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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

DOUGLAS WAYNE ROSS, JR., **NICOLE ROSS**, and **NEVILLE ROSS**, individually and as Successors-In-Interest to **DOUGLAS WAYNE ROSS, SR.**, decedent

Plaintiffs,

v.

THE UNITED STATES OF AMERICA, a governmental entity.

Defendant

CASE NO.

COMPLAINT:

1. **VIOLATIONS OF THE ELDER AND DEPENDENT ADULT CIVIL PROTECTION ACT [Welf. & Instit. Code § 15600 *et seq.*]**

2. **WRONGFUL DEATH [Code of Civil Procedure § 377.60]**

TABLE OF CONTENTS

I. INTRODUCTION

1. This case arises from the callous treatment of Douglas Wayne Ross, Sr. ("Mr. Ross" or "Decedent"), a seventy-two-year-old veteran of the United States Navy and the Vietnam War. Indeed, Mr. Ross's death certificate lists his cause of death as a head injury caused by a "fall, unwitnessed." This was shocking given that Defendant VA Palo Alto ("VA Palo Alto" or "Defendant") had designated Mr. Ross as a "high risk for falls." Inexplicably, the VA Palo Alto has denied responsibility. (See March 8, 2017 Letter from Department of Veterans Affairs, attached hereto as **Exhibit 1**). This case is yet another tragic failure in the VA's care for service men and women.

2. Mr. Ross died on May 5, 2016 from a traumatic head injury he suffered while he was a patient in the IICU at the VA Palo Alto. Mr. Ross sustained his traumatic head injury because the VA Palo Alto left him unattended in a chair in his hospital room. The VA Palo Alto left Mr. Ross unattended and unrestrained in his chair despite knowing he was at a serious risk of falls and in an extremely feeble condition due the intensive surgery he had recently undergone.

3. Mr. Ross had gone into cardiac arrest after a surgery and subsequently experienced shock. When the VA Palo Alto propped Mr. Ross in a chair and left him, he was on a multiple feeding tubes, his right foot was completely black and gangrenous from lack of circulation, and he was dependent on the VA Palo Alto's nurses and doctors for all activities of daily living and functional tasks. The VA Palo Alto knew Mr. Ross was at a high risk of falls and in extremely poor physical health when it left him alone in this extremely precarious condition, unattended in his hospital room chair.

4. The VA Palo Alto's actions violated California's Elder Abuse and Dependent Adult Civil Protection Act, which prohibits neglect and abuse of California's elders. Moreover, the VA Palo Alto's actions are further evidence of neglect of our veterans.

5. Plaintiffs Douglas Wayne Ross Jr., Nicole Ross, and Neville Ross (collectively "Plaintiffs"), individually and as heirs to Douglas Wayne Ross Sr., bring this action for damages under the Federal Tort Claims Act, 28 U.S.C. § 1346(b), 1402(b), 2401(b), and 2671-2680 ("FTCA"), against the United States of America, Department of Veterans Affairs, ("VA").

II. JURISDICTION AND VENUE

5. The VA was served with an administrative claim pursuant to the FTCA on or around July 21, 2016. On March 8, 2017, the VA denied Plaintiffs' administrative claim.

6. This Court has jurisdiction over all causes of action asserted against the federal government pursuant to 28 U.S.C. § 1346 because this is a civil action against the United States of America for money damages for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment.

7. Venue is proper pursuant to 28 U.S.C. § 1402 because at all times relevant, all of the wrongful acts and/or omissions complained of herein occurred in Santa Clara County, which is in this judicial district.

III. PARTIES

A. Plaintiff

8. Plaintiff Douglas Wayne Ross Jr. ("Plaintiff Doug Ross Jr." or "Doug Ross Jr.") is a natural person who is, and at all times mentioned in this complaint was, a resident of Spokane, Washington. Plaintiff Doug Ross Jr. brings this action in his individual capacity and as heir of the decedent, Douglas Wayne Ross Sr. ("Mr. Ross" or "Decedent"). Plaintiff Doug Ross Jr. is the Decedent's biological son. Plaintiff Doug Ross Jr. is lawfully entitled to pursue all claims and causes of action for damages pursuant to Code of Civil Procedure sections 377.32, 377.60, 377.61, Welfare and Institution Code section 15657.3(d), and Probate Code section 48. On Decedent's behalf, Plaintiff Doug Ross Jr. brings a cause of action against Defendant for elder abuse. Plaintiff Doug Ross Jr. also brings a cause of action against Defendant for wrongful death in his individual capacity as Decedent's heir.

9. Plaintiff Nicole Ross is a natural person who is, and at all times mentioned in this complaint was, a resident of Vieques, Puerto Rico. Plaintiff Nicole Ross is Decedent's biological daughter. Plaintiff Nicole Ross is lawfully entitled to pursue all claims and causes of action for damages pursuant to Code of Civil Procedure sections 377.32, 377.60, and 377.61. Plaintiff

Nicole Ross brings a cause of action against Defendant for wrongful death in her individual capacity as Decedent's heir.

10. Plaintiff Neville Ross is a natural person who is, and at all times mentioned in this complaint was, a resident of Gloucester, Massachusetts. Plaintiff Neville Ross is Decedent's biological son. Plaintiff Neville Ross is lawfully entitled to pursue all claims and causes of action for damages pursuant to Code of Civil Procedure sections 377.32, 377.60, 377.61. Plaintiff Neville Ross brings a cause of action against Defendant for wrongful death in his individual capacity as Decedent's heir.

B. Defendant

11. Defendant United States of America, Department of Veterans Affairs is an executive agency of the United States Government. The acts and omissions complained of herein occurred at the Veterans Administration Hospital in Palo Alto, California. The Veterans Administration Hospital in Palo Alto, California (hereinafter "VA Palo Alto"), is owned and/or operated by the Department of Veterans Affairs, an agency of the United States of America.

IV. THE VA'S MISTREATMENT OF VETERANS IS PERVASSIVE AND SYSTEMIC

12. The number of cases of veterans being mistreated by the VA has vastly increased in recent years. (See http://www.nydailynews.com/news/national/legal-settlements-veterans-affairs-triple-article-1.2654179). At VA facilities across the nation, veterans have been harmed by "blown diagnosis, botched procedures and substandard care." *Id.* Some shocking examples of veteran mistreatment are the following: A Cleveland army veteran who died from internal bleeding due to complications from a routine gallbladder removal surgery; a Gulf War veteran in Atlanta, who suffered from serious depression, suffocated to death following an electro shock therapy session; and a Vietnam veteran in St. Petersburg, Florida, who died from colon cancer after his doctor ignored red flags on an annual medical test for three years. *Id.* These are just a few examples of the numerous cases of substandard care and neglect at VA hospitals throughout the nation. The VA's mistreatment of our veterans has resulted in well over $848 million in payouts to veterans and their families since 2011. *Id.*

13. In February of 2017, a former Marine and his wife took pictures of the shocking conditions inside of a VA hospital in Durham, North Carolina and felt obligated post them on social media to expose the terrible veteran mistreatment they observed. (*See* http://nypost.com/2017/02/28/photos-of-vets-being-neglected-at-va-spark-outrage/). The couple reported that the veterans in the pictures were ignored for hours despite complaining of severe pain. *Id.*

14. In April of 2017, the Office of Inspector General issued an "Interim Summary Report" that detailed the terrible conditions at a VA hospital in Washington D.C. (*See* https://www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf). The OIG report noted "a number of serious and troubling deficiencies" at the VA Medical Center, including: (1) the lack of an effective inventory system for managing the availability of medical equipment and supplies used for patient care; (2) the lack of an effective system to ensure that supplies and equipment that were subject to patient safety recalls were not used on patients; and (3) that 18 of the 25 sterile satellite storage areas for supplies were dirty. *Id.* The OIG report found that the conditions at the VA Medical Center "placed patients at unnecessary risk by failing to ensure that appropriate medical supplies and equipment were available to providers when needed; that recalled supplies or equipment were not used on patients; and that sterile supplies were stored appropriately." *Id.*

15. Veteran mistreatment and substandard conditions have been reported at VA Palo Alto as well. For example, in 2014, an inpatient pharmacy technician at the VA Palo Alto complained to his superiors of "incompetent, uncaring management and inefficiencies in the delivery of medicine to patients." (See http://www.pogo.org/our-work/articles/2014/fear-and-retaliation-at-the-va.html). The technician also noted that "patients were suffering from 'missed doses, late doses, [and] wrong doses'," and characterized the VA Palo Alto's Inpatient Pharmacy as being in a "perpetual state of failure." *Id.* The technician further "cited additional medication errors, including a case in which a veteran's epidural drip of pain control medication ran dry, and another in which a chemotherapy drug that requires refrigeration was administered two-and-a-half hours after its expiration point and the patient subsequently developed a high fever." *Id.*

16. Additionally, in 2010, a number of Veterans sued the VA Palo Alto for vision loss caused by the substandard care they received as patients at the VA Palo Alto. (*See* http://www.mercurynews.com/2010/05/07/war-vet-87-sues-palo-alto-veterans-hospital-for-failing-to-properly-treat-his-vision-loss/; *see also* http://www.mercurynews.com/2010/11/23/another-veteran-settles-lawsuit-over-improper-care-at-palo-alto-va/). The Veterans who sued were part of a group of VA Palo Alto patients who "received letters disclosing that improper care at the facility may have resulted in their vision loss." *Id.*

17. These media and government reports of mistreatment and substandard conditions at VA hospitals across the nation show that the VA has a systemic problem.

V. STANDING TO BRING THIS SURVIVAL ACTION

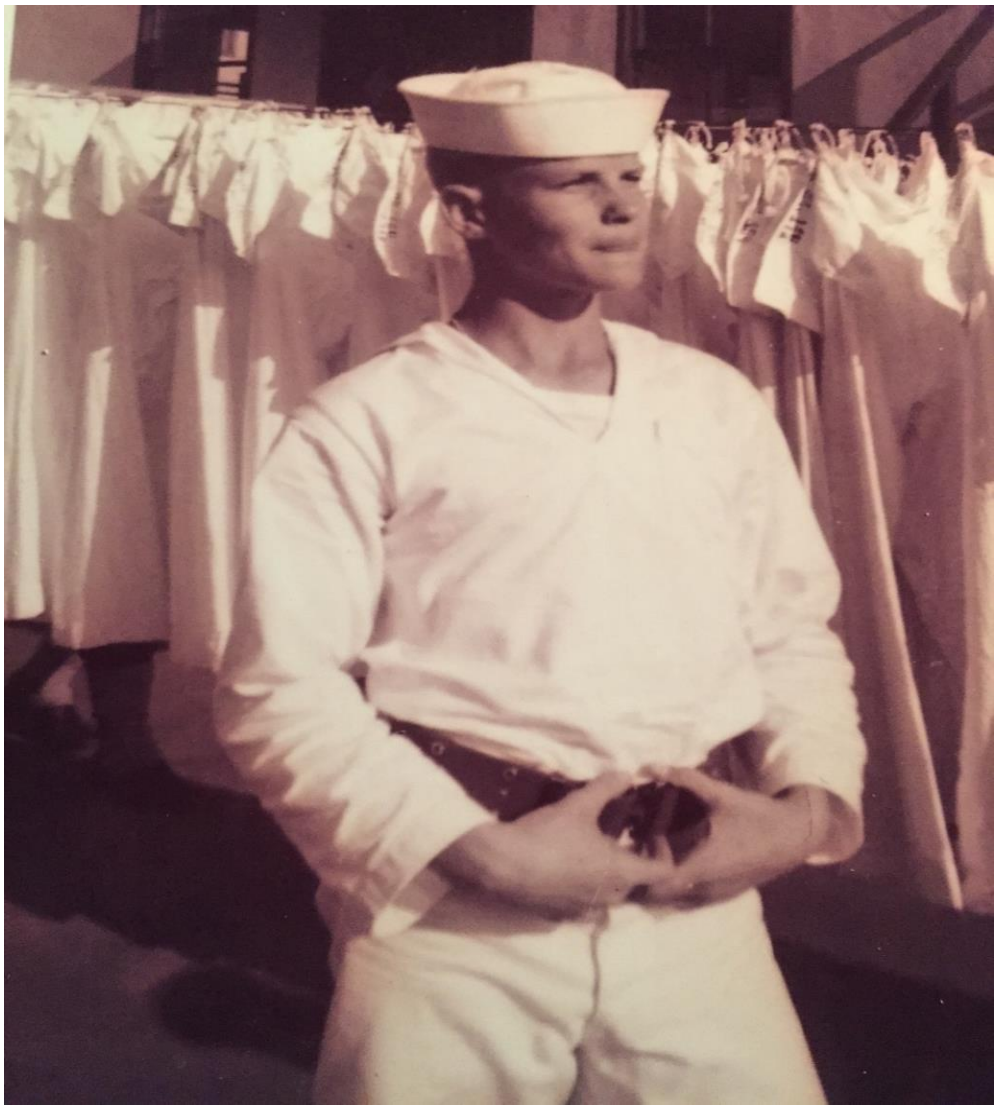
18. Pursuant to the provisions of Code of Civil Procedure section 377.32 and Welfare and Institutions Code section 15657.3(d), Plaintiffs, as successors-in-interest to decedent Douglas Wayne Ross Sr., are lawfully entitled to pursue all survival claims and causes of action for damages on behalf of decedent Douglas Wayne Ross Sr. In compliance with the provisions of Code of Civil Procedure section 377.32, Plaintiffs have executed the required declarations (attached as **Exhibits 2, 3, and 4**) and thereby proceed as successors-in-interest to the survival claims of decedent Douglas Wayne Ross Sr. The decedent was seventy-two years old at the time of his death.

19. Additionally, pursuant to the provisions of Welfare and Institutions Code section 15657.3(d) and section 48 of the Probate Code, Plaintiffs are interested persons, as defined by section 48 of the Probate Code, and are thus each lawfully entitled to pursue all claims and causes of action in a survival action on behalf of decedent Douglass Wayne Ross Sr.

VI. FACTUAL ALLEGATIONS

21. Douglas Wayne Ross Sr. ("Decedent" or "Mr. Ross"), a seventy-two-year-old veteran of the United States Navy and the Vietnam War, died on May 5, 2016 from a traumatic head injury he suffered while he was a patient in the IICU at the VA Palo Alto. Mr. Ross's death certificate indicates the cause of death as a "closed head injury" caused by a "fall, unwitnessed."

22. From 1960 to 1964, Mr. Ross served as an Armorer in the United States Navy. He was assigned to the USS Hancock, which was stationed in the South China Sea during the Vietnam War. After his military service, he owned and operated a charter sailing business in the U.S. Virgin Islands until 2007. After retiring from his sailing business, he moved to Jamestown, California where he was a member of a gold miner's association and enjoyed teaching others how to pan for gold. He hoped that his VA surgery would relieve the pain he was experiencing in his legs so that he could return to gold panning. He was also an ordained minister, having become ordained in the early 1980s. Mr. Ross very much cherished his role as a minister. He is survived by his three children and six grandchildren. Below is a picture of Mr. Ross in his Navy sailing uniform:



23. Mr. Ross initially came to the VA Palo Alto in late February of 2016 for revascularization surgery to increase blood flow to his lower extremities. Mr. Ross's VA Palo Alto doctors determined he would require multiple surgeries due to the complicated nature of his condition. After his first surgery, however, Mr. Ross suffered a heart attack and had to be revived after going into cardiac arrest. Thereafter, Mr. Ross continued to have poor circulation, which caused him to develop infections in his lower extremities. Mr. Ross also experienced shock, and became irreversibly dialysis dependent. VA Palo Alto doctors put Mr. Ross on the maximum amount of blood thinners to prevent another heart attack and treat his blood clots. The blood thinners put Mr. Ross at risk of bleeding excessively if he suffered any fall. VA Palo Alto doctors determined he could not undergo any additional surgeries due to his feeble condition. Mr. Ross's file noted he was a "high risk for falls." (See **Exhibit 5**).

24. While in this extremely feeble state, Mr. Ross was left unattended and unrestrained in a chair in his room in the IICU, during which time he fell from his chair and hit his head. The fall caused Mr. Ross to bleed around his head and internally in his brain. Mr. Ross died a week later from the injuries and consequent complications caused by his fall. The VA Palo Alto has acknowledged that Mr. Ross was "injured as a result of a fall in his room." (See Letter from Stephen C. Ezeji-Okoye, MD, attached hereto as **Exhibit 6**). Despite this admission, and the fact his death certificate says "closed head injury" was the cause of death, the VA Palo Alto denies any responsibility for Mr. Ross's death. (See March 8, 2017 Letter from Department of Veterans Affairs, attached hereto as **Exhibit 1**).

25. The VA Palo Alto knew Mr. Ross was at a "high risk for falls." In fact, as depicted below, on April 20, 2016, the VA Palo Alto noted in its Progress Notes that Mr. Ross was at a "high risk for falls":

```
MORSE FALL SCALE
  The Morse Fall scale was performed and score was 85.  This is indicative
  of high risk for falls.
```

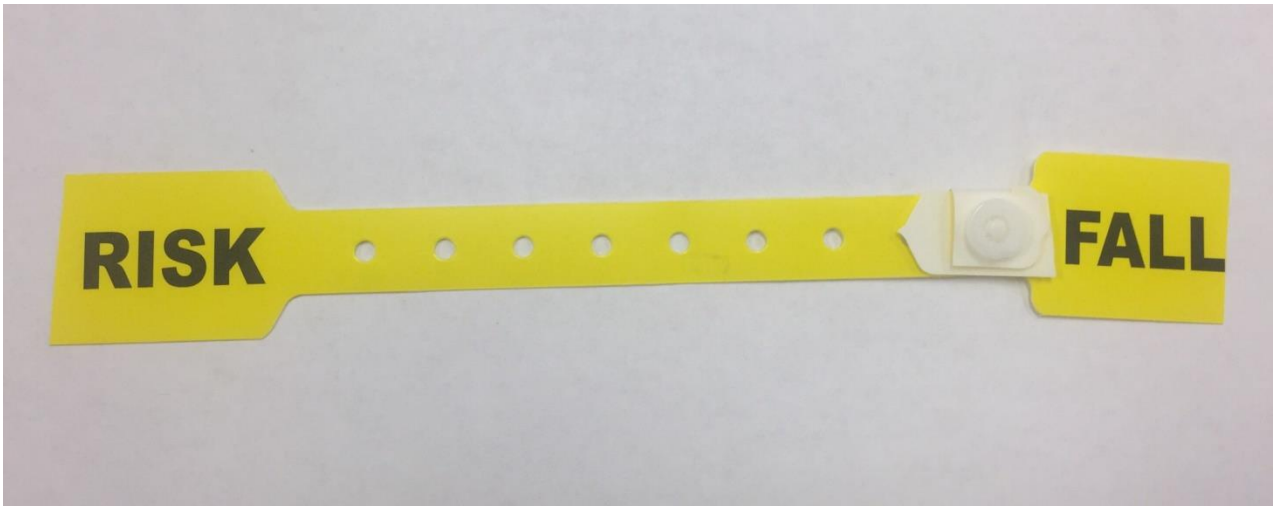
In those same notes, as depicted below, the VA Palo Alto noted that Mr. Ross was taking medication that "may increase the risk of falls or injury from falls":

```
OTHER RISK FACTORS
  Secondary Diagnosis
      The patient/resident is on multiple medications to manage
      co-morbidities.
    Medications that may increase risk of falls or of injury from falls:
      Opioids
```

Additionally, as noted in the Progress Notes, Mr. Ross was dependent on the VA Palo Alto for all basic tasks.

26. Mr. Ross's medical records show that just two days before his fall a "[m]echanical lift was used by nursing to get [Mr. Ross] out of bed." Mr. Ross's medical records also show that at the time he was left unsupervised and unrestrained in a chair in his room, he was on a nasogastric feeding tube, rectal tube, and intravenous medication. His medical records also show, as mentioned earlier, that he had infections in his lower extremities, and specifically that his right foot was black and gangrenous. Mr. Ross should not have been left alone in a chair while in such an extremely fragile physical condition. Moreover, appropriate precautions, such as soft restraints, were needed for any patient who was at "high risk for falls."

27. For example, warnings such as the standard "fall risk" bracelet depicted below, accompanied by substantive precautions, should have been used on Mr. Ross to ensure he did not fall:



28. Despite knowing that Mr. Ross was in a frail condition and a fall risk, the VA Palo Alto left him alone in a chair for, according to his medical records, roughly 40 minutes. That was like leaving an infant unattended in a bath for 40 minutes. VA Palo Alto's conduct exemplifies a failure on its part to take reasonable and necessary precautions to ensure that Mr. Ross did not fall. VA Palo Alto's neglect and failure to provide due care ultimately caused Mr. Ross to suffer the devastating fall on April 28, 2016. VA Palo Alto's neglect resulted in and/or contributed substantially to Mr. Ross's death.

29. It defies explanation why VA Palo Alto would leave Mr. Ross unattended and unrestrained in a chair knowing he was in an extremely feeble condition and at a high risk for falls. VA Palo Alto's actions violated California's Elder Abuse and Dependent Adult Civil Protection Act, which prohibits neglect and abuse of California's elders.

VII. CAUSES OF ACTION

FIRST CAUSE OF ACTION

ELDER ABUSE UNDER THE ELDER ABUSE AND DEPENDENT ADULT CIVIL PROTECTION ACT

(Brought by Plaintiff Doug Ross, Jr. Against Defendant)

30. Plaintiffs incorporate by reference and re-allege all of the allegations contained in the preceding paragraphs of this Complaint as though fully set forth herein.

31. At all relevant times, Decedent was an elder as defined by Welfare & Institutions Code section 15610.27. He was seventy-two at the time of Defendant's conduct.

32. The actions described above constitute abuse of an elder as defined by the Welfare and Institutions Code section 15610.07. Defendant neglected Decedent, which resulted in Decedent's physical harm, pain and mental suffering. In addition, Defendant, as Decedent's care custodian, deprived Decedent of services that were necessary to avoid physical harm and mental suffering.

33. The actions described above constitute neglect as defined by the Welfare and Institutions Code section 15610.57 in that the Defendant negligently failed to exercise a degree of care that a reasonable person in a like position would exercise. Among other things, Defendant

failed to: (1) exercise the degree of care that a reasonable person in a like position would exercise; and (2) protect Decedent from health and safety hazards.

34. Decedent has been harmed by Defendant's conduct as described herein. Defendant's conduct was a substantial factor in causing Decedent to suffer physical, emotional, and economic harm, as well as other damages in an amount to be determined according to proof.

35. Defendant acted with recklessness, malice, oppression, and/or fraud. Among other things, Defendant neglected to take the necessary precautions to prevent Decedent's injuries. Decedent is entitled to punitive damages in an amount to be determined according to proof, as well as attorney's fees and costs pursuant to Welfare and Institutions Code section 15657.

WHEREFORE, Plaintiffs pray for relief as set forth below.

SECOND CAUSE OF ACTION

NEGLIGENCE/WRONGFUL DEATH

(Brought by All Plaintiffs Against Defendant)

36. Plaintiffs incorporate by reference and re-allege all of the allegations contained in the preceding paragraphs of this Complaint as though fully set forth herein.

37. By virtue of their roles as caretakers and by virtue of the fact that Decedent was a dependent adult and inpatient at the VA Palo Alto, Defendant had a duty to exercise a degree of care that a reasonable person in a like position would exercise. Defendant failed to do so. Among other things Defendant had a duty to:

a. Provide services that meet standards of care;

b. Ensure that an adequate patient care plan, that identified Decedent as being at a high risk for falling, was developed, reviewed, revised and carried out;

c. Take all reasonable and necessary precautions to ensure that Decedent did not fall;

d. Adequately supervise Decedent;

e. Treat Decedent with respect, dignity, and without abuse.

38. During the period of his stay at the VA Palo Alto, Defendant breached its duty to Decedent. Among other things, and without limiting the generality of the foregoing, VA Palo Alto failed to:

a. Provide services that meet professional standards of quality.

b. Ensure that an adequate patient care plan, that identified Decedent as being at a high risk for falling, was developed, reviewed, revised and carried out;

c. Take all reasonable and necessary precautions to ensure that Decedent did not fall;

d. Adequately supervise Decedent;

39. Defendant's negligence, carelessness, recklessness, and unlawfulness was a substantial factor in causing Decedent to suffer tremendous physical, emotional, economic, and fatal harm as well as other damages to be proven at the time of the trial.

40. Decedent died as a direct and legal result of Defendant's wrongful acts and omissions.

41. By reason of the wrongful death of Decedent that resulted from the wrongful acts and omissions of Defendant, Plaintiffs suffered and continue to suffer loss of love, companionship, comfort, affection, solace, and moral support of Decedent in the amount to be determined at trial.

42. By reason of the wrongful death of Decedent, resulting from the wrongful acts and/or omissions of Defendant, Plaintiffs hereby seek recovery of other such relief as may be just and provided for under the Civil Code section 377.61.

WHEREFORE, Plaintiffs pray for relief as set forth below.

VIII. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for relief as follows:

1. General and special compensatory damages according to proof;
2. Punitive damages according to proof, including treble punitive number damages per Civil Code section 3345;
3. For prejudgment and post-judgment interest upon such judgment at the maximum rate provided by law;

4. Reasonable costs of suit;

5. Attorney's fees per the Welfare and Institutions Code on the first cause of action; and

6. Such other further relief as the Court may deem proper.

Respectfully Submitted,

Dated: May 15, 2017

COTCHETT, PITRE & McCARTHY, LLP

By: */s/ Niall P. McCarthy*
NIALL P. McCARTHY
PETE McCLOSKEY, JR.
EMANUEL B. TOWNSEND

Attorneys for Plaintiffs

EXHIBIT 1

DEPARTMENT OF VETERANS AFFAIRS
Chief Counsel, Pacific District North
4150 Clement Street, Bldg. 210
San Francisco, CA 94121
Tel (415) 750-2288
Fax (415) 750-2255

Via Certified-Mail, Return-Receipt Requested

In Reply Refer to: # 280716

March 8, 2017

Emanuel B. Townsend
Cotchett Pitre& McCarthy
San Francisco Airport Office Center
840 Malcolm Road
Burlingame, CA 94010-1401

Re: Administrative Tort Claim

Dear Mr. Townsend:

The Department of Veterans Affairs (VA) has thoroughly investigated the facts and circumstances surrounding the administrative tort claim that you filed on behalf of Douglas W. Ross Jr. on July 27, 2016, alleging that Douglas Wayne Ross, Sr., died from a fall that occurred on April 28, 2016. The claim notes Mr. Ross was in a feeble state when he was left unattended and unrestrained in a chair in his room in the IICU. The VA's investigation of the claim included a review of Mr. Ross' medical records as well as a review of the claim and its facts and circumstances surrounding the fall by a medical expert in another part of the country.

The Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b) and 2671-2680, under which you filed the claim, provides for monetary compensation when a Government employee, acting within the scope of employment, injures another by a negligent or wrongful act or omission. Medical negligence means there was a breach in the standard of care and that breach proximately caused an injury. The standard of care is the level at which similarly qualified medical professionals would have managed the care under the same or similar circumstances.

Our review concluded there was no negligent or wrongful act on the part of an employee of the Department of Veterans Affairs acting within the scope of employment that caused compensable harm. Accordingly, we deny this claim.

If your client is dissatisfied with this decision, you may file a request for reconsideration of your claim with the VA General Counsel by either of the following means:

(1) by mail to the Department of Veterans Affairs, General Counsel (021B), 810 Vermont Avenue, N.W., Washington, DC 20420; or
(2) by data facsimile (fax) to (202) 273-6385.

To be timely, VA must receive this request within six months of the mailing of this final denial. The VA has six months to act on the reconsideration request. After that time, you have the option of filing suit in an appropriate U.S. District Court under 28 U.S.C. § 2675(a). 28 C.F.R. § 14.9.

In the alternative, if your client is dissatisfied with the denial of this claim, you may file suit directly under the FTCA, 28 U.S.C. §§ 1346(b) and 2671-2680. The FTCA provides that when an agency denies an administrative tort claim, the claimant may seek judicial relief in a Federal district court. The claimant must initiate the suit within six months of the mailing of this notice as shown by the date of this denial (28 U.S.C. § 2401(b)). In any lawsuit, the proper party defendant is the United States, not the Department of Veterans Affairs.

Sincerely,

Kristen A. Nelson for

SUZANNE C. WILL
Chief Counsel

EXHIBIT 2

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

DOUGLAS WAYNE ROSS JR., NICOLE ROSS, AND NEVILLE ROSS, individually and as Successors-In-Interest to **DOUGLAS WAYNE ROSS SR.,** decedent,

Plaintiffs,

vs.

THE UNITED STATES OF AMERICA, a governmental entity.

Defendants.

Case No. _____

DECLARATION OF DOUGLAS WAYNE ROSS, JR.

DECLARATION OF DOUGLAS WAYNE ROSS, JR.

I, **DOUGLAS WAYNE ROSS, JR.**, declare:

1. I am a resident of Spokane, Washington in Spokane County;

2. My father, Douglas Wayne Ross, Sr., died on May 5, 2016 at VA Medical Center, 3801 Miranda Avenue, Palo Alto, California 94304;

3. No proceeding is now pending in California for administration of the decedent's estate;

4. I am Douglas Wayne Ross, Sr.'s successor in interest (as defined in Section 377.11 of the California Code of Civil Procedure) and I succeed to his interest in the action or proceeding to be filed against the United States of America, on the grounds that I am one of Douglas Wayne Ross, Sr.'s three children.

5. No other person has a superior right to commence the action or proceeding;

6. Attached as Exhibit A is a certified copy of my father's death certificate as required by Section 377.32 of the California Code of Civil Procedure;

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on this 14 day of April, 2017 at Spokane (City), WA (State).

DOUGLAS WAYNE ROSS, JR.

EXHIBIT A

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY of SANTA CLARA
PUBLIC HEALTH DEPARTMENT
VITAL RECORDS AND REGISTRATION

CERTIFICATE OF DEATH (STATE OF CALIFORNIA — USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS — 16-11 (REV 2/04))

STATE FILE NUMBER: | LOCAL REGISTRATION NUMBER: 3201643003911

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT – FIRST (Given)	2. MIDDLE	3. LAST (Family)
DOUGLAS	WAYNE	ROSS

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	If UNDER ONE YEAR Months / Days	If UNDER 24 HOURS Hours / Minutes	6. SEX
09/16/1943	72			M

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/RDP* (at time of death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
UT	567-56-1998	[X] YES [ ] NO [ ] UNK	DIVORCED	05/05/2016	0855

13. EDUCATION – Highest Level/Degree (see worksheet on back)	14/15. WAS DECEDENT HISPANIC/LATINO/A/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
HS GRADUATE	[ ] YES [X] NO	CAUCASIAN

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION
SAILBOAT CAPTAIN	RECREATION	25

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)				
10678 WIGWAN ROAD				
21. CITY	**22. COUNTY/PROVINCE**	**23. ZIP CODE**	**24. YEARS IN COUNTY**	**25. STATE/FOREIGN COUNTRY**
JAMESTOWN	TUOLUMNE	95327	10	CA

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
DOUGLAS W. ROSS JR, SON	3323 N. PITTSBURG STREET, SPOKANE, WA 99207

SPOUSE/RDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/RDP – FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
-	-	-	
31. NAME OF FATHER/PARENT – FIRST	**32. MIDDLE**	**33. LAST**	**34. BIRTH STATE**
WALTER	JAMES	ROSS	UT
35. NAME OF MOTHER/PARENT – FIRST	**36. MIDDLE**	**37. LAST (BIRTH NAME)**	**38. BIRTH STATE**
KATHRYN	-	THOMAS	UT

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION		
05/10/2016	RESIDENCE OF NICOLE ROSS A54 F. CALLE ANDUCE, VE QUES PUERTO RICO 00765		
41. TYPE OF DISPOSITION(S)	**42. SIGNATURE OF EMBALMER**		**43. LICENSE NUMBER**
CR/TR/RES	▸ NOT EMBALMED		-
44. NAME OF FUNERAL ESTABLISHMENT	**45. LICENSE NUMBER**	**46. SIGNATURE OF LOCAL REGISTRAR**	**47. DATE mm/dd/ccyy**
SANTA CLARA FUNERAL & CREMATION SERVICE	FD2072	▸ SARA H CODY, MD	05/09/2016

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
VA MEDICAL CENTER	[X] IP [ ] ER/OP [ ] DOA	[ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [ ] Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SANTA CLARA	3801 MIRANDA AVENUE	PALO ALTO

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(a) CLOSED HEAD INJURY	(a) DAYS
Sequentially list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(b) FALL, UNWITNESSED	(b) DAYS
	(c)	(c)
	(d)	(d)

108. DEATH REPORTED TO CORONER?	109. BIOPSY PERFORMED?	110. AUTOPSY PERFORMED?	111. USED IN DETERMINING CAUSE?
[X] YES [ ] NO	[ ] YES [X] NO	[ ] YES [X] NO	[ ] YES [ ] NO
Medical examiner / coroner case # 16-01704			

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; RECENT HEART ATTACK

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)
NO

113A. IF FEMALE, PREGNANT WITHIN YEAR? [ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FOR THE CAUSES STATED	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
Decedent Attended Since: (A) mm/dd/ccyy (B) mm/dd/ccyy — Decedent Last Seen Alive	▸		
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE			

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FOR THE CAUSES STATED	120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
MANNER OF DEATH: [ ] Natural [X] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined	[ ] YES [X] NO [ ] UNK	04/28/2016	1445

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)
HOSPITAL

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)
UNWITNESSED FALL OFF CHAIR

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)
3801 MIRANDA AVENUE, PALO ALTO, CA 94306

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸ MICHELLE A JORDEN MD	05/09/2016	MICHELLE A JORDEN MD, ME

STATE REGISTRAR	A	B	C	D	E		FAX AUTH.#	CENSUS TRACT
						C1000100324123Z		

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA } SS
COUNTY OF SANTA CLARA }

DATE ISSUED By MAY 16 2016

H03049709

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, DEPARTMENT OF PUBLIC HEALTH.

SARA H. CODY
HEALTH OFFICER AND LOCAL REGISTRAR
OF BIRTHS AND DEATHS

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT 3

DECLARATION OF NICOLE ROSS

I Nicole Ross, declare:

1. I am a resident of Vieques, Puerto Rico;

2. My father, Douglas Wayne Ross, Sr., died on May 5, 2016 at VA Medical Center, 3801 Miranda Avenue, Palo Alto, California 94304;

3. No proceeding is now pending in California for administration of the decedent's estate;

4. I am Douglas Wayne Ross, Sr.'s successor in interest (as defined in **Section 377.11** of the California Code of Civil Procedure) and I succeed to his interest in the action or proceeding to be filed against the United States of America, on the grounds that I am one of Douglas Wayne Ross, Sr.'s three children.

5. No other person has a superior right to commence the action or proceeding;

6. Attached as **Exhibit A** is a certified copy of my father's death certificate as required by **Section 377.32** of the California Code of Civil Procedure;

I declare under the penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on the 10th day of May 2017, at Vieques, Puerto Rico.

X Nicole Ross

Nicole Ross

EXHIBIT A

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY of SANTA CLARA
PUBLIC HEALTH DEPARTMENT
VITAL RECORDS AND REGISTRATION

CERTIFICATE OF DEATH (STATE OF CALIFORNIA) — USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS — VS-11 (REV. 2/2014)

STATE FILE NUMBER: 3201643003911 — LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT–FIRST (Given)	2. MIDDLE	3. LAST (Family)
DOUGLAS	WAYNE	ROSS

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	If Under One Year: Months / Days	If Under One Day: Hours / Minutes	6. SEX
09/16/1943	72			M

8. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/RDP (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	9. HOUR (24 Hours)
UT	567-56-1998	[X] YES [ ] NO [ ] UNK	DIVORCED	05/05/2016	0855

13. EDUCATION – Highest Level/Degree (see worksheet on back)	14. U.S. WAS DECEDENT HISPANIC/LATINO/A/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
HS GRADUATE	[ ] YES [X] NO	CAUCASIAN

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION
SAILBOAT CAPTAIN	RECREATION	25

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)				
10678 WIGWAN ROAD				
21. CITY	**22. COUNTY/PROVINCE**	**23. ZIP CODE**	**24. YEARS IN COUNTY**	**25. STATE/FOREIGN COUNTRY**
JAMESTOWN	TUOLUMNE	95327	10	CA

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
DOUGLAS W. ROSS JR, SON	3323 N. PITTSBURG STREET, SPOKANE, WA 99207

SPOUSE/RDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/RDP–FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
-	-	-	
31. NAME OF FATHER/PARENT–FIRST	**32. MIDDLE**	**33. LAST**	**34. BIRTH STATE**
WALTER	JAMES	ROSS	UT
35. NAME OF MOTHER/PARENT–FIRST	**36. MIDDLE**	**37. LAST (BIRTH NAME)**	**38. BIRTH STATE**
KATHRYN	-	THOMAS	UT

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION		
05/10/2016	RESIDENCE OF NICOLE ROSS A54 F. CALLE ANDUCE, VE QUES PUERTO RICO 00765		
41. TYPE OF DISPOSITION(S)	**42. SIGNATURE OF EMBALMER**		**43. LICENSE NUMBER**
CR/TR/RES	▸ NOT EMBALMED		-
44. NAME OF FUNERAL ESTABLISHMENT	**45. LICENSE NUMBER**	**46. SIGNATURE OF LOCAL REGISTRAR**	**47. DATE mm/dd/ccyy**
SANTA CLARA FUNERAL & CREMATION SERVICE	FD2072	▸ SARA H CODY, MD	05/09/2016

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
VA MEDICAL CENTER	[X] IP [ ] ER/OP [ ] DOA	[ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [ ] Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SANTA CLARA	3801 MIRANDA AVENUE	PALO ALTO

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

Time Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → (a)	CLOSED HEAD INJURY	(a) DAYS
Sequentially list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST (b)	FALL, UNWITNESSED	(b) DAYS
(c)		(c)
(d)		(d)

108. DEATH REPORTED TO CORONER? [X] YES [ ] NO — CORONER'S CASE NUMBER: 16-01704

109. BIOPSY PERFORMED? [ ] YES [X] NO

110. AUTOPSY PERFORMED? [ ] YES [X] NO

111. USED IN DETERMINING CAUSE? [ ] YES [ ] NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107:
HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; RECENT HEART ATTACK

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)
NO

113a. IF FEMALE, PREGNANT IN LAST YEAR? [ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED. FROM THE CAUSES STATED.
Decedent Attended Since: (a) mm/dd/ccyy — Decedent Last Seen Alive: (b) mm/dd/ccyy

115. SIGNATURE AND TITLE OF CERTIFIER ▸

116. LICENSE NUMBER | 117. DATE mm/dd/ccyy

118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED. FROM THE CAUSES STATED.
MANNER OF DEATH: [ ] Natural [X] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined

120. INJURED AT WORK? [ ] YES [X] NO [ ] UNK

121. INJURY DATE mm/dd/ccyy: 04/28/2016

122. HOUR (24 Hours): 1445

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)
HOSPITAL

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)
UNWITNESSED FALL OFF CHAIR

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)
3801 MIRANDA AVENUE, PALO ALTO, CA 94306

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸MICHELLE A JORDEN MD	05/09/2016	MICHELLE A JORDEN MD, ME

STATE REGISTRAR

A	B	C	D	E		FAX AUTH.#	CENSUS TRACT
					01000100324123Z		

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA } SS
COUNTY OF SANTA CLARA }

DATE ISSUED By MAY 16 2016

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SARA H. CODY
HEALTH OFFICER AND LOCAL REGISTRAR
OF BIRTHS AND DEATHS

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT 4

NIALL P. McCARTHY (SBN 160175)
nmccarthy@cpmlegal.com
EMANUEL B. TOWNSEND (SBN 305373)
etownsend@cpmlegal.com
COTCHETT, PITRE & McCARTHY, LLP
San Francisco Airport Office Center
840 Malcolm Road
Burlingame, CA 94010
Telephone: (650) 697-6000
Facsimile: (650) 697-0577

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

DOUGLAS WAYNE ROSS JR., NICOLE ROSS, AND NEVILLE ROSS, individually and as Successors-In-Interest to **DOUGLAS WAYNE ROSS SR.,** decedent,

Plaintiffs,

vs.

THE UNITED STATES OF AMERICA, a governmental entity.

Defendants.

Case No. _____

DECLARATION OF NEVILLE ROSS

DECLARATION OF NEVILLE ROSS

I, **NEVILLE ROSS**, declare:

1. I am a resident of Gloucester, Massachusetts in Essex County;

2. My father, Douglas Wayne Ross, Sr., died on May 5, 2016 at VA Medical Center, 3801 Miranda Avenue, Palo Alto, California 94304;

3. No proceeding is now pending in California for administration of the decedent's estate:

4. I am Douglas Wayne Ross, Sr.'s successor in interest (as defined in Section 377.11 of the California Code of Civil Procedure) and I succeed to his interest in the action or proceeding to be filed against the United States of America, on the grounds that I am one of Douglas Wayne Ross, Sr.`s three children.

5. No other person has a superior right to commence the action or proceeding;

6. Attached as Exhibit A is a certified copy of my father's death certificate as required by Section 377.32 of the California Code of Civil Procedure;

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on this 30 day of April, 2017 at Gloucester, MA.

(City) (State)

Neville Ross

NEVILLE ROSS

EXHIBIT A

CERTIFICATION OF VITAL RECORD

COUNTY of SANTA CLARA

PUBLIC HEALTH DEPARTMENT

VITAL RECORDS AND REGISTRATION

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

STATE FILE NUMBER: 3201043003911 — LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT–FIRST	2. MIDDLE	3. LAST (Family)
DOUGLAS	WAYNE	ROSS

AKA, ALSO KNOWN AS – Include AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs	If Under 24 Hours: Months / Days	If Under 1 Hour: Hours / Minutes	6. SEX
09/16/1943	72			M

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/DOMESTIC PARTNERSHIP (at time of death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 hours)
UT	567-56-1998	[X] YES [ ] NO [ ] UNK	DIVORCED	05/05/2016	0855

13. EDUCATION – Highest Level/Degree (see instructions on back)	14/15. WAS DECEDENT HISPANIC/LATINO/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE – Up to 8 races may be listed (see worksheet on back)
HS GRADUATE	[ ] YES [X] NO	CAUCASIAN

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION
SAILBOAT CAPTAIN	RECREATION	25

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20. DECEDENT'S RESIDENCE (Street and number, or location)				
10678 WIGWAN ROAD				
21. CITY	**22. COUNTY/PROVINCE**	**23. ZIP CODE**	**24. YEARS IN COUNTY**	**25. STATE/FOREIGN COUNTRY**
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INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
DOUGLAS W. ROSS JR, SON	3323 N. PITTSBURG STREET, SPOKANE, WA 99207

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-	-	-	
31. NAME OF FATHER/PARENT–FIRST	**32. MIDDLE**	**33. LAST**	**34. BIRTH STATE**
WALTER	JAMES	ROSS	UT
35. NAME OF MOTHER/PARENT–FIRST	**36. MIDDLE**	**37. LAST (BIRTH NAME)**	**38. BIRTH STATE**
KATHRYN	-	THOMAS	UT

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION	
05/10/2016	RESIDENCE OF NICOLE ROSS A54 F. CALLE ANDUCE, VE QUES PUERTO RICO 00765	
41. TYPE OF DISPOSITION(S)	**42. SIGNATURE OF EMBALMER**	**43. LICENSE NUMBER**
CR/TR/RES	▸ NOT EMBALMED	-
44. NAME OF FUNERAL ESTABLISHMENT	**45. LICENSE NUMBER**	**46. SIGNATURE OF LOCAL REGISTRAR** / **47. DATE mm/dd/ccyy**
SANTA CLARA FUNERAL & CREMATION SERVICE	FD2072	▸ SARA H CODY, MD 05/09/2016

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
VA MEDICAL CENTER	[X] IP [ ] DOR [ ] DOA	[ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [ ] Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
SANTA CLARA	3801 MIRANDA AVENUE	PALO ALTO

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death	108. DEATH REFERRED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death)	I) CLOSED HEAD INJURY	(d) DAYS	[X] YES [ ] NO
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	II) FALL, UNWITNESSED	(d) DAYS	109. BIOPSY PERFORMED? [ ] YES [X] NO
	III)	(d)	110. AUTOPSY PERFORMED? [ ] YES [X] NO
	IV)	(d)	111. USED IN DETERMINING CAUSE? [ ] YES [ ] NO

INTERNAL CASE NO: 16-01704

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107: HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; RECENT HEART ATTACK

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113b. IF FEMALE, PREGNANT IN LAST YEAR?
NO	[ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
Decedent Attended Since: (A) mm/dd/ccyy; Decedent Last Seen Alive: (B) mm/dd/ccyy	▸		
	118. TYPE/ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.	120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
MANNER OF DEATH: [ ] Natural [X] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined	[ ] YES [X] NO [ ] UNK	04/28/2016	1445

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.): HOSPITAL

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury): UNWITNESSED FALL OFF CHAIR

125. LOCATION OF INJURY (Street and number, or location, and city, and zip): 3801 MIRANDA AVENUE, PALO ALTO, CA 94306

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▸ MICHELLE A JORDEN MD	05/09/2016	MICHELLE A JORDEN MD, ME

STATE REGISTRAR	A	B	C	D	E		FAX AUTH #	CENSUS TRACT
						01000100324132		

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STATE OF CALIFORNIA
COUNTY OF SANTA CLARA } SS

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SARA H. CODY
HEALTH OFFICER AND LOCAL REGISTRAR OF BIRTHS AND DEATHS

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EXHIBIT 5

Progress Notes

Appearance of IV site(s):
CDI, no s/s of infiltration

Wound Dressing:
Sacral mepilex.

Drainage Tubes:
flexiseal

Pacer Wires:
Not applicable

MORSE FALL SCALE
The Morse Fall scale was performed and score was 85. This is indicative of high risk for falls.

History of falling in past 3 months?
No

Secondary diagnosis:
Yes

Ambulatory aid:
Furniture

Intravenous therapy/Heparin lock:
Yes

Gait/Transferring:
Impaired

Mental Status:
Oriented to own ability/knows own limitations

NEW PRESSURE ULCER VALIDATION
A NEW PRESSURE ULCER WAS NOTED
No

SKIN
BRADEN SCALE - For Predicting Pressure Sore Risk

The patient's Braden Scale Score is 13. The patient is at moderate risk for development of pressure ulcers.

Sensory perception -- ability to respond meaningfully to pressure-related discomfort
Slightly limited.

Moisture -- degree to which skin is exposed to moisture

EXHIBIT 6

DEPARTMENT OF VETERANS AFFAIRS
Palo Alto Health Care System
3801 Miranda Ave.
Palo, Alto, CA 94304

10678 Wigwam Rd. SPC. 23
Jamestown, CA 95327

Dear Mr. Ross:

I am writing to confirm the contents of our telephone conversation. I am very sorry to learn of your recent loss, and want to share important information about an event on April 28 during your father's stay at VA Palo Alto Health Care System. Because your father was injured as a result of a fall in his room, we'd like to offer our sincere apologies. We are always very concerned about fall prevention, and we continue to look for opportunities to reduce them even further by considering procedure changes based on what happened with this fall.

As we discussed, if you feel that you have suffered any permanent injury or have been harmed, you can apply for compensation from VA by filing a benefits claim with the Veterans' Benefits Administration (VBA) and/or by filing a claim based on the Federal Tort Claim Act (FTCA). If your benefits claim is granted by the VBA, you would be eligible for monthly benefit payments. On the other hand, if you decide to file an administrative tort claim based on the FTCA, the claim will need to be investigated and granted by the Office of the VA Regional Counsel and the Facility Director. A benefits claim may be filed at any time to the VBA, but an administrative tort claim based on the FTCA must be filed within two years of the date of discovery of your injury. I have enclosed a pamphlet that provides you with the information listed above.

If you have any questions, please contact Shelagh Davis, Risk Manager, at 650-493-5000, extension 61364.

Sincerely,

Stephen C. Ezeji-Okoye, MD
Deputy Chief of Staff

Enclosure