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JESSE BRAVO

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

JESSE BRAVO,

Plaintiff,

v.

WHITE MEMORIAL MEDICAL CENTER, a California corporation; ADVENTIST HEALTH SYSTEM/WEST, a California corporation; MICHAEL HERNANDEZ, M.D., an Individual; MICHAEL HERNANDEZ, M.D., Inc., A Professional Corporation; and DOES 1 to 100, inclusive,

Defendants.

Case No.: BC478343

COMPLAINT FOR DAMAGES:

1. **Elder Abuse & Neglect (*Welfare & Institutions Code* § 15600, *et seq.*)**
2. **Breach of Fiduciary Duty**
3. **Intentional Infliction of Emotional Distress**
4. **False Imprisonment**
5. **Negligence Per Se**
6. **Professional Negligence**
7. **Hospital Negligence**

DEMAND FOR JURY TRIAL

COMES NOW the plaintiff, JESSE BRAVO, by and through his attorneys of record, KIESEL BOUCHER LARSON LLP and PUBLIC COUNSEL, and for cause of action against Defendants, and each of them, hereby alleges upon personal knowledge with respect to his own acts, and upon information and belief as to all other matters, as follows.

INTRODUCTION

1. On February 11, 2011, Defendants White Memorial Medical Center, a California corporation, and Adventist Health System/West, a California corporation; their physicians, nurses, staff members, employees and agents; Michael Hernandez, M.D., an Individual; Michael Hernandez, M.D., Inc., A Professional Corporation; and DOES 1 through 100, inclusive (hereinafter collectively referred to as the "Defendants"), discharged an unstable, paranoid schizophrenic and heavily medicated man without his consent and then physically restrained him and transported him to an unfamiliar location against his will, abandoning and "dumping" him on the sidewalk without the ability to return home. During the two weeks prior to that abandonment and "dumping" Jesse Bravo (hereinafter also referred to as "Mr. Bravo" or "Plaintiff") had been an inpatient at White Memorial Medical Center. Other than administering multiple prescription psychotropic medications, Defendants provided little care and treatment for him and did not stabilize the acute psychiatric condition that had led to his admission to the hospital. Defendants ignored the fact that Mr. Bravo was a married man who resided with his family and, instead, treated him as if he were a homeless person by unilaterally deciding to discharge him from White Memorial Medical Center to a shelter that cares for homeless people. Insofar as Defendants formulated treatment goals for Mr. Bravo, their own stated goal was not to discharge him until 24 hours had passed without any aggressive behavior on his part. At 10:10 p.m. on February 10, 2011, Defendants administered 100 milligrams of Thorazine to Mr. Bravo because they determined that his behavior was a threat to his own safety and to the safety of others. Less than 12 hours later, however, they began the process that led to his discharge, abandonment and dumping.

2. Defendants did not assess Mr. Bravo's options for post-discharge care, did not plan his discharge in advance, and discharged him so hastily that they never obtained his

signature on several discharge forms. Defendants misrepresented the nature of their discharge plan to Mr. Bravo, a patient who was sedated and confused. Mr. Bravo asked to be discharged to his mother's house—where he had been staying while his wife recovered from surgery—but Defendants made only one attempt to call his mother at an unverified and incorrect number. Notwithstanding having spoken to her numerous times during Mr. Bravo's hospitalization, and contrary to his written consent to have and keep her informed about his condition and discharge planning, Defendants failed to include Mr. Bravo's wife in the discharge planning process and, further, failed to inform her that her husband was being discharged. Instead, Defendants unilaterally decided to discharge Mr. Bravo to a transitional living facility without evaluating the suitability of this option or explaining the discharge to him, and without obtaining his consent thereto.

3. When Mr. Bravo realized that he was not being discharged into his family's care, he protested. In response, White Memorial Medical Center staff members forced him into a transport van and secured his wrists with plastic restraints while he continued to beg to be taken to his wife. White Memorial Medical Center staff members then drove Mr. Bravo to 1932 Rochester Circle, where witnesses observed him get out of the van looking "drugged." Without escorting him to the door or otherwise transitioning or "handing off" his care to others, the van drove off, abandoning and "dumping" Mr. Bravo, who was left standing, unattended, medicated and confused on the sidewalk. Unable to understand why he was there, Mr. Bravo wandered away after a few minutes, stopping briefly to try to feed his medication to a dog. He then spent several days homeless, cold and wandering the streets, during which time he was attacked by unknown third persons, and was injured such that he later required surgery followed by a difficult recovery. On Sunday, February 13, 2011, police officers found Mr. Bravo on Skid Row attempting to climb into a van that resembled his wife's, apparently in a desperate attempt to find his way home.

4. Defendants' actions violate every standard of professional conduct. By failing to care for and then releasing a mentally ill, unstable, paranoid and schizophrenic man and abandoning him on the street in an unfamiliar and dangerous area, Defendants, and each of

them, have willfully engaged in the "abuse of a dependent adult" in violation of California's Elder Abuse and Dependent Adult Civil Protection Act, California *Welfare & Institutions Code* section 15600 *et seq*. In addition, Defendants actions violated California *Health & Safety Code* section 1262.5 by failing to make appropriate arrangements for Mr. Bravo's discharge and by abandoning him on the sidewalk outside 1932 Rochester Circle. Defendants White Memorial Medical Center, a California corporation, and Adventist Health System/West, a California corporation, further violated federal statute and Centers for Medicare and Medicaid regulations by not engaging in patient assessment or treatment planning within the meaning of 42 C.F.R. section 482.61.

PARTIES

5. Plaintiff Jesse Bravo is a married father of four and a resident of San Bernardino County, California. At the time of the incident in question, Mr. Bravo was forty-nine years old and was suffering from an acute mental illness.

6. Defendant White Memorial Medical Center, a California corporation (hereinafter referred to as "White Memorial"), is owned and operated by Defendant Adventist Health System/West, a California corporation (hereinafter referred to as "Adventist Health"), and is a participant in the federal Medicare program. Defendants White Memorial and Adventist Health are hereinafter collectively referred to as the "HOSPITAL DEFENDANTS"). At all times herein mentioned the HOSPITAL DEFENDANTS were doing business at 1720 E. Cesar E. Chavez Avenue in the City and County of Los Angeles, State of California.

7. At all times herein mentioned, Defendant Michael Hernandez, M.D., an Individual, was and now is a physician and surgeon licensed to practice medicine and/or perform surgery under the laws of the State of California, and was engaged in the practice of medicine at 1720 E. Cesar E. Chavez Avenue in the City and County of Los Angeles, State of California.

8. At all times herein mentioned, Defendant Michael Hernandez, M.D., Inc., A Professional Corporation, was and now is doing business under the laws of the State of California, and was engaged in the practice of medicine at 1720 E. Cesar E. Chavez Avenue in

the City and County of Los Angeles, State of California. Defendants Michael Hernandez, M.D., an Individual and Michael Hernandez, M.D., Inc., A Professional Corporation are hereinafter collectively referred to as "DR. HERNANDEZ."

9. The HOSPITAL DEFENDANTS, their physicians, nurses, staff members, employees and agents, and DR. HERNANDEZ, together with Defendants DOES 1 through 100, are hereafter collectively referred to herein as the "Defendants."

10. The true names and capacities of Defendants sued herein as DOES 1 through 100, inclusive, are unknown to Plaintiff, who sues said Defendants by such fictitious names. When the true names and capacities of said Defendants have been ascertained, Plaintiff will ask leave of the court to amend this Complaint to insert the true names and capacities of said fictitiously named Defendants. Plaintiff is informed and believes and, upon such information and belief, alleges that DOES 1 through 100, and each of them, participated in, and are responsible for, the wrongful conduct alleged herein.

11. At all relevant times, each Defendant was acting as an agent, servant, employee, co-conspirator, co-schemer, or joint venturer of, for and with the other Defendants, and each of them, and in doing the acts alleged herein, was acting within the course and scope of said agency, service, employment, conspiracy, scheme, or joint venture. Because of the agency, service, employment, conspiracy, scheme, joint venture and/or corporate relationships between Defendants, each Defendant had actual knowledge, collective knowledge, or constructive notice of and ratified the acts of each of the other Defendants. In doing the acts alleged herein, each Defendant caused and/or aided and abetted the wrongful acts of the other Defendants.

JURISDICTION AND VENUE

12. This court has jurisdiction because Defendants' conduct, and Plaintiff's injuries, occurred within the jurisdictional boundaries of this Court. All of the Defendants conduct substantial business within the County of Los Angeles, State of California.

13. Venue is proper in this Court under California *Code of Civil Procedure* sections 395 and 395.5 because at all relevant times White Memorial Medical Center has been and is located and doing business at 1720 E. Cesar Chavez Avenue, Los Angeles, California 90033

and each and all Defendants' respective liabilities and obligations arose, and all of their respective breaches occurred at that same location within the County of Los Angeles, State of California.

DEFENDANTS' UNLAWFUL TREATMENT OF MR. BRAVO

14. In late January 2011, Plaintiff's wife was recovering from surgery. To give her time to recuperate, Mr. Bravo went to stay with his mother. While staying with his mother the Plaintiff's prior mental illness worsened. Plaintiff was transported to White Memorial by ambulance on January 28, 2011 after his mother became alarmed by his agitated and fevered state.

15. When Mr. Bravo arrived at White Memorial, hospital staff variously described his state as paranoid, confused, assaultive, psychotic and combative. White Memorial personnel administered emergency sedatives and placed him in five-point restraints. Mr. Bravo was unable to supply a coherent contact number, but his wife, Laura Bravo (hereinafter referred to as "Mrs. Bravo"), contacted White Memorial within a few hours of his admission. Because of Mr. Bravo's acute mental illness he was unable to understand and consent to diagnostic testing that was recommended by the HOSPITAL DEFENDANTS. At 9:40 p.m., Mrs. Bravo provided consent for a lumbar puncture. Mr. Bravo was subsequently admitted as a patient into White Memorial with a diagnosis of "altered mental status." While an in-patient in the medical ward, he expressed paranoid ideations, ran naked through the halls, took items from other patients' rooms and physically assaulted a male nurse. Pursuant to California *Welfare & Institutions Code* section 5150, on February 1, 2011 Mr. Bravo was determined to be a "gravely disabled" adult and White Memorial obtained a 72-hour hold (known as a "5150 hold") for further psychiatric evaluation and treatment of him.

16. Mr. Bravo was transferred to White Memorial's Behavioral Medicine Services ("BMS") unit and placed in the care of DR. HERNANDEZ. Mr. Bravo's BMS Pre-Admission Data Sheet identifies Mrs. Bravo as his next of kin and contains her correct phone number. On February 1, Mr. Bravo signed the BMS Next of Kin Notification form, which identifies Laura Bravo as his wife. This form authorized White Memorial and DR. HERNANDEZ to discuss

Mr. Bravo's care, treatment and discharge planning with Mrs. Bravo.

17. Multiple records from this hospitalization describe Plaintiff as an unreliable source of information, yet Defendants relied on Mr. Bravo's representations rather than attempting to compile a patient history that could inform his treatment and discharge. White Memorial Social Worker Gina Gamboa obtained his consent to speak to Mrs. Bravo for his Psychosocial Evaluation and further treatment of him.

18. Mrs. Bravo complained to White Memorial at about 8:00 a.m. on February 11 concerning DR. HERNANDEZ's refusal to keep her informed and the poor care Mr. Bravo had been receiving. White Memorial and DR. HERNANDEZ began her husband's discharge less than an hour later. Defendants discharged Mr. Bravo without allowing Mrs. Bravo to participate in the discharge planning process, without informing her of the planned discharge and without confirming the identity or location of the proposed discharge facility to her even though she was speaking to hospital staff while the discharge was in progress.

19. Defendants had previously identified and documented two goals that had to be met before Mr. Bravo could be discharged. First, his condition had to be stabilized so that he was no longer a threat to the safety of himself or others, and second, his altered thought processes had to be stabilized. While in the BMS unit, Mr. Bravo received minimal treatment and made minimal progress. On February 7, 2011 a hearing was held pursuant to California *Welfare & Institutions Code* section 5250. Not only was Mr. Bravo determined to still be a "gravely disabled" adult, at this hearing he was also determined to be a "danger to others" and his involuntary stay at White Memorial was extended. Plaintiff attacked another patient later that same day. No treatment record indicates any psychiatric progress between the date of this 5250 hearing and Mr. Bravo's discharge from White Memorial on February 11.

20. DR. HERNANDEZ's brief discharge summary indicates that he had no significant involvement with his patient. DR. HERNANDEZ never signed one treatment plan during the entirety of this hospitalization, only signed one a month or more after Plaintiff's discharge, and did not enter any notes about Mr. Bravo's treatment into his hospital chart. These facts suggest that DR. HERNANDEZ may not have participated in treatment or

treatment planning as required by the standards of his profession and federal Medicare regulations. Claiming patient confidentiality, DR. HERNANDEZ repeatedly ignored Mr. Bravo's prior written consent to have and keep Mrs. Bravo informed about his condition, treatment and discharge planning and refused to speak to her—even as White Memorial's nurses were routinely speaking with her regarding her husband's care.

21. The BMS unit's treatment records are sparse; more documents relate to discharge than to the preceding ten days of psychiatric hospitalization (unless one counts emergency sedation forms). To subdue Mr. Bravo's aggressive and psychotic behavior, the HOSPITAL DEFENDANTS staff administered Haldol and Ativan on February 6, Thorazine and Ativan on February 7, and Thorazine at 10:10 p.m. on February 10, less than twelve hours before initiating Mr. Bravo's discharge. Two hours later— nine hours before, allegedly, "consenting" to his discharge plan—Mr. Bravo remained confused and agitated and was restlessly pacing his room, according to White Memorial's own records.

22. Mrs. Bravo called White Memorial and the BMS unit daily and visited her husband regularly during his in-patient hospitalization. If Defendants were planning in advance to discharge Mr. Bravo to his mother's (Rafaela Guerrero's) care, no one on the staff discussed this plan with Mrs. Guerrero (or even verified her phone number) or Mrs. Bravo. Social worker Jacob Avery tried to call Mrs. Guerrero for the first time on February 11, shortly before Mr. Bravo's discharge. Mr. Avery called an incorrect number. By 9:16 a.m., after receiving no answer, Mr. Avery had ceased attempting to reach Mrs. Guerrero. Instead, for the first time, he proposed an entirely different discharge plan to Plaintiff: placement at a transitional living facility. Because of his continued altered mental state and ongoing sedation, Mr. Bravo was unable to understand and consent to this entirely different discharge plan. His mental state was so impaired, and the effects of the multiple psychotropic medications administered to him by the Defendants were so great, that Mr. Bravo was unable to understand and sign the necessary discharge documentation.

23. Notwithstanding that Mr. Bravo could not understand and did not consent to this discharge, and without adequate planning and with no communication to Mr. Bravo's wife or

family, Defendants went ahead with this entirely different discharge plan. As he was being escorted from White Memorial by two staff persons, Mr. Bravo began to ask where they were taking him and whether he was being taken to be with his wife. Mr. Bravo stated repeatedly that he wanted to be taken to his wife. When the staff persons ignored him, Mr. Bravo protested. The HOSPITAL DEFENDANTS' staff persons then forced him into a van, physically handcuffed him by placing plastic restraints on his wrists, and transported him against his will to a transitional living facility located at 1932 Rochester Circle in Los Angeles. When the HOSPITAL DEFENDANTS' van arrived at this destination, the driver did not get out of the van to accompany Mr. Bravo to the door to "hand off" his care to others at that facility, and did nothing to ensure that Mr. Bravo understood what was happening and would receive the necessary and intended care. Instead, the HOSPITAL DEFENDANTS' van driver abandoned and "dumped" him alone on the sidewalk in a strange and unfamiliar part of the city. Confused and disoriented, Mr. Bravo wandered away and spent two nights on the streets without warm clothing, money, identification or medication.

STATUTORY PROTECTION OF DEPENDENT ADULTS

24. The California Legislature has acted to protect the elderly and dependent adults from the unique and invidious forms of abuse faced by those who cannot protect their own rights adequately. These members of society are often subjected to inhumane treatment but are incapable of finding a voice to express their needs or otherwise ameliorate their circumstances. Due to physical or mental impairment, such persons cannot always take "reasonable" steps to protect themselves or be counted on to act in their own interest.

25. With these challenges in mind, the Legislature enacted section 15600 *et seq.* of the California *Welfare & Institutions Code*, which defines "abuse of an elder or a dependent adult" in section 15610.07 in relevant part as:

> (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.

"Neglect" is defined in California *Welfare & Institutions Code* section 15610.57:

> (a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. [...]

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. [...]

(3) Failure to protect from health and safety hazards.

"Abandonment" is defined in California *Welfare & Institutions Code* section 15610.05 as "the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody."

26. Mr. Bravo was and is a paranoid schizophrenic whose acute mental illness causes delusions, disruption and, on occasion, leads to episodes of violence. Notwithstanding his mental illness, Mr. Bravo is also a loving husband, father, and son who looks after his elderly mother. A care custodian who ejects an unstable, mentally ill dependent adult from treatment before discovering such basic facts about him—or before stabilizing his mental condition such that he is capable of representing himself and his wishes accurately—fundamentally contravenes California's Elder Abuse and Dependent Adult Civil Protection Act.

STATUTORY MANDATE FOR DISCHARGE PLANNING AND POST-DISCHARGE CARE

27. The California Legislature has recognized the importance of planning for post-discharge care as a means of protecting vulnerable patients from the health and safety risks attendant to discharge. Accordingly, it has imposed certain obligations on hospitals in this state to develop, implement, and follow policies that address the post-discharge needs of patients who are otherwise more likely to experience adverse health consequences following their discharge.

28. Specifically, the Legislature has enacted California *Health & Safety Code*

section 1262.5. That statutory provision provides, in pertinent part:

> (a) Each hospital shall have a written discharge planning policy and process.
>
> (b) The policy required by subdivision (a) shall require that appropriate arrangements for post hospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for post hospital care, the hospital shall provide for that counseling.

29. No discharge policy or process that includes abandoning and "dumping" a mentally ill married man on the sidewalk outside of a transitional living facility in a strange and unfamiliar part of the city before his acute mental illness has been stabilized and when he had not one but two family homes to return to—whether due to sheer inattention or to failure to learn about him as a person and as a patient—complies with California *Health & Safety Code* section 1262.5.

FEDERAL REGULATION OF PSYCHIATRIC HOSPITALS PARTICIPANTING IN THE MEDICARE SYSTEM

30. Congress also has addressed the need to govern psychiatric care carefully, through its power to regulate the hospitals that participate in the federal Medicare system. As part of an effort to ensure that psychiatric patients are actively treated, rather than locked away or ignored, Congress has imposed special record requirements for psychiatric facilities.

31. These requirements are stated in 42 C.F.R. section 482.61 and numerous interpretive regulations and guidelines. 42 C.F.R. section 482.61(a) concerns the development of assessment or diagnostic data:

> (4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

32. 42 C.F.R. section 482.61(c) mandates an "individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities." The Centers for Medicare and Medicaid have specified that this requirement means "an individualized

program of treatment ... developed by a physician in conjunction with staff members." Treatment plans should be developed and updated at "team meetings."

33. When the HOSPITAL DEFENDANTS' social worker left the "discharge plan" ("home plans") section of the Psychosocial Assessment blank, the HOSPITAL DEFENDANTS' treatment of Mr. Bravo fell short of Medicare participation requirements for the care and treatment of psychiatric patients. Similarly, because Mr. Bravo's treatment plans were filled out by various staff members over a period of days rather than at team meetings and were either signed by DR. HERNANDEZ a month after discharge or never signed at all, the HOSPITAL DEFENDANTS did not meet Medicare participation requirements for the care and treatment of psychiatric patients.

34. Plaintiff alleges that he is entitled to prejudgment interest pursuant to California *Civil Code* section 3288, *et seq.*, from the date of his discharge from, abandonment and "dumping" by Defendants on February 11, 2011 up to and including the date of judgment, according to proof.

FIRST CAUSE OF ACTION

ABUSE AND NEGLECT OF A DEPENDENT ADULT IN VIOLATION OF CALIFORNIA *WELFARE & INSTITUTIONS CODE* § 15600, et seq.

(Brought Against All Defendants)

35. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System, Paragraphs 1 through 34, inclusive of this Complaint as though set forth in full herein.

36. At all times relevant to this action, Jesse Bravo was a "dependent adult" within the meaning of California *Welfare & Institutions Code* section 15610.23 because: (a) he had mental limitations that restricted his ability to carry out normal activities or to protect his rights; and (b) he was an inpatient in a 24-hour health facility.

37. At all times relevant to this action, Defendants were "care custodians" within the meaning of California *Welfare & Institutions Code* section15610.17 because (a) White Memorial is a 24-hour health facility, and (b) the HOSPITAL DEFENDANTS' physicians, nurses, staff members, employees, agents and DR. HERNANDEZ were persons providing health services to dependent adults, pursuant to the provisions of the Elder Abuse and Dependent Adult Civil Protection Act.

38. Defendants' conduct described above constitutes actionable neglect within the meaning of California *Welfare & Institutions Code* section 15610.57. Defendants failed to exercise that degree of care that reasonable persons in a like position would exercise insofar as they: (a) did not provide medical care for Mr. Bravo's mental health needs both by not actively treating him while he was an inpatient, and by discharging him before his condition had stabilized; (b) failed to protect him from the health and safety hazards to which a psychiatric patient is especially vulnerable upon discharge; and (c) abandoned and "dumped" him under circumstances in which a reasonable person would have continued to provide care and custody.

39. Specifically, Defendants did not treat, or negligently and recklessly treated, Mr. Bravo by never obtaining an accurate patient history and never assessing his options for post-discharge care, despite the degree to which a patient's post-discharge prospects should inform his or her treatment. The HOSPITAL DEFENDANTS and DR. HERNANDEZ did not engage in treatment planning dictated by Medicare regulations and hospital policy. DR. HERNANDEZ apparently did not interact with his patient except to prescribe psychotropic medications. Moreover, Plaintiff was discharged before those medications had stabilized his psychosis.

40. Defendants further did not treat Plaintiff in that they identified only token treatment goals for Mr. Bravo, one of which was that he would no longer be a threat to others. Notwithstanding that on February 7, 2011 the Defendants confirmed that Mr. Bravo was determined to be a "gravely disabled" and a "danger to others," the only psychiatric records between then and his February 11 release are emergency sedation forms. Defendants set Mr. Bravo's discharge in motion less than twelve hours after administering an emergency anti-

psychotic drug to him due to his ongoing aggressive behavior. Plaintiff needed continued treatment, but Defendants abruptly chose to discharge, abandon and "dump" him rather than to care for his continuing serious mental health needs.

41. Likewise, Defendants failed to protect Mr. Bravo from the health and safety hazards threatening a psychiatric patient by never obtaining a minimally comprehensive patient history, never assessing his options for post-discharge care, never investigating what aftercare had been successful or unsuccessful in the past, not planning Plaintiff's discharge in advance, not communicating with and including Mrs. Bravo in his discharge planning, and by not allowing sufficient time or making adequate effort to facilitate Plaintiff's discharge to his chosen destination, i.e., home. Defendants misrepresented Plaintiff's discharge destination to him and, when he objected, handcuffed him with plastic restraints and transported him to 1932 Rochester Circle without his consent, against his express will, and without ensuring that he understood the discharge sufficiently to receive its potential protections and benefits. By abandoning and "dumping" Mr. Bravo on the sidewalk in a strange neighborhood, while heavily medicated and so confused that he could neither walk properly nor even ask for the help he needed, while he was dressed in inadequate clothing and without the resources to sustain himself or to return home, Defendants, and each of them, recklessly subjected Mr. Bravo to a significantly increased likelihood of harm, and failed to fulfill their duties as care custodians to protect him against known risks to his health and safety.

42. In addition to neglect, the Defendants abandoned Mr. Bravo insofar as they discharged him before his serious mental illness was stable, and without making any significant effort to arrange his discharge to his requested, and logical, discharge destination, i.e., home. Defendants also failed to take minimal precautions to ensure that Plaintiff received the medically necessary continued care and treatment following that discharge.

43. Defendants deserted Mr. Bravo in his time of need in several different ways. First, by discharging him from this in-patient hospitalization without first stabilizing his acute mental illness and while he still required continued inpatient psychiatric care. Second, by failing to delay his discharge and provide continued care and custody for the few hours it might

have taken to contact Mr. Bravo's wife and family to include them in the discharge planning process to ensure a smooth and successful discharge to an appropriate facility. Instead, Defendants made only a nominal effort to contact Mrs. Guerrero and then discharged Plaintiff to an inadequate facility, i.e., a homeless shelter, so as not to disrupt their inexplicably short discharge timetable. Third, Defendants abandoned and "dumped" Mr. Bravo when they left him standing on the sidewalk at 1932 Rochester Circle, rather than taking the reasonable and obvious step of escorting him into the premises of Rochester House in order to complete the "hand off" to new care providers to ensure that he would receive the intended benefit of their discharge planning.

44. As a sole, direct and proximate result of the above-described conduct of the Defendants, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

45. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the Defendants, and each of them, Jesse Bravo was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this

Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

SECOND CAUSE OF ACTION

BREACH OF FIDUCIARY DUTY

(Brought Against All Defendants)

46. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragraphs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

47. At all relevant times, Defendants held themselves out to the general public and to Mr. Bravo as health care providers duly qualified and licensed to practice medicine and/or nursing or related health care services in the City of Los Angeles, County of Los Angeles, and throughout the State of California. Defendants further held themselves out as possessing that degree of skill, ability, and learning of medical and/or nursing or related health care practitioners in the relevant medical community to members of the general public, including Mr. Bravo.

48. Defendants became and were Mr. Bravo's "care custodians" within the meaning of California *Health & Safety Code* section 15610.57, and each and all of them owed a fiduciary duty to him with all of the rights, duties and obligations attendant thereto.

49. As described above, Defendants breached their fiduciary duties by never obtaining a remotely accurate patient history, by never assessing Plaintiff's options for post-discharge care, by not engaging in required treatment planning, by not actively treating Plaintiff, and by releasing him before his treatment goals had been met and before his acute mental illness had been stabilized such that he would no longer be a threat to the safety of himself or to others.

50. A dearth of reasonable diligence also characterized Plaintiff's discharge. Defendants did not plan Mr. Bravo's discharge in advance, did not allow sufficient time or make an adequate effort to facilitate his discharge to his chosen destination, failed to include Mr. Bravo's wife and family in the discharge planning process, misrepresented the discharge destination the Plaintiff and failed to ensure that Plaintiff understood the discharge sufficiently to receive its potential protections.

51. The HOSPITAL DEFENDANTS further breached their fiduciary duties by physically restraining and forcibly transporting Plaintiff to 1932 Rochester Circle without his consent and against his express will, discharging Mr. Bravo in such a manner that he did not receive any follow-up care thereby placing him in a situation of greater harm by discharging, abandoning and "dumping" him on the sidewalk in a strange neighborhood, while heavily medicated and so confused that he could neither walk properly nor even ask for the help he needed, and while he was dressed in inadequate clothing and without the resources to sustain himself or to return home.

52. These actions were in violation of Defendants' fiduciary duties as care custodians which required that they protect Mr. Bravo against known risks to his health and safety.

53. Defendants' conduct was outrageous, intentional and malicious, and was done with reckless disregard of the probability of causing Mr. Bravo to suffer physical harm, humiliation, mental anguish, and emotional distress.

54. As a sole, direct and proximate result of the above-described conduct of the Defendants, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such

information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

55. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the Defendants, and each of them, Jesse Bravo was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

56. The actions of the Defendants constitute reprehensible and despicable conduct that subjected Mr. Bravo to cruel and unjust hardship in conscious disregard of his rights. In doing the foregoing acts, the Defendants acted with malice as defined by California *Civil Code* section 3288 and with a willful and conscious disregard of the safety and well-being of Jesse Bravo. Such conduct qualifies as despicable conduct as that term is defined in California *Civil Code* section 3294, warranting the imposition of punitive or exemplary damages against the Defendants, and each of them, in order to set an example of them, and to dissuade them from future reckless and illegal conduct.

THIRD CAUSE OF ACTION

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

(Brought Against All Defendants)

57. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in

the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragraphs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

58. The above-described conduct by Defendants, and each of them, was outrageous, intentional and malicious, and was done with reckless disregard of the probability of causing Mr. Bravo to suffer humiliation, mental anguish, and emotional distress.

59. As a sole, direct and proximate result of the above-described conduct of the Defendants, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

60. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the Defendants, and each of them, Jesse Bravo was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

61. The actions of Defendants, and each of them, constitute reprehensible and

despicable conduct that subjected Mr. Bravo to cruel and unjust hardship in conscious disregard of his rights. In doing the foregoing acts, Defendants acted with malice as defined by California *Civil Code* section 3288 and with a willful and conscious disregard of the safety and well-being of Jesse Bravo. Such conduct qualifies as despicable conduct as that term is defined in California *Civil Code* section 3294, warranting the imposition of punitive or exemplary damages against Defendants in order to set an example of them, and to dissuade them from future reckless and illegal conduct.

FOURTH CAUSE OF ACTION

FALSE IMPRISONMENT

(Brought Against the HOSPITAL DEFENDANTS and DOES 1 through 100, Inclusive)

62. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragrpahs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

63. The HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, unlawfully violated Plaintiff's personal liberty rights when they used false pretenses, applied plastic restraints to handcuff and otherwise physically restrain and intentionally confine him without his consent and without lawful privilege in their transport van. Thereafter, the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, drove him to 1932 Rochester Circle where they abandoned and "dumped" him on the sidewalk, thereby causing him extreme anxiety and severe emotional distress.

64. The HOSPITAL DEFENDANTS' and DOES 1 through 100, inclusive, conduct was outrageous, intentional and malicious, and was done with reckless disregard of the probability of causing Mr. Bravo to suffer physical harm, humiliation, mental anguish, and emotional distress.

65. The HOSPITAL DEFENDANTS' and DOES 1 through 100, inclusive, actions constitute reprehensible and despicable conduct that subjected Mr. Bravo to cruel and unjust hardship in conscious disregard of his rights. In doing the foregoing acts, the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, acted with malice as defined by California *Civil Code* section 3288 and with a willful and conscious disregard of the safety and well-being of Jesse Bravo. Such conduct qualifies as despicable conduct as that term is defined in California *Civil Code* section 3294, warranting the imposition of punitive or exemplary damages against the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, in order to set an example of them, and to dissuade them from future reckless and illegal conduct.

FIFTH CAUSE OF ACTION

NEGLIGENCE *PER SE*

(Brought Against the HOSPITAL DEFENDANTS and DR. HERNANDEZ)

66. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragraphs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

67. At all times relevant to this action, the HOSPITAL DEFENDANTS and DR. HERNANDEZ had, and have, a duty under California *Health & Safety Code* section1262.5 to draft and implement an appropriate discharge planning policy. Specifically, this mandated policy must "require that appropriate arrangements for post-hospital care … are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning."

68. Because of his acute mental illness and psychiatric condition, Mr. Bravo is an individual who was, and continues to be, likely to suffer adverse health consequences upon

discharge as a result of inadequate discharge planning, and he is within the class of persons whom California *Health & Safety Code* section 1262.5 was designed to protect.

69. The HOSPITAL DEFENDANTS have instituted a policy within the meaning of California *Health & Safety Code* section 1262.5, but acted without regard to their statutory and fiduciary duties by failing to conform their actions to this policy. The HOSPITAL DEFENDANTS and DR. HERNANDEZ did not determine what arrangements were appropriate for Plaintiff—falling well short of ultimately making appropriate arrangements for his discharge—and thereby breached their duty to Mr. Bravo and to the public.

70. As participants in the federal Medicare system, the HOSPITAL DEFENDANTS and DR. HERNANDEZ also had, and have, a duty to comply with 42 C.F.R. section 482.61 and the regulations and guidelines that interpret it. These provisions manifestly seek to ensure that psychiatric patients like Mr. Bravo receive appropriate attention and care, protecting him and others from lackadaisical or slipshod assessment and treatment.

71. 42 C.F.R. section 482.61(a) prescribes the contents of social workers' psychosocial assessments. Psychosocial Assessments play a key role in documenting a patient's social and medical history, as well as laying the foundation for discharge planning by determining what options are available to the patient.

72. The HOSPITAL DEFENDANTS' Social Worker responsible for his Psychosocial Assessment, Gina Gamboa, never spoke to Mr. Bravo. Instead, she obtained his consent to speak to his wife. However, she never spoke with Mrs. Bravo and the HOSPITAL DEFENDANTS and DR. HERNANDEZ failed to include Mr. Bravo's wife and family in the discharge planning process. The HOSPITAL DEFENDANTS and DR. HERNANDEZ left the "discharge plan" section of the report blank, thereby failing to comply with their duty under federal statute to document potential "home plans."

73. 42 C.F.R. section 482.61(c)(1) mandates that a physician develop—or lead the development of—the patient's treatment plan. DR. HERNANDEZ signed one of Mr. Bravo's treatment plans on March 4, 2011, well after Mr. Bravo's discharge on February 11, and never signed the other. If DR. HERNANDEZ contributed to Mr. Bravo's treatment plans, he would

have signed them at the time. Accordingly, his failure to sign indicates a failure to participate and breaches the HOSPITAL DEFENDANTS and DR. HERNANDEZ's duty as participants in the Medicare system.

74. As a sole, direct and proximate result of the above-described conduct of the HOSPITAL DEFENDANTS and DR. HERNANDEZ, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

75. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the HOSPITAL DEFENDANTS and DR. HERNANDEZ, and each of them, Jesse Bravo was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

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SIXTH CAUSE OF ACTION

PROFESSIONAL NEGLIGENCE

(Brought Against All Defendants)

76. Plaintiff realizes and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragraphs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

77. Between January 28, 2011 and February 11, 2011, Defendants undertook the management, care, treatment and all other things necessary to preserve the health and well-being of Jesse Bravo, including, but not limited to, the management, care, and treatment of his medical complaints and his general medical and psychiatric condition.

78. Defendants negligently managed, cared for, treated, discharged, abandoned and "dumped" Mr. Bravo during the relevant period, causing him to suffer injuries.

79. As described above, Defendants negligently failed to make reasonable efforts to obtain a remotely accurate patient history, to assess Plaintiff's options for post-discharge care, to engage in required treatment planning, to actively treat Plaintiff and failed to include Mr. Bravo's wife and family in the discharge planning process, notwithstanding his prior express consent and request that they communicate with and include Mrs. Bravo in all aspects of his care and treatment, including discharge planning. Instead, Defendants released, discharged, falsely imprisoned and transported him against his will, abandoned and "dumped" him before their own treatment goals had been met and before Mr. Bravo's acute mental illness had been stabilized such that he would no longer be a threat to the safety of himself or others. In doing so, Defendants negligently and recklessly failed to provide the level and standard of care that is expected of professionals in their field.

80. A dearth of reasonable diligence also characterized Plaintiff's discharge.

Defendants did not plan Mr. Bravo's discharge in advance, did not allow sufficient time or make an adequate effort to facilitate Plaintiff's discharge to his chosen destination, misrepresented the discharge destination, discharged Plaintiff without his consent and failed to ensure that Plaintiff understood the discharge sufficiently to receive its potential protections.

81. In addition, Defendants' discharge, abandonment and "dumping" of Mr. Bravo on the sidewalk at 1932 Rochester Circle in a strange neighborhood—while heavily medicated and so confused that he could neither walk properly nor even ask for the help he needed, and while he was dressed in inadequate clothing and without the resources to sustain himself or to return home—constituted professional negligence in that, among other things, Defendants did not properly stabilize Mr. Bravo's acute mental illness first so that he could understand and consent to this or any hospital discharge.

82. As a sole, direct and proximate result of the above-described conduct of the Defendants, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to *California Code of Civil Procedure* section 425.10.

83. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the Defendants, and each of them, JESSE BRAVO was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-

economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

SEVENTH CAUSE OF ACTION

HOSPITAL NEGLIGENCE

(Brought Against the HOSPITAL DEFENDANTS and DOES 1 through 100, Inclusive)

84. Plaintiff realleges and incorporates by reference every allegation contained in the preceding Introduction, Parties, Jurisdiction and Venue, Defendants' Unlawful Treatment of Mr. Bravo, Statutory Protection of Dependent Adults, Statutory Mandate for Discharge Planning and Post-Discharge Care, Federal Regulation of Psychiatric Hospitals Participating in the Medicare System as set forth in Paragraphs 1 through 34, inclusive, and the First Cause of Action as set forth in Paragraphs 36 through 43, inclusive, of this Complaint as though set forth in full herein.

85. Between January 28, 2011 and February 11, 2011, the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, undertook the management, care, treatment and all other things necessary to preserve the health and well-being of Mr. Bravo.

86. The HOSPITAL DEFENDANTS' and DOES 1 through 100, inclusive, duties included, but were not limited to, the diagnosis, care, treatment and discharge of psychiatric patients such as Mr. Bravo. Specifically, the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, had and have a common law duty to use reasonable diligence in safeguarding a patient committed to their charge—a duty that is measured by the patient's capacity to care for himself. Here, the HOSPITAL DEFENDANTS' and DOES 1 through 100, inclusive, breach includes, but is not limited to, the fact that they never made a reasonable effort to assess Plaintiff's capacity for self-care.

87. As described above, the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, breached their fiduciary duties by never obtaining an accurate patient history, by never assessing Plaintiff's options for post-discharge care, by not actively treating Plaintiff,

by not engaging in required treatment planning, by failing to include Mr. Bravo's wife and family in the discharge planning process, notwithstanding his prior express consent and request that they communicate with and include Mrs. Bravo in all aspects of his care and treatment, including discharge planning and by releasing him before his treatment goals had been met and before he had been stabilized such that he no longer would be a threat to himself or to others.

88. A dearth of reasonable diligence also characterized Plaintiff's discharge, abandonment and "dumping." The HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, did not plan Mr. Bravo's discharge in advance, did not allow sufficient time or make adequate effort to facilitate Plaintiff's discharge to his chosen destination, misrepresented the discharge destination, and physically restrained and forcibly transported Plaintiff to 1932 Rochester Circle without his consent, against his express will and without ensuring that he understood the discharge sufficiently to receive its potential protections.

89. By discharging, abandoning and "dumping" Mr. Bravo on the sidewalk in a strange neighborhood--while heavily medicated and so confused that he could neither walk properly nor even ask for the help he needed, and while he was dressed in inadequate clothing and without the resources to sustain himself or to return home--the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, and each of them, failed to fulfill their duty to be reasonably diligent in safeguarding the welfare of psychiatric patients such as Plaintiff, who at that time was completely unable to care for himself both because of his acute mental illness, altered mental status and because of ongoing sedation.

90. The HOSPITAL DEFENDANTS' and DOES 1 through 100, inclusive, conduct was outrageous, intentional and malicious, and was done with reckless disregard of the probability of causing Mr. Bravo to suffer physical harm, humiliation, mental anguish, and emotional distress.

91. As a sole, direct and proximate result of the above-described conduct of the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, and each of them, Jesse Bravo was injured and hurt in his health, strength and activity, sustained serious personal injuries to his body, and suffered extreme humiliation and emotional distress, all of which have

required medical care and treatment. In addition to the foregoing, Plaintiff is informed and believes and, upon such information and belief, alleges that he has suffered other, as yet undiagnosed, injuries as well as shock and injury to his nervous system and person, all of which injuries have caused and continue to cause him great physical, mental and nervous pain and suffering. Plaintiff is informed and believes and, upon such information and belief, alleges that said injuries will result in permanent disability to him, all to his general and non-economic damages in an amount that is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

92. As a further, direct and proximate result of the injuries sustained as a sole, direct and proximate result of the above-mentioned conduct of the HOSPITAL DEFENDANTS and DOES 1 through 100, inclusive, and each of them, Jesse Bravo was required to submit to, undergo and endure medical and psychiatric care and treatment and has also sustained other injuries for which he has and will suffer severe pain, suffering, fear, worry and anguish in connection therewith, all to his further general and non-economic damages. Plaintiff is informed and believes, and thereon alleges, that some of these injuries will be permanent, all to his general damages in an amount which is in excess of this Court's minimum jurisdictional amount and which will be stated according to proof, pursuant to California *Code of Civil Procedure* section 425.10.

PRAYER FOR RELIEF

Wherefore, Plaintiff Jesse Bravo prays for judgment and relief as against Defendants, and each of them, as follows:

1. That the Court order Defendants, and their agents, servants, employees, partners, associates, officers, representatives and all persons acting under or in concert with or for them, to comply with all laws and regulations regarding the treatment and discharge of dependent adults;
2. For general, special, and compensatory damages in amounts to be proven at trial;
3. For punitive damages in an amount to be proven at trial on the Second, Third and

Fourth Causes of Action;

4. For prejudgment interest as allowed by law;

5. For costs and reasonable attorneys' fees; and

6. For such other relief as is just and equitable.

Dated: February 3, 2012

KIESEL BOUCHER LARSON LLP
PUBLIC COUNSEL

By: _____
Paul R. Kiesel
Steven D. Archer
Attorneys for Plaintiff
JESSE BRAVO

DEMAND FOR JURY TRIAL

Plaintiff Jesse Bravo hereby demands a trial by jury on all issues triable to a jury.

Dated: February 3, 2012

KIESEL BOUCHER LARSON LLP
PUBLIC COUNSEL

By: _____
Paul R. Kiesel
Steven D. Archer
Attorneys for Plaintiff
JESSE BRAVO