh.

118. Defendant Grzyb told BWH investigators about the conditions of the morgue and inaction by hospital administrators, including John Doe #1, when they were notified of those problems well before losing Baby Everleigh.

119. Defendant Grzyb told BWH investigators that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there."

120. Defendant Grzyb told investigators that the Pathology Department had "filed safety reports and complaints about how other departments leave their work space." Grzyb told investigators that he had "learned to work with other departments' mistakes."

121. Defendant Grzyb told investigators that he had "spoken to his boss, Michelle, about these complaints." Upon information and belief, "Michelle" is Defendant Michelle Siciliano, who was Technical Operations Manager, Autopsy and Decedent Affairs.

122. A transport employee at BWH who was interviewed by investigators told them that she remembered working on August 6, 2020 and saw the condition of the morgue cooler that morning. She told investigators that "she remembers the morgue cooler being a mess and with linens [sic]."

123. Defendant Plaisted, who is also a Pathologist at the BWH morgue, previously filed complaints to BWH supervisors about the conditions of the BWH morgue.

124. Upon information and belief, Defendants MGB, BWH, Jon Aster, John Doe #1, and Michelle Siciliano took no action and failed to address the written and verbal complaints about the morgue made by the BWH pathologists.

125. After the disappearance of Baby Everleigh, BWH began posting job listings for a "morgue attendant" and a "senior morgue specialist." Both postings contain job descriptions that include the type of oversight that would have prevented Baby Everleigh's disappearance.

126. BWH was aware of the issues at the morgue and chose not to hire for these roles prior to Baby Everleigh's disappearance for reasons related to the entrepreneurial and business operations of MGB and the BWH.

COUNT I
(MGB & BWH - BREACH OF CONTRACT)

127. The Plaintiffs incorporate all of the foregoing paragraphs of the complaint as if set forth in full below.

128. Plaintiffs and MGB/BWH signed an agreement whereby the hospital, its staff, and its employees would care for Baby Everleigh. This care included safeguarding Baby Everleigh's body and returning it to the family for burial after her passing.

129. The Plaintiffs fulfilled all of their obligations under the contract between the parties.

130. The contract was supported by valid consideration.

131. By their actions, and inaction, the Defendants have breached the contract.

132. The Defendants' breach is material and goes to the heart of the contract between the parties.

133. The Defendants' breach has caused injury, damage and harm to the Plaintiffs.

COUNT II
(MGB & BWH - BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING)

134. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

135. The contract between the Plaintiffs and Defendants MGB and BWH includes an implied covenant of good faith and fair dealing.

136. The covenant requires that neither party act to deprive the other party of the fruits and benefits of the contract.

137. MGB and BWH promise each of their patients "superior care that is patient- and family-centered, accessible, and equitable."

138. In accepting the care and treatment of Baby Everleigh, MGB and BWH accepted responsibility to live up to that promise which was supported by the consideration they received in the form of the fees they charged to the Plaintiffs and their insurance carriers.

139. By its actions, and inaction, the Defendants failed to abide by the terms of this agreement and have breached the covenant of good faith and fair dealing.

140. The Defendants' breach has caused injury, damage, and harm to the plaintiff.

COUNT III
(DEFENDANTS TAYLOR, CONRADO, AMATO, JANE DOE #1, JANE DOE #2, JOHN DOE #1, LOPES, GRZYB, PLAISTED, SICILIANO ASTER, SLATTERY, CAREY-MULLANEY & NEIDER ONLY – NEGLIGENCE)

141. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

142. The Defendants owed the Plaintiffs a duty of care in transportation, handling, and safeguarding of Baby Everleigh.

143. The Defendants failed to use reasonable care by mishandling Baby Everleigh and throwing her body away like trash.

144. The Defendants' failure to use reasonable care caused injury, damage, and harm to the Plaintiffs.

COUNT IV
(MGB & BWH - VIOLATION OF M.G.L. c. 93A, § 9)

145. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

146. On or about December 22, 2021, the Plaintiffs, through counsel, delivered a demand letter to the Defendants containing the specific allegations of conduct by the Defendants that constituted violations of Massachusetts General Laws c. 93A, § 9. (*See* **Exhibit A**, Chapter 93A Demand Letter).

147. Plaintiffs' demand letter satisfied the required written notice of claim provision of Massachusetts General Laws c. 93A, §9.

148. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants were engaged in trade and commerce.

149. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants held themselves out as the "most trusted name in women's health," and promised to provide "superior care that is patient- and family-centered, accessible, and equitable."

150. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions were unfair and deceptive.

151. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants acted willfully and intentionally.

152. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions occurred primarily and substantially in Massachusetts.

153. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, as a result of the Defendants' unfair and deceptive actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT V
(DEFENDANTS TAYLOR, CONRADO, AMATO, JANE DOE #1, JANE DOE #2, JOHN DOE #1, LOPES, GRZYB, PLAISTED, SICILIANO ASTER, SLATTERY, CAREY-MULLANEY & NEIDER ONLY– INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS)

154. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

155. The Defendants knew, or should have known, that their conduct would cause emotional distress.

156. The conduct of the Defendants was extreme and outrageous.

157. The conduct of the Defendants caused emotional distress to the Plaintiffs.

158. The emotional distress suffered by the Plaintiffs as a result of the conduct of the Defendants was severe.

159. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT VI
(DEFENDANTS TAYLOR, CONRADO, AMATO, JANE DOE #1, JANE DOE #2, JOHN DOE #1, LOPES, GRZYB, PLAISTED, SICILIANO ASTER, SLATTERY, CAREY-MULLANEY & NEIDER ONLY - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS)

160. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

161. As a direct and proximate result of the Defendants' negligence, Plaintiffs have suffered severe emotional distress and anguish, and have suffered physical

manifestations and harms as a result of the severe and profound emotional distress inflicted upon them by Defendants' negligence.

162. A reasonable person in the same position of Plaintiffs would have suffered severe and profound emotional distress due to Defendants' negligence.

COUNT VII
(DEFENDANTS TAYLOR, CONRADO, AMATO, JANE DOE #1, JANE DOE #2, JOHN DOE #1, LOPES, GRZYB, PLAISTED, SICILIANO ASTER, SLATTERY, CAREY-MULLANEY & NEIDER ONLY - TORTIOUS INTERFERENCE WITH HUMAN REMAINS)

163. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

164. The Defendants were responsible for caring for the human remains of Baby Everleigh.

165. The Plaintiffs were entitled to a peaceful disposition of Baby Everleigh.

166. The conduct of the Defendants was intentional, reckless, or negligent.

167. The conduct of the Defendants prevented the proper internment or cremation of Baby Everleigh.

168. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

JURY DEMAND

The Plaintiffs demand a jury trial on all claims and issues triable by jury.

PRAYER FOR RELIEF

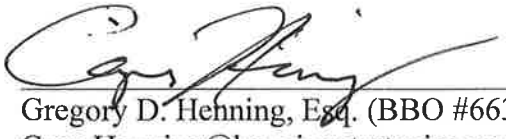
WHEREFORE, Plaintiffs hereby request that the Court enter the following relief:

I. Enter judgment for the Plaintiffs on all counts of this Complaint.

II. Order the Defendants to pay damages, legal fees, costs, and expenses as appropriate, including double or treble damages under G.L. c. 93A.

III. Award the Plaintiffs such other and further relief as is just and appropriate in the circumstances.

Respectfully Submitted
For the Plaintiffs



Gregory D. Henning, Esq. (BBO #663189)
Greg.Henning@henningstrategies.com
Henning Strategies
141 Tremont Street – 3rd floor
Boston, MA 02111
Tel: (617) 293-6534

Respectfully Submitted
For the Plaintiffs

Patrick Driscoll, Esq. (BBO #669560)
pdriscoll@boyleshaughnessy.com
Boyle | Shaughnessy Law, P.C.
695 Atlantic Avenue, 11th Floor
Boston, MA 02111
Tel: (617) 451-2000

EXHIBIT

A

BOYLE | SHAUGHNESSY LAW

BOYLE | SHAUGHNESSY LAW PC

695 ATLANTIC AVENUE, 11TH FLOOR
BOSTON, MA 02111
(617) 451.2000 TEL
(617) 451.5775 FAX
www.boyleshaughnessy.com

PATRICK DRISCOLL
pdriscoll@boyleshaughnessy.com

December 22, 2021

VIA CERTIFIED MAIL: ____

Mass General Brigham Incorporated
c/o Anne Klibanksi, M.D., President and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

RE: Alana Ross & Daniel McCarthy v. Mass General Brigham & Brigham and Women's Hospital
Our File No.: BSC.2278

M.G.L. c. 93A DEMAND LETTER

Dear Dr. Klibanski:

Please be advised that this office, in conjunction with Henning Strategies, LLC, represents Alana Ross ("Alana") & Daniel McCarthy ("Dan") (collectively referred to hereinafter as "Claimants") concerning Mass General Brigham / Brigham and Women's Hospital's (collectively, "MGB") outrageous, appalling and inexcusable mishandling of the deceased remains of Claimants' child, Everleigh Ross ("Everleigh" or "Baby Everleigh"). This correspondence is sent pursuant to §9 of M.G.L c. 93A. At this time, we request that you preserve all evidence related to MGB's handling of Baby Everleigh's remains, including but not limited to any physical evidence, notes, reports, photos, witness statements, surveillance / security videos, phone records, e-mails, and letters.

I. BACKGROUND AND UNDERLYING FACTS

i. Alana's First and Second Pregnancies

Dan and Alana have known each other since the 5th grade and have been in a committed relationship for a dozen years. Dan and Alana first decided they wanted to start a family in June of 2018. On Valentine's Day in February 2019, Claimants were elated to learn that Alana was pregnant with their first child, and perhaps naively expected an uneventful pregnancy. However, their joy quickly turned to heartache, as Alana experienced heartbreaking complications with her pregnancy, resulting in a medically induced miscarriage.

Despite their overwhelming devastation, Claimants were determined to keep trying. Alana's doctors at MGB advised her to wait at least three months before attempting to get pregnant again. Over

the next three months, while waiting to try again to start their family, Alana underwent a number of procedures to confirm that her uterus was normal and her fallopian tubes were open. While the procedures were exceptionally invasive, including the vaginal insertion of a catheter advanced through her cervix and into her uterus, it was ultimately determined that her fallopian tubes were undamaged and her uterus was normal. In July 2019, Dan and Alana discovered that Alana was once again pregnant. Claimants were overcome with elation, and ready to turn the page and move on from the tragic first pregnancy. The first pregnancy had failed following a "million to one shot" problem. Surely, the second would fare better.

The second pregnancy was uneventful until around twelve weeks in, when Alana's doctors discovered some troubling issues with the baby. Dana and Alana did everything they could to monitor the baby's condition, but it was no use. On November 4, 2019, during an ultrasound-guided amniocentesis procedure, Claimants' providers discovered that the baby's heart had stopped, and that the baby had died inside of Alana's body. Through heartbreak and tears the procedure continued, as the amniocentesis was the only way to tell exactly what had happened. Alana could not bring herself to undergo a natural birth of the child who had passed. Instead, she underwent a dilation and evacuation to remove the child from her body. This procedure spanned two days. The child's body was so malformed, the hospital could not so much as provide footprints of the child. DNA and chromosomal testing later revealed the baby had suffered from Turner's syndrome. Only one sex chromosome had transferred to the baby. Alana and Dan's genetic testing showed they had no anomalies to pass down. Turner's Syndrome occurs in only one out of every 2,000 live births. Again, Alana and Dan had suffered at the hands of chance. Still, despite their unimaginable sadness, Claimants remained determined to try again.

ii. Baby Everleigh

Two months later, Alana's doctors gave her the green light to resume trying to start her family. After another round of intrauterine insemination, on February 14, 2020, Valentine's Day—and one year to the day of their first positive pregnancy test—they learned they were pregnant again. This was baby Everleigh. This time around, the Claimants were understandably nervous and worried, but were hopeful that they could finally start a family. Alana and Dan's anxiety over this pregnancy was only compounded by the COVID-19 epidemic. What few appointments Alana was permitted showed a healthy baby. Due to COVID-19 related restrictions, Dan was unable to be a part of any of those appointments. Eighteen weeks into the pregnancy, Alana noticed a change in her vaginal discharge and spoke to the doctors at Brigham and Women's Hospital on May 28. They asked Alana to come in for an ultrasound, which again Dan was not permitted to attend. The ultrasound showed shortening of her cervix and an amniotic sac which was bulging into her vaginal cavity. It appeared they may lose Everleigh. Alana was admitted to the hospital with the expectation that the following day the staff would attempt an emergency cerclage placement (i.e. a procedure to stitch the cervix shut). She spent that night alone in the hospital as Dan was not permitted to remain. Just before the procedure the next morning, Dan saw an ultrasound of Everleigh for the first and only time.

The procedure, which was expected to last thirty to sixty minutes, stretched to ninety minutes. Through the whole operation, Alana was awake, as only a spinal amnesia would allow baby Everleigh a chance to survive. Alana's body was inverted with her feet in the air and her head down by the floor. She felt nauseous from the medications and vomited while inverted. It took everything in Alana's power

to fight off a panic attack as the inversion made her feel as though she was suffocating. In her mind she told herself that it would be alright, that she could take the pain, take the panic, take the sensation that her breath was being snatched from her body if it meant it would save baby Everleigh. Though excruciating, the operation was a success. Alana spent the next two nights as an inpatient for observation. After her release from the hospital, Alana's physician placed her on modified bed rest and ordered her to begin progesterone suppositories which are inserted vaginally each night. Alana was willing to do whatever was necessary because she knew she needed the pregnancy to last as long as possible.

The pregnancy lasted two more months. After midnight, on July 23, 2020, Alana went to use the bathroom in her home. Everleigh was always a very active baby and had been kicking Alana sharply earlier in the night. Just as Alana was falling back to sleep she felt her water break. Alana ran to the bathroom and hoped the water would stop. It didn't stop. Alana and Dan called an emergency number at Brigham and Women's Hospital. They were told the on-call doctor had been paged and that they should wait for a call back. Five minutes became ten minutes became fifteen minutes stretching to thirty minutes. No call came. In a desperate panic, Dan and Alana made the decision to go to the hospital. During the thirty-minute drive to the hospital they called again; the doctor was paged anew. Dan and Alana's frantic calls for help went unanswered. The "on-call" doctor failed to be "on-call".

Dan dropped Alana off at the front door and, as Alana was wheeled up to delivery, he went to park the car. The doctors performed blood cultures, and placed Alana on an intravenous catheter, through which they gave Alana magnesium to stave off further contractions. At that point, she also received the first of two steroid injections to help strengthen the baby's lungs. Alana spent that night in the hospital and, the following day, was moved to the antenatal floor. The following day, Alana continued to undergo tests, invasive examinations, and further magnesium injections. The blood cultures finally returned and the doctors learned that Alana had an infection, but it was unknown if the infection had come after her water broke, or precipitated the break.

On the morning of July 25, Alana was awakened by cramps. She summonsed the nurses who placed her on contraction monitors which confirmed the cramps were contractions. Alana was brought back to labor and delivery and given yet more magnesium in an effort to stop the contractions. Alana asked to use the bathroom and, afterwards, mentioned that she still felt like her bladder was full. A doctor overheard her say this and did a manual examination of her cervix, which revealed, despite her intact cerclage, her cervix had already dilated to ten centimeters. Alana was immediately deemed an emergency C-section and they began preparing her for surgery.

While Alana expected to have a C-section with a spinal anesthesia, she had already received her daily blood thinner injection and would, therefore, have to be placed under general anesthesia instead. To minimize the time she was under anesthesia, for the sake of Everleigh, she was prepped before being put under. The oxygen mask was strapped tightly to her face and she fought the urge to vomit. She yelled out that she was about to vomit and, only at the last minute, did someone remove the mask from her face, allowing her to expel her vomit. Alana was awake as the doctors forced a sterile gauze soaked in disinfectant up her vaginal canal and pushed a sterile catheter up her urethra. Alone without Dan, she screamed into the oxygen mask and felt an anxiety attack approaching, brought on by the pain of the prep, the suddenness of the situation, and the fact that with all the noise in the room and the oxygen mask, no one could hear her.

They closed the drapes and told Alana that she was going to feel pressure on her shoulders and neck, but that everything would be fine. She remembers asking into the oxygen mask, "Why would I feel pressure?" Suddenly, she felt as though a one hundred pound weight was locked down on her shoulders and neck and she couldn't move or breathe. Alana wasn't yet intubated; she panicked, fearing they would do the procedure while she was still awake; she was frantic, unable to take in enough air. Ten seconds later a doctor was telling her that Dan had already been to the NICU and met baby Everleigh, and she would be able to do the same too. Dan had arrived just as the procedure began and had just arrived at labor and delivery five minutes before Everleigh was wheeled past him, stopping long enough to wrap her tiny fingers around his finger.

Alana was brought up to the NICU and, while still in her hospital bed, she could look and see the isolette that contained baby Everleigh. Alana will never forget how tiny she looked. Moments later Alana was brought back up to her room on the antenatal floor to continue her recovery. With the nightmare of two failed pregnancies, and an emergency C-section behind her, Alana spoke with a lactation consultant and pumped for the first time later that night. Alana remained in the hospital for four more days, until July 30 when she was discharged. In the four days before her discharge, Dan visited every day and the two went to see Everleigh in the NICU. The doctors assumed Everleigh had the same infection Alana had suffered but couldn't tell for certain. Shortly before Alana's discharge, Alana and Dan were told that the most recent brain ultrasound showed massive bleeding in Everleigh's brain. The doctors hoped she might live, but confessed she would likely be challenged with life-long disabilities. Alana and Dan were prepared for that and, on August 1, because Everleigh was having a good day medically, Dan and Alana were permitted to hold her for the first time. Alana gave Dan the first opportunity; Alana had months of kicks, pokes and ultrasounds, and she wanted Dan to have that same bond, too. As Dan held her, Alana read to her for the first time: *Little Red Riding Hood.* Unfortunately, Everleigh's CO_2 levels began to rise and she had to be placed back in her isolette before Alana was given the opportunity to hold her.

On August 2, the doctors explained what the brain bleed would mean going forward and prepared the family to expect severe disabilities. In the days that followed, the brain bleed appeared not to progress any further, but her intestinal tract had stopped functioning and she was no longer producing feces. The doctors thought perhaps her pain medication was the cause of this, and they reduced it. The doctors then discovered that Everleigh's lungs weren't inflating properly; one lung was overinflated while the other was underinflated. Beginning on August 3, her CO_2 levels weren't stabilizing and continued to increase. Everleigh's ventilator settings had to be adjusted several times a day. The doctors suggested that perhaps her lungs had been damaged during the extensive CPR that was needed at birth. This was the first Alana and Dan had learned that CPR was conducted at all. Throughout this whole time, Alana continued to produce breast milk and, while Everleigh could not yet eat, the nurses would rub the milk on her lips and inside her mouth to help boost her immune response. Through this time, Alana read to Everleigh; when she left the hospital on August 5, Alana had made it through halfway through the third book in a series called *Judy Moody Saves the World.*

On August 6, 2020 at 9:47 am, Dan and Alana received a call from Dr. Everrett who told them that Everleigh had a very difficult night and that they had exhausted their treatment options. When they arrived at the hospital, Everleigh's CO_2 levels were elevated and she was back on morphine. The doctors

gave her paralyzing medication to make her comfortable with the rigorous ventilator settings. She was retaining water and hadn't had a bowel movement in a week. Everleigh's little body was shutting down.

At the urging of the medical staff, Alana held Everleigh in her arms for the first and only time—her body still attached to the ventilator.

Dan's mother baptized Everleigh at the end, just before the doctors injected her with a large dose of morphine and disconnected the ventilator. Alana held Everleigh for a half hour, watching the heart monitor slowly fade and flat line. Dan, Alana, and their parents took turns holding her and saying goodbye. When they were ready, they handed Everleigh to the nurses who cleaned her body and dressed her in a simple white satin gown, which they did in the room with the family present. The nurses put together her memory box, containing pictures, collages, and keepsakes, such as her baptism water. She was placed in her isolette and the family said goodbye one last time. It was the last time they would see Baby Everleigh.

iii. The Loss of Everleigh's Remains

The following day, August 7, Dan and Alana returned to the hospital to pick up the finished memory box. Alana waited at the entrance while Dan went up and, upon his return with the beautiful white cushioned box, they broke down in the car. They couldn't bring themselves to drive for a while. That weekend they attempted to process their grief and, while Dan's father offered to make the funeral arrangements, they all agreed that Dan and Alana should pick the funeral home and cemetery. Despite the difficulty, they resolved to make their selections by that Monday, August 10. The idea of Everleigh spending more time in a cold morgue was too much for the family to bear.

That Monday, the family selected a funeral home near their house and decided to bury Everleigh in a cemetery containing Dan's grandmother so Everleigh would be near family. While they should have been selecting a new crib for their child, they selected a casket, executed the contract for the funeral home, spoke to the director, and granted him permission to retrieve Everleigh from the hospital. The funeral home pledged to handle everything and to call back shortly. Five hours later, Alana and Dan received a call from Brigham and Women's Hospital. Dan took the call. He listened and ended the call.

He turned to Alana, fighting tears, and told her that the hospital couldn't find Everleigh's body. The trauma was too much for Dan and Alana to bear and Dan's mother, Andrea Taber ("Andrea"), took the lead coordinating with the hospital while his father, Dan, Sr., served as the primary point of contact during the subsequent police investigation.

iv. The Unsuccessful Search for Everleigh

After Andrea fought through her own tears of shock and horror that baby Everleigh's remains had been lost, she called Kevin Flaherty ("Flaherty"), the Director of Security at Brigham & Women's Hospital. Flaherty informed Andrea that the hospital had called a meeting with staff from security, patient and family advocates, and the NICU and that they would call him after the meeting. As 8:00 stretched to 9:00 and eventually to 9:30, Andrea called the hospital again, only to be told that the meeting was running late. Around 10:15 that evening, Andrea received a call from Flaherty, Terry Indur from the NICU, and Niv Paterson from Patient and Family Safety. The hospital was unable to convey any useful information. Nobody could answer the myriad questions Andrea had: What happened? Is there security footage? Who brought her to the morgue? What happened when she got there? Was she logged in? Where was she placed and why wasn't she still there when they came for her? Did another funeral home take her by mistake? Who is the pathologist? Did they send her for an autopsy by mistake? Who supervises what goes into and comes out of that morgue? Aren't there some sort of protocols that must be adhered to? The hospital staff assured Andrea that they were doing everything in their power to find answers, though it was clear that they had none. Patterson promised a call the following morning, August 11, by 11:00 am.

The following morning, Patterson and Flaherty called Andrea and informed her Everleigh was "put in the wrong place" by the nurse when she brought her to the morgue. They added that there were two nurses, accompanied by security, who brought her to the morgue. There is security footage of them bringing Everleigh in but, unfortunately, the camera did not capture the area where she was placed. She was in a blanket and was wearing an ankle bracelet. While Everleigh was logged into the morgue she was never logged out. The hospital promised that it was reviewing all the traffic in and out of the morgue including "badge - in and badge - out" staff as well as outsiders who must log-in. Andrea was told that Everleigh was wrapped in a blanket. They did not elaborate what type of blanket or why she was not in a body bag. Following the unproductive conversations with Brigham & Women's staff, the family spoke with Sgt. John Boyle and Deputy Superintendent Miller of the Boston Police Department. The police confirmed that they were exploring the possibility that Everleigh's body had been discarded in the soiled linens and entered the laundry system. The police informed the family that they were combing through hundreds of yards of trash and linens looking for Everleigh or any trace of her. The officers, both of whom have decades of service, informed the family that they had never seen anything like this before.

Baby Everleigh's remains were never discovered. She is, presumably, decomposing in a landfill or has been atomized by the industrial laundry machines at MGB's facility. In any event, her remains will never be recovered and she will never be afforded a proper Christian burial.

v. The Police Investigation

On August 11, 2020, investigators from the Boston Police Department, led by Detective Kevin Cook, reported to Brigham and Women's Hospital to investigate the disappearance of Baby Everleigh's remains. Hospital staff informed the police that Baby Everleigh had passed away on August 6 and could not be located on August 10 when funeral home staff attempted to pick the body up from the hospital. Hospital security staff informed the police that while there was a security camera located outside the morgue cooler and inside part of the morgue examination room, there was no camera inside the morgue cooler. Security staff provided the police with a copy of the badge history report which logs all staff entering and exiting the morgue, and the handwritten Morgue Log Book, which records the movement of bodies to and from the morgue. The same staff reviewed the video captured from the area and showed the police selective clips which the staff believed were pertinent to the investigation.

The morgue cooler is a relatively small room. When one enters the morgue cooler, straight ahead on the back wall, which can be seen immediately upon entering, there are four stainless steel racks. The first two racks from left to right are for adults, the third rack is for children, and the fourth rack is for adults. To the right side when one walks inside the morgue cooler there are two additional racks for adults. On the other side of these racks is the entrance and exit door for the morgue examination area, where the pathologists conduct autopsies. The morgue cooler has three gurneys utilized specifically for moving deceased adults within the hospital. The room also has a lift that hangs from the ceilings. This lift utilizes slings to assist in the transport of remains. On the left side of the morgue cooler, as one enters, there is a bin for the soiled slings to be placed for cleaning. This bin is strictly for slings; cleaning of the slings is outsourced. All refuse is placed in color coded bags. Soiled linens are placed in blue bags. Soiled slings are placed in orange bags. Hazardous waste is placed in red bags.

The security video depicts two nurses from the NICU entering the morgue shortly before 9:00 pm on August 6. The video depicts Nurse Heide Taylor recording the arrival of "Baby Ross" while Nurse Jennifer Conrado holds Baby Everleigh's remains, swaddled in hospital linens. Hospital policy would call for Baby Everleigh to also be in a "shroud," described as a small off-white bag with a black zipper. The two nurses then bring Baby Everleigh into the morgue cooler at 8:56 pm. As the NICU nurses watched the transport personal move a deceased adult with the sling, Nurse Conrado is observed holding Baby Everleigh. It appears as though the transport personnel are blocking the stainless-steel children's rack that would have been used for baby Everleigh. While waiting, Nurse Conrado is seen looking to her right, which is a stainless-steel rack reserved for adult remains. Nurse Conrado steps to her right and out of frame and, moments later, exits the cooler. At this time, nobody is holding Baby Everleigh. It was busy, and morgue staff appeared to be occupied. Claimants understand that the nurses asked the first person they saw – a hospital Transport employee named Jose Lopes ("Lopes") who happened to be inside of the morgue – where they should place "fetal remains." Lopes apparently told them that they could "put that anywhere."[1] The police eventually drew the inference that Baby Everleigh's remains were placed on a tray to the right, which should have been used for adults.

Until Baby Everleigh's remains were reported missing, various staff enter and exit the cooler. None are seen carrying linens that could have contained Baby Everleigh's remains. At one point, on August 7, 2020, Pathologist John Grzyb ("Grzyb") is seen assisting funeral home staff retrieving adult remains. Grzyb can be seen removing the orange soiled sling bag and place it outside the morgue cooler

[1] That statement – "put that anywhere" – was apparently overheard by at least one morgue employee, Jacob Plaisted. Yet neither Plaisted nor anyone else intervened.

door. He also later removed a blue soiled linen bag from the interior of the morgue cooler. The police questioned Grzyb. He told the police that staff are always exceptionally careful to only use the appropriate color-coded receptacle. He was also adamant to detectives that he did not remove, nor observe any soiled linens when he was inside the morgue cooler on Friday, August 7, 2020.

The police then contacted the hospital's linen cleaning service, Angelica Linen Service. Angelica Linen Service informed the police that linens are picked up three to four times per week from the hospital, and that when hospital waste is found in the linens, it is deposited in their on-site compactor. The contents of the compactor were last emptied on August 10, 2020 and transported to a transfer station on Howard Avenue in Roxbury. The refuse from Angelica Linen Service would have arrived at the Roxbury transfer station in the early morning hours of August 10, 2020. The police were informed that, by the time they arrived there, the refuse would have already been at one of three end-points: a landfill in New Hampshire; an incinerator in Haverhill; or a landfill in South Carolina. After reviewing video, however, it appeared a portion of the load from Angelica Linen Services may still have been inside the Roxbury transfer station.

The police located refuse inside the Roxbury facility that appeared to be from the hospital. The refuse contained soiled linens, towels, rags, and hazardous waste such as blood and feces. The manager of the transfer station shut down all operations and turned away all arriving trucks to allow for a thorough search for Baby Everleigh. The refuse was searched by police and transfer station staff for the next eight hours. The search was ultimately fruitless.

Later that day, the police were informed by hospital security that, outside the presence of the police, they had re-interviewed Grzyb. In a dramatic departure from his earlier statement to the police just hours earlier, Grzyb now admitted to seeing what he believed to be linens on the stainless-steel tray inside the morgue and disposing of the linen in the blue bags for the soiled linens. The police were then provided with a new video clip that appears to show Grzyb disposing of the linens. Based upon this delayed disclosure, the police, with the assistance of Angelica Linen, determined that it was possible that Baby Everleigh was still in the Angelica Linen compactor and had not been transported to the transfer station. The transfer station sent their first available truck and, again, shut down their facility to facilitate a search. Unfortunately, again, Baby Everleigh's remains were not located.

Notably, one of the nurses responsible for taking Everleigh to the morgue, Nurse Jennifer Conrado, was contacted by phone on the morning of August 11, 2020. She was briefly interviewed, by phone, some four hours later when she returned a voicemail from a Brigham investigator. Based on all information available to the Claimants, the second nurse who transported Everleigh, Nurse Heide Taylor, has never been interviewed and has not cooperated with any investigation by the Brigham security department or the Boston Police Department. The final page of the Boston Police investigative report detailing their work on the case provides a damning summation of the Brigham's efforts to locate Baby Everleigh and discover what happened:

> *It should be noted that detectives were not informed of the situation until at least twenty-four hours after "Baby Ross" was observed to be missing.*
>
> ...

> *It should also be noted that [Boston Police] detectives were not provided the complete video from the time "Baby Ross" arrived at the morgue cooler to the time it was observed that "Baby Ross" was known to be missing. Furthermore, [Boston Police] detectives did not interview either NICU nurse. [Boston Police] Detectives were informed during the initial briefing with BWH security that one of the nurses did provide an initial statement, the other nurse was not answering calls from the hospital.*

Ultimately, the police concluded that it was probable that Baby Everleigh had been improperly stored in the morgue cooler by the NICU nurses. Grzyb then mistook Baby Everleigh's remains for soiled linen and placed her remains inside the blue soiled linen bag. The remains were then transported to Angelica Linen and eventually brought to the Roxbury transfer station. From the transfer station, her remains were then transported to either landfills in South Carolina or New Hampshire, or incinerated in Haverhill.

vi. MGB's Cover-up & Failure to Adequately Investigate and Cooperate

As described above, in several important respects—despite promises to the Claimants and their family to do everything in their power to locate Baby Everleigh's remains—MGB refused to cooperate with the police investigation or provided untruthful answers to police questions. In addition to Grzyb's mendacious approach to his interview with police, the NICU nurses declined to speak to the police and the hospital provided video to police in a piecemeal fashion.

To date, incredibly, MGB still refuses to produce all of the video from August 6 – 10 to law enforcement. MGB's lack of cooperation and deliberate evasiveness extinguished *any chance* of locating and recovering Baby Everleigh's body. This theme of obstruction is placed in stark relief when contrasted with the cooperation of the staff from Angelica Linen and the Roxbury transfer station. It is a sad comment that the employees at Angelica Linen and the transfer station, who owed no duty of care to the Claimants and their family, responded with greater compassion, urgency, and transparency than MGB's staff, including the NICU nurses, Jose Lopes, and Pathologist Grzyb.

vii. MGB Knew Morgue Conditions Were a Problem

MGB was well aware of problematic conditions in the Brigham and Women's Hospital morgue prior to the disappearance of Baby Everleigh. Pathologist Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there." He told investigators that the Pathology department had "filed safety reports and complaints about how other departments leave their work space." Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

Gryzb was hardly alone. A transport employee named Sheila Cox was interviewed by Brigham security, and remembered that it was "a mess" on the day of Everleigh's disappearance. Another pathologist, Jacob Plaisted, had also put Brigham on notice about the conditions of the morgue. Unlike Gryzb, Plaisted had apparently lodged formal complaints with hospital administrators prior to the

disappearance of Baby Everleigh. The discovery process of formal litigation will undoubtedly turn up additional complaints made to the Brigham, demonstrating that the hospital was well aware of the problem prior to the disappearance of Baby Everleigh.

Recently, Brigham has posted job listings for a "morgue attendant" and a "senior morgue specialist." Both postings contain job descriptions that include just the sort of oversight that would have prevented Everleigh's disappearance. What's more, the existence of these jobs leads to a series of damning conclusions for the Brigham: either they were (1) aware of the issues at the morgue and chose not to hire for these roles for reasons related to the "entrepreneurial and business aspects of providing medical services";[2] (2) aware of the issues at the morgue and ignored the problem despite repeated complaints; or (3) unaware of the issues despite repeated complaints by staff, demonstrating a horrific lack of management and oversight.

II. MASS. GEN. LAWS. c. 93A LIABILITY

M.G.L. c. 93A prohibits "unfair or deceptive acts or practices in the conduct of any trade or commerce." *See* M.G.L. c. 93A §2(a). Chapter 93A requires a showing of (1) a deceptive act or practice on the part of the defendant; (2) an injury or loss suffered by the plaintiff; and (3) a causal connection between the defendant's deceptive act or practice and the plaintiff's injury. *Casavant v. Norweigan Cruise Line, Ltd.*, 76 Mass.App.Ct. 73, 76 (2009), *aff'd* 460 Mass. 500 (2011); *Hershenow v. Enterprise Rent-A-Car Co. of Boston, Inc.*, 445 Mass. 790, 797 (2006). It is "well established that breach of contract can lead to a violation of Chapter 93A." *Clinical Technology, Inc. v. Covidien Sales*, 192 F.Supp.3d 223, 242 (2016) (quoting *Ahern v. Scholz,* 85 F.3d 774, 798 (1st Cir. 1996)).

Dan and Alana chose to have Baby Everleigh at Brigham and Women's Hospital because of its reputation. The Brigham advertises and markets to patients by claiming, "For over 180 years, Brigham and Women's Hospital has been the most trusted name in women's health." Moreover, MGB promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable." Dan and Alana trusted MGB to live up its promise and self-imposed duty when they selected MGB. What they did not prepare for, however – indeed what no parent could ever anticipate – is that a healthcare institution would literally lose their child. MGB – and its staff and employees – are clearly liable for the disappearance of Baby Everleigh. That fact is essentially beyond dispute. MGB's failure to properly care and account for the body of Baby Everleigh – knowing that Dan, Alana, and their family relied upon MGB's promises to handle Everleigh's remains with dignity and respect – constitutes an unfair and deceptive practice in violation of Chapter 93A. Moreover, MGB employees' repeated references to Baby Everleigh's body as "that" further demonstrates their callous indifference to her existence. As described above, MGB's *own employees* had apparently raised numerous complaints about the morgue's cleanliness and management before Baby Ross' remains were lost. However, MGB apparently ignored the importance of those complaints, much like it did to Baby Ross' body. Had Dan and Alana known any of this, they would have undoubtedly selected a different hospital for their care. Instead, based on false promises and misrepresentations, they mistakenly placed their trust in MGB to conduct itself professionally and humanely.

[2] *Soderstrom v. Beaumont Nursing Home*, 25 Mass. L. Rep. 12, (2008) (denying medical provider's summary judgment motion where plaintiff's 93A claim alleged inadequate staffing as a business decision), citing *Darviris v. Petros*, 442 Mass. 274, 279 (2004).

Perhaps even more deceptive and unfair were MGB's promises to Dan, Alana and their family that it would do everything in its power to locate Baby Everleigh, only to conduct what can only be classified as a half-hearted, ineffective, and dilatory investigation. With no system in place to track infant bodies being delivered to the morgue, it took MGB 3 ½ days to even discover the horrific chain of events described above. When Boston Police – prompted by the family of Baby Everleigh – arrived at the hospital to begin their own investigation, they received what can only be described as incomplete cooperation. Hospital employees lied to the detectives; others, including a nurse who delivered Everleigh to the morgue, were not made available for interviews. Hospital investigators provided limited, and often incorrect information to law enforcement, who spent hours frantically digging through medical waste in search of the child (and without the assistance of MGB personnel). The conduct of the hospital and its employees derailed any chance that Boston Police would have to locate and recover Baby Everleigh.

Under M.G.L. c. 93A §2(c), in addition to recovering actual damages, Claimants are entitled to recover attorney fees and up to treble damages as a result of MGB's egregious deception and breach of contract as fully described above. Furthermore, under M.G.L. c. 93A §9(3), MGB is liable for treble damages in the event it fails to provide a reasonable offer to the Claimants in response to this demand, with knowledge or reason to know that MGB's actions constituted a breach.

The Claimants now demand that MGB provide financial compensation in the amount of $13.5 Million and fully cooperate with an independent investigation by an investigator of the Claimants' choosing to uncover the systemic failures on your part which allowed this tragedy to unfold and ensure that no family ever has to experience such pain and anguish at your hands ever again. The hours, weeks, and months of therapy that the Claimants' and their families will undergo in the years to come will be intense, and costly. Dan and Alana suffered through two previous miscarriages before they had Baby Everleigh; the trauma of losing their daughter to a premature death has been exponentially increased because of the conduct of Brigham and its employees.

A thought that helped Alana get through that first weekend after Baby Everleigh's passing, while they searched for a funeral home and cemetery, was that she could visit Baby Everleigh's gravesite on a beautiful day, sit on the grass, and finish reading her *Judy Moody Saves the World*, so she would know how Judy Moody finally saved the world. Alana can't do that now. Alana will never be able to go visit Baby Everleigh and just talk. Dan and Alana are horrified and forever traumatized and scarred by the notion that Baby Everleigh is somewhere rotting, and they have no idea where. Each day that passes without her is a day where more of her is gone and she is further from her mother and father's arms. We trust you understand that such a hole in their life can never be fully closed and we hope you embrace this opportunity to help heal the wounds you have inflicted.

In the event that MGB fails to respond within thirty (30) days of the mailing of this letter with a reasonable offer of settlement, the Claimants will file a complaint in a Massachusetts Court which will include, but not be limited to, claims for breach of contract, negligence, negligent / intentional infliction of emotional distress, tortious interference with human remains, breach of the implied covenant of good faith and fair dealing, and violation of M.G.L. c. 93A, exposing MGB to treble damages.

Please direct your response to this 93A demand to my attention at the above Boston office location. I look forward to receiving your response.

Very truly yours,

Patrick Driscoll

cc: Greg Henning, Esq.
Christopher R. Lavoie, Esq. (Dunn and Dunn) (via email only clavoie@dunnanddunn.com)

From: Greg Henning
Sent: Wednesday, December 22, 2021 11:16 AM
To: Chris Lavoie <CLavoie@dunnanddunn.com>
Cc: Driscoll, Patrick <PDriscoll@boyleshaughnessy.com>; Sisk, Edward P. <ESisk@boyleshaughnessy.com>
Subject: RE: In Re: Baby Everleigh - 93A Demand Letter

Chris,

My apologies – the 93A demand from the previous email should have the Boston Police Report as an attachment.

Both are now included in this email.

Please let us know re: service and accepting service.

Thanks,

Greg

From: Greg Henning
Sent: Wednesday, December 22, 2021 11:09 AM
To: Chris Lavoie <CLavoie@dunnanddunn.com>
Cc: Driscoll, Patrick <PDriscoll@boyleshaughnessy.com>; Sisk, Edward P. <ESisk@boyleshaughnessy.com>
Subject: In Re: Baby Everleigh - 93A Demand Letter

Good morning, Chris.

CC'd on this email are Patrick Driscoll and Ted Sisk from Boyle Shaughnessy, who are co-counsel with me in representing the plaintiffs in this case.

Attached is a demand letter. As you know, 93A requires that a corporate officer be served with the 93A demand via certified mail. Can you confirm to us that you are able to accept service on behalf of – and in lieu of – us serving Dr. Klibanksi?

Let me know if you have any questions. I'm free to chat today if you'd like.

Thanks,

Greg

Gregory D. Henning

Principal
Henning Strategies
Please note the change of address to "Suite 300"
141 Tremont Street, Suite 300
Boston, MA 02111
(P) (617) 299-6534 x701
(M) (617) 504-2707
www.henningstrategies.com

Important Notice

EXHIBIT C

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
C.A.

MADELEINE BOTHE & EDWARD FELSTEAD

Plaintiffs,

v.

MASS GENERAL BRIGHAM, BRIGHAM & WOMEN'S HOSPITAL, JON C. ASTER, JESSICA MARKS, LYNN BLECH, MICHELLE SICILIANO, JOHN DOE #1, JANE DOE #1

Defendants.

COMPLAINT AND JURY DEMAND

Plaintiffs, Madeline Bothe ("Madeleine") and Edward Felstead ("Ed") (collectively, "Plaintiffs") state as follows for their complaint in this action:

PARTIES

1. Plaintiffs Madeleine Bothe and Ed Felstead have, at all times relevant to this matter, resided in Norwich, Vermont.

2. Defendant Mass General Brigham ("MGB") is, upon information and belief, a company with a principal place of business at 800 Boylston Street, Boston, Massachusetts in the county of Suffolk.

3. Defendant Brigham & Women's Hospital ("BWH") is a company with a principal place of business at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.

4. Defendant John C. Aster is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Interim Chair of Pathology.

5. Defendant Jessica Marks is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Social Worker.

6. Defendant Lynn Blech is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Director of Patient/Family Relations at Brigham and Women's Hospital.

7. Defendant Michelle Siciliano is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Technical Operations Manager of Autopsy and Decedent Affairs.

8. Defendant John Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, his position was/is a member of the pathology department.

9. Defendant Jane Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is member of the pathology department.

JURISDICTION AND VENUE

10. This Court has subject matter jurisdiction over this action pursuant to G.L. c. 223A §§ 2, 3.

11. This Court has personal jurisdiction over each and every Defendant pursuant to G.L. c. 223 § 1. Defendants Mass General Brigham and Brigham and Women's Hospital transact business, trade, and commerce in Massachusetts, including in connection with the property involved in this action located at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Mass General Brigham and Brigham & Women's Hospital have their principal places of business in Massachusetts.

12. Each of the individually named Defendants have their principal place of employment at the Brigham & Women's Hospital located at 75 Francis Street in Boston, Massachusetts.

13. All of the Defendants have engaged in a course of conduct which has caused harm and injury to Plaintiffs in Massachusetts.

14. Venue exists in Suffolk County pursuant to G.L. c. 223 § 1 because each of the Defendants have as their principal places of business, or principal places of employment, a location in Suffolk County.

FACTUAL BACKGROUND

15. Madeleine Bothe and Ed Felstead ("Plaintiffs") conceived their second child, Baby Oliver, in April of 2020.

16. In September of 2020, tests revealed that Baby Oliver would have severe, life-limiting disability. Plaintiffs decided to undergo a consultation at Boston Children's Hospital.

17. The consultation with Boston Children's Hospital indicated that Oliver's condition was even worse than originally diagnosed.

18. In October of 2020, roughly twenty-two weeks into their pregnancy, Plaintiffs traveled to Boston to undergo a procedure to end the pregnancy and then meet with a geneticist to determine what caused Baby Oliver's issue and whether they could conceive a healthy child in the future.

19. Plaintiffs chose Brigham and Women's Hospital ("BWH") to have the procedure because BWH held itself out and represented itself to consumers through marketing, advertising, and its online presence as "the most trusted name in women's health…a world leader in helping women live longer, healthier lives."

20. At BWH, Madeleine underwent the pregnancy-ending procedure. The next day, doctors induced Madeleine and she delivered Oliver.

21. The doctors withdrew a genetic testing sample and prepared Baby Oliver to be taken to the morgue. After the family said their goodbyes, staff members took Baby Oliver for a visual autopsy.

22. When authorizing the procedure to end the pregnancy, Madeleine and Ed were required to sign paperwork, including forms indicating how they wished to handle Baby Oliver's remains. Madeleine and Ed checked off the box on a form indicating that they would assume the responsibility for the burial or cremation of Baby Oliver's remains.

23. They reiterated to the medical staff and social workers they interacted with, including social worker Jessica Marks, that their final wish for Oliver's remains was to perform a cremation after the completion of the visual autopsy.

24. Understandably, Madeleine and Ed were overcome with grief and sorrow at the time they were required to fill out paperwork regarding how to handle their deceased child's remains.

25. One of the forms Madeleine and Ed were required to sign involved the disposition of Oliver's remains.

26. Madeleine and Ed's selection on the disposition of remains form stated:

> I will assume the responsibility for burial or cremation of the remains following any necessary examination by a pathologist, and I will make the necessary arrangements. If I have not done so within fourteen (14) days, I agree that Brigham and Women's Hospital will handle disposal in accordance with its hospital policy.

27. Madeleine and Ed signed the document prior to the procedure.

28. Madeleine and Ed were not provided with physical copies of the paperwork to take with them, nor did they receive any instruction regarding the fourteen-day period referenced in the disposition of remains form.

29. About a week after undergoing the procedure, Madeleine received a call from MGB social worker Jessica Marks. Marks again asked Madeleine what she intended to do with Baby Oliver's remains.

30. Madeleine confirmed her intent to have Baby Oliver cremated so Marks provided her with the names of funeral homes to contact.

31. Madeleine specifically asked Marks how much time they had to decide and make arrangements.

32. Marks assured Madeleine and Ed that they had "six months, so plenty of time" to decide, and that Baby Oliver's remains would be safely kept in the hospital morgue until arrangements were made.

33. Relying on this assertion, Madeleine and Ed took a few weeks to grieve their loss, prior to making arrangements for Oliver's remains.

34. On December 7, 2020, a few weeks after her phone call with Marks, Madeleine called a funeral home to arrange to pick up Baby Oliver's remains and prepare him for cremation.

35. The funeral home called the hospital and then immediately called Madeleine and Ed with horrifying news: Baby Oliver was not in the morgue.

36. According to the funeral home, the Brigham informed the funeral home that Baby Oliver's remains were no longer in the morgue because the Brigham had made "other arrangements."

37. The Brigham never disclosed to Madeleine and Ed what "hospital policy" it was referring to in the disposition of remains form, how long the genetic testing and autopsy would take, or the firm date that Baby Oliver's remains needed to be retrieved after the completion of the genetic testing and autopsy.

38. Instead, Jessica Marks, a Brigham representative, assured Madeleine and Ed after Baby Oliver's death that his remains would be kept safely in the morgue for up to six months.

39. Madeleine and Ed were horrified to discover that the Brigham, without so much as a phone call, letter, or text, callously disposed of Baby Oliver against Madeleine and Ed's wishes.

40. When Ed called the hospital and Jessica Marks to ask what happened, Marks told him she would find out and get back to them.

41. Marks never called back.

42. Neither Marks, nor the Brigham ever informed Madeleine and Ed about who made the decision to discard Baby Oliver or why it had occurred.

43. Nobody ever informed Madeleine and Ed who discarded Baby Oliver.

44. Madeleine called BWH numerous times but received no answers.

45. Finally, Madeleine reached Lynn Blech, the Director of Patient/Family Relations at Brigham and Women's Hospital and spoke with her.

46. Blech informed Madeleine that the hospital discarded Baby Oliver's remains because more than fourteen days had passed, and the hospital followed its policy.

47. Madeleine could not believe that the hospital did not call her or Ed to verify their intent on the disposition of Baby Oliver's remains, especially where Marks stated to them that Baby Oliver would remain in the morgue for several months.

48. Blech told Madeleine that BWH used to call parents of deceased children to verify the intended disposition of remains but found that it "caused more harm than good," re-traumatizing people about their deceased child.

49. Rather than make a phone call to ensure that the Plaintiffs' wishes were honored, and Baby Oliver's remains respected, Brigham chose to discard Baby Oliver without telling anyone.

50. Madeleine asked Blech if they could get copies of the disposition of remains paperwork. She was informed that they could access the forms through the BWH online portal.

51. When Plaintiffs attempted to locate the forms on the online portal, the forms were nowhere to be found.

52. They did not receive a copy of the disposition of remains form until months later.

53. Madeleine ended her phone call with Blech with a plea: do not let this happen again to another family.

54. Months later, BWH sent Madeleine a bill for $33.11.

55. Approximately two months after her call with Blech, Madeleine found out through a social media support group that her plea fell on deaf ears: BWH discarded another deceased child's remains against the wishes of the parents.

56. Madeleine and Ed never received any answers regarding how or why the Brigham discarded Baby Oliver's remains.

57. Plaintiffs have been forever deprived of any opportunity to grieve and bury their son.

58. After enduring the grief caused by BWH's inexcusable mishandling of their child's remains coupled with BWH's callous and outrageous response to the situation, Madeleine and Ed have decided that they do not wish to get pregnant ever again.

COUNT I
(MGB & BWH - BREACH OF CONTRACT)

59. The Plaintiffs incorporate all of the foregoing paragraphs of the complaint as if set forth in full below.

60. Plaintiffs and MGB/BWH signed an agreement whereby the hospital, its staff, and its employees would properly handle Baby Oliver's remains.

61. This included safeguarding Baby Oliver's body and returning it to the family for burial after his passing, in accordance with the documented request of the Plaintiffs.

62. BWH assured the Plaintiffs that Baby Oliver's remains would be safely kept in the morgue for up to six months.

63. BWH and its agent, Jessice Marks, did not tell the Plaintiffs that the BWH morgue has a history of erroneously discarding infant remains.

64. BWH knew, as of at least August 2020, that their faulty morgue operation had caused the hospital to lose at least one other deceased child's remains – Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022).

65. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, within 90 days of discarding Baby Everleigh Ross, Brigham's morgue again discarded a deceased child's remains – Baby Oliver.

66. The Plaintiffs fulfilled all of their obligations under the contract between the parties.

67. The contract was supported by valid consideration.

68. By their actions, and inaction, the Defendants have breached the contract.

69. The Defendants' breach is material and goes to the heart of the contract between the parties.

70. The Defendants' breach has caused injury, damage and harm to the Plaintiffs.

COUNT II
(MGB & BWH - BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING)

71. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

72. The contract between the Plaintiffs and Defendants MGB and BWH includes an implied covenant of good faith and fair dealing.

73. The covenant requires that neither party act to deprive the other party of the fruits and benefits of the contract.

74. MGB and BWH promise each of their patients "superior care that is patient- and family-centered, accessible, and equitable."

75. In accepting the care and treatment of Baby Oliver, MGB and BWH accepted responsibility to live up to that promise which was supported by the consideration they received in the form of the fees they charged to the Plaintiffs and their insurance carriers.

76. By its actions, and inaction, the Defendants failed to abide by the terms of this agreement and have breached the covenant of good faith and fair dealing by discarding Baby Oliver's remains without notice to his parents.

77. The Defendants' breach has caused injury, damage, and harm to the plaintiff.

COUNT III
(DEFENDANTS ASTER, MARKS, BLECH, SICILIANO, JOHN DOE #1, & JANE DOE #1 – NEGLIGENCE)

78. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

79. The Defendants owed the Plaintiffs a duty of care in the handling and safeguarding of Baby Oliver's remains.

80. The Defendants failed to use reasonable care by mishandling Baby Oliver and throwing his body away.

81. The Defendants' failure to use reasonable care caused injury, damage, and harm to the Plaintiffs.

COUNT IV
(BWH - VIOLATION OF M.G.L. c. 93A, § 9)

82. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

83. BWH assured the Plaintiffs that Baby Oliver's remains would be safely kept in the morgue for up to six months.

84. BWH's failure to properly care and account for the body of Baby Oliver – knowing that Madeleine, Ed, and their family relied upon BWH's promises to keep Baby Oliver's body safely in the morgue – constitutes an unfair and deceptive practice in violation of Chapter 93A.

85. Moreover, MGB employees' shocking disregard and dismissal of phone calls by grieving parents is a wanton behavior tantamount to a deceptive practice.

86. Neither BWH or its agent, Jessice Marks, informed the Plaintiffs that the BWH morgue has a history of erroneously discarding infant remains against family wishes.

87. BWH knew, as of at least August 2020, that their faulty morgue operation had caused the hospital to lose/discard at least one other deceased child's remains – Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022).

88. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, within 90 days Brigham's morgue again discarded a deceased child's remains – Baby Oliver.

89. BWH has deliberately attempted to conceal the ineptitude of its morgue operations for financial gain.

90. At the time Baby Everleigh Ross was "thrown away" by Brigham staff, the Brigham was on notice that its morgue operation and leadership were ill equipped to safely retain child remains in its morgue.

91. Notwithstanding this knowledge, BWH continued to allow its social workers to falsely represent to grieving parents that their child's remains would be safely kept in the morgue until arrangements were made.

92. BWH then attempted to conceal the discarding of Baby Oliver, by not providing answers about how this happened and instead blaming Madeleine and Ed for not following the fine print, as opposed to placing the blame on the work of BWH's social worker, morgue, and pathology department who caused this tragic loss.

93. Plaintiffs were not provided any answers regarding how Oliver was "disposed of."

94. No one explained to Plaintiffs who discarded Baby Oliver and why Marks told them that he would be kept safe for up to six months.

95. BWH's refusal to provide answers and attempts to blame Plaintiffs can only be explained by BWH's hopes that no one will ever ask what happened to Baby Oliver and why.

96. BWH's repeated attempts to cover-up the loss of Baby Everleigh and Baby Oliver is evidence of their unfair and deceptive conduct, as they continued to represent to the public that it was the premiere hospital for women's health despite the ineptitude of its morgue operation.

97. On or about September 11, 2023, the Plaintiffs, through counsel, delivered a demand letter to the Defendants containing the specific allegations of

conduct by the Defendants that constituted violations of Massachusetts General Laws c. 93A, § 9. (*See* **Exhibit A**, Chapter 93A Demand Letter).

98. Plaintiffs' demand letter satisfied the required written notice of claim provision of Massachusetts General Laws c. 93A, § 9.

99. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, BWH was engaged in trade and commerce.

100. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, BWH held themselves out as the "most trusted name in women's health," and promised to provide "superior care that is patient- and family-centered, accessible, and equitable."

101. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, BWH's actions were unfair and deceptive.

102. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, BWH acted willfully and intentionally.

103. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, BWH actions occurred primarily and substantially in Massachusetts.

104. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, as a result of BWH's unfair and deceptive actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT V
(DEFENDANTS ASTER, MARKS, BLECH, SICILIANO, JOHN DOE #1, & JANE DOE #1 – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS)

105. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

106. The Defendants knew, or should have known, that their conduct would cause emotional distress.

107. The conduct of the Defendants was extreme and outrageous.

108. The conduct of the Defendants caused emotional distress to the Plaintiffs.

109. The emotional distress suffered by the Plaintiffs as a result of the conduct of the Defendants was severe.

110. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT VI
(DEFENDANTS ASTER, MARKS, BLECH, SICILIANO, JOHN DOE #1, & JANE DOE #1 - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS)

111. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

112. As a direct and proximate result of the Defendants' negligence, Plaintiffs have suffered severe emotional distress and anguish, and have suffered physical manifestations of harms as a result of the severe and profound emotional distress inflicted upon them by Defendants' negligence.

113. A reasonable person in the same position as Plaintiffs would have suffered severe and profound emotional distress due to Defendants' negligence.

COUNT VII
(DEFENDANTS ASTER, MARKS, BLECH, SICILIANO, JOHN DOE #1, JANE DOE #1 - TORTIOUS INTERFERENCE WITH HUMAN REMAINS)

114. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

115. The Defendants were responsible for caring for the human remains of Baby Oliver.

116. The Plaintiffs were entitled to a peaceful disposition of Baby Oliver.

117. The conduct of the Defendants was intentional, reckless, or negligent.

118. The conduct of the Defendants prevented the proper interment or cremation of Baby Oliver.

119. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

JURY DEMAND

The Plaintiffs demand a jury trial on all claims and issues triable by jury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that the Court enter the following relief:

I. Enter judgment for the Plaintiffs on all counts of this Complaint.

II. Order the Defendants to pay damages, legal fees, costs, and expenses as appropriate, including double or treble damages under G.L. c. 93A.

III. Award the Plaintiffs such other and further relief as is just and appropriate in the circumstances.

Respectfully Submitted
For the Plaintiffs,

/s/ Gregory D. Henning

Gregory D. Henning, Esq. (BBO #663189)
Greg.Henning@henningstrategies.com
Henning Strategies
141 Tremont Street – 3rd floor
Boston, MA 02111
Tel: (617) 293-6534

DATE: 10/18/23

Respectfully Submitted
For the Plaintiffs,

/s/ Patrick Driscoll

Patrick Driscoll, Esq. (BBO #669560)
pdriscoll@boyleshaughnessy.com
Christopher W. Upperman, Esq. (BBO#711713)
cupperman@boyleshaughnessy.com
Boyle | Shaughnessy Law, P.C.
695 Atlantic Avenue, 11th Floor
Boston, MA 02111
Tel: (617) 451-2000

EXHIBIT D

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
C.A.

JODIE SKRZAT & CHRISTIAN NOEL

Plaintiffs,

v.

MASS GENERAL BRIGHAM, BRIGHAM & WOMEN'S HOSPITAL, JON C. ASTER, JOHN DOE #1, & JANE DOE #1

Defendants

COMPLAINT AND JURY DEMAND

Plaintiffs, Jodie Skrzat ("Jodie") and Christian Noel ("Christian") (collectively, "Plaintiffs") state as follows for their complaint in this action:

PARTIES

1. Plaintiffs Jodie Skrzat and Christian Noel have, at all times relevant to this matter, resided in Westborough, MA

2. Defendant Mass General Brigham ("MGB") is, upon information and belief, a company with a principal place of business at 800 Boylston Street, Boston, Massachusetts in the county of Suffolk.

3. Defendant Brigham & Women's Hospital ("BWH") is, upon information and belief, a company with a principal place of business at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.[1]

4. Defendant John C. Aster is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Interim Chair of Pathology.

5. Defendant John Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, his position was/is a member of the pathology department.

6. Defendant Jane Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is Social Worker.

JURISDICTION AND VENUE

7. This Court has subject matter jurisdiction over this action pursuant to G.L. c. 223A §§ 2, 3.

8. This Court has personal jurisdiction over each and every Defendant pursuant to G.L. c. 223 § 1. Defendants Mass General Brigham and Brigham and Women's Hospital transact business, trade, and commerce in Massachusetts, including in connection with the property involved in this action located at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.

[1] Defendants MGB and BWH are hereinafter collectively referred to as, "The Brigham."

Mass General Brigham and Brigham & Women's Hospital have their principal places of business in Massachusetts.

9. Each of the individually named Defendants has their principal place of employment at the Brigham & Women's Hospital located at 75 Francis Street in Boston, Massachusetts.

10. All the Defendants have engaged in a course of conduct which has caused harm and injury to Plaintiffs in Massachusetts.

11. Venue exists in Suffolk County pursuant to G.L. c. 223 § 1 because each of the Defendants have as their principal places of business, or principal places of employment, a location in Suffolk County. Plaintiffs reside in Westborough, Massachusetts. Westborough is located in Worcester County.

FACTUAL BACKGROUND

12. Jodie and Christian met while serving in the military. As a doctor and medic, respectively, the two fell in love over their shared passion for serving and caring for others.

13. After over a decade of dedicated service to our country, Christian was discharged from the Army in 2015; Jodie continued to serve in the Navy until 2020.

14. In 2015, Jodie and Christian got married and sought to start a family. Soon, however, their dreams of having children were shaken by difficulties in getting pregnant.

15. In 2017, nearly two years after starting their journey to parenthood, with assistance from a reproductive endocrinologist, Jodie and Christian welcomed their first child, Joseph.

16. Around 2018, the couple began looking into intrauterine insemination in the hopes that it would assist them in having another child. After a few early pregnancy losses, Jodie and Christian were delighted to welcome their second child, Jacob, in March 2019.

17. In late 2019, Jodie and Christian again consulted their reproductive endocrinology team to begin the process of trying for a third child. After months of extensive testing, Jodie and Christian were ready to move forward with another cycle of intrauterine insemination, but the COVID pandemic caused the shutdown of fertility clinics.

18. In the summer of 2020, the couple moved to Massachusetts, where fertility clinics were beginning to reopen. In August 2020, after nearly two years of delays, struggles, and anticipation, Jodie and Christian conceived their third child, Baby Katherine.

19. For the first five months, the pregnancy was easy, and everything seemed normal. Then, in mid-December 2020, an anatomy scan identified concerns with Baby Katherine's heart.

20. The family was referred to UMASS Medical for additional testing. On December 23, 2020, doctors confirmed that Baby Katherine was suffering from hypoplastic left heart syndrome and referred the family to Children's Hospital for further testing.

21. The family met with world experts on the disease at Children's Hospital who tested Baby Katherine and confirmed the diagnosis.

22. Doctors informed Jodie and Christian that Katherine would not survive outside the uterus.

23. Devastated with the diagnosis, Jodie and Christian were forced to make the difficult decision to surgically terminate the pregnancy.

24. After a lengthy discussion, the couple agreed that they wanted Katherine's remains returned to them so that she could have a proper burial and the family would have a place to celebrate her life.

25. For the dilation and evacuation procedure ("D&E"), Jodie and Christian were referred to Brigham and Women's Hospital.

26. Plaintiffs chose the Brigham to have the procedure because the Brigham held itself out and represented itself to consumers through marketing, advertising, and its online presence as "the most trusted name in women's health…a world leader in helping women live longer, healthier lives."

27. The Brigham touted itself as a leader in women's health care with a premier Department of Obstetrics and Gynecology.

28. On December 28, 2020, Jodie underwent the D&E procedure at the Brigham. Due to hospital restrictions, Jodie was alone, unable to bring her husband, Christian, into her room for support.

29. Jodie had multiple conversations with Brigham medical professionals regarding how to handle Katherine's remains after the procedure.

30. Prior to undergoing the most stressful and invasive procedure of her life, Jodie was forced to fill out multiple consent forms.

31. Jodie was overcome with grief and sorrow at the time she was required to fill out paperwork regarding how to handle her deceased child's remains and she was never given time to review the forms.

32. The resident obstetrician told Jodie she had three options for the handling of Katherine's remains: (1) remains returned to Jodie and Christian; (2) remains donated to science; or (3) remains destroyed by the hospital.

33. Jodie indicated on the forms and in conversation with the resident obstetrician assisting her that she wanted Baby Katherine to be returned to her.

34. Jodie was never informed that the hospital would dispose of Katherine's remains if they were not collected within two weeks.

35. On the contrary, Jodie was told by the resident obstetrician that before the remains can be returned, the pathology department first must complete an autopsy and genetic testing.

36. Jodie was told that these procedures would take "some time," and that the hospital would contact Jodie and Christian when Katherine's remains were ready to be picked up.

37. Jodie left the hospital nervously awaiting the phone call from the Brigham telling her she could finally bury her daughter.

38. Complicating Jodie's grief and attempts to heal, Jodie suffered complications from a retained placenta after the dilation and evacuation procedure and required surgery to alleviate her issues over the next month.

39. During that month, Jodie and Christian never received a phone call or received any information from the Brigham regarding Katherine's remains.

40. Once she recovered from her surgeries, as it had been over a month since Katherine had passed with no contact from the hospital, Jodie asked Chrisitan to call the social worker at the Brigham.

41. When Christian called the social worker to ask when they could pick up Katherine's remains, he was shocked and appalled at the answer – "I don't know if we can still track that down; it's usually two weeks and then no recourse."

42. Nobody had ever contacted Jodie and Christian to tell them Katherine's remains were ready to be picked up, as the Brigham and the resident obstetrician had promised they would.

43. Instead, the Brigham unilaterally disposed of Katherine's remains without ever informing Jodie and Christian. The Brigham never contacted Jodie and Christian to inform them that Katherine's remains were ready to be picked up or that her remains would be disposed of.

44. Christian told the social worker what Jodie was told by the Brigham and the resident obstetrician – that they would be contacted when the remains were ready to be picked up.

45. In response, the social worker said, "That's a story I've heard multiple times before. This isn't an isolated incident."

46. Jodie went looking for help. She joined support groups on social media to see if anyone else had dealt with something like this.

47. As a radiologist at UMASS Medical, Jodie also sought information in a social media group for female physicians.

48. Jodie found out that one of her high school acquaintances, Dr. Beth Harrison, worked in the pathology department at Brigham and Women's Hospital.

49. Jodie told Dr. Harrison her story and Dr. Harrison said she would investigate it and get back to her.

50. Jodie reached out the following day and Dr. Harrison told her she was working on it and relaying concerns to the appropriate people.

51. From then on, Jodie never heard from Dr. Harrison again. Jodie tried to contact her multiple times and Dr. Harrison never responded.

52. Christian continued calling the social worker who had told him that this was "not an isolated incident."

53. The two communicated a few times but once concerns started to rise, the social worker stopped returning calls from Christian.

54. As the communications from the Brigham ceased, Jodie sought help in one of her social media support groups – a group for people that terminated their pregnancies due to lethal diagnoses for their unborn children.

55. In that support group, Jodie met Madeleine Bothe – a mother whose deceased child's remains were similarly discarded by the Brigham a month prior.

56. Jodie learned from Madeleine that Madeleine and her husband, Ed, had endured a similar ordeal with the Brigham – the Brigham told them that they would be contacted when the remains of their child, Oliver, were ready for pickup, only for the Brigham to unilaterally discard the remains of Baby Oliver without any prior communication with Madeleine and Ed.

57. Finding out that their child's remains were discarded by the Brigham was devastating to Jodie and Christian. It compounded their grief and made them feel like they lost their daughter all over again.

58. Without Baby Katherine's remains, Jodie and Ed were denied the opportunity to bury their child and denied any sense of closure.

59. Jodie and Christian's grief was exacerbated when they discovered that this tragedy was entirely preventable; the Brigham had done this to other families, was aware of the issues with its morgue operation, and was clearly not instituting any changes to ensure it never happened again.

60. The Brigham was well aware of the problems in its pathology department and morgue prior to the discarding of Baby Katherine in December 2020.

61. In August 2020, the Brigham inexcusably discarded the remains of Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County Superior Court, filed June 23, 2022). In November 2020, the Brigham discarded Baby Oliver Bothe's remains without contacting the parents. *See generally, Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023).

62. During the Brigham's investigation into the loss of Baby Everleigh, Pathologist John Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems.

63. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there."

64. Gryzb told investigators that the pathology department had "filed safety reports and complaints about how other departments leave their workspace."

65. Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

66. Gryzb was hardly alone; Sheila Cox, a transport employee at BWH, was interviewed by Brigham security in the Baby Everleigh matter and remembered that it was "a mess" on the day of Everleigh's disappearance.

67. Another pathologist, Jacob Plaisted, had also put Brigham on notice about the conditions of the morgue prior to the loss of Baby Everleigh.

68. Unlike Gryzb, Plaisted had lodged formal complaints with hospital administrators prior to the disappearance of Baby Everleigh and informed Brigham investigators of this fact after the loss of Baby Everleigh.

69. Notably, while the Brigham has touted its "transparency" in sharing information with patients' families, in the Baby Everleigh matter, the Brigham has refused to disclose pertinent information regarding their investigation, including, but not limited to, complaints about the morgue levied by hospital employees and complete video surveillance of the morgue on the relevant dates.

70. The Brigham also did not produce any information regarding the loss of remains other than Baby Everleigh, even though the cases of Baby Oliver and Baby Katherine are irrefutably responsive to the Baby Everleigh Plaintiffs' discovery requests.

71. Within four months of discarding Baby Everleigh in August of 2020, BWH threw out the remains of Baby Oliver.

72. One month later, BWH threw away Baby Katherine.

73. Baby Katherine's body has never been recovered.

COUNT I

(MGB & BWH - BREACH OF CONTRACT)

74. The Plaintiffs incorporate all the foregoing paragraphs of the complaint as if set forth in full below.

75. Plaintiffs and MGB/BWH signed an agreement whereby the hospital, its staff, and its employees would care for Baby Katherine.

76. This care included safeguarding Baby Katerine's body and returning it to the family for burial after her passing, in accordance with the documented request of the Plaintiffs.

77. BWH assured the Plaintiffs that Baby Katherine's remains would be safely kept in the morgue until BWH contacted the family to retrieve her body.

78. BWH and its agents, including the resident obstetrician, did not tell the Plaintiffs that the BWH morgue has a history of erroneously discarding infant remains.

79. BWH knew, as of at least August 2020, that their faulty morgue operation had caused the hospital to lose the remains of at least two other deceased children: (1) Baby Everleigh and (2) Baby Oliver. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County Superior Court, filed June 23, 2022); *Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023).

80. Rather than institute changes to the morgue in August of 2020 to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, the Brigham threw out the remains of Baby Oliver and Baby Katherine within approximately 30 days of each other.

81. The Plaintiffs fulfilled all their obligations under the contract between the parties.

82. The contract was supported by valid consideration.

83. By their actions, and inaction, the Defendants have breached the contract.

84. The Defendants' breach is material and goes to the heart of the contract between the parties.

85. The Defendants' breach has caused injury, damage and harm to the Plaintiffs.

COUNT II

(MGB & BWH - BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING)

86. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

87. The contract between the Plaintiffs and Defendants MGB and BWH includes an implied covenant of good faith and fair dealing.

88. The covenant requires that neither party act to deprive the other party of the fruits and benefits of the contract.

89. MGB and BWH promise each of their patients "superior care that is patient- and family-centered, accessible, and equitable."

90. In accepting the care and treatment of Baby Katherine, MGB and BWH accepted responsibility to live up to that promise which was supported by the consideration they received in the form of the fees they charged to the Plaintiffs and their insurance carriers.

91. By its actions, and inaction, the Defendants failed to abide by the terms of this agreement and have breached the covenant of good faith and fair dealing.

92. The Defendants' breach has caused injury, damage, and harm to the plaintiff.

COUNT III

(DEFENDANTS ASTER, JOHN DOE #1, JANE DOE #1 – NEGLIGENCE)

93. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

94. The Defendants owed the Plaintiffs a duty of care in the handling and safeguarding of Baby Katherine.

95. The Defendants failed to use reasonable care by mishandling Baby Katherine and throwing her body away.

96. The Defendants' failure to use reasonable care caused injury, damage, and harm to the Plaintiffs.

COUNT IV

(MGB & BWH - VIOLATION OF M.G.L. c. 93A, § 9)

97. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

98. The Brigham assured the Plaintiffs that Baby Katherine's remains would be safely kept in the morgue until they were contacted by the Brigham to retrieve them.

99. The Brigham's failure to properly care and account for the body of Baby Katherine – knowing that Jodie, Christian, and their family relied upon the Brigham's promises to keep Baby Katherine's body safely in the morgue – constitutes an unfair and deceptive practice in violation of Chapter 93A.

100. Moreover, the Brigham's employees' shocking disregard and dismissal of phone calls by grieving parents looking for information is a wanton behavior tantamount to a deceptive practice.

101. Neither the Brigham nor its agents informed the Plaintiffs that the Brigham morgue has a history of erroneously discarding infant remains.

102. BWH knew, as of at least August 2020, that their faulty morgue operation had caused the hospital to lose the remains of at least two other deceased children: (1) Baby Everleigh and (2) Baby Oliver. *See generally*, *Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County Superior Court, filed June 23, 2022); *Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023).

103. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, within 90 days Brigham's morgue again discarded a deceased child's remains – Baby Oliver.

104. One month later, the Brigham threw away Baby Katherine.

105. The Brigham has deliberately attempted to conceal the ineptitude of its pathology department and morgue operations for financial gain.

106. By August of 2020, at the time Baby Everleigh Ross was thrown away by Brigham staff, the Brigham was already on notice that its pathology department and leadership were ill equipped to safely retain child remains in its morgue.

107. Notwithstanding this knowledge, the Brigham continued to allow its agents to falsely represent to grieving parents that their child's remains would be safely kept in the morgue until hospital staff contacted the family to retrieve the bodies.

108. The Brigham then attempted to conceal the discarding of Baby Katherine by not providing answers about how this happened or returning inquiries from the Plaintiffs.

109. Plaintiffs were not provided any answers regarding how Katherine was "disposed of."

110. No one explained to Plaintiffs who discarded Baby Katherine and why the family was told she would be kept safe until the Brigham contacted the Plaintiffs to retrieve her body.

111. The Brigham's refusal to provide answers and attempts to blame Plaintiffs can only be explained by the Brigham's hopes that no one will ever ask what happened to Baby Katherine and why.

112. The Brigham's repeated attempts to cover-up the loss of Baby Everleigh, Baby Oliver, and Baby Katherine is evidence of their unfair and deceptive conduct, as they continued to represent to the public that it was the premiere hospital for women's health despite the ineptitude of its morgue operation and pathology department.

113. On or about September 15, 2023, the Plaintiffs, through counsel, delivered a demand letter to the Defendants containing the specific allegations of conduct by the Defendants that constituted violations of Massachusetts General Laws c. 93A, § 9. (*See* **Exhibit A**, Chapter 93A Demand Letter).

114. Plaintiffs' demand letter satisfied the required written notice of claim provision of Massachusetts General Laws c. 93A, § 9.

115. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants were engaged in trade and commerce.

116. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants held themselves out as the "most trusted name in women's health," and promised to provide "superior care that is patient- and family-centered, accessible, and equitable."

117. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions were unfair and deceptive.

118. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants acted willfully and intentionally.

119. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, the Defendants' actions occurred primarily and substantially in Massachusetts.

120. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, as a result of the Defendants' unfair and deceptive actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT V

(DEFENDANTS ASTER, JOHN DOE #1, JANE DOE #2 – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS)

121. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

122. The Defendants knew, or should have known, that their conduct would cause emotional distress.

123. The conduct of the Defendants was extreme and outrageous.

124. The conduct of the Defendants caused emotional distress to the Plaintiffs.

125. The emotional distress suffered by the Plaintiffs as a result of the conduct of the Defendants was severe.

126. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT VI

(DEFENDANTS ASTER, JOHN DOE #1, JANE DOE #2 - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS)

127. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

128. As a direct and proximate result of the Defendants' negligence, Plaintiffs have suffered severe emotional distress and anguish, and have suffered physical manifestations and harms as a result of the severe and profound emotional distress inflicted upon them by Defendants' negligence.

129. A reasonable person in the same position as the Plaintiffs would have suffered severe and profound emotional distress due to Defendants' negligence.

COUNT VII

(DEFENDANTS ASTER, JOHN DOE #1, JANE DOE #2 - TORTIOUS INTERFERENCE WITH HUMAN REMAINS)

130. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

131. The Defendants were responsible for caring for the human remains of Baby Katherine.

132. The Plaintiffs were entitled to a peaceful disposition of Baby Katherine.

133. The conduct of the Defendants was intentional, reckless, or negligent.

134. The conduct of the Defendants prevented the proper interment or cremation of Baby Katherine.

135. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

JURY DEMAND

The Plaintiffs demand a jury trial on all claims and issues triable by jury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that the Court enter the following relief:

I. Enter judgment for the Plaintiffs on all counts of this Complaint.

II. Order the Defendants to pay damages, legal fees, costs, and expenses as appropriate, including double or treble damages under G.L. c. 93A.

III. Award the Plaintiffs such other and further relief as is just and appropriate in the circumstances.

Respectfully Submitted
For the Plaintiffs,

/s/ Gregory D. Henning

Gregory D. Henning, Esq. (BBO #663189)
Greg.Henning@henningstrategies.com
Henning Strategies
141 Tremont Street – 3rd floor
Boston, MA 02111
Tel: (617) 293-6534

Respectfully Submitted
For the Plaintiffs,

/s/ Patrick Driscoll

Patrick Driscoll, Esq. (BBO #669560)
pdriscoll@boyleshaughnessy.com
Christopher W. Upperman, Esq. (BBO # 711713)
cupperman@boyleshaughnessy.com
Boyle | Shaughnessy Law, P.C.
695 Atlantic Avenue, 11th Floor
Boston, MA 02111
Tel: (617) 451-2000

Date: 12/15/2023

Exhibit A

BOYLE | SHAUGHNESSY LAW

BOYLE | SHAUGHNESSY LAW PC

695 ATLANTIC AVENUE, 11TH FLOOR
BOSTON, MA 02111
(617) 451.2000 TEL
(617) 451.5775 FAX
www.boyleshaughnessy.com

PATRICK DRISCOLL
pdriscoll@boyleshaughnessy.com

September 15, 2023

VIA CERTIFIED & US MAIL:
7022 2410 0001 7851 2136

Mass General Brigham Incorporated
c/o Anne Klibanski, M.D., President and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

RE: Jodie Skrzat & Christian Noel v. Mass General Brigham & Brigham and Women's Hospital
Our File No.: BSC.3169

M.G.L. c. 93A DEMAND LETTER

Dear Dr. Klibanski:

Please be advised that this office, in conjunction with Henning Strategies, LLC, represents Jodie Skrzat ("Jodie") & Christian Noel ("Christian") (collectively referred to hereinafter as "Claimants") concerning Mass General Brigham / Brigham and Women's Hospital's (collectively, "MGB") outrageous, appalling, and inexcusable mishandling of the deceased remains of Claimants' child, Katherine ("Katherine" or "Baby Katherine"). This correspondence is sent pursuant to § 9 of M.G.L c. 93A. At this time, we request that you preserve all evidence related to MGB's handling of Baby Katherine's remains, including but not limited to any physical evidence, notes, reports, photos, witness statements, surveillance / security videos, phone records, e-mails, and letters.

I. BACKGROUND AND UNDERLYING FACTS

Jodie and Christian met while serving in the military. As a doctor and medic, respectively, the two fell in love over their shared passion for serving and caring for others. After over a decade of dedicated service to our country, Christian was discharged from the Army in 2015; Jodie continued to serve in the Navy until 2020. In 2015, Jodie and Christian got married and sought to start a family. Soon, however, their dreams of having children were shaken by difficulties in getting pregnant. In 2017, nearly two years after starting their journey to parenthood, with assistance from a reproductive endocrinologist, Jodie and Christian welcomed their first child, Joseph. Due to their advanced age, Jodie and Christian's attempts for a second child were met with more difficulties. Around 2018, the couple began looking into intrauterine insemination in the hopes that it would assist them in having another child. After a few early pregnancy losses, Jodie and Christian were delighted to welcome their second child, Jacob, in March 2019.

In late 2019, Jodie and Christian again consulted their reproductive endocrinology team to begin the process of trying for a third child. After months of extensive testing, Jodie and Christian were ready to move forward with another cycle of intrauterine insemination, but the COVID pandemic caused the shutdown of fertility clinics. In the summer of 2020, the couple moved to Massachusetts, where fertility clinics were beginning to reopen. In August 2020, after nearly two years of delays, struggles, and anticipation, Jodie and Christian conceived their third child, Baby Katherine. For the first five months, the pregnancy was easy, and everything seemed normal. Then, in mid-December 2020, an anatomy scan identified concerns with Baby Katherine's heart. The family was referred to UMASS Medical for additional testing. On December 23, 2020, doctors confirmed that Baby Katherine was suffering from hypoplastic left heart syndrome and referred the family to Children's Hospital for further testing. The family met with world experts on the disease who tested Baby Katherine and confirmed the diagnosis. Doctors informed Jodie and Christian that Katherine would not survive outside the uterus.

Devastated with the diagnosis, Jodie and Christian were forced to make the difficult decision to surgically terminate the pregnancy. After a lengthy discussion, the couple agreed that they wanted Katherine's remains returned to them so that she could have a proper burial and the family would have a place to celebrate her life. For the dilation and evacuation procedure ("D&E"), Jodie and Christian were referred to Brigham and Women's Hospital, touted as a leader in women's health care with a premier Department of Obstetrics and Gynecology. On December 28, 2020, Jodie underwent the D&E procedure at Brigham and Women's Hospital, ending Baby Katherine's life. With COVID restrictions in place, Jodie was alone, unable to bring her husband into her room for support.

Jodie had multiple conversations with MGB medical professionals regarding how to handle Katherine's remains after the procedure. Prior to undergoing the most stressful and invasive procedure of her life, Jodie was forced to fill out a multitude of forms. Even though Jodie was terminating her pregnancy because of a lethal diagnosis, she was required to fill out multiple consent forms. Understandably, Jodie was overcome with grief and sorrow at the time she was required to fill out paperwork regarding how to handle her deceased child's remains and she was never given time to review the forms. The resident obstetrician told Jodie she had three options for the handling of Katherine's remains: (1) remains returned; (2) remains donated to science; or (3) remains destroyed by the hospital. Jodie indicated on the forms and in conversation with the resident obstetrician assisting her that she wanted the remains returned to her.

Jodie was never informed that the hospital would dispose of Katherine's remains if they were not collected within two weeks. On the contrary, she was informed by the resident obstetrician that before the remains can be returned, the pathology department first must complete an autopsy and genetic testing. She was told that these procedures would take "some time," and that the hospital would contact them when Katherine's remains were ready to be picked up. Jodie left BWH nervously awaiting the phone call from the hospital telling her she could finally bury her daughter.

Complicating Jodie's grief and attempts to heal, Jodie suffered complications from a retained placenta after the dilation and evacuation procedure and required surgery to alleviate her issues over the next month. During that month, Jodie and Christian never received a phone call or received any information from MGB regarding Katherine's remains. Once she recovered from her surgeries, as it had been over a month since Katherine had passed with no contact from the hospital, Jodie asked Chrisitan to call the social worker at MGB.

When Christian called the social worker to ask when they could pick up Katherine's remains, he was shocked and appalled at the answer – "I don't know if we can still track that down; it's usually two weeks and then no recourse." Nobody had ever contacted Jodie and Christian to tell them Katherine's remains were ready to be picked up, as MGB and the resident obstetrician had promised they would. Instead, MGB unilaterally disposed of Katherine's remains without ever informing Jodie and Christian. Christian told the social worker what he was told by MGB – that they would be contacted when the remains were ready to be picked up. In response, the social worker said, "That's a story I've heard multiple times before. This isn't an isolated incident."

Jodie went looking for help. She joined support groups on social media to see if anyone else had dealt with something like this. As a radiologist at UMASS Medical, she also sought information in a social media group for female physicians. Amazingly, Jodie found out that one of her high school acquaintances, Dr. Beth Harrison, worked in the pathology department at Brigham and Women's Hospital. She told Harrison her story and Harrison said she would investigate it and get back to her. Jodie reached out the following day and Harrison told her she was working on it and relaying concerns to the appropriate people. From then on, Jodie never heard from Harrison again. Jodie tried to contact her multiple times and Harrison never responded.

Meanwhile, Christian kept calling the social worker. The two communicated a few times but once concern started to rise, the social worker stopped returning calls. As the communications from MGB ceased, Jodie sought help in one of her social media support groups – a group for people that terminated their pregnancies due to lethal diagnoses for their unborn children. In that support group, Jodie met Maddie Bothe – a mother whose deceased child's remains were similarly discarded by MGB a month prior when MGB told the parents they would be contacted when the remains were ready for pickup, only to unilaterally discard them without any prior communication with the family.

Finding out that their child's remains were discarded by MGB was devastating to Jodie and Christian. It compounded their grief and made them feel like they lost their daughter all over again. On top of losing any sense of closure by having their child returned to them, Jodie and Christian's grief was exacerbated when they discovered that MGB had done this to other families and was clearly not instituting any changes to ensure it never happened again. When they raised their concerns with the social worker, Jodie and Christian could not believe the ease at which the social worker told them their situation was not an isolated incident – how could a renowned hospital like MGB repeatedly discard children's remains without contacting the parents?

Jodie and Christian know that MGB can never return their daughter to them. They pray that no other family ever again endures what MGB put them through. Knowing this has happened on multiple occasions has further devastated Jodie and Christian because they feel that MGB knows they are mishandling remains but has chosen to cover up the pathology department's misdeeds, instead of taking measures to ensure that MGB stops discarding child remains against parents' wishes.

i. MGB Knew Morgue Conditions Were a Problem

MGB was well aware of problematic conditions in the Brigham and Women's Hospital morgue prior to the discarding of Baby Katherine in December 2020. In August 2020, MGB inexcusably discarded the remains of Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General*

Brigham, et al., No. 01419 (Suffolk County Superior Court, filed June 23, 2022). In November 2020, MGB discarded Baby Oliver Bothe's remains without contacting the parents. *See* Madeleine Bothe and Edward Felstead 93A Demand Letter, dated September 11, 2023. During MGB's investigation into the loss of Baby Everleigh, Pathologist John Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there." He told investigators that the Pathology department had "filed safety reports and complaints about how other departments leave their workspace." Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

Gryzb was hardly alone. Sheila Cox, a transport employee, was interviewed by Brigham security in the Baby Everleigh Ross matter and remembered that it was "a mess" on the day of Everleigh's disappearance. Another pathologist, Jacob Plaisted, had also put Brigham on notice about the conditions of the morgue. Unlike Gryzb, Plaisted had apparently lodged formal complaints with hospital administrators prior to the disappearance of Baby Everleigh. Notably, while MGB has touted its transparency in sharing information with patients' families, in the Baby Everleigh Ross matter, MGB has refused to disclose pertinent information regarding their investigation, including, but not limited to, complaints about the morgue levied by hospital employees and video surveillance of the morgue. Further, MGB did not produce any information regarding the loss of remains other than Baby Everleigh even though the cases of Baby Oliver and Baby Katherine are irrefutably responsive to the Baby Everleigh Plaintiffs' discovery requests. The discovery process of formal litigation will undoubtedly turn up additional complaints made to the Brigham, demonstrating that the hospital was well aware of the problem prior to the disappearance of Baby Everleigh, the discarding of Baby Oliver, and the discarding of Baby Katherine.

In a statement released by MGB regarding the investigation into the discarding of the remains of Baby Everleigh Ross, Chief Medical Officer Dr. Sunil Eappen stated:

> As with any instance in which there is a concern raised related to our standard of care or practice, we readily and transparently shared the details with the patient's family. We always evaluate both system and human factors that contribute to errors or potential issues raised by patients, family members or staff and take action.

Not only was this clearly a false statement regarding the information shared with the Ross family, but it also highlights the callous indifference of MGB where MGB attempts to shield significant information regarding their investigation into their inexcusable discarding of the remains of deceased children yet represents to the public that they readily share information with affected families. Further, where MGB asserted that they "always evaluate" concerns raised by patients and "take action", MGB did nothing to address issues in the morgue, because within four months of discarding Baby Everleigh, MGB discarded Baby Oliver; a month later, MGB discarded Baby Katherine.

Social workers and other staff members at MGB have told affected families that MGB unilaterally discarding their child's remains without first contacting the family is not an isolated incident. It keeps happening.

II. MASS. GEN. LAWS. c. 93A LIABILITY

M.G.L. c. 93A prohibits "unfair or deceptive acts or practices in the conduct of any trade or commerce." *See* M.G.L. c. 93A § 2(a). Chapter 93A requires a showing of (1) a deceptive act or practice on the part of the defendant; (2) an injury or loss suffered by the plaintiff; and (3) a causal connection between the defendant's deceptive act or practice and the plaintiff's injury. *Casavant v. Norweigan Cruise Line, Ltd.*, 76 Mass.App.Ct. 73, 76 (2009), *aff'd* 460 Mass. 500 (2011); *Hershenow v. Enterprise Rent-A-Car Co. of Boston, Inc.*, 445 Mass. 790, 797 (2006). It is "well established that breach of contract can lead to a violation of Chapter 93A." *Clinical Technology, Inc. v. Covidien Sales*, 192 F.Supp.3d 223, 242 (2016) (quoting *Ahern v. Scholz*, 85 F.3d 774, 798 (1st Cir. 1996)).

Jodie and Christian chose to have their pregnancy-ending procedure at Brigham and Women's Hospital because of its reputation. The Brigham advertises and markets to patients by claiming, "For over 180 years, Brigham and Women's Hospital has been the most trusted name in women's health." Moreover, MGB promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable." Jodie and Christian trusted MGB to live up to its promise and self-imposed duty when they selected MGB. What they did not prepare for, however – indeed what no parent could ever anticipate – is that a healthcare institution would literally lose their child. MGB – and its staff and employees – are clearly liable for the disappearance of Baby Katherine. MGB's failure to properly care and account for the body of Baby Katherine – knowing that Jodie, Christian, and their family relied upon MGB's promises to transfer Baby Katherine's body to the funeral home chosen by Jodie and Christian – constitutes an unfair and deceptive practice in violation of Chapter 93A. Moreover, MGB employees' shocking disregard and dismissal of grieving parents is a wanton behavior tantamount to a deceptive practice. Had Jodie and Christian known any of this, they would have undoubtedly selected a different hospital for their care. Instead, based on false promises and misrepresentations, they mistakenly placed their trust in MGB to conduct itself professionally and humanely.

Importantly, in their phone call with the MGB social worker, the Claimants were informed that this was not an isolated incident. MGB knew, as of at least 2020, that their faulty morgue operation had caused the hospital to lose or unilaterally discard at least two other deceased child's remains – Baby Everleigh Ross and Baby Oliver Bothe – and possibly others. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022); Madeleine Bothe and Edward Felstead's 93A Demand Letter, dated September 11, 2023. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, within five months of discarding Baby Everleigh and within two months of discarding Baby Oliver they again discarded a deceased child's remains – Baby Katherine. MGB's conduct is inexcusable where MGB was responsible for the reckless and wanton disposal of Baby Everleigh Ross in August 2020, Baby Oliver Bothe in November 2020, and Baby Katherine Noel in January 2021.

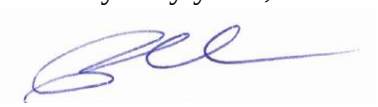
Under M.G.L. c. 93A § 2(c), in addition to recovering actual damages, Claimants are entitled to recover attorney fees and up to treble damages as a result of MGB's egregious deception and breach of contract as fully described above. Furthermore, under M.G.L. c. 93A § 9(3), MGB is liable for treble damages in the event it fails to provide a reasonable offer to the Claimants in response to this demand, with knowledge or reason to know that MGB's actions constituted a breach.

The Claimants now demand that MGB provide financial compensation in the amount of $5 Million and fully cooperate with an independent investigation by an investigator of the Claimants' choosing to uncover the systemic failures on your part which allowed this tragedy to unfold and ensure that no family ever has to experience such pain and anguish at your hands ever again. The hours, weeks, and months of therapy that the Claimants and their families will undergo in the years to come will be intense and costly. For Jodie and Christian, the trauma of losing their daughter to a premature death has been exponentially increased because of the conduct of MGB and its employees. We trust you understand that such a hole in their life can never be fully closed, and we hope you embrace this opportunity to help heal the wounds you have inflicted.

In the event that MGB fails to respond within thirty (30) days of the mailing of this letter with a reasonable offer of settlement, the Claimants will file a complaint in a Massachusetts Court which will include, but not be limited to, claims for breach of contract, negligence, negligent / intentional infliction of emotional distress, tortious interference with human remains, breach of the implied covenant of good faith and fair dealing, and violation of M.G.L. c. 93A, exposing MGB to treble damages.

Please direct your response to this 93A demand to my attention at the above Boston office location. I look forward to receiving your response.

Very truly yours,



Patrick Driscoll

cc: Greg Henning, Esq.

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Mass General Brigham Incorporated
c/o Anne Klibanski, M.D., President
and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

9590 9402 7290 2028 9628 25

2. Article Number *(Transfer from service label)*

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X ☐ Agent ☐ Addressee

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Mass General Brigham Incorporated
c/o Anne Klibanski, M.D., President
and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

9590 9402 7290 2028 9628 25

2. Article Number *(Transfer from service label)*

7022 2410 0001 7851 2136

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☒ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery 9/8/23

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If YES, enter delivery address below: ☐ No

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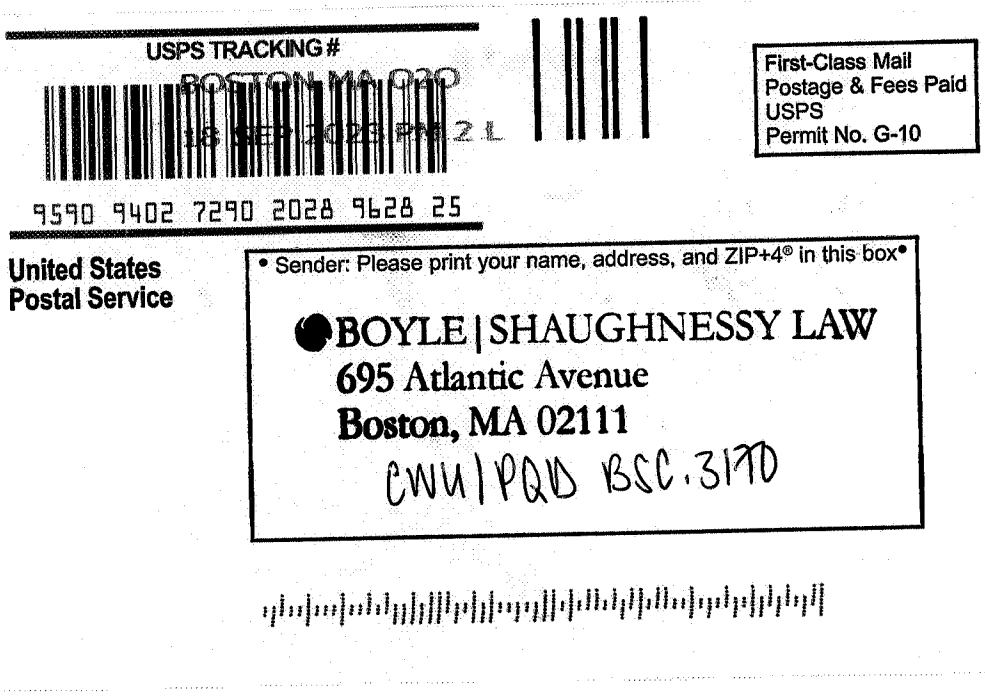

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Boston, MA 02111
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EXHIBIT E

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
C.A.

LAUREN EMERY AND MICHAEL WARD

Plaintiffs,

v.

MASS GENERAL BRIGHAM, BRIGHAM & WOMEN'S HOSPITAL, JON C. ASTER, REBECCA REIMERS, MICHELLE SICILIANO, JOHN DOE #1, JANE DOE #1

Defendants.

COMPLAINT AND JURY DEMAND

Plaintiffs, Lauren Emery ("Lauren") and Michael Ward ("Michael") (collectively, "Plaintiffs"), state as follows for their complaint in this action:

PARTIES

1. Plaintiffs Lauren Emery and Michael Ward have, at all times relevant to this matter, resided in North Attleboro, Massachusetts.

2. Defendant Mass General Brigham ("MGB") is, upon information and belief, a company with a principal place of business at 800 Boylston Street, Boston, Massachusetts in the county of Suffolk.

3. Defendant Brigham & Women's Hospital ("BWH") is, upon information and belief, a company with a principal place of business at 75 Francis Street, Boston, Massachusetts in the county of Suffolk.[1]

4. Defendant John C. Aster is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. His position was/is Interim Chair of Pathology.

5. Defendant Rebecca Reimers is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. At all relevant times, her position was Maternal-Fetal Medicine and Medical Genetics Fellow at BWH.[2]

6. Defendant Michelle Siciliano is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Her position was/is Technical Operations Manager of Autopsy and Decedent Affairs.

7. Defendant John Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, his position was/is a member of the pathology department.

8. Defendant Jane Doe #1 is an individual who at all times relevant to this matter was an employee of Brigham & Women's Hospital with a principal place of

[1] Defendants MGB and BWH are hereinafter collectively referred to as, "The Brigham."
[2] Dr. Reimers is now Maternal-Fetal Medicine and Medical Geneticist at San Diego Perinatal Center and Rady Children's Hospital in San Diego, CA.

employment at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Upon information and belief, her position was/is member of the pathology department.

JURISDICTION AND VENUE

9. This Court has subject matter jurisdiction over this action pursuant to G.L. c. 223A §§ 2, 3.

10. This Court has personal jurisdiction over each and every Defendant pursuant to G.L. c. 223 § 1. Defendants Mass General Brigham and Brigham and Women's Hospital transact business, trade, and commerce in Massachusetts, including in connection with the property involved in this action located at 75 Francis Street, Boston, Massachusetts in the county of Suffolk. Mass General Brigham and Brigham & Women's Hospital have their principal places of business in Massachusetts.

11. Each of the individually named Defendants has, or at times relevant to this matter had, their principal place of employment at the Brigham & Women's Hospital located at 75 Francis Street in Boston, Massachusetts.

12. All the Defendants have, or at times relevant to this matter had, engaged in a course of conduct which has caused harm and injury to Plaintiffs in Massachusetts.

13. Venue exists in Suffolk County pursuant to G.L. c. 223 § 1 because each of the Defendants have, or at times relevant to this matter had, as their principal places of business, or principal places of employment, a location in Suffolk County.

FACTUAL BACKGROUND

14. Lauren Emery and Michael Ward ("Plaintiffs") conceived their second child, Baby Kaylee, in late 2020.

15. Prior to Kaylee's conception, Plaintiffs had two boys and endured two previous miscarriages.

16. Plaintiffs decided to undergo ultrasounds and anatomy scans in February 2021 with their obstetrician in Plainville, Massachusetts, and a pregnancy specialist in Providence, Rhode Island.

17. The testing revealed that Baby Kaylee had a spot on her brain.

18. To follow up, Lauren and Michael went to the Boston Children's Hospital, where Baby Kaylee was diagnosed with severe brain abnormalities. At this point, Lauren was twenty-three weeks and four days into pregnancy.

19. Due to the severity of the condition, the doctors recommended that Lauren medically terminate the pregnancy.

20. On March 1, 2021, Lauren and Michael made the difficult decision to terminate the pregnancy in accordance with their doctors' recommendations.

21. Plaintiffs chose The Brigham to have the procedure because The Brigham held itself out and represented itself to consumers through marketing, advertising, and its online presence as "the most trusted name in women's health…a world leader in helping women live longer, healthier lives."

22. Once they arrived at the hospital, Plaintiffs were required to fill out multiple forms regarding their decision to terminate the pregnancy, including forms regarding how they would like the hospital to handle Baby Kaylee's remains.

23. Lauren and Michal indicated multiple times, on the forms and in conversations with the Brigham social worker assisting them, that they wished to have Baby Kaylee's remains returned to them and then cremated.

24. While Lauren and Michael completed the paperwork, hospital staff updated Lauren and Michael's contact information to ensure that they could contact them when Baby Kaylee's remains were ready to be picked up.

25. On March 2, 2021, Lauren was induced at The Brigham and in the early morning of March 3, 2021, Baby Kaylee was born stillborn at twenty-four weeks, weighing one pound and one-and-a-half ounces, and measuring twelve inches long.

26. Hospital staff at The Brigham requested to perform an autopsy on Baby Kaylee and to perform genetic testing to research the "rare disease" that the hospital told Lauren and Michael that Baby Kaylee suffered from.

27. Lauren and Michael agreed to an autopsy to determine whether there was a connection between the two prior miscarriages and the complications affecting Baby Kaylee, and to assess whether there was a genetic condition causing pregnancy complications.

28. Lauren and Michael once again made sure to officially designate that they wanted to have Baby Kaylee's remains returned to them and cremated by way of a funeral home after the hospital performed the autopsy.

29. Plaintiffs were familiar with this procedure, having previously gone through two miscarriages.

30. A social worker from The Brigham read off a list of names of funeral homes in the area and asked Lauren to indicate which funeral home the hospital should contact to arrange for the transfer of Kaylee's remains.

31. Lauren selected a funeral home in Brockton, Massachusetts.

32. The social worker informed Lauren and Michael that she would contact the funeral home and take care of everything once Baby Kaylee's remains were ready to be picked up.

33. The social worker assured the Plaintiffs that the hospital would call them after the autopsy and that the results of the autopsy would be shared with them.

34. No one from the hospital ever called and Lauren and Michael never received documentation of the autopsy results.

35. Approximately one week after leaving The Brigham, Lauren called the social worker who had promised to call her, but Lauren did not receive a reply.

36. Lauren called the funeral home but did not receive any information.

37. Lauren called The Brigham and was simply told that they would call her back with information.

38. Lauren never received a call back from anyone at The Brigham.

39. In mid-April of 2021, after calling The Brigham more than ten times without getting any answers regarding where Baby Kaylee's remains were, Lauren and Michael received a call from a doctor at The Brigham who identified herself as "Dr. Reimers."

40. Upon information and belief, the person calling Lauren and Michael was Dr. Rebecca Reimers, who practiced Maternal-Fetal Medicine and was a Medical Genetics Fellow at BWH.

41. Dr. Reimers informed Lauren and Michael that the hospital did not have Baby Kaylee's remains because it had been more than fourteen days since Baby Kaylee passed, and after remains have been in the morgue for more than fourteen days, it is the hospital's practice to discard them.

42. Dr. Reimers stated that the BWH pathology department never received a call from anyone to arrange to transport Baby Kaylee's remains to a funeral home.

43. Lauren and Michael asked Dr. Reimers whether that meant the social worker failed to do her job, as they were told that everything would be taken care of by the hospital and that they should simply wait until the hospital contacted them.

44. Dr. Reimers responded that she did not have all the necessary information but that it appeared that "a communication did not get to the right people."

45. Dr. Reimers acknowledged and agreed that Lauren and Michael indicated in conversations with The Brigham staff and on the disposition of remains form that they wanted Baby Kaylee's remains returned to them.

46. Dr. Reimers stated that the BWH pathology department was expecting someone to contact their department within fourteen days to arrange for a funeral, but that did not happen.

47. Dr. Reimers explained that after fourteen days the hospital will "take care of the remains" and it appeared that Baby Kaylee "went down that route."

48. Lauren and Michael asked if this meant that the hospital discarded Baby Kaylee's remains in the trash.

49. Dr. Reimers responded that she didn't believe Kaylee was "thrown away" but she acknowledged that Kaylee was not respected and cremated the way Lauren and Michael wished.

50. Dr. Reimers further assured Lauren and Michael that she would find out what the hospital was doing to ensure that this mistake never happened again.

51. Dr. Reimers assured Lauren and Michael that Lauren and Michael did not input the wrong selection on the disposition of remains form, and that Lauren and Michael had consistently expressed their desire to have Kaylee cremated and buried, and the hospital did not honor that request.

52. Dr. Reimers stated that someone from BWH attempted to call Lauren and Michael, but the hospital did not have their correct contact information and were unable to reach them.

53. This was shocking to Lauren and Michael, as they specifically remembered updating their contact information at the hospital on March 1, 2021.

54. According to Dr. Reimers, after the BWH pathology department did not receive a call within the alleged fourteen-day period, rather than contact Lauren and Michael to determine what to do with Baby Kaylee's remains, they simply discarded her.

55. Dr. Reimers admitted that mistakes were made by The Brigham staff and told Lauren and Michael that she filed a "major complaint" within the hospital and would be meeting with the department heads to find out what happened.

56. Dr. Reimers assured Lauren and Michael that she would call them with an update after her meeting with the department heads.

57. Dr. Reimers never called back.

58. Lauren and Michael never received Kaylee's remains, nor have they ever been told by The Brigham what happened to Kaylee's remains.

59. Instead, their memory of Baby Kaylee is enshrined on Michael's forearm:

60. In July of 2023, Plaintiffs suffered another failed pregnancy; after enduring the tragedy of The Brigham unilaterally discarding Baby Kaylee's remains, Lauren and Michael vowed to never return to The Brigham.

61. Plaintiffs chose to have their July 2023 pregnancy-ending procedure at Boston Medical Center ("BMC").

62. Before authorizing the procedure, due to the horrifying ordeal caused by the actions of The Brigham, Lauren and Michael thoroughly questioned the BMC staff regarding the disposition of their deceased child's remains to ensure that their child's remains would be returned to them.

63. BMC staff were confused by Lauren and Michael's pleas, as the staff explained that returning fetal remains to the parents is a routine task.

64. When Lauren and Michael explained what happened to them at The Brigham, BMC staff were shocked and appalled.

65. BMC thereafter handled the return of their child's remains easily and efficiently – proving to Lauren and Michael that The Brigham's policies regarding the disposition of fetal remains are inadequate for a renowned hospital like The Brigham.

66. On September 27, 2023, Lauren and Michael, through Counsel, served The Brigham with a Demand Letter pursuant to M.G.L. c. 93A.

67. On January 17, 2024, The Brigham provided a response which did not explain why The Brigham discarded Baby Kaylee without contacting Lauren and Michael and caused more questions for Lauren and Michael regarding the supposed fourteen-day period which The Brigham insists allowed them to discard Baby Kaylee without contacting Lauren and Michael.

68. In The Brigham's response to Lauren and Michael's Chapter 93A Demand Letter, The Brigham explained that after Baby Kaylee's passing on March 3, 2021, testing of Baby Kaylee's remains was not completed until April 1, 2021.

69. The Brigham's response explained that Baby Kaylee's remains were discarded on April 7, 2021, thirty-seven (37) days after Lauren and Michael signed the disposition of remains form, thirty-five (35) days after Baby Kaylee passed, and six (6) days after the last report of testing.

70. The Brigham provided no explanation for the timeline and insisted that The Brigham followed its hospital policy in disposing Baby Kaylee, without any explanation as to how the prolonged testing of Baby Kaylee's remains affected the hospital policy regarding disposal of fetal remains.

71. The Brigham provided no response to Lauren and Michael's assertions regarding communications with The Brigham social workers or their conversations with Dr. Reimers.

72. The Brigham provided no response to Lauren and Michael's assertions that they were told that The Brigham would call them after the autopsy of Baby Kaylee was completed.

73. The Brigham did not explain how Baby Kaylee was discarded, who discarded her, or who made the decision to discard her.

74. The Brigham did not explain why nobody called Lauren and Michael prior to discarding Baby Kaylee.

75. Instead, The Brigham blamed Lauren and Michael for not properly communicating arrangements, while completely ignoring the fact that Lauren and Michael

informed The Brigham of their desire to have Baby Kaylee's remains returned to them and made several follow-up calls which The Brigham ignored.

COUNT I
(MGB & BWH - BREACH OF CONTRACT)

76. The Plaintiffs incorporate all of the foregoing paragraphs of the complaint as if set forth in full below.

77. Plaintiffs and The Brigham signed an agreement whereby the hospital, its staff, and its employees would properly handle Baby Kaylee's remains.

78. This included safeguarding Baby Kaylee's body and returning it to the family for cremation after her passing, in accordance with the documented request of the Plaintiffs.

79. The Brigham assured the Plaintiffs that Baby Kaylee's remains would be safely kept while genetic testing was performed, and that the hospital would coordinate with Plaintiffs and the funeral home of their choice when Kaylee was ready to be picked up.

80. The Brigham and its agents never called the Plaintiffs to coordinate the transfer of Baby Kaylee's remains, as The Brigham assured the Plaintiffs it would.

81. The Brigham and its agents did not tell the Plaintiffs that The Brigham morgue has a history of erroneously discarding infant remains.

82. The Brigham was well aware of problematic conditions in the Brigham and Women's Hospital morgue prior to the discarding of Baby Kaylee.

83. In August 2020, The Brigham threw away the remains of Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022).

84. In November 2020, The Brigham threw away Baby Oliver Bothe's remains without contacting the parents. *See generally, Madeleine Bothe, et al. v. Mass General Brigham, et al.,* No. 02366 (Suffolk County Superior Court, filed October 18, 2023).

85. In December 2020, The Brigham threw away Baby Katherine Noel's remains without contacting the parents. *See generally, Jodie Skrzat, et al. v. Mass General Brigham, et al.,* No. 02863 (Suffolk County Superior Court, filed December 15, 2023).

86. During The Brigham's investigation into the loss of Baby Everleigh, Pathologist John Grzyb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems.

87. Grzyb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there."

88. He told investigators that the Pathology department had "filed safety reports and complaints about how other departments leave their workspace."

89. Grzyb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

90. A Brigham transport employee named Sheila Cox was interviewed by Brigham security during the search for Baby Everleigh and remembered that it was "a mess" on the day of Everleigh's disappearance.

91. Another pathologist, Jacob Plaisted, had also put The Brigham on notice about the conditions of the morgue by lodging a formal complaint with BWH administrators prior to the disappearance of Baby Everleigh.

92. Social workers and other staff members at The Brigham have told affected families that The Brigham unilaterally discarding their child's remains without first contacting the family is not an isolated incident, and it has happened before.

93. The Plaintiffs fulfilled all their obligations under the contract between the parties.

94. The contract was supported by valid consideration.

95. By their actions, and inaction, the Defendants have breached the contract.

96. The Defendants' breach is material and goes to the heart of the contract between the parties.

97. The Defendants' breach has caused injury, damage, and harm to the Plaintiffs.

COUNT II
(MGB & BWH - BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING)

98. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

99. The contract between the Plaintiffs and Defendants MGB and BWH (collectively, "The Brigham") includes an implied covenant of good faith and fair dealing.

100. The covenant requires that neither party act to deprive the other party of the fruits and benefits of the contract.

101. The Brigham promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable."

102. In accepting the care and treatment of Baby Kaylee, the Brigham accepted responsibility to live up to that promise which was supported by the consideration they received in the form of the fees they charged to the Plaintiffs and their insurance carriers.

103. By their actions, and inaction, the Defendants failed to abide by the terms of this agreement and have breached the covenant of good faith and fair dealing by discarding Baby Kaylee's remains without notice to her parents, in violation of the express wishes of Lauren and Michael, as stated on the disposition of remains form and their express wishes conveyed to The Brigham staff.

104. The Defendants violated the covenant of good faith and fair dealing by depriving Lauren and Michael of their right to receive the fruits of the contract – the safe return of Baby Kaylee's remains.

105. The Defendants' breach has caused injury, damage, and harm to the plaintiff.

COUNT III
(DEFENDANTS ASTER, REIMERS, SICILIANO, JOHN DOE #1, & JANE DOE #1 – NEGLIGENCE)

106. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

107. The Defendants owed the Plaintiffs a duty of care in the handling and safeguarding of Baby Kaylee's remains.

108. The Defendants failed to use reasonable care by mishandling Baby Kaylee and throwing her body away.

109. The Defendants' failure to use reasonable care caused injury, damage, and harm to the Plaintiffs.

COUNT IV
(MGB & BWH - VIOLATION OF M.G.L. c. 93A, § 9)

110. The Plaintiffs incorporate all the foregoing paragraphs of this complaint as if set forth in full below.

111. The Brigham assured the Plaintiffs that Baby Kaylee's remains would be safely kept while genetic testing was performed, and that the hospital would coordinate with Plaintiffs and the funeral home of their choice when Kaylee was ready to be picked up.

112. The Brigham's failure to properly care and account for the body of Baby Kaylee – knowing that Lauren, Michael, and their family relied upon the Brigham's promises to keep Baby Kaylee's body safely and to contact the family for pickup – constitutes an unfair and deceptive practice in violation of Chapter 93A.

113. Lauren and Michael chose to have Baby Kaylee's procedure performed at Brigham and Women's Hospital because of its reputation.

114. The Brigham advertises and markets to patients by claiming, "For over 180 years, Brigham and Women's Hospital has been the most trusted name in women's health."

115. Moreover, The Brigham promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable."

116. Lauren and Michael trusted The Brigham to live up to its promise and self-imposed duty when they selected The Brigham.

117. The Brigham knew that, prior to March of 2021, the faulty morgue operation at BWH had caused the hospital to lose or discard at least three other deceased child's remains – Baby Everleigh Ross, Baby Oliver Bothe, and Baby Katherine Noel. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County

Superior Court, filed June 23, 2022); *Madeleine Bothe, et al. v. Mass General Brigham, et al.*, No. 02366 (Suffolk County Superior Court, filed October 18, 2023).; *Jodie Skrzat, et al. v. Mass General Brigham, et al.*, No. 02863 (Suffolk County Superior Court, filed December 15, 2023).

118. Despite being on notice that The Brigham's inept morgue operation caused the improper disposal of the remains of multiple children, The Brigham chose to ignore the issues with its morgue and refused to institute changes to its morgue operation.

119. Rather than institute changes to the morgue to ensure that the hospital never again discarded another deceased child's remains against the wishes of the parents, The Brigham continued the practices which led to the disposal of Baby Everleigh, Baby Oliver, and Baby Katherine, which led to The Brigham discarding another child – Baby Kaylee.

120. Notwithstanding this knowledge, The Brigham continued to allow its social workers to falsely represent to grieving parents that their child's remains would be safely kept in the morgue until arrangements were made, and that the families would be contacted to pick up the remains of their children.

121. The Brigham's conduct was unconscionable.

122. The Brigham has deliberately attempted to conceal the ineptitude of its morgue operations for financial gain.

123. Plaintiffs were not provided any answers regarding how Kaylee was "disposed of."

124. The Brigham's refusal to provide answers can only be explained as The Brigham hoping that no one will ever ask what happened to Baby Kaylee and why.

125. The Brigham's repeated attempts to cover-up the loss of Baby Everleigh, Baby Oliver, Baby Katherine, and Baby Kaylee is evidence of their unfair and deceptive

conduct, as they continued to represent to the public that The Brigham was the premiere hospital for women's health despite the ineptitude of its morgue operation.

126. On or about September 27, 2023, the Plaintiffs, through counsel, delivered a demand letter to The Brigham containing the specific allegations of conduct by the Defendants that constituted violations of Massachusetts General Laws c. 93A, § 9. (*See* **Exhibit A**, Chapter 93A Demand Letter).

127. The Brigham's morgue operation does not comply with existing rules, statutes, regulations, or laws meant for the protection of the public's health, safety, or welfare.

128. Plaintiffs' demand letter satisfied the required written notice of claim provision of Massachusetts General Laws c. 93A, § 9.

129. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, The Brigham was engaged in trade and commerce.

130. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, The Brigham held itself out as the "most trusted name in women's health," and promised to provide "superior care that is patient- and family-centered, accessible, and equitable."

131. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, The Brigham's actions were unfair and deceptive.

132. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, The Brigham acted willfully and intentionally.

133. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, The Brigham's actions occurred primarily and substantially in Massachusetts.

134. As outlined above and in Plaintiffs' Chapter 93A Demand Letter, as a result of The Brigham's unfair and deceptive actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT V
(DEFENDANTS ASTER, REIMERS SICILIANO, JOHN DOE #1, & JANE DOE #1 –
INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS)

135. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

136. The Defendants knew, or should have known, that their conduct would cause emotional distress.

137. The Defendants' conduct was extreme and outrageous.

138. The Defendants' conduct caused emotional distress to the Plaintiffs.

139. The emotional distress suffered by the Plaintiffs as a result of the Defendants' conduct was severe.

140. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

COUNT VI
(DEFENDANTS ASTER, REIMERS, SICILIANO, JOHN DOE #1, & JANE DOE #1 - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS)

141. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

142. As a direct and proximate result of the Defendants' negligence, Plaintiffs have suffered severe emotional distress and anguish, and have suffered physical manifestations of harms as a result of the severe and profound emotional distress inflicted upon them by Defendants' negligence.

143. A reasonable person in the same position as Plaintiffs would have suffered severe and profound emotional distress due to Defendants' negligence.

COUNT VII
(DEFENDANTS ASTER, REIMERS, SICILIANO, JOHN DOE #1, JANE DOE #1 - TORTIOUS INTERFERENCE WITH HUMAN REMAINS)

144. The Plaintiffs incorporate all of the foregoing paragraphs of this complaint as if set forth in full below.

145. The Defendants were responsible for caring for the human remains of Baby Kaylee.

146. The Plaintiffs were entitled to a peaceful disposition of Baby Kaylee.

147. The Defendants' conduct was intentional, reckless, or negligent.

148. The Defendants' conduct prevented the proper interment or cremation of Baby Kaylee.

149. As a result of the Defendants' actions, the Plaintiffs have been injured, harmed, and damaged to an extent that will be proven at trial.

JURY DEMAND

The Plaintiffs demand a jury trial on all claims and issues triable by jury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that the Court enter the following relief:

I. Enter judgment for the Plaintiffs on all counts of this Complaint.

II. Order the Defendants to pay damages, legal fees, costs, and expenses as appropriate, including double or treble damages under G.L. c. 93A.

III. Award the Plaintiffs such other and further relief as is just and appropriate in the circumstances.

Respectfully Submitted
For the Plaintiffs,

/s/ Gregory D. Henning

Gregory D. Henning, Esq. (BBO #663189)
Greg.Henning@henningstrategies.com
Henning Strategies
141 Tremont Street – 3rd floor
Boston, MA 02111
Tel: (617) 293-6534

DATE: 3/21/24

Respectfully Submitted
For the Plaintiffs,

/s/ Patrick Driscoll

Patrick Driscoll, Esq. (BBO #669560)
pdriscoll@boyleshaughnessy.com
Christopher W. Upperman, Esq. (BBO#711713)
cupperman@boyleshaughnessy.com
Boyle | Shaughnessy Law, P.C.
695 Atlantic Avenue, 11th Floor
Boston, MA 02111
Tel: (617) 451-2000

Exhibit A

BOYLE | SHAUGHNESSY LAW

BOYLE | SHAUGHNESSY LAW PC

695 ATLANTIC AVENUE, 11TH FLOOR
BOSTON, MA 02111
(617) 451.2000 TEL
(617) 451.5775 FAX
www.boyleshaughnessy.com

PATRICK DRISCOLL
pdriscoll@boyleshaughnessy.com

September 27, 2023

VIA CERTIFIED MAIL and US Mail:
Certified Mail: 7022 2410 0001 7851 2174

Mass General Brigham Incorporated
c/o Anne Klibanski, M.D., President and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

RE: Lauren Emery & Michael Ward v. Mass General Brigham & Brigham and Women's Hospital
Our File No.: BSC.3169

M.G.L. c. 93A DEMAND LETTER

Dear Dr. Klibanski:

Please be advised that this office, in conjunction with Henning Strategies, LLC, represents Lauren Emery ("Lauren") & Michael Ward ("Michael") (collectively referred to hereinafter as "Claimants") concerning Mass General Brigham / Brigham and Women's Hospital's (collectively, "MGB") outrageous, appalling, and inexcusable mishandling of the deceased remains of Claimants' child, Kaylee ("Kaylee" or "Baby Kaylee"). This correspondence is sent pursuant to § 9 of M.G.L c. 93A. At this time, we request that you preserve all evidence related to MGB's handling of Baby Kaylee's remains, including but not limited to any physical evidence, notes, reports, photos, witness statements, surveillance / security videos, phone records, e-mails, and letters.

I. BACKGROUND AND UNDERLYING FACTS

Lauren and Michael have two boys and have had two prior miscarriages. In late 2020, the couple conceived Baby Kaylee. Lauren and Michael decided to undergo ultrasounds and anatomy scans in February 2021, with their Obstetrician in Plainville, Massachusetts, and a pregnancy specialist in Providence, Rhode Island. The testing revealed that Baby Kaylee had a spot on her brain. To follow up, Lauren and Michael went to the Children's Hospital, where Baby Kaylee was diagnosed with severe brain abnormalities. At this point, Lauren was twenty-three weeks and four days into pregnancy. Due to the severity of the condition, the doctors recommended that Lauren medically terminate the pregnancy.

On March 1, 2021, Lauren and Michael made the difficult decision to terminate the pregnancy at MGB. Once they arrived at the hospital, they were required to fill out multiple forms regarding their decision to terminate the pregnancy, including forms regarding how they would like the hospital to

handle Baby Kaylee's remains. Lauren and Michal indicated multiple times, on the forms and in conversations with the MGB social worker assisting them, that they wished to have Baby Kaylee's remains cremated and returned to them. While Lauren and Michael completed the paperwork, hospital staff updated Lauren and Michael's contact information to ensure that they could contact them when Baby Kaylee's remains were ready to be picked up.

On March 2, 2021, Lauren was induced and in the early morning of March 3, 2021, Baby Kaylee was born stillborn at twenty-four weeks, weighing one pound and one-and-a-half ounces, and measuring twelve inches long. Hospital staff requested to perform an autopsy on Baby Kaylee and to perform genetic testing to research the "rare disease" that the hospital told Lauren and Michael that Baby Kaylee suffered from. Lauren and Michael agreed to an autopsy to determine whether there was a connection between the two prior miscarriages and the complications affecting Baby Kaylee, and to assess whether there was a genetic condition causing pregnancy complications. Lauren and Michael once again made sure to officially designate that they wanted to have Baby Kaylee's remains cremated and returned to them by way of a funeral home after the hospital performed the autopsy. Because they had had two prior miscarriages, they were familiar with this procedure.

A social worker in the hospital read off a list of names of funeral homes in the area and asked Lauren to indicate which funeral home the hospital should contact to arrange for the transfer of Kaylee's remains. Lauren selected a funeral home in Brockton, Massachusetts. The social worker informed Lauren and Michael that she would contact the funeral home and take care of everything once Baby Kaylee's remains were ready to be picked up. The social worker informed Lauren and Michael that they would receive a call in about a week.

Lauren and Michael were assured that the hospital would call them after the autopsy and that the results of the autopsy would be shared with them. No one from the hospital ever called and Lauren and Michael never received documentation of the autopsy results. Over the next week, Lauren called the social worker, but did not receive a reply; she called the funeral home but did not receive any information; she called MGB and was simply told that they would call her back with information. No one ever called back.

Finally, after calling MGB more than ten times without getting any answers regarding where Baby Kaylee's remains were, in mid-April, Lauren and Michael received a call from a doctor who identified herself as "Dr. Reimer." Dr. Reimer informed Lauren and Michael that the hospital did not have Baby Kaylee's remains because it had been more than fourteen days since Baby Kaylee passed, and after remains have been in the morgue for more than fourteen days, it is the hospital's practice to discard them. Dr. Reimer stated that the pathology department never received a call from anyone to arrange to transport Baby Kaylee's remains to a funeral home. Lauren and Michael asked whether that meant the social worker failed to do her job, as they were told that everything would be taken care of by the hospital and that they should simply wait until the hospital contacted them. Dr. Reimer responded that she did not have all the necessary information but that it appeared that "a communication did not get to the right people."

Dr. Reimer acknowledged that Lauren and Michael indicated in conversations with MGB staff and on the disposition of remains form that they wanted Baby Kaylee's remains returned to them. Dr. Reimer stated that the pathology department was expecting someone to contact their department within

fourteen days to arrange for a funeral but that did not happen. Dr. Reimer explained that after fourteen days the hospital will "take care of the remains" and it appeared that Baby Kaylee "went down that route." Lauren and Michael understood this to mean that the hospital discarded her remains in the trash. Dr. Reimer responded that she didn't believe Kaylee was "thrown away" but she acknowledged that Kaylee would not be respected and cremated the way Lauren and Michael wished. Dr. Reimer further assured Lauren and Michael that she would find out what the hospital was doing to ensure that this mistake never happened again. Dr. Reimer assured Lauren and Michael that Lauren and Michael did not input the wrong selection on the form and that the Claimants had consistently expressed their desire to have Kaylee cremated and buried, and the hospital did not honor that request.

Dr. Reimer stated that someone from the hospital attempted to call Lauren and Michael, but the hospital did not have their correct contact information and were unable to reach them. This was shocking to Lauren and Michael as they specifically remembered updating their contact information at the hospital on March 1, 2021. Apparently, after the pathology department did not receive a call within the alleged fourteen-day period, rather than contact Lauren and Michael to determine what to do with Baby Kaylee's remains, they simply discarded her. Dr. Reimer admitted that mistakes were made and told Lauren and Michael that she filed a "major complaint" against the hospital and would be meeting with the department heads to find out what happened. Dr. Reimer assured Lauren and Michael that she would call them with an update after her meeting with the department heads. Dr. Reimer never called back.

Lauren and Michael never learned what happened to their daughter's remains. Lauren and Michael have been forever deprived of any opportunity to grieve and bury their daughter's remains. While Lauren and Michael will never receive Kaylee's remains to properly memorialize her, their memory of Baby Kaylee is enshrined on Michael's forearm:

Determined to grow their family, Lauren and Michael tried again for another child. Sadly, after the early joys of conception, in July 2023, Lauren and Michael suffered another failed pregnancy. After enduring the tragedy of BWH unilaterally discarding Baby Kaylee's remains, Lauren and Michael vowed to never return to BWH. Accordingly, they chose to have their July 2023 pregnancy-ending

procedure at Boston Medical Center ("BMC"). Before authorizing the procedure, due to the horrifying ordeal caused by the actions of BWH, Lauren and Michael emphatically questioned the BMC staff regarding the disposition of their deceased child's remains to ensure that their child's remains would be returned to them. Notably, BMC staff were confused by the couple's pleas, as they found that returning fetal remains to the parents is a rather routine task. When Lauren and Michael explained what happened to them at BWH, BMC staff were shocked and appalled. BMC thereafter handled the return of their child's remains easily and efficiently – proving to Lauren and Michael that BWH's policies regarding the disposition of fetal remains are inadequate for a renowned hospital like BWH, even after BWH discarded the remains of three other children.

i. MGB Knew Morgue Conditions Were a Problem

MGB was well aware of problematic conditions in the Brigham and Women's Hospital morgue prior to the discarding of Baby Kaylee. In August 2020, MGB threw away the remains of Baby Everleigh Ross. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022). In November 2020, MGB threw away Baby Oliver Bothe's remains without contacting the parents. *See* Madeleine Bothe and Edward Felstead 93A Demand Letter, dated September 11, 2023. In December 2020, MGB threw away Baby Katherine Noel's remains without contacting the parents. *See* Jodie Skrzat and Christian Noel 93A Demand Letter, dated September 15, 2023. During MGB's investigation into the loss of Baby Everleigh, Pathologist John Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there." He told investigators that the Pathology department had "filed safety reports and complaints about how other departments leave their workspace." Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

Gryzb was hardly alone. A transport employee named Sheila Cox was interviewed by Brigham security and remembered that it was "a mess" on the day of Everleigh's disappearance. Another pathologist, Jacob Plaisted, had also put Brigham on notice about the conditions of the morgue. Unlike Gryzb, Plaisted had apparently lodged formal complaints with hospital administrators prior to the disappearance of Baby Everleigh. The discovery process of formal litigation will undoubtedly turn up additional complaints made to the Brigham, demonstrating that the hospital was well aware of the problem prior to the disappearance of Baby Everleigh and the discarding of Baby Kaylee.

Social workers and other staff members at MGB have told affected families that MGB unilaterally discarding their child's remains without first contacting the family is not an isolated incident. It keeps happening.

II. MASS. GEN. LAWS. c. 93A LIABILITY

M.G.L. c. 93A prohibits "unfair or deceptive acts or practices in the conduct of any trade or commerce." *See* M.G.L. c. 93A § 2(a). Chapter 93A requires a showing of (1) a deceptive act or practice on the part of the defendant; (2) an injury or loss suffered by the plaintiff; and (3) a causal connection between the defendant's deceptive act or practice and the plaintiff's injury. *Casavant v. Norweigan*

Cruise Line, Ltd., 76 Mass.App.Ct. 73, 76 (2009), *aff'd* 460 Mass. 500 (2011); *Hershenow v. Enterprise Rent-A-Car Co. of Boston, Inc.*, 445 Mass. 790, 797 (2006). It is "well established that breach of contract can lead to a violation of Chapter 93A." *Clinical Technology, Inc. v. Covidien Sales*, 192 F.Supp.3d 223, 242 (2016) (quoting *Ahern v. Scholz*, 85 F.3d 774, 798 (1st Cir. 1996)).

Lauren and Michael chose to have Baby Kaylee's procedure performed at Brigham and Women's Hospital because of its reputation. The Brigham advertises and markets to patients by claiming, "For over 180 years, Brigham and Women's Hospital has been the most trusted name in women's health." Moreover, MGB promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable." Lauren and Michael trusted MGB to live up to its promise and self-imposed duty when they selected MGB. What they did not prepare for, however – indeed what no parent could ever anticipate – is that a healthcare institution would literally lose their child. MGB – and its staff and employees – are clearly liable for the discarding of Baby Kaylee. That fact is essentially beyond dispute, as Dr. Reimer admitted as much in a phone call to Lauren and Michael. MGB's failure to properly care and account for the body of Baby Kaylee – knowing that Lauren, Michael, and their family relied upon MGB's promises to transfer Baby Kaylee's body to the funeral home chosen by Lauren and Michael – constitutes an unfair and deceptive practice in violation of Chapter 93A. Moreover, MGB employees' shocking disregard and dismissal of dozens of phone calls by grieving parents is a wanton behavior tantamount to a deceptive practice. Had Lauren and Michael known any of this, they would have undoubtedly selected a different hospital for their care. Instead, based on false promises and misrepresentations, they mistakenly placed their trust in MGB to conduct itself professionally and humanely.

Importantly, in the April 2021 phone call with Dr. Reimer, Dr. Reimer assured the Claimants that she filed a "major complaint" with the hospital to ensure that this never happens again. What Dr. Reimer did not tell the Claimants is that this is not the first time that MGB impermissibly discarded a deceased child's remains. MGB knew, as of at least 2021, that their faulty morgue operation had caused the hospital to lose or discard at least three other deceased child's remains – Baby Everleigh Ross, Baby Oliver Bothe, and Baby Katherine Noel. *See generally*, *Alana Ross, et al. v. Mass General Brigham, et al.*, No. 01419 (Suffolk County Superior Court, filed June 23, 2022); Madeleine Bothe and Edward Felstead's 93A Demand Letter, dated September 11, 2023; Jodie Skrzat and Christian Noel 93A Demand Letter, dated September 15, 2023. Rather than institute changes to the morgue to ensure that the hospital never discarded another deceased child's remains against the wishes of the parents, within one year they again discarded a deceased child's remains – Baby Kaylee.

Under M.G.L. c. 93A § 2(c), in addition to recovering actual damages, Claimants are entitled to recover attorney fees and up to treble damages as a result of MGB's egregious deception and breach of contract as fully described above. Furthermore, under M.G.L. c. 93A § 9(3), MGB is liable for treble damages in the event it fails to provide a reasonable offer to the Claimants in response to this demand, with knowledge or reason to know that MGB's actions constituted a breach.

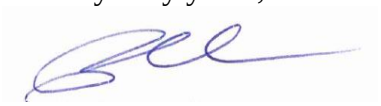
The Claimants now demand that MGB provide financial compensation in the amount of $5 Million and fully cooperate with an independent investigation by an investigator of the Claimants' choosing to uncover the systemic failures on your part which allowed this tragedy to unfold and ensure that no family ever has to experience such pain and anguish at your hands ever again. The hours, weeks, and months of therapy that the Claimants and their families will undergo in the years to come will be

intense and costly. Lauren and Michael suffered through two previous miscarriages before they had Baby Kaylee; the trauma of losing their daughter to a premature death has been exponentially increased because of the conduct of MGB and its employees. We trust you understand that such a hole in their life can never be fully closed, and we hope you embrace this opportunity to help heal the wounds you have inflicted.

In the event that MGB fails to respond within thirty (30) days of the mailing of this letter with a reasonable offer of settlement, the Claimants will file a complaint in a Massachusetts Court which will include, but not be limited to, claims for breach of contract, negligence, negligent / intentional infliction of emotional distress, tortious interference with human remains, breach of the implied covenant of good faith and fair dealing, and violation of M.G.L. c. 93A, exposing MGB to treble damages.

Please direct your response to this 93A demand to my attention at the above Boston office location. I look forward to receiving your response.

Very truly yours,



Patrick Driscoll

cc: Greg Henning, Esq.

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Mass General Brigham Incorporated
c/o Anne Klibanski, M.D.
President and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

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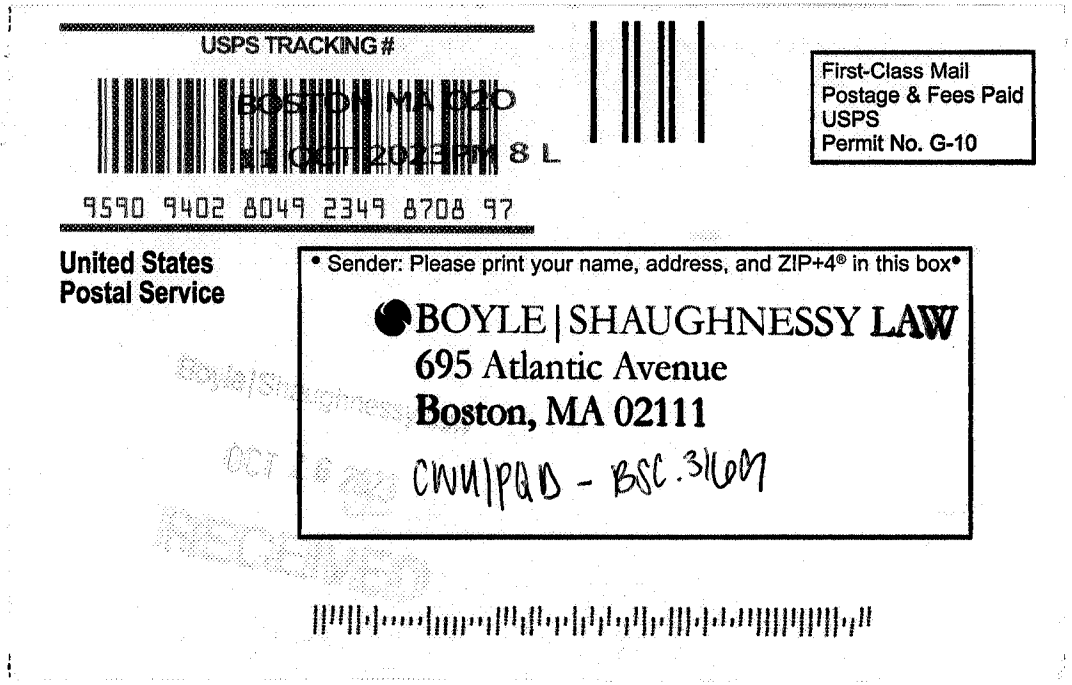

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695 ATLANTIC AVENUE, 11TH FLOOR
BOSTON, MA 02111
(617) 451.2000 TEL
(617) 451.5775 FAX
www.boyleshaughnessy.com

PATRICK DRISCOLL
pdriscoll@boyleshaughnessy.com

October 11, 2023

VIA FIRST CLASS AND
CERTIFIED MAIL: 7022 2410 0001 7851 2198

Mass General Brigham Incorporated
c/o Anne Klibanski, M.D., President and Chief Executive Officer
800 Boylston Street
Boston, MA 02199

RE: Kelly Omu & David Omu v. Mass General Brigham & Brigham and Women's Hospital
Our File No.: BSC.3168

M.G.L. c. 93A DEMAND LETTER

Dear Dr. Klibanski:

Please be advised that this office, in conjunction with Henning Strategies, LLC, represents Kelly Omu ("Kelly") & David Omu ("David") (collectively referred to hereinafter as "Claimants") concerning Mass General Brigham / Brigham and Women's Hospital's (collectively, "MGB") outrageous, appalling, and inexcusable mishandling of the deceased remains of Claimants' child, Mariposa Omu ("Mariposa" or "Baby Mariposa"). This correspondence is sent pursuant to § 9 of M.G.L c. 93A. At this time, we request that you preserve all evidence related to MGB's handling of Baby Mariposa's remains, including but not limited to any physical evidence, notes, reports, photos, witness statements, surveillance / security videos, phone records, e-mails, and letters.

I. BACKGROUND AND UNDERLYING FACTS

In September 2021, three months after exchanging their wedding vows, Kelly and David conceived their first child, Baby Mariposa, in their hometown of Jaffrey, New Hampshire. Over the next four and a half months, their elation and joy turned into fear and sadness when tests revealed that Baby Mariposa would have severe life-limiting disabilities. Sadly, Kelly and David were advised to seek a medically induced abortion. Understanding the tremendous limitations and struggles that Baby Mariposa would face in her life, Kelly and David made the difficult decision to terminate the pregnancy to save Mariposa from suffering.

On January 20, 2022, roughly eighteen and a half weeks into pregnancy, with heavy hearts, Kelly and David traveled from New Hampshire to Women's Health Services in Brookline, Massachusetts to undergo the tragic pregnancy-ending procedure. Due to the gestational age of the pregnancy, the

procedure was to take two days, requiring an overnight stay in Massachusetts. On the first day, Kelly was required to fill out multiple forms consenting to the procedure as well as a "Massachusetts Consent for Burial and/or Cremation" form regarding how she and David wished to handle the disposition of Mariposa's remains. Notably, the "Consent for Burial and/or Cremation" form is separated into two sections, requiring the parents to indicate whether pathology studies are needed. Kelly and David were informed that genetic testing would be performed on Baby Mariposa's remains at Brigham and Women's Hospital and that the clinic would ship the remains to BWH after the procedure. Accordingly, because pathology studies were needed, Kelly checked the box in the first section, indicating that she wished to assume the responsibility for the handling of Mariposa's remains after the genetic testing was completed. She input Smith and Heald Funeral Home in Milford, New Hampshire, a funeral home run by her cousin, Patrick Brooks, as the funeral home handling the arrangements.

On January 21, 2022, Kelly underwent the traumatic procedure to end her child's life. Kelly was informed that the clinic was going to send Mariposa's remains to Brigham and Women's Hospital, where pathologists would perform genetic testing. Kelly was informed that someone from BWH would contact her when Mariposa's remains were ready to be transferred to the funeral home. Nobody ever informed Kelly and David how long the genetic testing would take or when they could expect Baby Mariposa's remains to be ready. Kelly provided the relevant documents to Mr. Brooks at Smith and Heald Funeral Home on January 21, 2022, and anxiously waited for the day that her daughter's remains would be ready for a proper funeral. Kelly and David were informed that someone at BWH told Mr. Brooks that the genetic testing would take "a few weeks." Thereafter, every week, Kelly checked her online medical records portal to monitor whether there was any information regarding the results of the genetic testing.

Weeks went by and each time Kelly checked the portal, there was no information regarding Mariposa. Kelly assumed the genetic testing was still ongoing. Then, approximately six weeks after sending Mariposa's remains to BWH, during one of her weekly reviews of the portal, Kelly noticed that the genetic testing results had been uploaded to her portal. The testing report indicated that the testing was completed nearly a month prior, on February 7, 2022. Nobody ever contacted Kelly, David, or the funeral home to inform them that the testing was completed, and Mariposa's remains were ready for transfer. Upon seeing the testing results in her portal, on March 5, 2022, Kelly texted her cousin at Smith and Heald Funeral Home to tell him that it appeared the testing was completed, and that Mariposa's remains were ready to be picked up. Mr. Brooks, an experienced funeral home director, was confused as to why the hospital never contacted him, when the hospital knew Smith and Heald was listed as the funeral home handling the arrangements for Baby Mariposa's remains.

Mr. Brooks then immediately contacted Brigham and Women's Hospital on March 5, 2022, to arrange to transfer Baby Mariposa's remains. Nobody from Brigham and Women's Hospital answered his calls and nobody called the funeral home back to arrange for the transfer. Mr. Brooks told Kelly and David that the hospital was not giving him information, and he was getting the sense that something was wrong. He said the hospital was "giving him the run around" as by March 9, 2022, he had spoken to three different people at BWH and had still received no information regarding the whereabouts of Baby Mariposa's remains. Mr. Brooks indicated that it was very unprofessional for the hospital to refuse to contact Kelly, David, or the funeral home immediately when Mariposa's remains were ready for transfer. It was even more concerning to Mr. Brooks that the hospital was not answering their calls to transfer Mariposa's remains or to explain where her remains were. Mr. Brooks was especially confused

because he thought a renowned hospital like Brigham and Women's would understand how to handle the transfer of remains and would have policies in place to efficiently facilitate such transfers.

Kelly and David were shocked and confused. They called the hospital demanding an explanation. On March 10th, approximately five days after Kelly and David discovered, on their own, that the testing had been completed a month prior, they received a call from Dr. Mutter, the pathologist who performed the genetic testing of Mariposa. Dr. Mutter told Kelly and David that Mariposa's remains were "misplaced" and apparently discarded. Dr. Mutter said he never saw the form indicating how Kelly and David wished to handle Mariposa's remains. After apologizing and recognizing BWH's egregious failure in not honoring Kelly and David's wish to have a proper burial for their child, Dr. Mutter explained that the only remnant of Mariposa's remains that were still in the possession of BWH were the small tissue samples that were kept for genetic testing. Dr. Mutter offered to send the small remnants of tissue samples as a consolation. While Kelly and David had envisioned a beautiful memorial for their child, allowing them to visit her and remember her in a respectful manner, Dr. Mutter suggested that Kelly and David turn the tissue sample into a candle.

Kelly and David never received any answers regarding how or why the Brigham discarded Baby Mariposa's remains. They have been forever deprived of any opportunity to grieve and bury their daughter. After enduring the grief caused by MGB's inexcusable mishandling of their child's remains coupled with MGB's callous and outrageous response to the situation, Kelly and David have questioned whether they want to try to get pregnant again.

i. MGB Knew Morgue Conditions Were a Problem

MGB was well aware of problematic conditions in the Brigham and Women's Hospital morgue prior to the discarding of Baby Mariposa. In August 2020, MGB threw away the remains of Baby Everleigh Ross. *See generally*, *Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022). In November 2020, MGB threw away Baby Oliver Bothe's remains without contacting the parents. *See* Madeleine Bothe and Edward Felstead 93A Demand Letter, dated September 11, 2023. In December 2020, MGB threw away Baby Katherine Noel's remains without contacting the parents. *See* Jodie Skrzat and Christian Noel 93A Demand Letter, dated September 15, 2023. In March 2021, MGB threw away Baby Kaylee Emery's remains without contacting the parents. *See* Lauren Emery and Michael Ward 93A Demand Letter, dated September 27, 2023. During MGB's investigation into the loss of Baby Everleigh, Pathologist John Gryzb unloaded on Brigham investigators about the conditions of the morgue and inaction by hospital administrators when they were notified of these problems. Gryzb noted that it was "common practice" for him to "pick up slings, linens, and trash left in the morgue by others who have access in there." He told investigators that the Pathology department had "filed safety reports and complaints about how other departments leave their workspace." Gryzb told investigators that he had "learned to work with the other departments' mistakes," but he also acknowledged that he had "spoken to his boss, Michelle [Siciliano], about these complaints."

Gryzb was hardly alone. A transport employee named Sheila Cox was interviewed by Brigham security and remembered that it was "a mess" on the day of Everleigh's disappearance. Another pathologist, Jacob Plaisted, had also put Brigham on notice about the conditions of the morgue. Unlike Gryzb, Plaisted had apparently lodged formal complaints with hospital administrators prior to the disappearance of Baby Everleigh. The discovery process of formal litigation will undoubtedly turn up

additional complaints made to the Brigham, demonstrating that the hospital was well aware of the problem prior to the disappearance of Baby Everleigh and the discarding of Baby Mariposa.

Social workers and other staff members at MGB have told affected families that MGB unilaterally discarding their child's remains without first contacting the family is not an isolated incident. It keeps happening.

II. MASS. GEN. LAWS. c. 93A LIABILITY

M.G.L. c. 93A prohibits "unfair or deceptive acts or practices in the conduct of any trade or commerce." *See* M.G.L. c. 93A § 2(a). Chapter 93A requires a showing of (1) a deceptive act or practice on the part of the defendant; (2) an injury or loss suffered by the plaintiff; and (3) a causal connection between the defendant's deceptive act or practice and the plaintiff's injury. *Casavant v. Norweigan Cruise Line, Ltd.*, 76 Mass.App.Ct. 73, 76 (2009), *aff'd* 460 Mass. 500 (2011); *Hershenow v. Enterprise Rent-A-Car Co. of Boston, Inc.*, 445 Mass. 790, 797 (2006). It is "well established that breach of contract can lead to a violation of Chapter 93A." *Clinical Technology, Inc. v. Covidien Sales,* 192 F.Supp.3d 223, 242 (2016) (quoting *Ahern v. Scholz,* 85 F.3d 774, 798 (1st Cir. 1996)).

Kelly and David chose to have Baby Mariposa's genetic testing performed at Brigham and Women's Hospital because the Brigham holds itself out as the premiere hospital for women's health. Specifically, the Brigham advertises and markets to patients by claiming, "For over 180 years, Brigham and Women's Hospital has been the most trusted name in women's health." Moreover, MGB promises each of its patients "superior care that is patient- and family-centered, accessible, and equitable." Kelly and David trusted MGB to live up to its promise and duty when they selected the Brigham to provide care during their family's most vulnerable moment. What they did not prepare for, however – indeed what no parent could ever anticipate – is that a healthcare institution would discard their child and ignore two grieving parents' request for answers.

MGB – and its staff and employees – are clearly liable for the inexcusable discarding of Baby Mariposa. MGB's failure to properly care and account for the body of Baby Mariposa – knowing that Kelly, David, and their family relied upon MGB's promises to keep Baby Mariposa's body safely in the morgue – constitutes an unfair and deceptive practice in violation of Chapter 93A. Moreover, MGB employees' shocking disregard and dismissal of phone calls by grieving parents is a wanton behavior tantamount to a deceptive practice. Had Kelly and David known any of this, they would have undoubtedly selected a different hospital for their care. Instead, based on false promises and misrepresentations, they mistakenly placed their trust in MGB to conduct itself professionally and humanely.

Dr. Mutter apologized to Kelly and David for MGB's inexcusable mishandling of their child's remains. What Dr. Mutter did not tell the Claimants is that the MGB morgue has a history of erroneously discarding infant remains. MGB knew, as of at least March 2022, that their faulty morgue operation had caused the hospital to lose at least four other deceased child's remains – Baby Everleigh Ross, Baby Oliver Bothe, Baby Kaylee Ward, and Baby Katherine Noel. *See generally, Alana Ross, et al. v. Mass General Brigham, et al.,* No. 01419 (Suffolk County Superior Court, filed June 23, 2022); Madeleine Bothe and Edward Felstead 93 Demand Letter, dated September 11, 2023; Jodie Skzrat and Christian Noel 93A Demand Letter, dated September 15, 2023; Lauren Emery and Michael Ward 93A Demand Letter, dated September 27, 2023. Rather than institute changes to the morgue to ensure that the hospital

never discarded another deceased child's remains against the wishes of the parents, within one year of discarding Baby Katherine Noel, Brigham's morgue again discarded a deceased child's remains – Baby Mariposa.

The Brigham has deliberately attempted to conceal the ineptitude of its morgue operations for financial gain. At the time Baby Mariposa was "thrown away" by Brigham staff, the Brigham was on notice that its morgue operation and leadership were ill equipped to safely retain child remains in its morgue. Notwithstanding this knowledge, the Brigham continued to allow its social workers to falsely represent to grieving parents that their child's remains would be safely kept in the morgue until arrangements were made. The Brigham then attempted to conceal the discarding of Baby Mariposa by not providing answers about how this happened.

Like Daniel McCarthy and Alana Ross, Kelly and David were not provided any answers regarding how Mariposa was "disposed of." No one explained to Kelly and David who discarded Baby Mariposa and why nobody contacted Kelly, David, or the funeral home to arrange to transfer Baby Mariposa's remains for a funeral. The Brigham's refusal to provide answers can only be explained by Brigham's hopes that no one will ever ask what happened to Baby Mariposa and why. The Brigham's repeated attempts to cover-up the loss of Baby Everleigh, Baby Oliver, Baby Kaylee, Baby Katherine, and Baby Mariposa is evidence of their unfair and deceptive conduct, as they continued to represent to the public that it was the premiere hospital for women's health despite the ineptitude of its morgue operation.

Under M.G.L. c. 93A § 2(c), in addition to recovering actual damages, Claimants are entitled to recover attorney fees and up to treble damages as a result of MGB's egregious deception and breach of contract as fully described above. Furthermore, under M.G.L. c. 93A § 9(3), MGB is liable for treble damages in the event it fails to provide a reasonable offer to the Claimants in response to this demand, with knowledge or reason to know that MGB's actions constituted a breach.

The Claimants demand that MGB provide financial compensation in the amount of $5 Million and fully cooperate with an independent investigation by an investigator of the Claimants' choosing to uncover the systemic failures on Brigham's part which allowed this tragedy to unfold and ensure that no family ever has to experience such pain and anguish at your hands ever again. The hours, weeks, and months of therapy that the Claimants and their families will undergo in the years to come will be intense and costly. For Kelly and David, the trauma of losing their daughter to a premature death has been exponentially increased because of the conduct of MGB and its employees. Indeed, after the trauma caused at the hands of the Brigham, Kelly and David have chosen not to have additional children, which was their dream. We trust you understand that such a hole in their life can never be fully closed, and we hope you embrace this opportunity to help heal the wounds you have inflicted.

In the event that MGB fails to respond within thirty (30) days of the mailing of this letter with a reasonable offer of settlement, the Claimants will file a complaint in a Suffolk Superior Court which will include, but not be limited to, claims for breach of contract, negligence, negligent / intentional infliction of emotional distress, tortious interference with human remains, breach of the implied covenant of good faith and fair dealing, and violation of M.G.L. c. 93A, exposing MGB to treble damages. In addition, Kelly and David request that all physical evidence regarding the handling of Baby Mariposa's remains, including but not limited to, notes, reports, photos, witness statements, surveillance

/ security videos, phone records, e-mails, and letters be produced to counsel in advance of any offer by the Brigham. In the media, the Brigham stated that it would be "transparent" with the Ross family. The Brigham has fallen woefully short of that promise. Kelly and David are giving the Brigham an opportunity to meet its transparency promise.

Please direct your response to this 93A demand to my attention at the above Boston office location. I look forward to receiving your response.

Very truly yours,

Patrick Driscoll

cc: Greg Henning, Esq.

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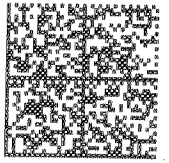

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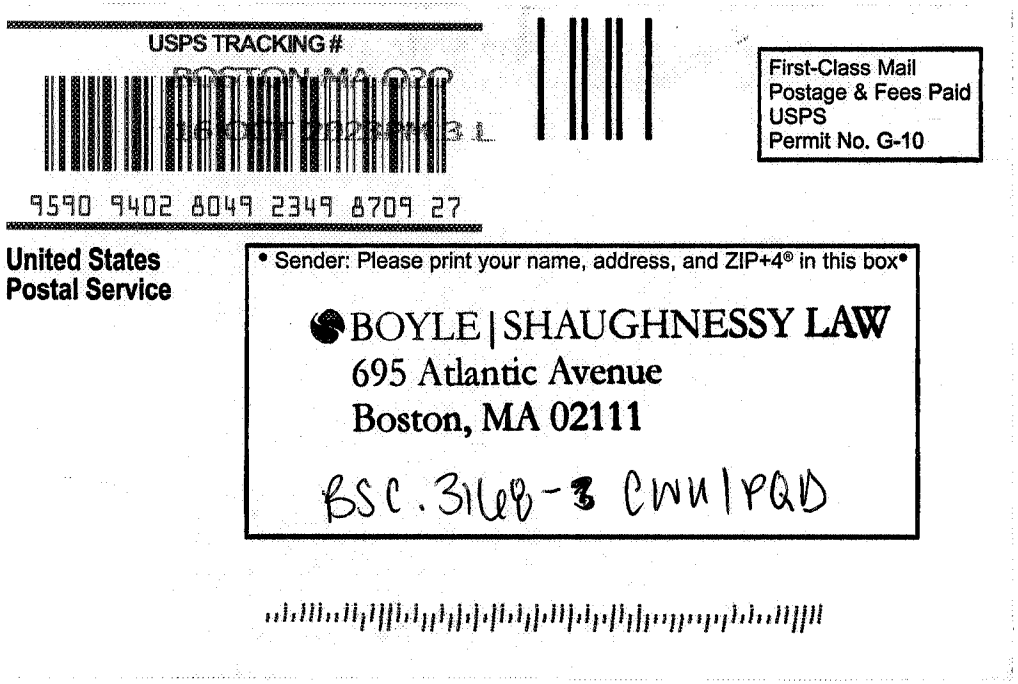

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