RETURN DATE: MAY 24, 2022	**:**	**SUPERIOR COURT**
JENNIFER ACAMPORA, JESSICA BARAJAS, RICARDO CALIZ, COLLEEN BAUM, MINGFEE CHOW-YEN, SHELDON STILGER, ANGELA CORTESE, HOLLY CORTESE, CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON, LAURA CZAR, JOHANNA D'ADDARIO, CRISTINE DEVOE, JAMES DEVOE, VIKTORIA DUBROVSKY, MARINA DUBROVSKY, LYNN ECONOMOPOULOS, DAVID BEHUN, LISA FUNARO, MARC FUNARO, KATHLEEEN GARRISON, STACEY GLENNON, SEAN GLENNON, BIANCA GOGLAS, RENE LOPEZ, CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM, CHRISTINA HARRIS, FRANK TORO, CHELSEA HARRY, KRYSTINA HENDERSON, ANNE HERING, JANINE HERR, PATRICK FEENEY, MICHELLE KELLY, PETER KELLY, JESSICA LACOBELLE, JEROME LACOBELLE, III, CAITLIN PETERSON, RYAN PETERSON, LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ, LAUREN ROSENBERG, DAY ROSENBERG, NATALIYA SOSTIN, OLEG SOSTIN, REBECCA TULIN, ADAM TULIN, CAMISE TURNER-EVANS, SHAWN EVANS, MARIA MCNAMARA, GREGORY MCNAMARA	**:** **:** **:**	**JUDICIAL DISTRICT OF WATERBURY** **AT WATERBURY**
v.		
YALE UNIVERSITY	**:**	**APRIL 26, 2022**

, INTRODUCTION

1. This is a civil action for damages stemming from the mass diversion of the opioid, fentanyl, at the Yale University Reproductive Endocrinology and Infertility Clinic ("REI Clinic"), a

1. Over at least a five-month period in 2020, and prior thereto, a YALE UNIVERSITY nurse was able to steal the contents of hundreds of vials of fentanyl—a pain medication 50–100 times more potent than morphine—from the opioid stockpiles at the REI Clinic, and replace the medication with saline (water), which was subsequently administered to the clinic's patients.[1]
2. The result was that dozens, perhaps hundreds, of women underwent the most painful fertility surgeries and procedures offered at the REI Clinic with little or no analgesia.
3. The true scale of the mass diversion of fentanyl at YALE UNIVERSITY remains unknown. But a Drug Enforcement Agency inspection and a criminal investigation found that over a five-month period, the diverting nurse adulterated *at least 75% of all fentanyl housed at the REI Clinic*.
4. Plaintiffs are thirty of YALE UNIVERSITY's victims.
5. Each plaintiff was prescribed fentanyl for a particularly invasive procedure performed at the REI Clinic, known as oocyte retrieval or a manual vacuum aspiration procedure.
6. But instead of receiving fentanyl to treat their pain, plaintiffs were administered saline.
7. For some of these women, the oocyte retrieval, which involves a surgeon maneuvering a thick needle through the vaginal wall, ovarian ligament, ovary, and ovarian follicle to aspirate mature eggs, was excruciating.
8. For some of these women, the manual vacuum aspiration is a surgical procedure in which the cervix is dilated to that the uterine lining can be scraped to remove tissue.
9. YALE UNIVERSITY providers were alerted to the problem with its supply of fentanyl, the sole analgesic administered to women during oocyte retrievals and manual vacuum aspiration procedures, through patients' intraoperative screams and postoperative reports of torturous pain.
10. But, upon information and belief, YALE UNIVERSITY never investigated these reports. Instead, pain was minimized as "normal" for the invasive procedures, or attributed to the unavailability of an anesthesiologist.
11. YALE UNIVERSITY takes no responsibility for the hundreds of fentanyl substitution events that took place at the REI Clinic; it blames the single nurse who was able to steal the fentanyl, unabated, for more than twenty weeks.
12. But for years, YALE UNIVERSITY recognized the lurking danger of opioid diversion, and the catastrophic injuries posed by healthcare worker opioid substitution.

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[1] *See United States v. Donna Monticone*, No. 3:21 cr31 (JCH), Government's Sentencing Memorandum (DN 22) at *3 (D. Conn. May 18, 2021).

13. YALE UNIVERSITY knew that just one opioid substitution event could result in a multitude of harms—inadequate pain management for patients; the impairment of a healthcare worker, resulting in patient care errors; and the transmission of infectious diseases, like HIV and hepatitis, from an opioid-addicted healthcare worker to patients.

14. YALE UNIVERSITY also knew that as one of the largest employers of healthcare workers in Connecticut, an opioid diversion attempt was not a question of if, but when.

15. Indeed, the mass diversion of fentanyl at the REI Clinic was not the first or even second time that opioids were diverted by a YALE UNIVERSITY clinician:

    a. One year earlier, in 2019, a YALE UNIVERSITY resident was arrested on thirty-five counts of narcotic distribution after writing illegal prescriptions for nearly 4,000 oxycodone tablets.[2]

    b. Four years earlier, in 2016, a YALE UNIVERSITY nurse was sanctioned by the Connecticut Board of Medical Examiners for using hydromorphone that she stole from Yale-New Haven Hospital.[3]

16. But even after these events, YALE UNIVERSITY failed to implement the most basic, *legally mandated*, steps to prevent against opioid diversion.

17. As Yale physicians warned patients to lock their medicine cabinets to minimize the risk of loved-ones accessing opioids, YALE UNIVERSITY failed to secure the very room where it warehoused hundreds of fentanyl vials at the REI Clinic[4]. Unlocked and unsecured, the diverting nurse was able to enter the room containing the opioid stockpiles, unmonitored.[5]

18. In fact, YALE UNIVERSITY adopted a business practice that would make another opioid diversion event *more* likely: At the peak of the opioid epidemic, YALE UNIVERSITY implemented a cost-reduction strategy whereby bulk orders of controlled substances, including fentanyl, were placed for delivery and storage on-site at the REI Clinic.

19. As part of this unlawful cost-reduction scheme, YALE UNIVERSITY appointed an opioid-addicted nurse—the very nurse who diverted hundreds of vials of fentanyl—to manage the

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[2] *See* Marisa Peryer, *YNHH Resident Arrested; Illegal Narcotics Distribution Suspected* (Aug. 14, 2019), https://yaledailynews.com/blog/2019/08/14/ynhh-resident-arrested-illegal-narcotic-distribution-suspected/ (reporting arrest of former Yale New Haven Hospital resident, who was charged with 35 counts of narcotic distribution without a legitimate medical purpose).
[3] *See* Kate Farrish, *CT Nurses Cited for Stealing Patients' Painkillers, Alcohol Abuse* (Apr. 26, 2019), https://www.ctpost.com/local/article/CT-nurses-cited-for-stealing-patients-13798206.php (detailing four-year probation on nurse "who stole the opioid painkiller Hydromorphone for her own use while working as a nurse at Yale New Haven Hospital in 2016").
[4] *See United States v. Donna Monticone*, No. 3:21 cr31 (JCH), Government's Sentencing Memorandum (DN 22) at *3 (D. Conn. May 18, 2021).
[5] *Id.*

stockpiles of opioids at the REI Clinic, without adequate diversion-prevention or -detection measures in place.

20. In adopting this business practice, YALE UNIVERSITY prioritized profits over patient safety.

21. Plaintiffs, just thirty of YALE UNIVERSITY's victims, seek transparency and justice for themselves and the untold number of women who suffered unimaginable terror and pain at the REI Clinic because of the carelessness and recklessness of YALE UNIVERSITY.

THE PARTIES

THE PLAINTIFFS

22. Plaintiffs are the women and the respective spouses of women who seek damages stemming from the mass diversion of the opioid, fentanyl, at the REI Clinic.

The Patient-Victims of Yale University

23. Plaintiffs underwent oocyte retrieval procedures or manual vacuum aspiration procedures at the REI Clinic in Orange or New Haven Connecticut when a REI Clinic nurse was employed by the REI Clinic and had access to its fentanyl supply.

24. Prior to undergoing invasive oocyte retrievals, described above, the plaintiffs first completed the following three taxing steps of in vitro fertilization—(1) *ovarian suppression*, where hormones are administered to downregulate the ovaries for subsequent stimulation; (2) *ovarian stimulation*, the process of administering a series of injections in the stomachs, buttocks, or upper thighs to initiate an intense stimulation cycle, which is often accompanied by fatigue, nausea and headaches; and (3) *ovulation induction*, the final step before oocyte retrieval (which must proceed within a specified period immediately thereafter), that is initiated through "trigger shots" containing chorionic gonadotrophin (HCG), Lupron, or both.

25. At all times relevant, the plaintiff, JENNIFER ACAMPORA was a resident of Waterbury, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about July 29, 2020. Ms. ACAMPORA woke up after the retrieval in excruciating pain.

26. At all times relevant, the plaintiff, COLLEEN BAUM, was a resident of New York, New York who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Long Wharf location of the REI Clinic on or about September 4, 2019, December 4, 2019, January 29, 2020. These retrievals were done without an anesthesiologist Ms. BAUM was awake for the duration of the procedures and felt agonizing pain. During the September 4, 2019 procedure, the pain was so unbearable

that she lost consciousness. Ms. BAUM then underwent an oocyte retrieval on June 24, 2020 at the Orange location and felt excruciating pain.

27. At all times relevant, the plaintiff, JESSICA BARAJAS, was a resident of New Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about August 12, 2020. Ms. BARAJAS experienced intense, excruciating pain after this oocyte retrieval.

28. At all times relevant, the plaintiff, ANGELA CORTESE, was a resident of Vernon, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about June 9, 2020. She recalls that she was in distress from the pain she experienced. ANGELA CORTESE also had an oocyte retrieval procedure at the Long Wharf location on December 3, 2019, without an anesthesiologist, and was awake for the duration of the procedure. She recalls experiencing horrific, excruciating pain.

29. At all times relevant, the plaintiff, CHENDAN CUI-LAUGHTON, was a resident of Enfield, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about October 27, 2020. Ms. CUI-LAUGHTON experienced agonizing pain upon awakening after the oocyte retrieval and recalls screaming.

30. At all times relevant, the plaintiff, LYNN ECONOMOPOULOS, was a resident of Wallingford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the New Haven location of the REI Clinic on or about June 19, 2019, August 17, 2019, November 16, 2019 and January 27, 2020, without an anesthesiologist and was awake for the duration of the procedures. LYNN ECONOMOPOULOS also had oocyte retrieval procedures at the Orange location of the REI Clinic on or about August 17, 2020, September 8, 2020, October 14, 2020 and November 1, 2020. She felt excruciating pain during and after the oocyte retrievals.

31. At all times relevant, the plaintiff, LISA FUNARO, was a resident of New Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent a manual vacuum aspiration procedure at the Orange location of the REI Clinic on or about July 24, 2020. Ms. FUNARO experienced significant pain immediately after this procedure.

32. At all times relevant, the plaintiff, KATHLEEN GARRISON, was a resident of New Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval on October 22, 2019, without an anesthesiologist and was awake for the duration of the procedure. She then underwent an oocyte retrieval on August 19, 2020, at the Orange location. She experienced excruciating pain for both procedures.

33. At all times relevant, the plaintiff, CRISTINA HARRIS, was a resident of Branford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about August 12, 2020. Ms. HARRIS experienced excruciating pain during and after the oocyte retrievals.

34. At all times relevant, the plaintiff, CHELSEA HARRY, was a resident of New Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about October 19, 2020. Ms. HARRY experienced excruciating pain during and after the oocyte retrievals.

35. At all times relevant, the plaintiff, KRYSTINA HENDERSON, was a resident of East Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about June 23, 2020. Ms. HENDERSON experienced excruciating pain after the oocyte retrieval.

36. At all times relevant, the plaintiff, ANNE HERING, was a resident of Madison, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent oocyte retrievals at the Orange location of the REI Clinic on or about August 4, 2020 and October 2, 2020. Ms. HERING experienced excruciating pain during and after the oocyte retrievals.

37. At all times relevant, the plaintiff, MICHELLE KELLY, was a resident of Norwalk, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent a manual vacuum aspiration procedure at the Orange location of the REI Clinic on or about September 14, 2020. She felt significant pain immediately after the procedure.

38. At all times relevant, the plaintiff, JESSICA LACOBELLE, was a resident of West Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about August 20, 2020. Ms. LACOBELLE experienced excruciating pain during and after the oocyte retrievals.

39. At all times relevant, the plaintiff, CAITLIN PETERSON, was a resident of Fairfield, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about July 3, 2020. Ms. PETERSON experienced excruciating pain during and after the oocyte retrieval.

40. At all times relevant, the plaintiff, LINDSAY RODRIGUEZ, was a resident of Branford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent a manual vacuum aspiration procedure at the Orange location of the REI

Clinic on or about September 24, 2020. She felt significant pain immediately after the procedure.

41. At all times relevant, the plaintiff, LAUREN ROSENBERG was a resident of Stamford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Long Wharf location of the REI Clinic on or about February 3, 2020 without an anesthesiologist and was awake for the duration of the procedure. She then underwent oocyte retrievals on June 14, 2020 and August 27, 2020, at the Orange location. She experienced significant pain during and after these oocyte retrievals.

42. At all times relevant, the plaintiff, CAMISE TURNER-EVANS, was a resident of Hamden, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about July 22, 2020. Ms. TURNER-EVANS experienced excruciating pain after the oocyte retrieval.

43. At all times relevant, the plaintiff, CHRISTINE DEVOE, was a resident of North Branford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about June 11, 2020. Ms. CHRISTINE DEVOE experienced excruciating pain after the oocyte retrieval.

44. At all times relevant, the plaintiff, REBECCA TULIN was a resident of Guilford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about August 19, 2020. Ms. REBECCA TULIN experienced unbearable pain immediately upon awakening after the oocyte retrieval.

45. At all times relevant, the plaintiff, JANINE HERR was a resident of Shelton, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or aboutOctober 6, 2020. Ms. JANINE HERR experienced significant pain immediately upon awakening after the oocyte retrieval.

46. At all times relevant, the plaintiff, CAROLINE GRUENBAUM was a resident of Fairfield, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about September 18, 2020. Ms. GRUENBAUM experienced significant pain immediately upon awakening after the oocyte retrieval.

47. At all times relevant, the plaintiff, LAURA CZAR was a resident of Milford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Long Wharf location of the REI Clinic on or about January 1, 2020, and February 7, 2020. She underwent these procedures without an

anesthesiologist and was awake for the duration. Ms. CZAR experienced torturous pain throughout the oocyte retrievals and afterwards.

48. At all times relevant, the plaintiff, JOHANNA D'ADDARIO was a resident of Cromwell, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Long Wharf location of the REI Clinic on or about February 7, 2020. She underwent this procedure without an anesthesiologist and was awake for the duration. Ms. D'ADDARIO experienced horrific, excruciating pain throughout the oocyte retrievals and afterwards, to the point where she was screaming.

49. At all times relevant, the plaintiff, VIKTORIA DUBROVSKY was a resident of Branford, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Long Wharf location of the REI Clinic on or about September 5, 2017. She underwent these procedures without an anesthesiologist and was awake for the duration. Ms. DUBROVSKY experienced excruciating pain that was so severe she lost consciousness.

50. At all times relevant, the plaintiff, STACEY GLENNON was a resident of Madison, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about September 12, 2020. She underwent these procedures without an anesthesiologist and was awake for the duration. Ms. GLENNON experienced unbearable pain during and after the procedure.

51. At all times relevant, the plaintiff, BIANCA GOGLAS was a resident of New Haven, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about August 8, 2020. She underwent this procedure without an anesthesiologist and was awake for the duration. Ms. GOGLAS experienced excruciating pain during and after the procedure.

52. At all times relevant, the plaintiff, NATALIYA SOSTIN was a resident of Danbury, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange and Long Wharf location of the REI Clinic on or about February 4, 2020 and October 3, 2020. She underwent these procedures without an anesthesiologist and was awake for the duration. Ms. SOSTIN experienced excruciating pain during and after the procedure.

53. At all times relevant, the plaintiff, MARIA MCNAMARA was a resident of Clinton, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Long Wharf location of the REI Clinic on or about August 1, 2019. She underwent these procedures without an anesthesiologist and was awake for the duration. Ms. MCNAMARA experienced agonizing pain during and after the procedure.

54. At all times relevant, the plaintiff, MINGFEE CHOW-YEN was a resident of Willimantic, Connecticut, who contracted with YALE UNIVERSITY to receive fertility services, and underwent an oocyte retrieval at the Orange location of the REI Clinic on or about June 2020. Ms. CHOW-YEN experienced excruciating pain to the point that she awakened during the procedure, and also experienced unbearable pain after the procedure.

Plaintiffs—Women Willing to Undergo Taxing and Invasive Procedures for a Chance to Achieve Their Dreams of Parenthood—Were Among a Vulnerable Patient Population

55. YALE UNIVERSITY knew plaintiffs were psychologically and emotionally vulnerable by virtue of being infertility patients, and even expressly acknowledged some of the reasons for this vulnerability on its website: "[O]ne partner [may be] more devoted to the process; infertility treatments can stretch on for months and become financially draining; people experiencing infertility [often] end up feeling alone and isolated."[6]

56. Specifically, up to one-half of women seeking fertility services describe infertility as the most upsetting experience of their lives.[7] Anxiety and fear about the quantity/quality of eggs retrieved and future failures in treatment can create feelings of hopelessness, isolation and inadequacy during the process. Indeed, some studies show that infertility causes anguish similar to that accompanying a cancer diagnosis or the loss of a loved one.[8]

57. The expense of pursuing fertility treatment also contributed to the special nature of the provider-patient relationship at the REI Clinic. Specifically:

    a. REI Clinic services are costly. A single IVF cycle—defined as ovarian stimulation, egg retrieval and embryo transfer—can range from $15,000 to $30,000.[9]
    b. Most insurance plans do not cover in vitro fertilization.[10]
    c. Even in the event that an insurance plan does "cover" the cost of treatment, patients are often responsible for out-of-pocket expenses such as office visits, diagnostic

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[6] *See Fertility Center Psychological Program*, YaleMedicine, https://www.yalemedicine.org/departments/fertility-center-psychological-program (last visited Oct. 27, 2021).

[7] *See* Ellen Freeman et al., *Psychological Evaluation and Support in Programs of In Vitro Fertilization and Embryo Transfer*, https://pubmed.ncbi.nlm.nih.gov/3965315/ (last visited October 29, 2021).

[8] *See* Kristin Rooney et al., *The Relationship Between Stress and Infertility* (March 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016043/ (last visited October 29, 2021).

[9] *See* Marissa Conrad, *How Much Does IVF* Cost, ForbesHealth (Sept. 28, 2021), https://www.forbes.com/health/family/how-much-does-ivf-cost/.

[10] *See* Nat. Infertility Assoc., *Health Insurance 101*, https://resolve.org/what-are-my-options/insurance-coverage/health-insurance-101/ (last visited Oct. 27, 20201).

tests/procedures, medication, genetic testing, donor sperm/egg use of storage fees and wages lost from time off work.[11]

The Defendant: Yale University

58. At all times mentioned herein, the defendant, YALE UNIVERSITY, was a specially chartered corporation organized and existing under the laws of the State of Connecticut and operating a hospital in New Haven, Connecticut, called Yale-New Haven Hospital, and the Yale Reproductive Endocrinology Clinic (REI Clinic), supplying physicians and other health care professionals to the same for the treatment of the general public.

59. At all times relevant, YALE UNIVERSITY operated and managed the REI Clinic, also known as the Yale Fertility Center ("REI Clinic"), a fertility center that held itself out to the public as providing fertility services, including oocyte suppression, ovarian suppression, ovarian stimulation, and oocyte retrievals.

60. At all times relevant YALE UNIVERSITY recruited and employed physicians and health care providers in specialties, including but not limited to gynecology, obstetrics, and reproductive endocrinology, to treat patients at the REI Clinic.

61. At all times when REI Clinic services were offered in Orange, Connecticut, there was no pharmacy or pharmaceutical services provided on-site.

62. At all times relevant, the REI Clinic was an Outpatient Surgical Facility, as defined by Conn. Gen. Stat. § 19a-493b(a) by the State of Connecticut.

63. At all times relevant, the REI Clinic was a Group Practice, as defined by Conn. Gen. Stat. § 19a-481i(a)(10).

64. At all times relevant, the REI Clinic was accredited by the Joint Commission.

65. At all times relevant, YALE UNIVERSITY—by or through the REI Clinic, which it operated and managed, and/or its agent(s), apparent(s), and/or employee(s)—made the following representations to induce plaintiffs to contract with YALE UNIVERSITY for their reproductive services:

    a. that the REI Clinic met and exceeded Best Practices in its provision of all fertility services"[12];
    b. that "physicians and researchers [at the REI Clinic] use the latest evidence-based fertility [practices]"[13];

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[11] *See* Gabriela Weigel et al., *Coverage and Use of Fertility Services in the U.S.,* KFF (Sept. 15, 2020), https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/.
[12] Carrie Macmillan, *Fertile Ground? The Truth Behind the (IVF) Headlines*, YaleMedicine (Apr. 12, 2018), https://www.yalemedicine.org/news/ivf-truth.
[13] *Id.*

c. that academic centers, including the REI Clinic, "are more up-to-date on best practices," than the "many places in the country—across the world—that are delivering good care"[14];
d. that the REI Clinic uses "a data-driven approach to individualized care"[15];
e. that "[u]sing the latest research and fertility science, [the REI Clinic's] goal is to maximize [its] patient's chances of successful pregnancy in the shortest possible time and with the *utmost attention to the wellbeing of our patients* and their future generations"[16];
f. that "[a]ll treatments" that Yale REI Clinic "offer[s] are vetted by solid data"[17];
g. that the REI Clinic "prioritize[s] patient safety and maximize[s] patient success"[18];
h. that "[t]ogether with our highly trained and experienced nurses and laboratory staff, we strive to make the fertility treatment a stress-free experience for our patients."[19]

66. At all times relevant, YALE UNIVERSITY—by or through the REI Clinic, which it operated and managed—represented in promotional/informational videos that oocyte retrievals would take approximately 30 minutes and would be conducted with "a combination of medications to keep you comfortable."

67. At all times relevant, to complete oocyte retrievals, YALE UNIVERSITY providers ordered the administration of the potent opioid, fentanyl, to each and every woman undergoing the invasive procedure at the clinic.

68. At all times relevant, YALE UNIVERSITY—by and through the REI Clinic—additionally stated that a patient "may experience minor discomfort but should be recovered in a couple of hours."

69. At all times relevant, YALE UNIVERSITY—by or through the REI Clinic, which it operated and managed—billed plaintiffs in return for the provision of fertility services to plaintiffs.

Agents, Apparent Agents, and Employees of Yale University

70. At all times relevant, Donna Monticone, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

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[14] *Id.* (quoting Lubna Pal, MBBS, Interim Section Chief of REI at Yale Medicine)
[15] *Id.* (quoting Lubna Pal, MBBS, Interim Section Chief of REI at Yale Medicine)
[16] YaleMedicine, Female Infertility, https://www.yalemedicine.org/conditions/infertility (last visited Oct. 27, 2021) (emphasis added).
[17] *Id.*
[18] *Id.* (quoting Lubna Pal, MBBS).
[19] YaleMedicine, In Vitro Fertilization (IVF) Fact Sheet, https://www.yalemedicine.org/conditions/ivf (last visited Oct. 27, 2021).

71. At all times relevant, Jenna Barolli, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

72. At all times relevant, Maureen Pothier, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

73. At all times relevant, Jessica Dorey, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

74. At all times relevant, Patrick Welch, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

75. At all times relevant, Aparajitha Srinivasan, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

76. At all times relevant, Susy Ferreira, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

77. At all times relevant, Susan Kornitsky, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

78. At all times relevant, Marie Longo, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

79. At all times relevant, Sarah Van Benschoten, RN, was an agent, apparent agent, and/or employee of the defendant, YALE UNIVERSITY, who was certified as a registered nurse by the Connecticut Department of Public Health, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

80. At all times mentioned herein, Trevor Banack, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

81. At all times mentioned herein, Trevor Banack, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

82. At all times mentioned herein, Jill Berlin, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

83. At all times mentioned herein, Jill Berlin, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

84. At all times mentioned herein, Marcelle Blessing, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

85. At all times mentioned herein, Marcelle Blessing, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

86. At all times mentioned herein, Robert Chow, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

87. At all times mentioned herein, Robert Chow, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

88. At all times mentioned herein, Jeremy Dennis, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

89. At all times mentioned herein, Jeremy Dennis, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

90. At all times mentioned herein, Jinlei Li, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

91. At all times mentioned herein, Jinlei Li, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

92. At all times mentioned herein, Alena Rady, DO, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

93. At all times mentioned herein, Alena Rady, DO, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

94. At all times mentioned herein, Jill Zafar, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

95. At all times mentioned herein, Jill Zafar, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

96. At all times mentioned herein, Donna-Ann Thomas, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

97. At all times mentioned herein, Donna-Ann Thomas, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY

98. At all times mentioned herein, Andrew Notarianni, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

99. At all times mentioned herein, Andrew Notarianni, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

100. At all times mentioned herein, Anitha Kilari, MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

101. At all times mentioned herein, Anitha Kilari, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

102. At all times mentioned herein, Elena Gutman MD, was certified by the appropriate American board as a specialist in anesthesiology, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

103. At all times mentioned herein, Elena Gutman, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

104. At all times mentioned herein, Sandra Carson, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

105. At all times mentioned herein, Sandra Carson, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

106. At all times mentioned herein, Stephen Collins, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

107. At all times mentioned herein, Stephen Collins, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

108. At all times mentioned herein, Valerie Flores, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

109. At all times mentioned herein, Valerie Flores, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

110. At all times mentioned herein, Amanda Kallen, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

111. At all times mentioned herein, Amanda Kallen, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

112. At all times mentioned herein, Pinar Kodaman, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

113. At all times mentioned herein, Pinar Kodaman, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

114. At all times mentioned herein, Alexander Kotlyar, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

115. At all times mentioned herein, Alexander Kotlyar, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

116. At all times mentioned herein, Amir Mor, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

117. At all times mentioned herein, Amir Mor, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

118. At all times mentioned herein, Lubna Pal, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

119. At all times mentioned herein, Lubna Pal, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

120. At all times mentioned herein, Pasquale Patrizio, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

121. At all times mentioned herein, Pasquale Patrizio, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

122. At all times mentioned herein, Samantha Simpson, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held herself out as a specialist in that field.

123. At all times mentioned herein, Samantha Simpson, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

124. At all times mentioned herein, Reshef Tal, MD, was certified by the appropriate American board as a specialist in reproductive endocrinology/infertility, was trained and experienced in that medical specialty, and/or held himself out as a specialist in that field.

125. At all times mentioned herein, Reshef Tal, MD, was a servant, agent, apparent agent, and/or employee of the defendant YALE UNIVERSITY.

YALE UNIVERSITY KNEW OR SHOULD HAVE KNOWN ABOUT THE HIGH LIKELIHOOD OF OPIOID DIVERSION, PARTICULARLY AT THE REI CLINIC, AND THE SEVERE HARMS THAT COULD RESULT

Yale University Knew or Should Have Known about High Likelihood of an Opioid Diversion Attempt by One of Its Healthcare Workers

Opioid Diversion at Healthcare Institutions is a Common Problem with a Common Origin: The Modern Opioid Epidemic

Opioid Dependence and Addiction

126. Fentanyl is an invaluable medication for its potent pain-blocking power. Indeed, its use is so important for the treatment and prevention of pain, that the World Health Organization has recognized fentanyl among its list of "Essential Medications"—the "minimum medicine needs for a basic health-care system."[20]

127. But because fentanyl activates powerful rewards centers in the brain, causing the release of endorphins—the brain's feel-good neurotransmitters—it is also subject to abuse and dependence.

128. When opioids are used repeatedly over time, the body slows its natural production of endorphins, leading to a diminished sense of euphoria with administration, a process known as tolerance. Individuals who develop tolerance require larger doses of opioids to produce the same levels of euphoria. They also develop symptoms of withdraw without continued use.

129. Today, millions of Americans are dependent or addicted to opioids. Over a half million Americans have died[21] from opioid overdoses since 1999.

130. Fentanyl's high risk of abuse and dependence accounts for its regulation as a Schedule II controlled substance—a classification reserved for treatments that pose the *highest* risk of abuse and dependence. 21 U.S.C. 812(b)(2).

Opioid Diversion by Healthcare Workers Is Common

131. Healthcare workers are not immune from opioid tolerance, dependence, and abuse. In fact, healthcare workers, who frequently have access to controlled substances, are at *higher* risk for the misuse of prescription drugs, including opioids.

132. The act of stealing or redirecting a controlled substance from a legal source, such as a hospital or clinic, to an illicit market or illicit use, is known as "diversion." Healthcare workers who are opioid-addicted or -dependent sometimes resort to stealing opioids, including fentanyl, to support their addiction or dependence.

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[20] WHO Model List of Essential Medicines, March 2017 20th Ed. at 3.

[21] Opioids kill by decreasing the sensitivity of the body to carbon dioxide and interfering with the regions of the brain that control breathing, causing the cessation of breathing.

133. The Centers for Disease Control (CDC) has designated a specific type of diversion—substitution—as the "worst" kind of drug diversion because of the harm that it poses to the patients of healthcare workers.

134. Substitution occurs when a healthcare worker diverts medication from a syringe, vial or other container and replaces medication with a similarly appearing substance. Typically the substitution of fentanyl occurs with the replacement of saline or water, both of which are visually indistinguishable.

135. Opioid diversion by healthcare providers has been documented for decades, even before opioid abuse reached epidemic proportions in the 1990s. The current opioid diversion crisis facing the healthcare industry reflects the history of opioid marketing and regulation in the United States, in what has been termed the "Three Waves" of the modern opioid epidemic.

136. In the "First Wave" of the modern opioid epidemic began in the early 1990s, when pharmaceutical companies—such as Purdue Pharma—began peddling opioids as a non-addictive treatment for pain. As prescriptions climbed, so did opioid deaths, in what became known as the "First Wave" of the modern opioid epidemic.

137. In the mid-2000s, in what is characterized "Second Wave" of the opioid epidemic, physicians, scrutinized for indiscriminate opioid prescribing practices, adopted more stringent prescribing practices. Opioid overdoses surged as individuals hooked on prescription opioids turned to a cheap and readily available substitute—heroin.

138. Today, America is in the midst of the "Third Wave" of the opioid epidemic, which began when powerful synthetic opioids—particularly fentanyl—entered illicit markets from both legal and illicit sources. In 2017, the opioid death rate had climbed to such dire levels that the Department of Health and Human Services declared the opioid epidemic a "public health crisis." This declaration coincided with a grave milestone: For the first time in history, an American was more likely to die from an accidental opioid overdose than from a motor vehicle collision.

139. During the second and third waves of the opioid epidemic, opioid diversion by healthcare workers became increasingly common as sources of legally prescribed opioids evaporated. For example, in 2014, the hospital manager of controlled substance surveillance at a university medical center reported, "I was catching at least one health care provider every month stealing medication." [22]

140. Studies suggest that even this hospital manager's account underrepresents the scope of the problem: One study identified more than 1 discrepancy involving a controlled

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[22] Keith H. Berge & William L. Lanier, Editorial, *Bloodstream Infection Outbreaks Related to Opioid-Diverting Health Care Workers: A Cost-Benefit Analysis of Prevention and Detection Programs*, 89 Mayo Clin. Proc. 866, 867 (2014).

substances—indicative of diversion—for every Medicare patient treated at a healthcare facility.[23]

Yale University, One of the Largest Employer of Healthcare Workers in the State, Knew or Should Have Known That It Was a Matter of Time Before One of Its Healthcare Workers Would Attempt to Divert Opioids

141. While horrific, the mass substitution of fentanyl at the REI Clinic was foreseeable.

142. It is inevitable that unless strict measures are implemented, diversion will take place in large healthcare institutions, including YALE UNIVERSITY.

143. YALE UNIVERSITY knew or should have known that it likely employed dozens of healthcare workers who were dependent or addicted to controlled substances, particularly opioids. Application of conservative prevalence rates for addiction and dependence suggests that by 2017, Yale New Haven Health Services Corporation, the parent company of YALE UNIVERSITY and the largest employer of healthcare workers in the State of Connecticut, likely employed more than 600 medical staff who abuse drugs and dozens of nurses who practice while impaired.[24]

144. By June 2017, the opioid crisis had reached epidemic proportions across the state. To address this epidemic, on June 14, 2017, YALE UNIVERSITY faculty hosted a media roundtable about the opioid crisis in collaboration with CORE, "a statewide initiative to address the opioid crisis and stem the rising tide of overdose deaths."[25]

145. About one week later after this media roundtable, twenty overdoses and three deaths were recorded at Yale-New Haven Hospital after a single batch of fentanyl-laced powder was

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[23] Chukwuma Anyanwu & Oliver Egwim, *The Prevalence and Determinants of Controlled Substance Discrepancies in a Level I Trauma Hospital*, 9 Am. Health Drug Benefits 128, 132 (2016).

[24] *See* YaleNewHavenHealth, *Facts and Figures*, https://www.ynhhs.org/about/corporate-overview/system-statistics.aspx (last visited Apr. 20, 2021) (noting that as the largest employer in Connecticut, Yale employs over 26,000 employees including more than 6,600 medical staff) *and* The Joint Commission, *Drug Diversion and Impaired Health Care* Workers, 48 Quick Safety 1 (2019), available at https://www.jointcommission.org/media/tjc/newsletters/quick_safety_drug_diversion_final2pdf.pdf (noting that The American Nurses Association (ANA) has estimated that one in 10 health care workers abuse drugs); *see also* Hazel Y. Tanga, *Nurse Drug Diversion and Nursing Leaders' Responsibilities: Legal, Regulatory, Ethical, Humanistic, and Practical Considerations*, 13 JONA's Healthcare Law, Ethics, and Regulation 11, 16 (2011) (citing ANA estimates that 6% to 8% of nurses are currently practicing while impaired).

[25] Denise Meyer, *Yale Faculty Host Media Roundtable About the Opioid Crisis*, (June 15, 2017), https://ysph.yale.edu/news-article/yale-faculty-host-media-roundtable-about-the-opioid-crisis/.

consumed by dozens in the vicinity of the New Haven Green.[26] An article detailing the harrowing event, which appeared in the Winter edition of Yale Medicine, noted that "deaths from fentanyl" were increasing in the state—disproportionately in New Haven: "In the first three months of 2016, fentanyl was involved in 83 out of 119 fatal overdoses, with New Haven leading the state with 24 deaths."[27]

146. Indeed, the REI Diversion event took place at a time when opioid abuse were approaching record highs in Connecticut. For example, while Connecticut hospitals reported only fourteen fentanyl-related deaths statewide in 2012, just seven years later, statewide deaths surged to nearly 1,000. In fact, by 2020, fentanyl was responsible for 82% of all unintentional drug overdose deaths statewide, a 7,000% increase from 2012.[28]

147. Although horrific, the figures actually underrepresented the severity of the epidemic in YALE UNIVERSITY's own backyard: By July 2020, the rate of fentanyl overdose-related deaths in New Haven County were double and six-times that of bordering Fairfield and Middlesex counties, respectively.[29]

148. In fact, years before the mass diversion of fentanyl at the REI Clinic, YALE UNIVERSITY had already witnessed drug diversion by healthcare workers at its own facilities—the 2016 diversion of hydromorphone by a nurse at Yale-New Haven Hospital[30] and the 2019 diversion of nearly 4,000 oxycodone tablets by a Yale-New Haven Hospital Emergency Medicine resident[31].

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[26] Sarah Faulkner, Yale Sch. Medicine, *An Opioid Crisis in the City and a Bad Night in the Emergency Room*, https://medicine.yale.edu/news/yale-medicine-magazine/an-opioid-crisis-in-the-city-and-a/ (last visited Oct. 27, 2021).

[27] *Id.*

[28] *See id.* ("In 2012, fentanyl was involved in 14 fatal overdoses."); Heather Clinton, Conn. Dept. Pub. Health, *Drug Overdose Deaths in Connecticut Data Dashboard, 2015 to 2021*, https://public.tableau.com/app/profile/heather.clinton/viz/SUDORS_Dashboard_final2/OverdoseDashboard (last visited Oct. 27, 2021) (hereinafter Clinton, *Drug Overdose Dashboard*) (detailing, on county-level, drug overdose death data in Connecticut between 2015 and 2021).

[29] *See* Clinton, *Drug Overdose Dashboard* (comparing fentanyl-related overdoses across New Haven, Fairfield, and Middlesex Counties in July 2020).

[30] *See* Kate Farrish, *CT Nurses Cited for Stealing Patients' Painkillers, Alcohol Abuse* (Apr. 26, 2019), https://www.ctpost.com/local/article/CT-nurses-cited-for-stealing-patients-13798206.php (detailing four-year probation on nurse "who stole the opioid painkiller Hydromorphone for her own use while working as a nurse at Yale New Haven Hospital in 2016").

[31] *See* Marisa Peryer, *YNHH Resident Arrested; Illegal Narcotics Distribution Suspected* (Aug. 14, 2019), https://yaledailynews.com/blog/2019/08/14/ynhh-resident-arrested-illegal-narcotic-distribution-suspected/ (reporting arrest of former Yale New Haven Hospital resident, who was charged with 35 counts of narcotic distribution without a legitimate medical purpose).

149. All healthcare workers are potentially at risk for diverting controlled substances. But known risk factors for opioid diversion highlighted that a diversion event was particularly likely at the REI Clinic.

150. Specifically, nurses who practice in surgical areas are at high risk for diverting opioids.[32] The drug that the REI Clinic nurse diverted, fentanyl, is the most commonly diverted opioid, which itself, is the most commonly diverted drug class[33].

Yale University Knew or Should Have Known that Opioid Diversion Posed a Serious Threat to Patient Safety: Inadequate Analgesia, Infectious Disease Outbreaks, and Impaired Healthcare Workers

151. YALE UNIVERSITY knew or should have known that diversion prevention and detection interventions were necessary because of the severity of harm associated with opioid substitution, a class of diversion.

152. The first harm of opioid substitution is the excruciating pain that patients suffer when an opioid is replaced with another substance.

153. Years and even decades before the mass diversion event at REI Clinic, accounts of AIDS patients not receiving medications for excruciating pain while in palliative care,[34] and patients experiencing torturous, untreated, pain during invasive procedures and surgeries,

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[32] *See* Carlos A. Pellegrini, Bulletin: Joint Commission Focuses on Strategies to Detect, Prevent Drug Diversion, (June 1, 2019) https://bulletin.facs.org/2019/06/joint-commission-focuses-on-strategies-to-detect-prevent-drug-diversion/ (describing "some of the most high-risk care settings" for drug diversion as including "surgical suites, surgical centers, anesthesia and procedural areas").

[33] The Joint Commission, *Drug Diversion and Impaired Health Care* Workers, 48 Quick Safety 1 (2019), available at https://www.jointcommission.org/media/tjc/newsletters/quick_safety_drug_diversion_final2pdf.pdf

[34] *See* Keith H. Berge, MD et al., *Diversion of Drugs within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention*, 87 Mayo Clin. Proc. 674, 676 (2012) (detailing case report of a procedural sedation nurse assigned to administer opioids and sedatives to patients during colonoscopy substituting fentanyl for saline, administering saline to her patients, and diverting the fentanyl for her own use) [hereinafter Berge, *Diversion of Drugs*].

such as colonoscopies[35] and kidney procedures,[36] were published in widely circulated peer-reviewed medical journals.

154. At the REI Clinic, fentanyl was the only analgesic ordered for pain relief during oocyte retrieval surgeries. Accordingly, in cases where fentanyl was substituted with saline, patients—including the plaintiffs—were left to endure excruciating pain.

155. Plaintiffs' reports of excruciating pain were either dismissed by healthcare providers as "normal" for oocyte retrievals, or in cases where an anesthesiologist was not present, blamed on the absence of anesthesia.

156. A second chief harm of opioid substitution is potential exposure of patients to bloodborne infectious disease, such as HIV and hepatitis. The medical literature is replete with case reports of dozens, hundreds, or even thousands of patients exposed to pathogens because of the nonsterile practices of a substituting healthcare worker:

   a. A single healthcare worker can potentially expose *thousands* of patients to bloodborne pathogens. In fact, the CDC reported that between 2008 and 2019, 28,989 individuals were exposed to hepatitis C infection from the substitution of controlled substances by just *four* healthcare workers[37];

   b. The traveling radiographer who infected 32 and exposed 1700 to hepatitis at a New Hampshire hospital[38];

   c. The Wisconsin nurse who infected six and killed one with a deadly bacteria, *Serratia marcescens*, after substituting morphine from patient-controlled analgesia syringes in 2014[39].

157. Third, healthcare workers who self-administer substituted opioids while caring for patients potentially expose patients to medical errors and inaccurate documentation of care.

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[35] *See* James A. Inciardi et al., *The Diversion of Prescription Drugs by Health Care Workers in Cincinnati, Ohio*, 41 Substance Use & Misuse 255, 259 (2006) (detailing how an Ohio hospice nurse substituted vials of opioids prescribed for palliative care to AIDS patients for tap water, using the opioids to support her drug habit).

[36] *See* Berge, *Diversion of Drugs*, at 676 (documenting diversion of fentanyl by Mayo Clinic sedation nurse who instructed the patient that he would have to "man up" and tolerate some pain during kidney procedure because he could not be given much pain medication).

[37] *See* CDC, *Healthcare-Associated Hepatitis B and C Outbreaks >2 Reported to the CDC 2008-2019*, https://www.cdc.gov/hepatitis/Outbreaks/PDFs/HealthcareInvestigationTable.pdf (last updated May 11, 2020).

[38] *See id.*

[39] *See* Leah M. Schuppener et al., Serratia Marcescens *Bacteremia: Nosocomial Cluster Following Narcotic Diversion*, 38 Infect Control Hosp Epidemiol 1027-31 (2017).

158. At least one plaintiff noted on the day of an oocyte retrieval that the nurse who subsequently admitted to diverting fentanyl from the REI Clinic appeared impaired and acted inappropriately; this plaintiff did not file a report because the retrieval had to occur that day and she feared repercussions if she filed a complaint.

YALE UNIVERSITY FAILED TO IMPLEMENT DIVERSION PREVENTION AND DETECTION MEASURES AT EVERY STAGE OF THE MEDICATION USE PROCESS, DESPITE FEDERAL LAW, STATE LAW, BEST PRACTICES, AND YALE UNIVERSITY POLICIES REQUIRING OTHERWISE

159. YALE UNIVERSITY was required by federal and state statutes, regulations, and guidance to prevent opioid diversion at *every* stage of the medication use process: from procurement, storage, prescribing, dispensing, administration through disposal.

160. At all times relevant, the Drug Enforcement Administration additionally required YALE UNIVERSITY to adhere to the best available practices for patient safety and drug security, regardless of whether those practices were explicitly spelled out in published regulations.

Diversion Prevention Failures

161. Yet, during one or more stages of the medication use process, YALE UNIVERSITY failed to identify, adopt, implement and/or enforce the following opioid diversion prevention measures at the REI Clinic, as set forth below:

    a. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

    b. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;

    c. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. § 1304.11; 21 C.F.R. § 1301.52(e)(1);

    d. improperly allowed flexible ordering of fentanyl with large dose ranges;

    e. improperly stored fentanyl at the REI Clinic in a room that was not always locked, and that the diverting nurse was able to access "without swiping her card," in violation of:

        i. Medicare Conditions of Participation requiring all scheduled drugs, including fentanyl to be stored in a locked secured are that is accessible only to authorized personnel, *see, e.g.*, 42 C.F.R. § 482.25[b][2][i]); Interpretive Guidelines 42 C.F.R. §482.25[b][2][iii];

ii. Connecticut Regulations requiring that stock totals for Schedule II drugs, such as fentanyl, that exceed 15 controlled substance units be stored in an approved safe in a securely safeguarded location, *see, e.g.*, Regs. Conn. St. Agencies § 21a-262-6;

iii. Connecticut Regulations forbidding controlled substance stocks from being "left unsecured or unattended in an examining room, treatment room, . . . or in any other location accessible to nonauthorized persons," *id.*;

iv. Best practices requiring electronic monitoring of storage sites with camera surveillance of areas not secured by electronic access;

v. YALE UNIVERSITY's own policies governing the storage of Schedule II controlled substances, *see* Yale Env. Health & Safety, Safety Guidelines: Proper Storage of Controlled Substances.

f. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent, *see, e.g.*, 21 U.S.C. § 827(b); 21 C.F.R. §§ 1301.52(e)(1), 1304.04(a), 1305.03; Conn. Gen. Stat. § 21a-254(f);

g. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

h. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

i. failed to create, implement, enforce, and/or regularly review or update policies and procedures to prevent the diversion of controlled substances, as required by Medicare Conditions of Participation, *see, e.g.*, Interpretive Guidelines 42 C.F.R. § 482.25;

j. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

k. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

l. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion.

Diversion Detection Failures

162. YALE UNIVERSITY, at all times relevant, additionally failed to develop, implement, or enforce policies and procedures necessary to the timely detection of fentanyl diversion.

163. YALE UNIVERSITY, at all times relevant, failed to complete mandated supervised inventory checks of stored fentanyl, as evidenced by its nurse's ability to remove 175 vials

of fentanyl from REI stock undetected, and the nurse's ability to refill vials of extracted fentanyl with sterile saline at home.[40]

164. YALE UNIVERSITY, at all times relevant, failed to follow best practices for the inspection of stored inventory for tampering, as evidenced by the FDA's identification of *multiple* puncture marks in the septa of single-dose fentanyl vials that were confiscated from the REI Clinic.[41]

165. YALE UNIVERSITY providers, at all times relevant, either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion—despite Medicare Conditions of Participation requirements that mandate healthcare institutions to "promptly investigate and resolve patient complaints and grievance," and provide a safe environment for patients that is "free from the threat or abuse of harm." *See, e.g.*, 42 C.F.R. §§ 482.13(a)(2), 482.13(c)(2).

166. YALE UNIVERSITY, at all times relevant, knew or should have known that the REI Clinic nurse was practicing while impaired and likely to be diverting fentanyl. But, upon information and belief, reports from patients that the REI nurse appeared to be practicing while impaired were not investigated or acted upon. The absence of such reports in the presence of clear signs of diversion suggest that employees/agents of YALE UNIVERSITY were unaware that they were required by DEA regulations and Medicare Conditions of Participation to report suspected diversion. *See, e.g.*, 21 C.F.R. § 1301.91; 42 C.F.R. § 482.25(b)(7).

167. YALE UNIVERSITY, at all times relevant, further failed to identify, adopt, implement and/or enforce diversion detection measures that would have allowed for timely recognition of fentanyl diversion at the REI Clinic as set forth below:

    a. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects, as required by federal regulations, *see, e.g.*, 42 C.F.R. § 482.25[b][1];

    b. failed to conduct audits of opioid administered in surgical and procedure areas a the end of every shift;

    c. failed to conduct regular inspection of fentanyl inventory for tampering;

    d. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

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[40] *See United States v. Donna Monticone*, No. 3:21 cr31 (JCH), Government's Sentencing Memorandum (DN 22) at *3 (D. Conn. May 18, 2021).

[41] *See id.*

e. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations, *see, e.g.*, 21 C.F.R. § 1304.04 *et seq.*; 42 C.F.R. § 482.24[c][2];

f. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

g. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, within the Yale-New Haven Health System, and to investigate reports of possible diversion;

h. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration.

YALE UNIVERSITY'S BUSINESS DECISION TO PURSUE BULK ORDERING OF FENTANYL UNLAWFULLY PRIORITIZED PROFITABILITY OVER PATIENT SAFETY AND MADE DIVERSION MORE LIKELY

168. By 2018, Yale publicly boasted about the "myriad [of] ways" that Yale faculty have confronted the opioid crisis, including the "Yale-developed plan to curb opioid overdose crisis."[42]

169. Yet, just two years later, YALE UNIVERSITY made a cost-saving business-decision that *eliminated* protections against opioid diversion and made diversion *more* likely.

Despite the Risk of Opioid Diversion, Yale University Abandoned Pharmacy Oversight of Controlled Substances for Cost-Saving Bulk Ordering at the REI Clinic.

170. At some time in early 2020, the REI Clinic was located in the Long Wharf section of New Haven, approximately two miles from Yale-New Haven Hospital. During this time, upon information and belief, controlled substances were ordered from a pharmacy immediately before a scheduled surgery or invasive procedure.

171. Within the first two months of 2020, the REI Clinic was relocated about seven miles from Yale-New Haven Hospital to the Yale West Campus in Orange, Connecticut. At the time of REI Clinic's relocation, the Yale West Campus did not house *any* clinical practice: The REI Clinic was its first.[43]

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[42] Ziba Kashef, *Yale-Developed Plan to Curb Opioid Overdose Crisis Helps State, Nation*, YaleNews, (Apr. 30, 2018), https://news.yale.edu/2018/04/30/yale-developed-plan-curb-opioid-overdose-crisis-helps-state-nation.

[43] Jon Atherton, *Yale Medicine Reproductive Endocrinology and Infertility to Relocate to West Campus* (Dec. 13, 2018), https://westcampus.yale.edu/news/yale-medicine-reproductive-endocrinology-infertility-relocate-west-campus?refresh=2 .

172. At or around the time that the REI Clinic relocated to the Yale West Campus, YALE UNIVERSITY made the business decision to pursue "bulk ordering" of controlled substances, whereby mass quantities of fentanyl were ordered directly from manufacturers distributors (instead of pharmacies) for on-site storage.[44]

173. Under the new bulk ordering procedure, YALE UNIVERSITY designated a nurse—not a pharmacist—with ordering mass quantities of fentanyl for the entire REI Clinic directly from controlled substance manufacturers and distributors.

174. Specifically, the nurse who subsequently admitted to diverting fentanyl from the REI Clinic was appointed by YALE UNIVERSITY to serve as the Alternate Coordinator for the clinic's Controlled Substance Ordering System (CSOS),[45] whereby large quantities of fentanyl were ordered using the DEA registration number of a physician or the institution.

175. Upon information and belief, YALE UNIVERSITY's business decision to pursue "bulk ordering" of fentanyl was made in whole or in part to reduce costs or increase the profitability of the REI Clinic.

Yale University's Bulk Ordering of Fentanyl Eliminated Critical, *Mandated*, Diversion Protections and Left Hundreds of Fentanyl Vials Unsecured.

176. Upon information and belief, YALE UNIVERSITY's business decision to pursue "bulk ordering" greatly reduced or entirely eliminated pharmacy supervision and control over the procurement, storage, dispensing, and destruction of controlled substances, such as fentanyl.

177. Under the bulk ordering procedure, mass quantities of fentanyl were stored on-site at the REI Clinic.

178. By minimizing or eliminating pharmacy oversight of fentanyl procurement, storage, dispensing, administration, and disposal, YALE UNIVERSITY increased the likelihood of widespread diversion.

179. Further exacerbating the risk of harm created by YALE UNIVERSITY's bulk ordering of fentanyl, the REI Clinic lacked basic protections against the diversion of fentanyl, many of which were required by federal *and* state law, as detailed herein.

COUNT ONE:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE.

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[44] *See United States v. Donna Monticone*, No. 3:21 cr31 (JCH), Government's Sentencing Memorandum (DN 22) at *3 (D. Conn. May 18, 2021).

[45] *See id.*

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of JENNIFER ACAMPORA for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, JENNIFER ACAMPORA suffered the following severe, serious, painful, and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by JENNIFER ACAMPORA, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about April 14, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit A.

COUNT TWO:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;

j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THREE:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT THREE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT FOUR:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FOUR.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT FIVE:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIVE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT SIX:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT SEVEN:
JENNIFER ACAMPORA v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT EIGHT:
COLLEEN BAUM v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT EIGHT.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of COLLEEN BAUM for the same or similar condition, which included one or more oocyte retrievals performed in 2019-2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, COLLEEN BAUM suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by COLLEEN BAUM, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. allowed inappropriate flexible ordering of fentanyl;
j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;
dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;
ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
gg. failed to properly supervise and/or monitor Nurse Donna Monticone;
hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;
ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about April 14, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit B.

COUNT NINE:
COLLEEN BAUM v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TEN:
COLLEEN BAUM v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT FOURTEEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT FOURTEEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;

g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ELEVEN:
COLLEEN BAUM v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ELEVEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;
c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care,

particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT TWELVE:
COLLEEN BAUM v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWELVE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THIRTEEN:
COLLEEN BAUM v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTEEN.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT FOURTEEN:
COLLEEN BAUM v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FOURTEEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.]

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT FIFTEEN:
ANGELA CORTESE v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT FIFTEEN.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of ANGELA CORTESE for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, ANGELA CORTESE suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by ANGELA CORTESE, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in

violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about March 31, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit C.

COUNT SIXTEEN:
HOLLY CORTESE v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT SIXTEEN.

184. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

185. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT SEVENTEEN:
ANGELA CORTESE v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTEEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT EIGHTEEN:
HOLLY CORTESE v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTEEN.

183. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

184. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT NINETEEN:
ANGELA CORTESE v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETEEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWENTY-EIGHT are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT NINETEEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWENTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWENTY:
HOLLY CORTESE v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT NINETEEN are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT TWENTY.

203. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

204. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWENTY-ONE:
HOLLY CORTESE v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (191), respectively, of this COUNT TWENTY-ONE.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWENTY-NINE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, HOLLY CORTESE suffered harm, including mental anguish and/or money damages.

COUNT TWENTY-TWO:
ANGELA CORTESE v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWENTY-TWO.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT TWENTY-THREE:
HOLLY CORTESE v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT TWENTY-THREE.

188. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

189. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWENTY-FOUR:
ANGELA CORTESE v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWENTY-FOUR.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT TWENTY-FIVE:
HOLLY CORTESE v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT TWENTY-FIVE.

192. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

193. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWENTY-SIX:
ANGELA CORTESE v. YALE UNIVERSITY(Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWENTY-SIX.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWENTY-SEVEN:
HOLLY CORTESE v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWENTY-SEVEN.

195. At all times mentioned herein, the plaintiff, HOLLY CORTESE, was the wife of ANGELA CORTESE.

196. As a result of the aforesaid injuries of plaintiff ANGELA CORTESE, HOLLY CORTESE has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWENTY-EIGHT:
ANGELA CORTESE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWENTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWENTY-NINE:
HOLLY CORTESE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT FIFTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWENTY-NINE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, HOLLY CORTESE, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, HOLLY CORTESE, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. HOLLY CORTESE performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, HOLLY CORTESE, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, HOLLY CORTESE, suffered harm, including mental anguish and/or money damages.

COUNT THIRTY:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT THIRTY

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CHENDAN CUI-LAUGHTON for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CHENDAN CUI-LAUGHTON suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CHENDAN CUI-LAUGHTON, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about April 14, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit D.

COUNT THIRTY-ONE:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183) respectively, of this COUNT THIRTY-ONE.

184. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON, was the husband of CHENDAN CUI-LAUGHTON.

185. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THIRTY-TWO:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-TWO

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THIRTY-THREE:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-184.Paragraphs 1 through 184 of COUNT THIRTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT THIRTY-THREE

185. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON, was the husband of CHENDAN CUI-LAUGHTON.

186. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THIRTY-FOUR:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-FOUR.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT FORTY-THREE are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE to ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT THIRTY-FOUR.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT FORTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT THIRTY-FIVE:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1 through 202 of COUNT THIRTY-FOUR are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT THIRTY-FIVE.

203. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON was the husband of CHENDAN CUI-LAUGHTON.

204. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THIRTY-SIX:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-SIX.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT THIRTY and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

184. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

185. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

186. As a result of YALE UNIVERSITY's violation of CUTPA, CHRISTOPHER LAUGHTON suffered harm, including mental anguish and/or money damages.

COUNT THIRTY-SEVEN:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-SEVEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT THIRTY-EIGHT:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-EIGHT.

183. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON was the husband of CHENDAN CUI-LAUGHTON.

184. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THIRTY-NINE:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THIRTY-NINE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. ability to carry on and enjoy life's activities;

    g. expenses for medical care and treatment;

    h. psychological, physiological and neurological sequelae.

COUNT FORTY:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-152 of COUNT THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT FORTY.

192. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON was the husband of CHENDAN CUI-LAUGHTON.

193. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FORTY-ONE:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-ONE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to

complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT FORTY-TWO:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT FORTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT FORTY-TWO.

195. At all times mentioned herein, the plaintiff, CHRISTOPHER LAUGHTON was the husband of CHENDAN CUI-LAUGHTON.

196. As a result of the aforesaid injuries of plaintiff CHENDAN CUI-LAUGHTON, CHRISTOPHER LAUGHTON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FORTY-THREE:
CHENDAN CUI-LAUGHTON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT FORTY-FOUR:
CHRISTOPHER LAUGHTON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT THIRTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff, CHRISTOPHER LAUGHTON, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, CHRISTOPHER LAUGHTON, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. CHRISTOPHER LAUGHTON performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, CHRISTOPHER LAUGHTON, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, CHRISTOPHER LAUGHTON, suffered harm, including mental anguish and/or money damages.

COUNT FORTY-FIVE:
LYNN ECONOMOPOULOS v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT FORTY-FIVE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of LYNN ECONOMOPOULOS for the same or similar condition, which included one or more oocyte retrievals performed in 2019-2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, LYNN ECONOMOPOULOS suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by LYNN ECONOMOPOULOS, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about July 26, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit E.

COUNT FORTY-SIX:
DAVID BEHUN v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-SIX.

183. At all times mentioned herein, the plaintiff, DAVID BEHUN, was the husband of LYNN ECONOMOPOULOUS.

184. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOUS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FORTY-SEVEN:
LYNN ECONOMOPOULOUS v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-SEVEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;

c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT FORTY-EIGHT:
DAVID BEHUN v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT FORTY-SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT FORTY-EIGHT.

185. At all times mentioned herein, the plaintiff, DAVID BEHUN, was the husband of LYNN ECONOMOPOULOUS.

186. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOUS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FORTY-NINE:
LYNN ECONOMOPOULOUS v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FORTY-NINE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198 Paragraphs 183-190 of COUNT FIFTY-EIGHT are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT FORTY-NINE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT FIFTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;

g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT FIFTY:
DAVID BEHUN v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT FORTY-NINE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT FIFTY.

203. At all times mentioned herein, the plaintiff, DAVID BEHUN, was the husband of LYNN ECONOMOPOULOUS.

204. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOUS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FIFTY-ONE:
DAVID BEHUN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-ONE.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT FIFTY-NINE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

184. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

185. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

186. As a result of YALE UNIVERSITY's violation of CUTPA, DAVID BEHUN suffered harm, including mental anguish and/or money damages.

COUNT FIFTY-TWO:
LYNN ECONOMOPOULOUS v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-TWO.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

   a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

   b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

   c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

   a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

   b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT FIFTY-THREE:
DAVID BEHUN v. YALE UNIVERSITY Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1 through 187 of COUNT FIFTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT FIFTY-THREE.

188. At all times mentioned herein, the plaintiff, DAVID BEHUN, was the husband of LYNN ECONOMOPOULOUS.

189. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOUS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FIFTY-FOUR:
LYNN ECONOMOPOULOUS v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-FOUR.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks

and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT FIFTY-FIVE:
DAVID BEHUN v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT FIFTY-FIVE.

192. At all times mentioned herein, the plaintiff, DAVID BEHUN was the husband of LYNN ECONOMOPOULOS.

193. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FIFTY-SIX:
LYNN ECONOMOPOULOS v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-SIX.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT FIFTY-SEVEN:
DAVID BEHUN v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT FIFTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT FIFTY-SEVEN.

195. At all times mentioned herein, the plaintiff, DAVID BEHUN was the husband of LYNN ECONOMOPOULOS.

196. As a result of the aforesaid injuries of plaintiff LYNN ECONOMOPOULOS, DAVID BEHUN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT FIFTY-EIGHT:
LYNN ECONOMOPOULOS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-EIGHT.

183. UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT FIFTY-NINE:
DAVID BEHUN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT FIFTY-NINE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, DAVID BEHUN, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, DAVID BEHUN, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. DAVID BEHUN performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, DAVID BEHUN, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, DAVID BEHUN, suffered harm, including mental anguish and/or money damages.

COUNT SIXTY:
LISA FUNARO v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT SIXTY.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of LISA FUNARO for the same or similar condition, which included a manual vacuum aspiration procedure performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, LISA FUNARO suffered the following severe, serious, painful, and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity
h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by LISA FUNARO, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about February 7, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit F.

COUNT SIXTY-ONE:
MARC FUNARO v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT SIXTY-ONE.

184. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

185. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SIXTY-TWO:
LISA FUNARO v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SIXTY-TWO.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;

c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT SIXTY-THREE:
MARC FUNARO v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT SIXTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT SIXTY-THREE.

185. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

186. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SIXTY-FOUR:
LISA FUNARO v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182.Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SIXTY-FOUR

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of manual vacuum aspiration procedure procedures on weekends or holidays without anesthesiology services increased the likelihood that

diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for manual vacuum aspiration procedures performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for manual vacuum aspiration procedures only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT SEVENTY-THREE are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198), of this COUNT SIXTY-FOUR.

205. YALE UNIVERSITY's breach of contract, as addressed in COUNT FOURTEEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

206. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

207. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

208. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT SIXTY-FIVE:
MARC FUNARO v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-160. Paragraphs 1-160 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SIXTY (160) respectively, of this COUNT SIXTY-FIVE.

209. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

210. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SIXTY-SIX:
MARC FUNARO v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SIXTY-SIX.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT SEVENTY-FOUR and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

184. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

185. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

186. As a result of YALE UNIVERSITY's violation of CUTPA, MARC FUNARO suffered harm, including mental anguish and/or money damages.

COUNT SIXTY-SEVEN:
LISA FUNARO v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SIXTY-SEVEN.

183. Fertility services, including a manual vacuum aspiration procedure, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures and manual vacuum aspiration procedures, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT SIXTY-EIGHT:
MARC FUNARO v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT SIXTY-SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT SIXTY-EIGHT.

188. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

189. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SIXTY-NINE:
LISA FUNARO v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SIXTY-NINE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo a manual vacuum aspiration procedure with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during a manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the manual vacuum aspiration procedure.

185. The use of fentanyl for analgesia during a manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during a manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the manual vacuum aspiration procedure.

187. The use of fentanyl for analgesia during a manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to manual vacuum aspiration procedure.

188. On or before the dates that plaintiff underwent an a manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of manual vacuum aspiration procedure in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent a manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the manual vacuum aspiration procedure, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT SEVENTY:
MARC FUNARO v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT SIXTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT SEVENTY.

192. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

193. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SEVENTY-ONE:
LISA FUNARO v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-ONE.

183. An a manual vacuum aspiration procedure with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an a manual vacuum aspiration procedure with the administration of fentanyl is different and distinct from an a manual vacuum aspiration procedure where no

fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of a manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an a manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of a manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits of a manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective a manual vacuum aspiration procedure, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an a manual vacuum aspiration procedure with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective manual vacuum aspiration procedure , YALE UNIVERSITY completed the a manual vacuum aspiration procedure on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective a manual vacuum aspiration procedure, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's manual vacuum aspiration procedure(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT SEVENTY-TWO:
MARC FUNARO v. YALE UNIVERSITY (Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT SEVNTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT SEVENTY-TWO.

195. At all times mentioned herein, the plaintiff, MARC FUNARO, was the husband of LISA FUNARO.

196. As a result of the aforesaid injuries of plaintiff LISA FUNARO, MARC FUNARO has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT SEVENTY-THREE:
LISA FUNARO v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving a manual vacuum aspiration procedures is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedure under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform a manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT SEVENTY-FOUR:
MARC FUNARO v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT SIXTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff, MARC FUNARO, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving the manual vacuum aspiration process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedure under anesthesia, plaintiff, MARC FUNARO, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. MARC FUNARO performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, MARC FUNARO, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, MARC FUNARO, suffered harm, including mental anguish and/or money damages.

COUNT SEVENTY-FIVE:
CRISTINA HARRIS v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT SEVENTY-FIVE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CRISTINA HARRIS for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CRISTINA HARRIS suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CRISTINA HARRIS, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about September 1, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit G.

COUNT SEVENTY-SIX:
CRISTINA HARRIS v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT SEVENTY-SEVEN:
CRISTINA HARRIS v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-SEVEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT EIGHTY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE (191) through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT SEVENTY-SEVEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT EIGHTY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;

d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT SEVENTY-EIGHT:
FRANK TORO v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT EIGHTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT SEVENTY-EIGHT.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT EIGHTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, FRANK TORO suffered harm, including mental anguish and/or money damages.

COUNT SEVENTY-NINE:
CRISTINA HARRIS v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT SEVENTY-NINE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT EIGHTY:
CRISTINA HARRIS v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. ability to carry on and enjoy life's activities;

    g. expenses for medical care and treatment;

    h. psychological, physiological and neurological sequelae.

COUNT EIGHTY-ONE:
CRISTINA HARRIS v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-ONE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT EIGHTY-TWO:
CRISTINA HARRIS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT EIGHTY-THREE:
FRANK TORO v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT SEVENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, FRANK TORO, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, FRANK TORO, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. FRANK TORO performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, FRANK TORO, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, FRANK TORO, suffered harm, including mental anguish and/or money damages.

COUNT EIGHTY-FOUR:
CHELSEA HARRY v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this EIGHTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of

CHELSEA HARRY for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CHELSEA HARRY suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CHELSEA HARRY, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
    d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
    e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
    f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
    g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
    h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
    i. allowed inappropriate flexible ordering of fentanyl;
    j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about March 31, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit H.

COUNT EIGHTY-FIVE:
CHELSEA HARRY v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-FIVE

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;

j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT EIGHTY-SIX:
CHELSEA HARRY v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-SIX.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT NINETY are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT EIGHTY-SIX

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT NINETY and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT EIGHTY-SEVEN:
CHELSEA HARRY v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-SEVEN

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it

failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT EIGHTY-EIGHT:
CHELSEA HARRY v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT EIGHTY-NINE:
CHELSEA HARRY v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT EIGHTY-NINE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT NINETY:
CHELSEA HARRY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT NINETY-ONE:
ANNE HERING v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT NINETY-ONE.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of ANNE HERING for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, ANNE HERING suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by ANNE HERING, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. allowed inappropriate flexible ordering of fentanyl;
j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;
dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;
ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
gg. failed to properly supervise and/or monitor Nurse Donna Monticone;
hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;
ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about September 1, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit I.

COUNT NINETY-TWO:
ANNE HERING v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-TWO.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT NINETY-THREE:
ANNE HERING v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT NINETY-SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT NINETY-THREE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT NINETY-SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;

c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT NINETY-FOUR:
ANNE HERING v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-FOUR.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT NINETY-FIVE:
ANNE HERING v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-FIVE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT NINETY-SIX:
ANNE HERING v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-SIX

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT NINETY-SEVEN:
ANNE HERING v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT NINETY-SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT NINETY-EIGHT:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this NINETY-EIGHT.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of LINDSAY RODRIGUEZ for the same or similar condition, which included a manual vacuum aspiration procedure performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, LINDSAY RODRIGUEZ suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by LINDSAY RODRIGUEZ, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about December 7, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit J

COUNT NINETY-NINE:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT NINETY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT NINETY-NINE.

184. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

185. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT NINETY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED ONE:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT ONE HUNDRED are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT ONE HUNDRED ONE

185. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

186. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED TWO:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWO.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of manual vacuum aspiration procedure procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for manual vacuum aspiration procedures performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for manual vacuum aspiration procedures only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198.) respectively, of this COUNT ONE HUNDRED TWO.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED ELEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED THREE:
ANTHONY RODRIGUEZv. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT ONE HUNDRED TWO are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT ONE HUNDRED THREE.

203. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

204. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FOUR:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT ONE HUNDRED TWELVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT ONE HUNDRED FOUR.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THIRTY and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, MARC FUNARO suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FIVE:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIVE.

183. Fertility services, including manual vacuum aspiration procedures, is highly personal and implicates vital
concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED SIX:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT ONE HUNDRED FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHT-SEVEN (187) respectively, of this COUNT ONE HUNDRED SIX.

188. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

189. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SEVEN:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVEN.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an manual vacuum aspiration procedure with administration of the analgesic, fentanyl.

193. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the manual vacuum aspiration procedure.

194. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

195. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the manual vacuum aspiration procedure.

196. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to manual vacuum aspiration procedure.

197. On or before the dates that plaintiff underwent an manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of manual vacuum aspiration procedure in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

198. On the dates that plaintiff underwent an manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

199. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

200. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the manual vacuum aspiration procedure, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED EIGHT:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-191. Paragraphs 1 through 191 of COUNT ONE HUNDRED SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191) respectively, of this COUNT ONE HUNDRED EIGHT.

192. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

201. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damages.

COUNT ONE HUNDRED NINE:
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINE.

183. An manual vacuum aspiration procedure with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an manual vacuum aspiration procedure with the administration of fentanyl is different and distinct from an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective manual vacuum aspiration procedures, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an manual vacuum aspiration procedure with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective manual vacuum aspiration procedure, YALE UNIVERSITY completed the manual vacuum aspiration procedure(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective manual vacuum aspiration procedure, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's manual vacuum aspiration procedure(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED TEN:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY (Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT ONE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWENTY-EIGHT.

195. At all times mentioned herein, the plaintiff, ANTHONY RODRIGUEZ, was the husband of LINDSAY RODRIGUEZ.

196. As a result of the aforesaid injuries of plaintiff LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED ELEVEN
LINDSAY RODRIGUEZ v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED ELEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving a manual vacuum aspiration procedures is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedures under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform a manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED TWELVE:
ANTHONY RODRIGUEZ v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT NINEY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWELVE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, ANTHONY RODRIGUEZ, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving the manual vacuum aspiration process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedure under anesthesia, plaintiff, ANTHONY RODRIGUEZ, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. ANTHONY RODRIGUEZ performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, ANTHONY RODRIGUEZ, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, ANTHONY RODRIGUEZ, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED THIRTEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED THIRTEEN.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of JESSICA BARAJAS for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, JESSICA BARAJAS suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by JESSICA BARAJAS, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about September 15, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit K.

COUNT ONE HUNDRED FOURTEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FOURTEEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED FIFTEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTEEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED TWENTY are hereby incorporated and realleged as paragraphs ONE HUNDRED NINTEY-ONE through ONE HUNDRED NINTEY-EIGHT (198) respectively, of this COUNT ONE HUNDRED FIFTEEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED TWENTY and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;

f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED SIXTEEN:
RICARDO CALIZ v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190 Paragraphs 1-190 of COUNT ONE HUNDRED TWENTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT ONE HUNDRED SIXTEEN.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT HUNDRED TWENTY-ONE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, RICARDO CALIZ suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED SEVENTEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTEEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED EIGHTEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTEEN.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. ability to carry on and enjoy life's activities;

    g. expenses for medical care and treatment;

    h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED NINETEEN:
JESSICA BARAJAS v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINETEEN.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED TWENTY:
JESSICA BARAJAS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED TWENTY-ONE:
RICARDO CALIZ v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-ONE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, RICARDO CALIZ under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving the manual vacuum aspiration process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedure under anesthesia, plaintiff, RICARDO CALIZ, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. RICARDO CALIZ performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, RICARDO CALIZ, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, RICARDO CALIZ, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED TWENTY TWO:
KATHLEEN GARRISON v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED TWENTY-TWO.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of

KATHLEEN GARRISON for the same or similar condition, which included one or more oocyte retrievals performed in 2019-2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, KATHLEEN GARRISON suffered the following severe, serious, painful, and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by KATHLEEN GARRISON, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
    d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
    e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
    f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
    g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
    h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
    i. allowed inappropriate flexible ordering of fentanyl;
    j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about July 22, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit L.

COUNT ONE HUNDRED TWENTY-THREE:
KATHLEEN GARRISON v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-THREE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;

j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED TWENTY-FOUR:
KATHLEEN GARRISON v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-FOUR

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED TWENTY-EIGHT are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNDRED TWENTY-FOUR.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED TWENTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED TWENTY-FIVE:
KATHLEEN GARRISON v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-FIVE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT ONE HUNDRED TWENTY-SIX:
KATHLEEN GARRISON v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-SIX

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED TWENTY-SEVEN:
KATHLEEN GARRISON v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-SEVEN.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to

complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED TWENTY-EIGHT:
KATHLEEN GARRISON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED TWENTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

COUNT ONE HUNDRED TWENTY-NINE
JESSICA LACOBELLE v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED TWENTY-NINE

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of JESSICA LACOBELLE for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, JESSICA LACOBELLE suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by JESSICA LACOBELLE, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about February 7, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit M.

COUNT ONE HUNDRED THIRTY:
JEROME LACOBELLE v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT ONE HUNDRED THIRTY.

184. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

185. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED THIRTY-ONE:
JESSICA LACOBELLE v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED THIRTY-ONE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

d. 21 U.S.C. § 827(b);
e. 21 C.F.R. § 1304.11;
f. 21 C.F.R. § 1301.52(e);
g. 21 C.F.R. § 1301.91;
h. 21 C.F.R. §1304.04;
i. 21 C.F.R. § 1305.03;
j. 42 C.F.R. § 482.13;
k. 42 C.F.R. § 482.24;

l. 42 C.F.R. § 482.25;
m. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
n. Conn. Gen. Stat. § 21a-254;
o. Regs. Conn. St. Agencies § 21a-262-6.

185. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED THIRTY-TWO:
JEROME LACOBELLE v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-185. Paragraphs 1 through 185 of COUNT ONE HUNDRED THIRTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FIVE (185), respectively, of this COUNT ONE HUNDRED THIRTY-TWO

186. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

187. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED THIRTY-THREE:
JESSICA LACOBELLE v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED THIRTY-THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED FORTY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNDRED THIRTY-THREE

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED FORTY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED THIRTY-FOUR:
JEROME LACOBELLE v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT ONE HUNDRED THIRTY-THREE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT ONE HUNDRED THIRTY-FOUR.

203. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

204. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED THIRTY-FIVE:
JEROME LACOBELLE v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT ONE HUNDRED FORTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT ONE HUNDRED THIRTY-FIVE.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT ONE HUNDRED FORTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, JEROME LACOBELLE suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED THIRTY-SIX:
JESSICA LACOBELLE v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED THIRTY-SIX.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

   a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

   b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

   c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

   a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

   b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED THIRTY-SEVEN:
JEROME LACOBELLE v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT ONE HUNDRED THIRTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT ONE HUNDRED THIRTY-SEVEN.

188. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

189. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED THIRTY-EIGHT:
JESSICA LACOBELLE v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED THIRTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks

and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED THIRTY-NINE:
JEROME LACOBELLE v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT ONE HUNDRED THIRTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT ONE HUNDRED THIRTY-NINE.

192. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

193. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FORTY:
JESSICA LACOBELLE v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FORTY.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED FORTY-ONE:
JEROME LACOBELLE v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT ONE HUNDRED FORTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT ONE HUNDRED FORTY-ONE.

195. At all times mentioned herein, the plaintiff, JEROME LACOBELLE, was the husband of JESSICA LACOBELLE.

196. As a result of the aforesaid injuries of plaintiff JESSICA LACOBELLE, JEROME LACOBELLE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FORTY-TWO:
JESSICA LACOBELLE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FORTY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FORTY-THREE:
JEROME LACOBELLE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED TWENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FORTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, JEROME LACOBELLE, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, JEROME LACOBELLE, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. JEROME LACOBELLE performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, JEROME LACOBELLE, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, JEROME LACOBELLE, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FORTY-FOUR:
CAITLIN PETERSON v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED FORTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CAITLIN PETERSON for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CAITLIN PETERSON suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CAITLIN PETERSON, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about September 1, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit N.

COUNT ONE HUNDRED FORTY-FIVE:
RYAN PETERSON v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT ONE HUNDRED FORTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT ONE HUNDRED FORTY-FIVE.

184. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

185. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FORTY-SIX:
CAITLIN PETERSON v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FORTY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;

c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED FORTY-SEVEN:
RYAN PETERSON v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT FORTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT FORTY-SEVEN.

185. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

186. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FORTY-EIGHT
CAITLIN PETERSON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FORTY-EIGHT.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place

at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED FIFTY-SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNRED FORTY-EIGHT.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED FIFTY-SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED FORTY-NINE
RYAN PETERSON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT ONE HUNDRED FORTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT ONE HUNDRED FORTY-NINE.

203. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

204. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FIFTY:
RYAN PETERSON v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT ONE HUNDRED FIFTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT ONE HUNDRED FIFTY-ONE

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT ONE HUNDRED FIFTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, RYAN PETERSON suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FIFTY-ONE:
CAITLIN PETERSON v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTY-ONE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED FIFTY -TWO:
RYAN PETERSON v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT ONE HUNDRED FIFTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT ONE HUNDRED FIFTY-TWO.

188. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

189. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FIFTY-THREE:
CAITLIN PETERSON v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTY-THREE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical

structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED FIFTY-FOUR:
RYAN PETERSON v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT ONE HUNDRED FIFTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT ONE HUNDRED FIFTY-FOUR

192. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

193. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FIFTY-FIVE:
CAITLIN PETERSON v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTY-FIVE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED FIFTY-SIX
RYAN PETERSON v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT ONE HUNDRED FIFTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT ONE HUNDRED FIFTY-SIX

195. At all times mentioned herein, the plaintiff, RYAN PETERSON, was the husband of CAITLIN PETERSON.

196. As a result of the aforesaid injuries of plaintiff CAITLIN PETERSON, RYAN PETERSON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED FIFTY-SEVEN:
CAITLIN PETERSON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTY-SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FIFTY-EIGHT:
RYAN PETERSON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FORTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED FIFTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff, RYAN PETERSON, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, RYAN PETERSON, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. RYAN PETERSON performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, RYAN PETERSON, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, RYAN PETERSON, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED FIFTY-NINE:
LAUREN ROSENBERG v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED FIFTY-NINE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of LAUREN ROSENBERG for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, LAUREN ROSENBERG suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by LAUREN ROSENBERG, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about June 11, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit O.

COUNT ONE HUNDRED SIXTY:
DAY ROSENBERG v. YALE UNIVERSITY (Medical Negligence – Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT ONE HUNDRED SIXTY.

184. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

185. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SIXTY-ONE:
LAUREN ROSENBERG v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SIXTY-ONE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED SIXTY-TWO:
DAY ROSENBERG v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT ONE HUNDRED SIXTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT ONE HUNDRED SIXTY-TWO.

185. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

186. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SIXTY-THREE
LAUREN ROSENBERG v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SIXTY-THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNDRED SIXTY-THREE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED SEVENTY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED SIXTY-FOUR:
DAY ROSENBERG v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT ONE HUNDRED SIXTY-THREE hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT ONE HUNDRED SIXTY-FOUR.

203. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

204. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SIXTY-FIVE:
DAY ROSENBERG v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT ONE HUNDRED SIXTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT ONE HUNDRED SIXTY-FIVE

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THIRTY and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, DAY ROSENBERG suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED SIXTY-SIX
LAUREN ROSENBERG v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SIXTY-SIX.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED SIXTY-SEVEN:
DAY ROSENBERG v. YALE UNIVERSITY (Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT ONE HUNDRED SIXTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT ONE HUNDRED SIXTY-SEVEN.

188. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

189. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SIXTY-EIGHT:
LAUREN ROSENBERG v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SIXTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED SIXTY-NINE:
DAY ROSENBERG v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT ONE HUNDRED SIXTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE NINETY-ONE (191), respectively, of this COUNT ONE HUNDRED SIXTY-NINE.

192. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

193. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SEVENTY:
LAUREN ROSENBERG v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED SEVENTY-ONE:
DAY ROSENBERG v. YALE UNIVERSITY (Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT ONE HUNDRED SEVENT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT ONE HUNDRED SEVENTY-ONE.

195. At all times mentioned herein, the plaintiff, DAY ROSENBERG, was the husband of LAUREN ROSENBERG.

196. As a result of the aforesaid injuries of plaintiff LAUREN ROSENBERG, DAY ROSENBERG has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED SEVENTY-TWO:
LAUREN ROSENBERG v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED SEVENTY-THREE:
DAY ROSENBERG v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, DAY ROSENBERG, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, DAY ROSENBERG, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. DAY ROSENBERG performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, DAY ROSENBERG, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, DAY ROSENBERG, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED SEVENTY-FOUR:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE. (179) respectively, of this COUNT ONE HUNDRED SEVENTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of KRYSTINA HENDERSON for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, KRYSTINA HENDERSON suffered the following severe, serious, painful, and permanent injuries:
    a. terror;

b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by KRYSTINA HENDERSON, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. allowed inappropriate flexible ordering of fentanyl;
j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;
dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
gg. failed to properly supervise and/or monitor Nurse Donna Monticone;
hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;
ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about July 22, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit P.

COUNT ONE HUNDRED SEVENTY-FIVE:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-FIVE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;

c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED SEVENTY-SIX:
KRYSTINA HENDERSON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-SIX.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED EIGHTY are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNDRED SEVENT-SIX.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED EIGHTY- and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED SEVENTY-SEVEN:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-SEVEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT ONE HUNDRED SEVENTY-EIGHT:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED SEVENTY-NINE:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED SEVENTY-NINE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED EIGHTY:
KRYSTINA HENDERSON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED SEVENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTY.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED EIGHTY-ONE:
MICHELLE KELLY v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED EIGHTY-ONE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of MICHELLE KELLY for the same or similar condition, which included a manual vacuum aspiration procedure performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, MICHELLE KELLY suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by MICHELLE KELLY as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about June 11, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit Q.

COUNT ONE HUNDRED EIGHTY-TWO:
PETER KELLY v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT ONE HUNDRED EIGHTY-TWO.

186. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

187. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED EIGHTY-THREE:
MICHELLE KELLY v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTY-THREE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");

k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

187. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED EIGHTY-FOUR:
PETER KELLY v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT ONE HUNDRED EIGHTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT ONE HUNDRED EIGHTY-FOUR.

188. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

189. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED EIGHTY-FIVE:
MICHELLE KELLY v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTY-FIVE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

191. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

192. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

193. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

194. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage

at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

195. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of manual vacuum aspiration procedure procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

196. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for manual vacuum aspiration procedures performed on weekends or holidays to reduce costs and/or maximize profits.

197. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for manual vacuum aspiration procedures only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT ONE HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT ONE HUNDRED EIGHTY-FIVE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT ONE HUNDRED NINETY-FOUR and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED EIGHTY-SIX:
PETER KELLY v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT ONE HUNDRED EIGHTY-FIVE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT ONE HUNDRED EIGHTY-SIX.

203. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

204. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED EIGHTY-SEVEN:
PETER KELLY v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTY-SEVEN.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT ONE HUNDRED NINETY-FIVE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

187. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

188. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

189. As a result of YALE UNIVERSITY's violation of CUTPA, PETER KELLY suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED EIGHTY-EIGHT:
MICHELLE KELLY v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED EIGHTY-EIGHT.

183. Fertility services, including manual vacuum aspiration procedures, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

   a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

   b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

   c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

   a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

   b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

   c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-

reduction—over the interests of plaintiff to receive quality and safe care, particularly during manual vacuum aspiration procedures, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT ONE HUNDRED EIGHTY-NINE:
PETER KELLY v. YALE UNIVERSITY (Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT ONE HUNDRED EIGHTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT ONE HUNDRED EIGHTY-NINE.

188. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

189. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED NINETY:
MICHELLE KELLY v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINETY.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an manual vacuum aspiration procedure with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the manual vacuum aspiration procedure.

185. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the manual vacuum aspiration procedure.

187. The use of fentanyl for analgesia during the manual vacuum aspiration procedure was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to manual vacuum aspiration procedure.

188. On or before the dates that plaintiff underwent an manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of manual vacuum aspiration procedure in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an manual vacuum aspiration procedure at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the manual vacuum aspiration procedure, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT ONE HUNDRED NINETY-ONE
PETER KELLY v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT ONE HUNDRED NINETY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT ONE HUNDRED NINETY-ONE.

192. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

193. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED NINETY-TWO:
MICHELLE KELLY v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINETY-TWO.

183. An manual vacuum aspiration procedure with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an manual vacuum aspiration procedure with the administration of fentanyl is different and distinct from an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an manual vacuum aspiration procedure with the administration of fentanyl are different and distinct from those of an manual vacuum aspiration procedure where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective manual vacuum aspiration procedures, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an manual vacuum aspiration procedure with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective manual vacuum aspiration procedure, YALE UNIVERSITY completed the manual vacuum aspiration procedure(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective manual vacuum aspiration procedure, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's manual vacuum aspiration procedure(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective manual vacuum aspiration procedure(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT ONE HUNDRED NINETY-THREE
PETER KELLY v. YALE UNIVERSITY (Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT ONE HUNDRED NINETY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT ONE HUNDRED NINETY-THREE.

195. At all times mentioned herein, the plaintiff, PETER KELLY, was the husband of MICHELLE KELLY.

196. As a result of the aforesaid injuries of plaintiff MICHELLE KELLY, PETER KELLY has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED NINETY-FOUR:
MICHELLE KELLY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINETY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

184. A contract involving a manual vacuum aspiration procedures is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedures under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform a manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED NINETY-FIVE
PETER KELLY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT ONE HUNDRED NINETY-FIVE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, PETER KELLY, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for IVF procedures including manual vacuum aspiration procedures.

191. A contract involving the manual vacuum aspiration process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

192. In consideration of YALE UNIVERSITY's promises, including performance of manual vacuum aspiration procedure under anesthesia, plaintiff, PETER KELLY, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

193. PETER KELLY performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

194. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, PETER KELLY, including the incorporated contractual covenant of good faith and fair dealing.

195. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

196. A contract whereby a fertility clinic undertakes to perform an manual vacuum aspiration procedure is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

197. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, PETER KELLY, suffered harm, including mental anguish and/or money damages.

COUNT ONE HUNDRED NINETY-SIX
CHRISTINE DEVOE v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT ONE HUNDRED NINETY-SIX.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CHRISTINE DEVOE for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CHRISTINE DEVOE suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CHRISTINE DEVOE, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about April 8, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit R.

COUNT ONE HUNDRED NINETY-SEVEN:
JAMES DEVOE v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT ONE HUNDRED NINETY-SEVEN.

184. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

185. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT ONE HUNDRED NINETY-EIGHT:
CHRISTINE DEVOE v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this ONE HUNDRED NINETY-EIGHT.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;

i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT ONE HUNDRED NINETY-NINE:
JAMES DEVOE v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 146 of ONE HUNDRED NINETY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED FORTY-SIX (184), respectively, of this COUNT ONE HUNDRED NINETY-NINE.

185. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

186. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED
CHRISTINE DEVOE v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWO HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED NINE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

i. terror;
j. pain and suffering;
k. mental and emotional distress;
l. loss of quality of life;
m. loss of enjoyment of life's activities;
n. medical expenses;
o. impaired future earning capacity;
p. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED ONE
JAMES DEVOE v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT TWO HUNDRED are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT TWO HUNDRED ONE.

203. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

204. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED TWO
JAMES DEVOE v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT TWO HUNDRED TEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT TWO HUNDRED TWO.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED TEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, JAMES DEVOE suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED THREE:
CHRISTINE DEVOE v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THREE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

   a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

   b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

   c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

   a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

   b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

   c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care,

particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT TWO HUNDRED FOUR:
JAMES DEVOE v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT TWO HUNDRED THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT TWO HUNDRED FOUR.

188. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

189. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FIVE
CHRISTINE DEVOE v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIVE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks

and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED SIX:
JAMES DEVOE v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT TWO HUNDRED FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT TWO HUNDRED SIX.

192. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

193. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED SEVEN:
CRISTINE DEVOE v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVEN.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED EIGHT:
JAMES DEVOE v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT TWO HUNDRED SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWO HUNDRED EIGHT.

195. At all times mentioned herein, the plaintiff, JAMES DEVOE, was the husband of CHRISTINE DEVOE.

196. As a result of the aforesaid injuries of plaintiff CHRISTINE DEVOE, JAMES DEVOE has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED NINE:
CHRISTINE DEVOE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED TEN:
JAMES DEVOE v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT ONE HUNDRED NINETY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff, JAMES DEVOE, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, JAMES DEVOE, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. JAMES DEVOE performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, JAMES DEVOE, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, JAMES DEVOE, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED ELEVEN:
REBECCA TULIN v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT TWO HUNDRED ELEVEN.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of REBECCA TULIN for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, REBECCA TULIN suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by REBECCA TULIN, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about September 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit S.

COUNT TWO HUNDRED TWELVE:
ADAM TULIN v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT TWO HUNDRED TWELVE.

184. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

185. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED THIRTEEN:
REBECCA TULIN v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTEEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;

c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED FOURTEEN:
ADAM TULIN v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT TWO HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHT-FOUR (184), respectively, of this COUNT TWO HUNDRED FOURTEEN

185. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

186. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FIFTEEN:
REBECCA TULIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTEEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

183. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

184. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

185. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

186. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

187. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

188. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

189. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWO HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED FIFTEEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED TWENTY FOUR and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:
   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED SIXTEEN
ADAM TULIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT TWO HUNDRED FIFTEEN are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT TWO HUNDRED SIXTEEN.

203. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

204. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED SEVENTEEN
ADAM TULIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT TWO HUNDRED TWENTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT TWO HUNDRED SEVENTEEN.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED TWENTY-FIVE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, ADAM TULIN suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED EIGHTEEN:
REBECCA TULIN v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED EIGHTEEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT TWO HUNDRED NINETEEN:
ADAM TULIN v. YALE UNIVERSITY (Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT TWO HUNDRED EIGHTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT TWO HUNDRED NINETEEN.

188. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

189. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED TWENTY
REBECCA TULIN v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED TWENTY-ONE:
ADAM TULIN v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT TWO HUNDRED TWENTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT TWO HUNDRED TWENTY-ONE.

192. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

193. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED TWENTY-TWO:
REBECCA TULIN v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY-TWO.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED TWENTY- THREE:
ADAM TULIN v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT TWO HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWO HUNDRED TWENTY-THREE.

195. At all times mentioned herein, the plaintiff, ADAM TULIN, was the husband of REBECCA TULIN.

196. As a result of the aforesaid injuries of plaintiff REBECCA TULIN, ADAM TULIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED TWENTY-FOUR:
REBECCA TULIN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED TWENTY-FIVE
ADAM TULIN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY-FIVE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, ADAM TULIN, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, ADAM TULIN, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. ADAM TULIN performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, ADAM TULIN, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, ADAM TULIN, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED TWENTY-SIX:
JANINE HERR v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT TWO HUNDRED TWENTY-SIX.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of

JANINE HERR for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, JANINE HERR suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by JANINE HERR, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about July 22, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit T

COUNT TWO HUNDRED TWENTY-SEVEN
JANINE HERR v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY-SEVEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED TWENTY-EIGHT:
JANINE HERR v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED TWENTY-EIGHT.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage

at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWO HUNDRED THIRTY-THREE are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED TWENTY-EIGHT.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED THIRTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED TWENTY-NINE:
PATRICK FEENEY v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT TWO HUNDRED THIRY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT TWO HUNDRED TWENTY-NINE.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED THIRTY-FOUR and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, PATRICK FEENEY suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED THIRTY:
JANINE HERR v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT TWO HUNDRED THIRTY-ONE:
JANINE HERR v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY-ONE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. ability to carry on and enjoy life's activities;

    g. expenses for medical care and treatment;

    h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED THIRTY-TWO:
JANINE HERR v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY-TWO.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED THIRTY-THREE:
JANINE HERR v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED THIRTY-FOUR
PATRICK FEENEY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff, PATRICK FEENEY, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, ADAM TULIN, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. PATRICK FEENEY performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, PATRICK FEENEY, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, PATRICK FEENEY, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED THIRTY-FIVE:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT TWO HUNDRED THIRTY-FIVE.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CAROLINE GRUENBAUM for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CAROLINE GRUENBAUM suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CAROLINE GRUENBAUM, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
    d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
    e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
    f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
    g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
    h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
    i. allowed inappropriate flexible ordering of fentanyl;
    j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about April 8, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit U.

COUNT TWO HUNDRED THIRTY-SIX:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT TWO HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT TWO HUNDRED THIRTY-SIX.

184. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

185. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED THIRTY-SEVEN:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRTY-SEVEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED THIRTY-EIGHT:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT TWO HUNDRED THIRTY-SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT TWO HUNDRED THIRTY-EIGHT.

185. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

186. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED THIRTY-NINE:
CAROLINE GRUENBAUM v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED THIRY-NINE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWO HUNDRED FOURTY-EIGHT are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED FORTY-ONE.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED FOURTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED FORTY:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act - Loss of Consortium)

1-202. Paragraphs 1 through 202 of COUNT TWO HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202), respectively, of this COUNT TWO HUNDRED FORTY.

203. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

204. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FORTY-ONE:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-ONE.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED FORTY-NINE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

184. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

185. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

186. As a result of YALE UNIVERSITY's violation of CUTPA, BENJAMIN GRUENBAUM suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED FORTY-TWO:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-TWO.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;

f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT TWO HUNDRED FORTY-THREE:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1 through 187 of COUNT TWO HUNDRED FORTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187), respectively, of this COUNT TWO HUNDRED FORTY-THREE.

188. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

189. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FORTY-FOUR:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-FOUR.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

183. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

187. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

188. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

190. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

191. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED FORTY-FIVE
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-FIVE.

183. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

184. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FORTY-SIX:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-SIX.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED FORTY-SEVEN:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY
(Medical Assault and Battery- Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT TWO HUNDRED FORTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWO HUNDRED FORTY-SEVEN.

195. At all times mentioned herein, the plaintiff, BENJAMIN GRUENBAUM, was the husband of CAROLINE GRUENBAUM.

196. As a result of the aforesaid injuries of plaintiff CAROLINE GRUENBAUM, BENJAMIN GRUENBAUM has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FORTY-EIGHT:
CAROLINE GRUENBAUM v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FOURTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED FORTY-NINE:
BENJAMIN GRUENBAUM v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FORTY-NINE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, BENJAMIN GRUENBAUM, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, BENJAMIN GRUENBAUM, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. BENJAMIN GRUENBAUM performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, BENJAMIN GRUENBAUM.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, BENJAMIN GRUENBAUM, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED FIFTY:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 through 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT TWO HUNDRED FIFTY.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of CAMISE TURNER-EVANS for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, CAMISE TURNER-EVANS suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by CAMISE TURNER-EVANS, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
    d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
    e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
    f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
    g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
    h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
    i. allowed inappropriate flexible ordering of fentanyl;
    j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about July 1, 2021 pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit V.

COUNT TWO HUNDRED FIFTY-ONE:
SHAWN EVANS v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT TWO HUNDRED FIFTY-ONE.

186. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

187. As a result of the aforesaid injuries of plaintiff CAMISE TURNER-EVANS, SHAWN EVANS has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FIFTY-TWO:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTY-TWO.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED FIFTY-THREE
SHAWN EVANS v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT TWO HUNDRED FIFTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT TWO HUNDRED FIFTY-THREE.

187. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

188. As a result of the aforesaid injuries of plaintiff CAMISE TURNER-EVANS, SHAWN EVANS has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FIFTY-FOUR:
CAMISE TURNER-EVANS v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTY-FOUR.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-142.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT TWO HUNDRED SIXTY-THREE are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED FIFTY-FOUR.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED SIXTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED FIFTY-FIVE:
SHAWN EVANS v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act - Loss of Consortium)

1-202. Paragraphs 1 through 202 of COUNT TWO HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202), respectively, of this COUNT TWO HUNDRED FIFTY-FIVE.

203. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

COUNT TWO HUNDRED FIFTY-SIX:
SHAWN EVANS v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTY-SIX.

183. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED SIXTY-FOUR and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

187. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

188. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

189. As a result of YALE UNIVERSITY's violation of CUTPA, SHAWN EVANS suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED FIFTY-SEVEN:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTY-SEVEN.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT TWO HUNDRED FIFTY-EIGHT:
SHAWN EVANS v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1 through 187 of COUNT TWO HUNDRED FIFTY-SEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187), respectively, of this COUNT TWO HUNDRED SIXTY.

190. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

191. As a result of the aforesaid injuries of plaintiff CAMISE TURNER-EVANS, SHAWN EVANS has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED FIFTY-NINE:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED FIFTY-NINE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SIXTY:
SHAWN EVANS v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-193. Paragraphs 1 through 193 of COUNT TWO HUNDRED FIFTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-THREE (193), respectively, of this COUNT TWO HUNDRED SIXTY.

194. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

195. As a result of the aforesaid injuries of plaintiff CAMISE TURNER-EVANS, SHAWN EVANS has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED SIXTY-ONE:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-ONE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SIXTY-TWO:
SHAWN EVANS v. YALE UNIVERSITY
(Medical Assault and Battery- Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT TWO HUNDRED SIXTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWO HUNDRED SIXTY-TWO.

195. At all times mentioned herein, the plaintiff, SHAWN EVANS, was the husband of CAMISE TURNER-EVANS.

196. As a result of the aforesaid injuries of plaintiff CAMISE TURNER-EVANS, SHAWN EVANS has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED SIXTY-THREE:
CAMISE TURNER-EVANS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED SIXTY-FOUR
SHAWN EVANS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED FIFTY. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-FOUR.

183. YALE UNIVERSITY entered into contracts with the plaintiff, SHAWN EVANS, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, SHAWN EVANS, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. SHAWN EVANS performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, SHAWN EVANS.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, SHAWN EVANS, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED SIXTY-FIVE
LAURA CZAR v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED FIFTY-SEVEN (179), respectively, of this COUNT TWO HUNDRED SIXTY-FIVE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of

LAURA CZAR for the same or similar condition, which included an oocyte retrieval performed on April 3, 2019.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, LAURA CZAR suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by LAURA CZAR as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
    d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
    e. failed, upon information and belief, to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
    f. failed, upon information and belief, to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
    g. failed, upon information and belief, to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
    h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
    i. failed, upon information and belief, to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

j. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
k. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
l. failed, upon information and belief, to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
m. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
n. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
o. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
p. failed, upon information and belief, to complete mandated supervised inventory checks of stored fentanyl;
q. failed to appropriately inspect controlled substance inventory for tampering;
r. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
s. failed, upon information and belief, to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
t. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
u. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
v. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
w. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
x. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
y. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
z. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
aa. improperly allowed for "flexible ordering," for fentanyl;
bb. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016;

cc. failed, upon information and belief, to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

dd. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ee. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

ff. failed to properly supervise and/or monitor Nurse Donna Monticone;

gg. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

hh. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;

ii. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about February 7, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit W.

COUNT TWO HUNDRED SIXTY-EIGHT:
LAURA CZAR v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY, upon information and belief, to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;

i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED SIXTY-SEVEN:
LAURA CZAR v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 - 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-SEVEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Prior to December 2020, anesthesiology services were not offered or made available to patients undergoing an oocyte retrieval on weekends or holidays at the Orange REI Clinic; anesthesiology services were only offered or made available on non-holiday weekdays.

185. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Orange REI Clinic on weekends or holidays to maximize profits and/or reduce costs, such as the costs associated with providing anesthesiology services on weekends or holidays or the costs associated with providing anesthesiology services on date(s) or at location(s) with low patient volume.

186. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Long Wharf REI Clinic to maximize profits and/or reduce costs, such as the costs associated with:

a. providing anesthesiology services at a clinic/location with low patient volume;
b. providing anesthesiology services at a clinic outside of Yale-New Haven Hospital (i.e. providing anesthesiology services outside of the Hospital located at or in immediate continuity to 20 York Street, New Haven, CT);
c. providing anesthesiology services on a date—including weekends and/or holidays—with low patient volume.

187. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its business decision to not offer anesthesiology services at the Long Wharf

REI Clinic would result in inadequate pain management and pose an unreasonable and egregious risk of physical injury to its patients.

188. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of not offering anesthesiology services for oocyte retrievals at the Long Wharf REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

189-197. Paragraphs 183-190 of COUNT TWO HUNDRED SEVENTY-ONE are hereby incorporated and realleged as paragraphs ONE HUNDRED EIGHTY-NINE through ONE HUNDRED NINETY-SEVEN (197) respectively, of this COUNT SIXTY-SEVEN

190. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED SEVENTY-ONE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

191. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

192. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

193. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED SIXTY-EIGHT:
LAURA CZAR v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-EIGHT.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184 At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;
c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic, upon information and belief, in violation of federal and/or state law.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it made the business decision not to provide anesthesiology services to patients undergoing oocyte retrievals at the REI Clinic.

COUNT TWO HUNDRED SIXTY-NINE:
LAURA CZAR v. YALE UNIVERSITY (Informed Consent)

1-179. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SIXTY-NINE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

168. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

190. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. impaired future earning capacity;
f. psychological, physiological and neurological sequelae.

191. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SEVENTY:
LAURA CZAR v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrieval(s), did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. impaired future earning capacity;
   f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SEVENTY-ONE:
LAURA CZAR v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-ONE.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation, including analgesia, deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED SEVENTY-FOUR:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179), respectively, of this COUNT TWO HUNDRED SEVENTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of JOHANNA D'ADDARIO for the same or similar condition, which included an oocyte retrieval performed on February 7, 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, JOHANNA D'ADDARIO suffered the following severe, serious, painful, and permanent injuries:
    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. loss of enjoyment of life's activities;
    f. medical expenses;
    g. impaired future earning capacity;
    h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by JOHANNA D'ADDARIO, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

    a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
    b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
    c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed, upon information and belief, to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed, upon information and belief, to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed, upon information and belief, to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. failed, upon information and belief, to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
j. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
k. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
l. failed, upon information and belief, to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
m. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
n. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
o. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
p. failed, upon information and belief, to complete mandated supervised inventory checks of stored fentanyl;
q. failed to appropriately inspect controlled substance inventory for tampering;
r. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
s. failed, upon information and belief, to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
t. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
u. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

v. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
w. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
x. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
y. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
z. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
aa. improperly allowed for "flexible ordering," for fentanyl;
bb. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016;
cc. failed, upon information and belief, to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
dd. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;
ee. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
ff. failed to properly supervise and/or monitor Nurse Donna Monticone;
gg. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;
hh. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
ii. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about September 28, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit X.

COUNT TWO HUNDRED SEVENTY-THREE:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SIXTY (160) respectively, of this COUNT TWO HUNDRED SEVENTY-FIVE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY, upon information and belief, to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED SEVENTY-FOUR:
JOHANNA D'ADDARIO v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1-181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-FOUR.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Prior to December 2020, anesthesiology services were not offered or made available to patients undergoing an oocyte retrieval on weekends or holidays at the Orange REI Clinic; anesthesiology services were only offered or made available on non-holiday weekdays.

185. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Orange REI Clinic on weekends or holidays to maximize profits and/or reduce costs, such as the costs associated with providing anesthesiology services on weekends or holidays or the costs associated with providing anesthesiology services on date(s) or at location(s) with low patient volume.

186. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Long Wharf REI Clinic to maximize profits and/or reduce costs, such as the costs associated with:

   d. providing anesthesiology services at a clinic/location with low patient volume;
   e. providing anesthesiology services at a clinic outside of Yale-New Haven Hospital (i.e. providing anesthesiology services outside of the Hospital located at or in immediate continuity to 20 York Street, New Haven, CT);
   f. providing anesthesiology services on a date—including weekends and/or holidays—with low patient volume.

187. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its business decision to not offer anesthesiology services at the Long Wharf REI Clinic would result in inadequate pain management and pose an unreasonable and egregious risk of physical injury to its patients.

188. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of not offering anesthesiology services for oocyte retrievals at the Long Wharf REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

189-197. Paragraphs 183-190 of COUNT TWO HUNDRED SEVENTY-EIGHT are hereby incorporated and realleged as paragraphs ONE HUNDRED EIGHTY-NINE through ONE HUNDRED NINETY-SEVEN (197) respectively, of this COUNT TWO HUNDRED SEVENTY-FOUR.

198. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED SEVENTY-EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

199. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

200. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

201. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;

d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED SEVENTY-FIVE:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1-181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-FIVE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;
c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-

reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

e. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic, upon information and belief, in violation of federal and/or state law.

f. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it made the business decision not to provide anesthesiology services to patients undergoing oocyte retrievals at the REI Clinic.

COUNT TWO HUNDRED SEVENTY-SIX:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1-181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-SIX.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical

structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. impaired future earning capacity;
f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SEVENTY-SEVEN:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1-181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-SEVEN.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184 The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrieval(s), did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192 As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. impaired future earning capacity;
f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED SEVENTY-EIGHT:
JOHANNA D'ADDARIO v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT TWO HUNDRED SEVENTY-TWO are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED SEVENTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation, including analgesia, deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED SEVENTY-NINE:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179), respectively, of this COUNT TWO HUNDRED SEVENTY-NINE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of VIKTORIA DUBROVSKY for the same or similar condition, which included an oocyte retrieval performed on September 5, 2017.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, VIKTORIA DUBROVSKY suffered the following severe, serious, painful, and permanent injuries:
   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;
   h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by VIKTORIA DUBROVSKY, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;
e. failed, upon information and belief, to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed, upon information and belief, to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed, upon information and belief, to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. failed, upon information and belief, to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
j. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
k. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
l. failed, upon information and belief, to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
m. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
n. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
o. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
p. failed, upon information and belief, to complete mandated supervised inventory checks of stored fentanyl;

q. failed to appropriately inspect controlled substance inventory for tampering;
r. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
s. failed, upon information and belief, to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
t. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
u. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
v. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
w. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;
x. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
y. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
z. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
aa. improperly allowed for "flexible ordering," for fentanyl;
bb. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016;
cc. failed, upon information and belief, to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
dd. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;
ee. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
ff. failed to properly supervise and/or monitor Nurse Donna Monticone;
gg. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

hh. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
ii. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about February 7, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit Y.

COUNT TWO HUNDRED EIGHTY:
MARINA DUBROVSKY v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-182. Paragraphs 1 through 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182), respectively, of this COUNT TWO HUNDRED EIGHTY.

184. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

185. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED EIGHTY-ONE:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED EIGHTY-ONE.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY, upon information and belief, to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;

i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED EIGHTY-TWO
MARINA DUBROVSKY v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT TWO HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT TWO HUNDRED EIGHTY-TWO.

185. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

186. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED EIGHTY-THREE:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED EIGHTY-THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Prior to December 2020, anesthesiology services were not offered or made available to patients undergoing an oocyte retrieval on weekends or holidays at the Orange REI Clinic; anesthesiology services were only offered or made available on non-holiday weekdays.

185. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Orange REI Clinic on weekends or holidays to maximize profits and/or reduce costs, such as the costs associated with providing anesthesiology services on weekends or holidays or the costs

associated with providing anesthesiology services on date(s) or at location(s) with low patient volume.

186. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Long Wharf REI Clinic to maximize profits and/or reduce costs, such as the costs associated with:

   a. providing anesthesiology services at a clinic/location with low patient volume;
   b. providing anesthesiology services at a clinic outside of Yale-New Haven Hospital (i.e. providing anesthesiology services outside of the Hospital located at or in immediate continuity to 20 York Street, New Haven, CT);
   c. providing anesthesiology services on a date—including weekends and/or holidays—with low patient volume.

187. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its business decision to not offer anesthesiology services at the Long Wharf REI Clinic would result in inadequate pain management and pose an unreasonable and egregious risk of physical injury to its patients.

188. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of not offering anesthesiology services for oocyte retrievals at the Long Wharf REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

189-196. Paragraphs 183-190 of COUNT TWO HUNDRED NINETY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED EIGHTY-NINE through ONE HUNDRED NINETY-SIX(196) respectively, of this COUNT TWO HUNDRED EIGHTY-THREE.

197. YALE UNIVERSITY's breach of contract, as addressed in COUNT TWO HUNDRED NINETY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

198. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

199. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

200. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

   a. terror;
   b. pain and suffering;
   c. mental and emotional distress;
   d. loss of quality of life;
   e. loss of enjoyment of life's activities;
   f. medical expenses;
   g. impaired future earning capacity;

h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED EIGHTY-FOUR
MARINA DUBROVSKY v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-200. Paragraphs 1 through 200 of COUNT TWO HUNDRED EIGHTY-THREE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED (200), respectively, of this COUNT TWO HUNDRED EIGHTY-FOUR.

201. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

202. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED EIGHTY-FIVE:
MARINA DUBROVSKY v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT TWO HUNDRED NINETY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED FIFTY-ONE (151), respectively, of this COUNT TWO HUNDRED EIGHTY-FIVE.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT TWO HUNDRED NINETY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, MARINA DUBROVSKY suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED EIGHTY-SIX:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED EIGHTY-SIX.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;
b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;
c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic, upon information and belief, in violation of federal and/or state law.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it

made the business decision not to provide anesthesiology services to patients undergoing oocyte retrievals at the REI Clinic.

COUNT TWO HUNDRED EIGHTY-SEVEN
MARINA DUBROVSKY v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1 through 187 of COUNT TWO HUNDRED EIGHTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187), respectively, of this COUNT TWO HUNDRED EIGHTY-SEVEN.

188. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

189. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED EIGHTY-EIGHT
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED EIGHTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks

and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. impaired future earning capacity;
f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED EIGHTY-NINE
MARINA DUBROVSKY v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-193. Paragraphs 1 through 193 of COUNT TWO HUNDRED EIGHTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-THREE (193), respectively, of this COUNT TWO HUNDRED EIGHTY-NINE.

191. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

192. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED NINETY:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED EIGHTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINETY.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184.. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185.. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrieval(s), did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192 As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT TWO HUNDRED NINETY-ONE
MARINA DUBROVSKY v. YALE UNIVERSITY
(Medical Assault and Battery- Loss of Consortium)

1-194. Paragraphs 1 - 194 of COUNT TWO HUNDRED NINETY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT TWO HUNDRED NINETY-ONE.

195. At all times mentioned herein, the plaintiff, MARINA DUBROVSKY, was the wife of VIKTORIA DUBROVSKY.

196. As a result of the aforesaid injuries of plaintiff VIKTORIA DUBROVSKY, MARINA DUBROVSKY has been deprived of the consortium, companionship, and society of her spouse, all to her damage.

COUNT TWO HUNDRED NINETY-TWO:
VIKTORIA DUBROVSKY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINETY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation, including analgesia, deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED NINETY-THREE:
MARINA DUBROVSKY v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 – 181, 183 of COUNT TWO HUNDRED SEVENTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINETY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, HOLLY CORTESE, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, MARINA DUBROVSKY, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. MARINA DUBROVSKY performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, MARINA DUBROVSKY, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, MARINA DUBROVSKY, suffered harm, including mental anguish and/or money damages.

COUNT TWO HUNDRED NINETY-FOUR:
STACEY GLENNON v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs 1 - 179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT TWO HUNDRED NINETY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERSITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of STACEY GLENNON for the same or similar condition, which included one or more oocyte retrievals performed in 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, STACEY GLENNON suffered the following severe, serious, painful, and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by STACEY GLENNON, as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;
b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;
c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;
d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;
f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;
g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to *different* healthcare workers;
h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, *see, e.g.*, 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);
i. allowed inappropriate flexible ordering of fentanyl;
j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;
k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;
l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;
m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;
n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;
o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;
p. failed to educate employees/agents on diversion, including the *mandatory* obligation of healthcare workers to report suspected diversion;
q. failed to complete mandated supervised inventory checks of stored fentanyl;
r. failed to appropriately inspect controlled substance inventory for tampering;
s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;
t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;
u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;
v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;
w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;
x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;
z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;
aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;
bb. improperly permitted "flexible ordering," for fentanyl;
cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;
dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;
ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;
ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;
gg. failed to properly supervise and/or monitor Nurse Donna Monticone;
hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;
ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations;
jj. failed to offer and provide appropriate anesthesiology services and pain management to plaintiff.

183. On or about March 11, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit Z.

COUNT TWO HUNDRED NINETY-FIVE:
SEAN GLENNON v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT TWO HUNDRED NINETY-FIVE

188. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

189. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED NINETY-SIX:
STACEY GLENNON v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 - 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINETY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

185. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT TWO HUNDRED NINETY-SEVEN:
SEAN GLENNON v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 - 184 of COUNT TWO HUNDRED NINETY-SIX hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT TWO HUNDRED NINETY-SEVEN.

185. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

186. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT TWO HUNDRED NINETY-EIGHT:
STACEY GLENNON v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 - 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT TWO HUNDRED NINETY-EIGHT.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

191. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

192. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

193. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

194. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

195. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

196. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

197. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT THREE HUNDRED SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT TWO HUNDRED NINETY-EIGHT

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT THREE HUNDRED SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT TWO HUNDRED NINETY-NINE:
SEAN GLENNON v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1 - 202 of COUNT TWO HUNDRED NINETY-EIGHT are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202), respectively, of this COUNT TWO HUNDRED NINETY-NINE.

203. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

204. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED:
SEAN GLENNON v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1 through 190 THREE HUNDRED EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THREE HUNDRED EIGHT and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, SEAN GLENNON suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED ONE:
STACEY GLENNON v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED NINETY-FOUR. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED ONE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

   a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

   b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

d. YALE UNIVERSITY prioritized and effectuated its own interests—including its interests in cost-reduction and profit maximization—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it failed to provide anesthesiology services to patients undergoing oocyte retrievals on Saturdays, Sundays, and holidays.

COUNT THREE HUNDRED TWO:
SEAN GLENNON v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1 through 187 of COUNT THREE HUNDRED ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187), respectively, of this COUNT THREE HUNDRED TWO.

188. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

189. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THREE:
STACEY GLENNON v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THREE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical

structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

192. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

193. As a further result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for each and every oocyte retrieval, the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED FOUR
SEAN GLENNON v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FOUR.

183. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

184. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIVE
STACEY GLENNON v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1 through 181, 183of COUNT TWO HUNDRED NINETY-FOUR. are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FIVE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED SIX
SEAN GLENNON v. YALE UNIVERSITY
(Medical Assault and Battery- Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT THREE HUNDRED FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT THRE HUNDRED SIX.

195. At all times mentioned herein, the plaintiff, SEAN GLENNON, was the husband of STACEY GLENNON.

196. As a result of the aforesaid injuries of plaintiff STACEY GLENNON, SEAN GLENNON has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED SEVEN:
STACEY GLENNON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

191. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

192. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

193. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

194. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

195. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

196. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

197. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED EIGHT:
SEAN GLENNON v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1 through 181, 183 of COUNT TWO HUNDRED NINETY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff, SEAN GLENNON, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, SEAN GLENNON, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. SEAN GLENNON performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, SEAN GLENNON.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, SEAN GLENNON, suffered harm, including mental anguish and/or money damages

COUNT THREE HUNDRED NINE:
BIANCA GOGLAS v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT THREE HUNDRED NINE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of BIANCA GOGLAS for the same or similar condition, which included one or more oocyte retrievals performed on or about August 8, 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, BIANCA GOGLAS suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by BIANCA GOGLAS as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

i. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

j. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

k. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

l. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

m. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

n. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

o. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

p. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

q. allowed inappropriate flexible ordering of fentanyl;

r. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

s. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

t. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

u. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

v. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

w. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

x. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

y. failed to complete mandated supervised inventory checks of stored fentanyl;

z. failed to appropriately inspect controlled substance inventory for tampering;

aa. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

bb. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

cc. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

dd. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

ee. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

ff. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

gg. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

hh. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

ii. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

jj. improperly permitted "flexible ordering," for fentanyl;

kk. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

ll. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

mm. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

nn. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

oo. failed to properly supervise and/or monitor Nurse Donna Monticone;

pp. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

qq. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about March 11, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed

with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit AA.

COUNT THREE HUNDRED TEN:
RENE LOPEZ v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT THREE HUNDRED TEN.

184. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

185. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED ELEVEN:
BIANCA GOGLAS v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED ELEVEN.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;

c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THREE HUNDRED TWELVE:
RENE LOPEZ v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT THREE HUNDRED ELEVEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT THREE HUNDRED TWELVE.

185. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

186. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THIRTEEN:
BIANCA GOGLAS v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THIRTEEN.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

198. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

199. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

200. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

201. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

202. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

203. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

204. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT THREE HUNDRED TWENTY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT THREE HUNDRED THIRTEEN.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT THREE HUNDRED TWENTY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

i. terror;
j. pain and suffering;
k. mental and emotional distress;
l. loss of quality of life;
m. loss of enjoyment of life's activities;
n. medical expenses;
o. impaired future earning capacity;
p. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED FOURTEEN:
RENE LOPEZ v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT THREE HUNDRED THIRTEEN are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT THREE HUNDRED FOURTEEN.

203. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

204. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIFTEEN:
RENE LOPEZ v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT THREE HUNDRED TWENTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT THREE HUNDRED FIFTEEN.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THREE HUNDRED TWENTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, RENE LOPEZ suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED SIXTEEN:
BIANCA GOGLAS v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SIXTEEN

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT THRE HUNDRED SEVENTEEN
RENE LOPEZ v. YALE UNIVERSITY (Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT THREE HUNDRED SIXTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT THREE HUNDRED SEVENTEEN

188. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

189. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED EIGHTEEN:
BIANCA GOGLAS v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1-181, 183of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED EIGHTEEN.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED NINETEEN:
RENE LOPEZ v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT THREE HUNDRED EIGHTEEN are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT THREE HUNDRED NINETEEN.

192. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

193. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED TWENTY:
BIANCA GOGLAS v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182), respectively, of this COUNT THREE HUNDRED TWENTY.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED TWENTY-ONE
RENE LOPEZ v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT THREE HUNDRED TWENTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT THREE HUNDRED TWENTY-ONE.

195. At all times mentioned herein, the plaintiff, RENE LOPEZ, was the husband of BIANCA GOGLAS.

196. As a result of the aforesaid injuries of plaintiff BIANCA GOGLAS, RENE LOPEZ has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED TWENTY-TWO
BIANCA GOGLAS v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED TWENTY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED TWENTY-THREE:
RENE LOPEZ v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED TWENTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, RENE LOPEZ, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, RENE LOPEZ, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. RENE LOPEZ performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, RENE LOPEZ, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, RENE LOPEZ, suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED TWENTY-FOUR:
NATALIYA SOSTIN v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT THREE HUNDRED TWENTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of NATALIYA SOSTIN for the same or similar condition, which included one or more oocyte retrievals performed on or about August 8, 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, NATALIYA SOSTIN suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by NATALIYA SOSTIN as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about April 8, 2021, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit BB.

COUNT THREE HUNDRED TWENTY-FIVE:
OLEG SOSTIN v. YALE UNIVERSITY (Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 145 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT THREE HUNDRED TWENTY-FIVE.

184. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

185. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED TWENTY-SIX:
NATALIYA SOSTIN v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED TWENTY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THREE HUNDRED TWENTY-SEVEN:
OLEG SOSTIN v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT THREE HUNDRED TWENTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT THREE HUNDRED TWENTY-SEVEN.

185. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

186. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED TWENTY-EIGHT:
NATALIYA SOSTIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED TWENTY-EIGHT.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

185. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

186. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

187. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

188. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

189. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

190. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT THREE HUNDRED THIRTY-SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE HUNDRED NINETY-EIGHT (198) respectively, of this COUNT THREE HUNDRED TWENTY-EIGHT.

199. YALE UNIVERSITY's breach of contract, as addressed in COUNT THREE HUNDRED THIRTY-SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

200. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

201. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

202. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED TWENTY-NINE:
OLEG SOSTIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT THREE HUNDRED THREE HUNDRED TWENTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT THREE HUNDRED TWENTY-NINE.

205. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

206. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THIRTY:
OLEG SOSTIN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT THREE HUNDRED THIRTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT THREE HUNDRED THIRTY.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THREE HUNDRED THIRTY-EIGHT reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, OLEG SOSTIN suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED THIRTY-ONE:
NATALIYA SOSTIN v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THIRTY-ONE.

190. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

191. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

192. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

193. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

194. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT THRE HUNDRED THIRTY-TWO:
OLEG SOSTIN v. YALE UNIVERSITY (Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT THREE HUNDRED THIRTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT THREE HUNDRED THIRTY-TWO.

188. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

189. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THIRTY-THREE:
NATALIYA SOSTIN v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THIRTY-THREE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED THIRTY-FOUR:
OLEG SOSTIN v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT THREE HUNDRED THIRTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT THREE HUNDRED THIRTY-FOUR.

192. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

193. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THIRTY-FIVE:
NATALIYA SOSTIN v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182), respectively, of this COUNT THREE HUNDRED THIRTY-FIVE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;
    b. pain and suffering;
    c. mental and emotional distress;
    d. loss of quality of life;
    e. impaired future earning capacity;
    f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED THIRTY-SIX:
OLEG SOSTIN v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT THREE HUNDRED THIRTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT THREE HUNDRED THIRTY-SIX.

195. At all times mentioned herein, the plaintiff, OLEG SOSTIN, was the husband of NATALIYA SOSTIN.

196. As a result of the aforesaid injuries of plaintiff NATALIYA SOSTIN, OLEG SOSTIN has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED THIRTY-SEVEN:
NATALIYA SOSTIN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THIRTY-SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED THIRTY-EIGHT:
OLEG SOSTIN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED TWENTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED THIRTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff, OLEG SOSTIN, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, OLEG SOSTIN, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. OLEG SOSTIN performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, OLEG SOSTIN, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, OLEG SOSTIN, suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED THIRTY-NINE:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT THREE HUNDRED THIRTY-NINE.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of MINGFEE CHOW-YEN for the same or similar condition, which included one or more oocyte retrievals performed on or about August 8, 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, MINGFEE CHOW-YEN suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by MINGFEE CHOW-YEN as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of

possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates, including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about April 8, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit CC.

COUNT THREE HUNDRED FORTY:
SHELDON STIGLER v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 145 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT THREE HUNDRED FORTY.

184. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

185. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FORTY-ONE:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FORTY.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THREE HUNDRED FORTY-TWO:
SHELDON STIGLER v. YALE UNIVERSITY (Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT THREE HUNDRED FORTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT THREE HUNDRED FORTY-TWO.

185. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

186. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FORTY-THREE:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FORTY-THREE.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

205. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its pursuit of bulk ordering of controlled substances, including opioids such as fentanyl, posed an unreasonable and egregious risk of physical injury to others.

206. YALE UNIVERSITY knew or should have known that hospitals, outpatient surgical centers, and outpatient medical facilities are particularly vulnerable to, and frequently the targets of opioid diversion and opioid substitution.

207. Upon information and belief, YALE UNIVERSITY made the business decision to pursue bulk ordering of controlled substances, including opioids such as fentanyl, to reduce costs and/or maximize profits.

208. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of ordering controlled substances, including opioids such as fentanyl, in bulk for storage at the REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

209. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its performance of oocyte retrieval procedures on weekends or holidays without anesthesiology services increased the likelihood that diversion would take place at those times, result in inadequate pain management, and pose an unreasonable and egregious risk of physical injury to its patients.

210. Upon information and belief, YALE UNIVERSITY made the business decision to not offer anesthesiology services for oocyte retrievals performed on weekends or holidays to reduce costs and/or maximize profits.

211. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of offering anesthesiology services for oocyte retrievals only on weekdays and non-holidays was carried out in the course of YALE UNIVERSITY's trade or commerce.

191-198. Paragraphs 183-190 of COUNT THREE HUNDRED FIFTY-TWO are hereby incorporated and realleged as paragraphs ONE HUNDRED NINETY-ONE through ONE

HUNDRED NINETY-EIGHT (198) respectively, of this COUNT THREE HUNDRED FORTY-THREE.

203. YALE UNIVERSITY's breach of contract, as addressed in COUNT THREE HUNDRED FIFTY-TWO and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

204. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

205. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

206. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED FORTY-FOUR:
SHELDON STIGLER v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act-Loss of Consortium)

1-202. Paragraphs 1-202 of COUNT THREE HUNDRED FORTY-THREE are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (202) respectively, of this COUNT THREE HUNDRED FORTY-FOUR.

203. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

204. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FORTY-FIVE:
SHELDON STIGLER v. YALE UNIVERSITY (Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT THREE HUNDRED FIFTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT THREE HUNDRED FORTY-FIVE.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THREE HUNDRED FIFTY-THREE and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, SHELDON STIGLER suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED FORTY-SIX:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FORTY-SIX.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;

g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT THRE HUNDRED FORTY-SEVEN:
SHELDON STIGLER v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT THREE HUNDRED FORTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT THREE HUNDRED FORTY-SEVEN.

188. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

189. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FORTY-EIGHT:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FORTY-EIGHT.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. ability to carry on and enjoy life's activities;

g. expenses for medical care and treatment;

h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED FORTY-NINE:
SHELDON STIGLER v. YALE UNIVERSITY (Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT THREE HUNDRED FORTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT THREE HUNDRED FORTY-NINE.

192. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

194. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIFTY:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182), respectively, of this COUNT THREE HUNDRED FIFTY.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED FIFTY-ONE:
SHELDON STIGLER v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT THREE HUNDRED FIFTY are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT THREE HUNDRED FIFTY-ONE.

195. At all times mentioned herein, the plaintiff, SHELDON STIGLER, was the husband of MINGFEE CHOW-YEN.

196. As a result of the aforesaid injuries of plaintiff MINGFEE CHOW-YEN, SHELDON STIGLER has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIFTY-TWO:
MINGFEE CHOW-YEN v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FIFTY-TWO.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED FIFTY-THREE:
SHELDON STIGLER v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED THIRTY-NINE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FIFTY-THREE.

183. YALE UNIVERSITY entered into contracts with the plaintiff, SHELDON STIGLER, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, SHELDON STIGLER, agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. SHELDON STIGLER performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, SHELDON STIGLER, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, SHELDON STIGLER, suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED FIFTY-FOUR:
MARIA MCNAMARA v. YALE UNIVERSITY (Medical Negligence)

1-179. Paragraphs **Error! Reference source not found.**-179 are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED SEVENTY-NINE (179) respectively, of this COUNT THREE HUNDRED FIFTY-FOUR.

180. At all times that plaintiff was a patient of YALE UNIVERITY's REI Clinic, YALE UNIVERSITY undertook the care, treatment, monitoring, diagnosing, and supervision of MARIA MCNAMARA for the same or similar condition, which included one or more oocyte retrievals performed on or about August 8, 2020.

181. While under the care, treatment, monitoring, diagnosing, and supervision of YALE UNIVERSITY, MARIA MCNAMARA suffered the following severe, serious, painful, and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. loss of enjoyment of life's activities;

f. medical expenses;

g. impaired future earning capacity

h. psychological, physiological and neurological sequelae.

182. The said injuries suffered by MARIA MCNAMARA as alleged in the preceding paragraph, were caused by the failure of YALE UNIVERSITY to exercise reasonable care under all the facts and circumstances then and there present in one or more of the following ways in that it:

a. failed to properly diagnose, care for, and treat plaintiff, as set forth herein;

b. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to prevent, identify, detect, evaluate, investigate, and/or respond to opioid diversion/substitution;

c. failed to regularly review or update policies and procedures to prevent and timely detect the diversion of controlled substances;

d. failed to devise, institute, and/or enforce proper policies, procedures, and/or systems to identify, evaluate, investigate, and/or intervene with opioid diversion/substitution;

e. failed to devise, institute, and/or enforce policies, procedures, and/or systems to prevent clinicians from additionally serving in the roles of opioid ordering, inventorying, and/or storage;

f. failed to utilize two healthcare workers—one of whom was a licensed pharmacy professional—to witness the delivery and inventory of controlled substances;

g. failed to separate the duties of controlled substance ordering and receipt of controlled-substance purchase orders to different healthcare workers;

h. failed, upon information and belief, to obtain a complete inventory that identifies the drug name, dosage form, drug strength, quantity, and date transferred, in violation of Medicare Condition of Participation and DEA Regulations, see, e.g., 21 C.F.R. 1304.11; 21 C.F.R. 1301.52(e)(1);

i. allowed inappropriate flexible ordering of fentanyl;

j. failed to devise, institute and/or enforce policies, procedures, and/or systems for the proper storage of controlled substances, including fentanyl, a Schedule II controlled substance;

k. failed, upon information and belief, to create, submit, and/or maintain appropriate records attending the procurement of opioids at the clinic, including but not limited to DEA Form 222 or an electronic equivalent;

l. failed, upon information and belief, to audit bulk transactions to document a chain of custody for every milligram of controlled substance received, transferred, or disposed;

m. failed to minimize excess stock of opioids stored at the REI Clinic to reduce the total quantity of drugs susceptible to diversion;

n. failed to screen and rescreen employees for risk factors and behavioral indicators of diversion;

o. failed to implement appropriate drug testing/screening, particularly for healthcare works who work in areas that are at elevated risk for diversion;

p. failed to educate employees/agents on diversion, including the mandatory obligation of healthcare workers to report suspected diversion;

q. failed to complete mandated supervised inventory checks of stored fentanyl;

r. failed to appropriately inspect controlled substance inventory for tampering;

s. either ignored or disregarded plaintiffs' complaints of excruciating pain that were not alleviated by additional doses of medication—a cardinal feature of opioid diversion;

t. failed to report a suspicion that Nurse Donna Monticone was practicing while impaired or diverting fentanyl;

u. failed to regularly assess patients to ensure that medications, including fentanyl, had its intended effects;

v. failed to conduct audits of opioid administered in surgical and procedure areas at the end of every shift;

w. failed, upon information and belief, to have two healthcare workers observe the wastage of controlled substances in real time with a visual line of sight;

x. failed, upon information and belief, to have every discrepancy between administration and waste documentation be readily or immediately resolved, as required by federal regulations;

y. failed, upon information and belief, to audit wasted or unused controlled substances using assay technologies, to confirm the identity and concentration of controlled substances that were documented as wasted;

z. failed to establish a diversion investigation team to audit the distribution of controlled substances and opioids, including fentanyl, and to investigate reports of possible diversion within the Yale-New Haven Health System, including the REI Clinic;

aa. failed to adequately train, educate, or instruct its servant(s), agent(s), apparent agent(s), and/or employee(s) to appropriately prevent, evaluate, investigate, intervene, and/or report concerns of opioid diversion/substitution;

bb. improperly permitted "flexible ordering," for fentanyl;

cc. failed to take appropriate remedial actions in response to controlled substance diversion/substitution events at YALE UNIVERSITY and/or partners/affiliates,

including those resulting in the arrest of YALE UNIVERSITY employees and/or partners/affiliates in 2016 and 2019;

dd. failed to properly examine opioids for signs of tampering, diversion, and substitution between each and every stage of medication use, including opioid dispensing and administration;

ee. failed to properly investigate patient reports of excruciating pain, despite the documentation of fentanyl administration;

ff. failed to investigate and/or properly respond to reports of uncontrolled pain or inadequate pain relief at the REI Clinic when fentanyl was administered by or in the presence of Nurse Donna Monticone;

gg. failed to properly supervise and/or monitor Nurse Donna Monticone;

hh. failed, upon information and belief, to investigate, address and/or properly respond to reports that Nurse Donna Monticone appeared incapacitated or impaired during her treatment of patients;

ii. failed to create and/or maintain adequate medical records in accordance with Section 19a-14-40 *et seq.* of the Connecticut Department of Public Health and Addiction Services Regulations.

183. On or about April 8, 2022, pursuant to Connecticut General Statutes § 52-190a(b), an automatic ninety (90) day extension of the applicable statutes of limitations was filed with and granted by the Superior Court. A copy of said petition is attached hereto as Exhibit DD.

COUNT THREE HUNDRED FIFTY-FIVE:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Medical Negligence- Loss of Consortium)

1-183. Paragraphs 1 through 145 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-THREE (183), respectively, of this COUNT THREE HUNDRED FIFTY-FIVE.

184. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

185. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIFTY-SIX:
MARIA MCNAMARA v. YALE UNIVERSITY (Negligence Per Se)

1-182. Paragraphs 1 through 181, 183of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FIFTY-SIX.

183. The said injuries suffered by plaintiff, as alleged herein, were caused by the failure of YALE UNIVERSITY to follow each and every statutory duty or duties, individually and in concert with one or more other identified statutory duty, listed below:

a. 21 U.S.C. § 827(b);
b. 21 C.F.R. § 1304.11;
c. 21 C.F.R. § 1301.52(e);
d. 21 C.F.R. § 1301.91;
e. 21 C.F.R. §1304.04;
f. 21 C.F.R. § 1305.03;
g. 42 C.F.R. § 482.13;
h. 42 C.F.R. § 482.24;
i. 42 C.F.R. § 482.25;
j. Conn. Gen. Stat. § 42-110a *et seq.* ("CUTPA");
k. Conn. Gen. Stat. § 21a-254;
l. Regs. Conn. St. Agencies § 21a-262-6.

184. For each and every statutory duty identified in the previous paragraph:

a. The statutory duty was designed to protect patients from injury;
b. The plaintiff is within the class of persons for whose benefit and protection the statutory duty was enacted;
c. The plaintiff has suffered an injury for which the statutory duty was intended to guard against.

COUNT THREE HUNDRED FIFTY-SEVEN:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Negligence Per Se- Loss of Consortium)

1-184. Paragraphs 1 through 184 of COUNT THREE HUNDRED FIFTY-SIX are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-FOUR (184), respectively, of this COUNT THREE HUNDRED FIFTY-SEVEN.

185. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

186. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED FIFTY-EIGHT:
MARIA MCNAMARA v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-182. Paragraphs 1 through 181, 183of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED FIFTY-EIGHT.

183. YALE UNIVERSITY knew, or should have known, of all of the foregoing information alleged at Paragraphs 1-182.

184. Prior to December 2020, anesthesiology services were not offered or made available to patients undergoing an oocyte retrieval on weekends or holidays at the Orange REI Clinic; anesthesiology services were only offered or made available on non-holiday weekdays.

185. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Orange REI Clinic on weekends or holidays to maximize profits and/or reduce costs, such as the costs associated with providing anesthesiology services on weekends or holidays or the costs associated with providing anesthesiology services on date(s) or at location(s) with low patient volume.

186. Upon information and belief, YALE UNIVERSITY made the business decision *not* to offer anesthesiology services for oocyte retrievals performed at the Long Wharf REI Clinic to maximize profits and/or reduce costs, such as the costs associated with:

a. providing anesthesiology services at a clinic/location with low patient volume;
b. providing anesthesiology services at a clinic outside of Yale-New Haven Hospital (i.e. providing anesthesiology services outside of the Hospital located at or in immediate continuity to 20 York Street, New Haven, CT);
c. providing anesthesiology services on a date—including weekends and/or holidays—with low patient volume.

187. Based on this and similar information, YALE UNIVERSITY knew, or should have known, that its business decision to not offer anesthesiology services at the Long Wharf REI Clinic would result in inadequate pain management and pose an unreasonable and egregious risk of physical injury to its patients.

188. YALE UNIVERSITY's engagement in the cost-reduction or profit-maximizing strategy of not offering anesthesiology services for oocyte retrievals at the Long Wharf REI Clinic was carried out in the course of YALE UNIVERSITY's trade or commerce.

189-196. Paragraphs 183-190 of COUNT THREE HUNDRED SIXTY-SEVEN are hereby incorporated and realleged as paragraphs ONE HUNDRED EIGHTY-NINE through ONE HUNDRED NINETY-SIX (196) respectively, of this COUNT THREE HUNDRED FIFTY-EIGHT.

198. YALE UNIVERSITY's breach of contract, as addressed in COUNT THREE HUNDRED SIXTY-SEVEN and reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

199. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

200. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

201. As a result of YALE UNIVERSITY's violation of CUTPA, plaintiff suffered the following injuries and losses:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED FIFTY-NINE:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act- Loss of Consortium)

1-201. Paragraphs 1-201 of COUNT THREE HUNDRED THREE HUNDRED FIFTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through TWO HUNDRED TWO (201) respectively, of this COUNT THREE HUNDRED FIFTY-NINE.

203. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

204. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED SIXTY:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Connecticut Unfair Trade Practices Act)

1-190. Paragraphs 1-190 of COUNT THREE HUNDRED SIXTY-EIGHT are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY (190), respectively, of this COUNT THREE HUNDRED SIXTY.

191. YALE UNIVERSITY's breach of contract, as alleged in COUNT THREE HUNDRED SIXTY-EIGHT reproduced herein, were so unfair or offensive that it constituted a violation of CUTPA.

192. Upon information and belief, YALE UNIVERSITY's conduct as previously alleged constituted a negligent, reckless, or knowing violation of the Connecticut Unfair Trade Practices Act, Connecticut General Statutes Section 42-110a *et seq.* ("CUTPA").

193. YALE UNIVERSITY's conduct, as previously alleged, was a substantial factor resulting in the injuries and suffering of the plaintiff, as further described in the following paragraph.

194. As a result of YALE UNIVERSITY's violation of CUTPA, GREGORY MCNAMARA suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED SIXTY-ONE:
MARIA MCNAMARA v. YALE UNIVERSITY (Breach of Fiduciary Duty)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SIXTY-ONE.

183. Fertility services, including oocyte retrievals, is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

184. At all relevant times herein, plaintiff placed a high degree of trust and confidence in YALE UNIVERSITY to provide such fertility services.

185. With regard to the allegations contained herein, there existed between YALE UNIVERSITY and plaintiff a continuing special and/or fiduciary relationship/duty characterized by:

a. plaintiff's unique degree of trust and confidence in YALE UNIVERSITY;

b. superior knowledge, skill, expertise, and/or position on the part of YALE UNIVERSITY;

c. a continuing duty imposed on YALE UNIVERSITY to represent the interests of plaintiff.

186. As a result of the breach of the special and/or fiduciary relationship/duty between YALE UNIVERSITY and plaintiff, the latter has suffered serious, painful and permanent injuries:

a. terror;
b. pain and suffering;
c. mental and emotional distress;
d. loss of quality of life;
e. loss of enjoyment of life's activities;
f. medical expenses;
g. impaired future earning capacity;
h. psychological, physiological and neurological sequelae.

187. The said injuries suffered by plaintiff were caused by the intentional, knowing, reckless, or negligent breach of the special and/or fiduciary relationship/duty owed by YALE UNIVERSITY to plaintiff in one or more of the following ways:

a. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it engaged in a cost-reduction strategy whereby controlled substances, including fentanyl, were ordered in bulk and stored at the REI Clinic without proper oversight, or necessary diversion-prevention and diversion-detection measures.

b. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it appointed and entrusted Nurse Donna Monticone to manage its fentanyl stores while also engaging in direct patient care responsibilities.

c. YALE UNIVERSITY prioritized and effectuated its own interests—including its interest in maximizing profitability of REI Clinic services and interest in cost-reduction—over the interests of plaintiff to receive quality and safe care, particularly during oocyte retrievals, when it stored fentanyl at the REI Clinic in violation of federal and/or state law.

COUNT THRE HUNDRED SIXTY-TWO:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Breach of Fiduciary Duty- Loss of Consortium)

1-187. Paragraphs 1-187 of COUNT THREE HUNDRED SIXTY-ONE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-SEVEN (187) respectively, of this COUNT THREE HUNDRED SIXTY-TWO.

188. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

189. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED SIXTY-THREE:
MARIA MCNAMARA v. YALE UNIVERSITY (Informed Consent)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SIXTY-THREE.

183. As part of its fertility treatment services, YALE UNIVERSITY recommended that plaintiff undergo an oocyte retrieval with administration of the analgesic, fentanyl.

184. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the nature of the oocyte retrieval.

185. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the risks and hazards of the procedure.

186. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the anticipated benefits of the oocyte retrieval.

187. The use of fentanyl for analgesia during the oocyte retrieval was material to YALE UNIVERSITY's informed disclosure to plaintiff of the alternatives to oocyte retrieval.

188. On or before the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY did not provide informed disclose to plaintiff of the nature, risks and hazards, alternatives, or anticipated benefits of oocyte retrieval in plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

189. On the dates that plaintiff underwent an oocyte retrieval at the REI Clinic, YALE UNIVERSITY inserted a large-bore needle through the vaginal wall and other anatomical structures of plaintiff with no fentanyl, or fentanyl that had been substituted or diluted with another agent.

190. While under the care of YALE UNIVERSITY, plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

191. As a result of the failure of YALE UNIVERSITY to provide informed disclosure and obtain proper consent for the oocyte retrieval, plaintiff suffered the following severe, serious, painful and permanent injuries:

    a. terror;

    b. pain and suffering;

    c. mental and emotional distress;

    d. loss of quality of life;

    e. impaired future earning capacity;

    f. ability to carry on and enjoy life's activities;

    g. expenses for medical care and treatment;

    h. psychological, physiological and neurological sequelae.

COUNT THREE HUNDRED SIXTY-FOUR:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Informed Consent- Loss of Consortium)

1-191. Paragraphs 1-191 of COUNT THREE HUNDRED SIXTY-THREE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-ONE (191), respectively, of this COUNT THREE HUNDRED SIXTY-FOUR.

192. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

193. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED SIXTY-FIVE:
MARIA MCNAMARA v. YALE UNIVERSITY (Medical Assault and Battery)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182), respectively, of this COUNT THREE HUNDRED SIXTY-FIVE.

183. An oocyte retrieval with administration of the analgesic, fentanyl, is a different and distinct medical procedure from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

184. The nature of an oocyte retrieval with the administration of fentanyl is different and distinct from an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

185. The risks and hazards of an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

186. The alternatives to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

187. The anticipated benefits to an oocyte retrieval with the administration of fentanyl are different and distinct from those of an oocyte retrieval where no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline, is administered.

188. At no time, prior to plaintiff's respective oocyte retrievals, did YALE UNIVERSITY provide informed disclosure to plaintiff or obtain proper consent from plaintiff to complete an oocyte retrieval with no fentanyl, or fentanyl that had been substituted or diluted with another agent, such as saline.

189. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY completed the oocyte retrieval(s) on plaintiff with no fentanyl or fentanyl that had been substituted or diluted with another agent, such as saline.

190. On each and every date of plaintiff's respective oocyte retrieval, YALE UNIVERSITY performed a nonconsensual touching on plaintiff.

191. While under the care of YALE UNIVERSITY, the plaintiff suffered serious, severe, painful and permanent injuries set forth in the subsequent paragraph.

192. As a result of the medical assault and/or battery by YALE UNIVERSITY, on each and every date of the plaintiff's oocyte retrieval(s), the plaintiff suffered the following severe, serious, painful and permanent injuries:

a. terror;

b. pain and suffering;

c. mental and emotional distress;

d. loss of quality of life;

e. impaired future earning capacity;

f. psychological, physiological and neurological sequelae.

193. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has been permanently deprived of her ability to carry on and enjoy life's activities.

194. As a further result of the medical assault and/or battery by YALE UNIVERSITY on each and every date of the plaintiff's respective oocyte retrieval(s), the plaintiff has incurred expenses for medical care and treatment to her financial loss.

COUNT THREE HUNDRED SIXTY-FIVE:
GREGORY MCNAMARA v. YALE UNIVERSITY
(Medical Assault and Battery – Loss of Consortium)

1-194. Paragraphs 1 through 194 of COUNT THREE HUNDRED SIXTY-FIVE are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED NINETY-FOUR (194), respectively, of this COUNT THREE HUNDRED SIXTY-SIX.

195. At all times mentioned herein, the plaintiff, GREGORY MCNAMARA, was the husband of MARIA MCNAMARA.

196. As a result of the aforesaid injuries of plaintiff MARIA MCNAMARA, GREGORY MCNAMARA has been deprived of the consortium, companionship, and society of his spouse, all to his damage.

COUNT THREE HUNDRED SIXTY-SEVEN:
MARIA MCNAMARA v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SIXTY-SEVEN.

183. YALE UNIVERSITY entered into contracts with the plaintiff under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff agreed to pay and did pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. Plaintiff performed the terms and conditions required of her under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened their objectively reasonable expectations under the contract.

189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff suffered harm, including mental anguish and/or money damages.

COUNT THREE HUNDRED SIXTY-EIGHT:
GREGORY MCNAMARA v. YALE UNIVERSITY (Breach of Contract)

1-182. Paragraphs 1-181, 183 of COUNT THREE HUNDRED FIFTY-FOUR are hereby incorporated and realleged as paragraphs ONE through ONE HUNDRED EIGHTY-TWO (182) respectively, of this COUNT THREE HUNDRED SIXTY-EIGHT.

183. YALE UNIVERSITY entered into contracts with the plaintiff, GREGORY MCNAMARA, under which YALE UNIVERSITY agreed to provide anesthesia and/or sedation for oocyte retrievals.

184. A contract involving oocyte retrievals and the in vitro fertilization process is highly personal and implicates vital concerns regarding parenthood, procreation and assisting others to achieve their family plans.

185. In consideration of YALE UNIVERSITY's promises, including performance of oocyte retrievals under anesthesia, plaintiff, GREGORY MCNAMARA, agreed to pay and did

pay substantial sums for the services rendered or exhausted covered round(s) under their insurance plans.

186. GREGORY MCNAMARA performed the terms and conditions required of him under her contract(s) with YALE UNIVERSITY.

187. Based on the conduct described herein, YALE UNIVERSITY breached its contract with plaintiff, GREGORY MCNAMARA, including the incorporated contractual covenant of good faith and fair dealing.

188. YALE UNIVERSITY's failure to administer anesthesia and/or sedation deprived the plaintiff of the fruits of the contracts and contravened his objectively reasonable expectations under the contract.

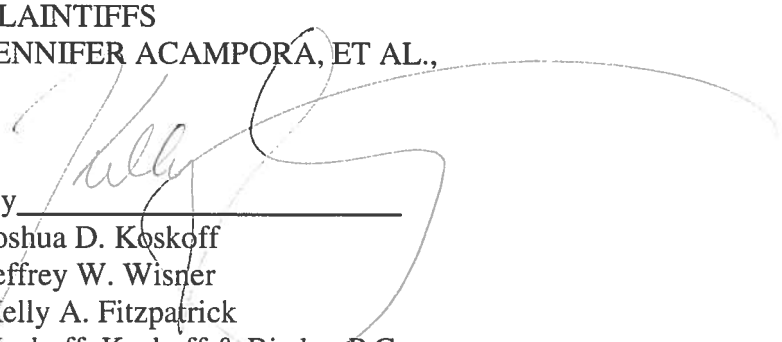
189. A contract whereby a fertility clinic undertakes to perform an oocyte retrieval is one as to which it is reasonably foreseeable that breach thereof will cause mental anguish to the person or persons who entrusted the clinic with this procedure.

190. As a direct and proximate cause of YALE UNIVERSITY's breach of contract, the plaintiff, GREGORY MCNAMARA, suffered harm, including mental anguish and/or money damages.

WHEREFORE, the plaintiffs claim:

1. Compensatory damages;
2. Punitive Damages;
3. Attorneys' Fees;
4. Costs; and
5. The Court enter such other relief as is deemed just and appropriate.

PLAINTIFFS
JENNIFER ACAMPORA, ET AL.,



By_____

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RETURN DATE: MAY 24, 2022	:	**SUPERIOR COURT**
JENNIFER ACAMPORA, ET AL	:	**J.D. OF WATERBURY**
V.	:	**AT WATERBURY**
YALE UNIVERSITY	:	**APRIL 26, 2022**

STATEMENT OF AMOUNT IN DEMAND

The amount of money damages claimed is greater than Fifteen Thousand Dollars ($15,000.00), exclusive of interest and costs.

PLAINTIFFS
JENNIFER ACAMPORA, ET AL.,

By_____

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WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Jennifer Acampora received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Acampora underwent an oocyte retrieval while under the care of anesthesiologist Dr. Andrew Philip Notarianni, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Notarianni, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Jennifer Acampora underwent an oocyte retrieval at the clinic.
- The medical records Jennifer Acampora, who was treated at the Yale REI Clinic in Orange, CT on July 29, 2020, which reflects that Ms. Acampora received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 50 mcg of fentanyl that was administered to Ms. Acampora on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

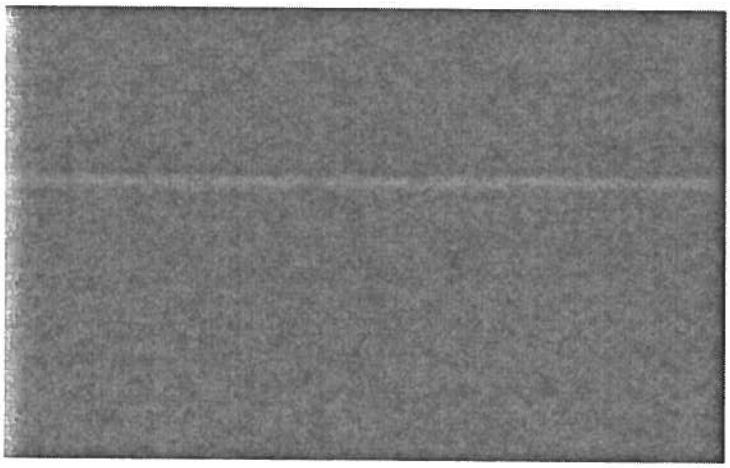
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Jessica Barajas received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Barajas underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jill Berlin, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Berlin, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Jessica Barajas underwent an oocyte retrieval at the clinic.
- The medical records Jessica Barajas, who was treated at the Yale REI Clinic in Orange, CT on August 12, 2020, which reflects that Ms. Barajas received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Barajas on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

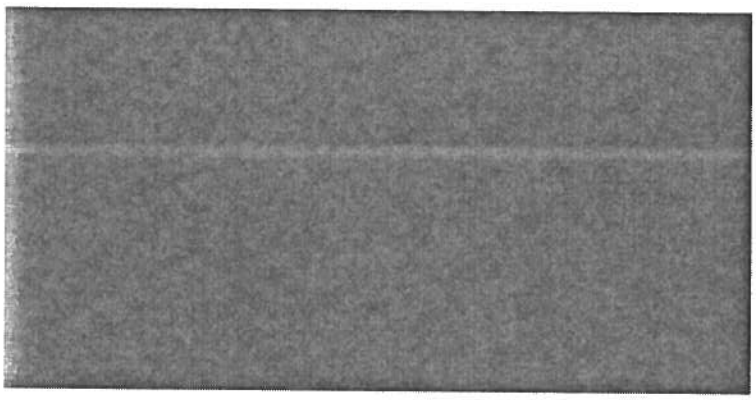
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Colleen Baum received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Baum underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jill Zafar, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Zafar, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Colleen Baum underwent an oocyte retrieval at the clinic.
- The medical records Colleen Baum, who was treated at the Yale REI Clinic in Orange, CT on June 24, 2020, which reflects that Ms. Baum received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Baum on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

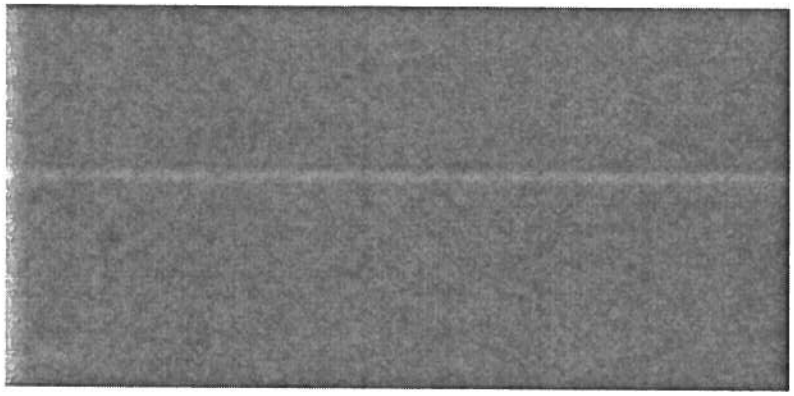
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case ofColleen Baum . This case involves the care that was provided to Colleen Baum by the following nurses and on the specified listed dates during egg retrieval procedures:

- Jessica Dorey, Registered Nurse, on September 4, 2019
- Patrick Welch, Registered Nurse, on December 4, 2019
- Aparajitha Srinivasan, Registered Nurse, on January 29, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Colleen Baum, which documented Nurse Jessica Dorey's involvement with her care during a September 4, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Dorey to

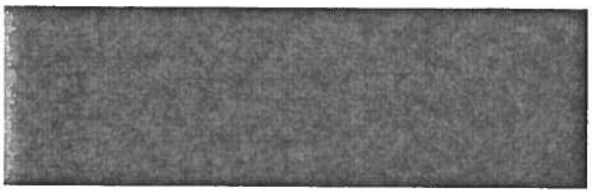
administer fentanyl 25 mcg every few minutes, as needed. Nurse Dorey documented that she administered seven doses of IV fentanyl (25 mcg each) in the perioperative period.

- The medical records of Colleen Baum, which documented Nurse Patrick Welch's involvement with her care during a December 4, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Welch to administer fentanyl 25 mcg every few minutes, as needed. Nurse Welch documented that he administered four doses of IV fentanyl (50 mcg each) in the perioperative period.
- The medical records of Colleen Baum, which documented Nurse Aparajitha Srinivasan's involvement with her care during a January 29, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Srinivasan to administer fentanyl 25 mcg every few minutes, as needed. Nurse Srinivasan documented that she administered four doses of IV fentanyl (25 mcg each) in the perioperative period.

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Dorey, Nurse Welch, Nurse Srinivasan, Nurse Monticone and their employer(s)/principal(s). The (1) severity of the pain reported by Laura Rosenberg despite 175 mcg of purported fentanyl administration documented by Nurse Dorey on September 4, 2019, 200 mcg of purported fentanyl administration documented by Nurse Welch on December 4, 2019, and 100 mcg of purported fentanyl administration documented by Nurse Srinivasan on January 29, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Rosenberg with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Dorey, Nurse Welch and Nurse Srinivasan administrated adulterated fentanyl to Ms. Rosenberg on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Dorey, Nurse Welch and Nurse Srinivasan to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Mingfee Chow-Yen received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Chow-Yen underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jill Zafar, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Zafar, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Mingfee Chow-Yen underwent an oocyte retrieval at the clinic.
- The medical records Mingfee Chow-Yen, who was treated at the Yale REI Clinic in Orange, CT on June 26, 2020, which reflects that Ms. Chow-Yen received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Chow-Yen on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

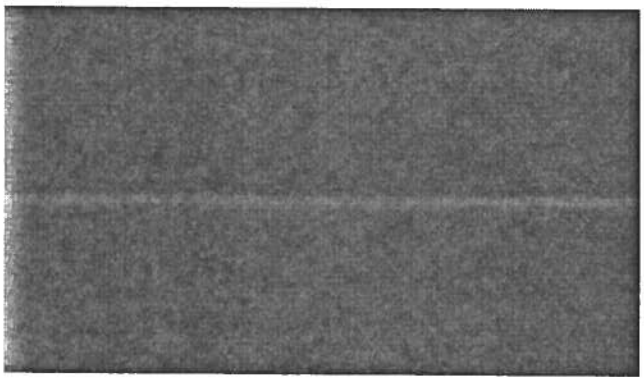
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Angela Cortese received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Cortese underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jill Zafar, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Zafar, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Angela Cortese underwent an oocyte retrieval at the clinic.
- The medical records Angela Cortese, who was treated at the Yale REI Clinic in Orange, CT on June 9, 2020, which reflects that Ms. Cortese received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Cortese on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

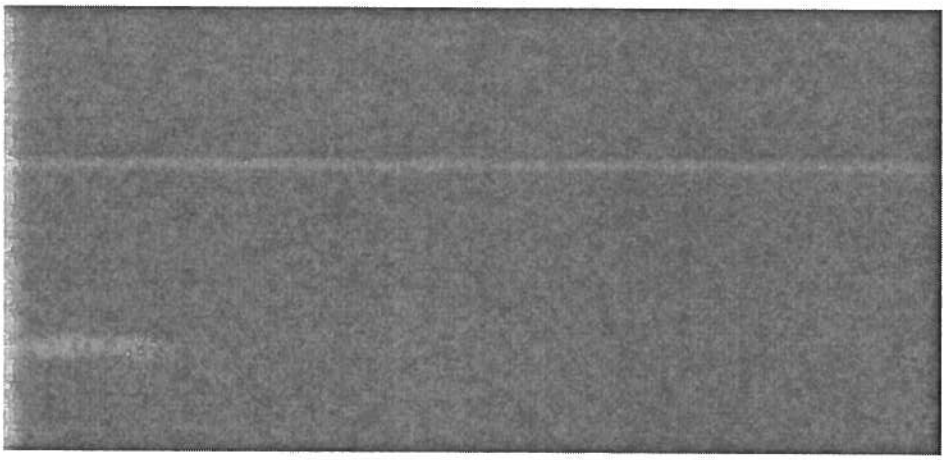
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Angela Cortese. This case involves the care that was provided to Angela Cortese by the following nurses and on the specified listed date during the egg retrieval procedure:

- Maureen Pothier, Registered Nurse, on December 3, 2019

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Angela Cortese, which documented Nurse Maureen Potheir's involvement with her care during a December 3, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Pothier to administer fentanyl 25 mcg every few minutes, as needed. Nurse Pothier documented

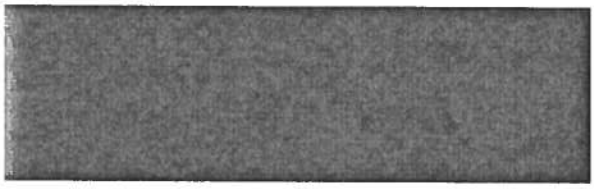
that she administered five doses of IV fentanyl (50 mcg each for four doses; 25 mcg for one dose) in the perioperative period.

- A brief summary of Ms. Cortese's experience at the REI Clinic on December 3, 2019 and June 9, 2020 as prepared by her attorneys. The summary indicates that Ms. Cortese reported pain during the retrieval procedure on December 3, 2019 despite the administration of five doses of IV fentanyl (50 mcg each for four doses; 25 mcg for one dose).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Pothier and their employer(s)/principal(s). The (1) severity of the pain reported by Angela Cortese despite 225 mcg of purported fentanyl administration documented by Nurse Pothier on December 3, 2019, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Cortese with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Pothier administrated adulterated fentanyl to Ms. Cortese on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Pothier to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Laura Czar. This case involves the care that was provided to Laura Czar by the following nurses and on the specified listed dates during the egg retrieval procedures:

- Marie Longo, Registered Nurse, on January 20, 2020
- Susy Ferreira, Registered Nurse, on February 7, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Laura Czar, which documented Nurse Marie Longo's involvement with her care during a January 20, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Pinar Hatice Kodaman ordered Nurse Longo to

administer fentanyl 25 mcg every few minutes, as needed. Nurse Longo documented that she administered four doses of IV fentanyl (25 mcg each) in the perioperative period.

- The medical records of Laura Czar, which documented Nurse Susy Ferreira's involvement with her care during a February 7, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Lubna Pal ordered Nurse Ferreira to administer fentanyl 25 mcg every few minutes, as needed. Nurse Ferreira documented that she administered five doses of IV fentanyl (50 mcg each) in the perioperative period.
- A brief summary of Ms. Czar's experience at the REI Clinic on January 20, 2020, and February 7, 2020, as prepared by her attorneys. The summary indicates that Ms. Czar reported pain during the retrieval procedures on January 20, 2020 despite the administration of six doses of IV fentanyl (25 mcg each); and on February 7, 2020 despite the administration of four doses of IV fentanyl (50 mcg each).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Longo, Nurse Monticone, Nurse Ferreira and their employer(s)/principal(s). The (1) severity of the pain reported by Laura Czar despite 100 mcg of purported fentanyl administration documented by Nurse Longo on January 20, 2020 and 250 mcg of purported fentanyl administration documented by Nurse Ferreira on February 7, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Czar with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Longo and Nurse Ferreira administrated adulterated fentanyl to Ms. Czar on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Longo and Nurse Pothier to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Johanna D'Addario. This case involves the care that was provided to Johanna D'Addario by the following nurse and on the specified listed dates during an egg retrieval procedure:

- Susy Ferreira, Registered Nurse, on February 7, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Johanna D'Addario, which documented Nurse Susy Ferreira's involvement with her care during a February 7, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Lubna Pal ordered Nurse Ferreira to administer fentanyl 25 mcg every few minutes, as needed. Nurse Ferreira documented that she

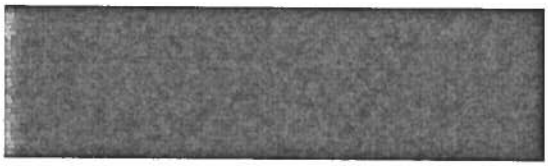
administered six doses of IV fentanyl (50 mcg each for four doses; 25 mcg each for two doses) in the perioperative period.

- A brief summary of Ms. D'Addario's experience at the REI Clinic on February 7, 2020 as prepared by her attorneys. The summary indicates that Ms. D'Addario reported pain during the retrieval procedure on February 7, 2020 despite the administration of six doses of IV fentanyl (50 mcg each for four doses; 25 mcg for two doses).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Ferreira and their employer(s)/principal(s). The (1) severity of the pain reported by Johanna D'Addario despite 250 mcg of purported fentanyl administration documented by Nurse Ferreira on February 7, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. D'Addario with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Ferreira administrated adulterated fentanyl to Ms. D'Addario on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Ferreira to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Cristine Devoe received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Devoe underwent an oocyte retrieval while under the care of anesthesiologist Dr. Anitha Kilari, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Kilari, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stored at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Cristine Devoe underwent an oocyte retrieval at the clinic.
- The medical records Cristine Devoe, who was treated at the Yale REI Clinic in Orange, CT on June 11, 2020, which reflects that Ms. Devoe received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 50 mcg of fentanyl that was administered to Ms. Devoe on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

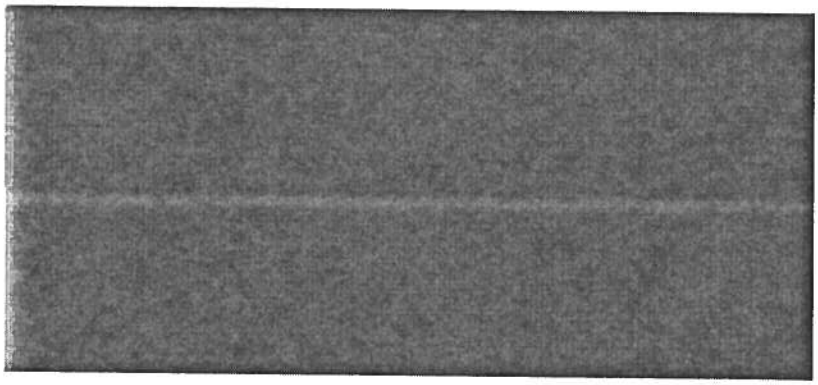
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Viktoria Dubrovsky. This case involves the care that was provided to Viktoria Dubrovsky by the following nurses and on the specified listed dates during egg retrieval procedure:

- Donna Monticone, Registered Nurse, on September 5, 2017

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.
- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).
- The medical records of Viktoria Dubrovsky, which documented Nurse Donna Monticone's involvement with her care during a September 5, 2017 egg retrieval procedure. Specifically, the records indicate that Dr. Lubna Pal ordered Nurse Monticone to administer fentanyl 12.5 mcg -50 mcg every few minutes, as needed up to 150 mcg.

Nurse Monticone documented that she administered four doses of IV fentanyl (50 mcg each) in the perioperative period.

- A brief summary of Ms. Dubrovsky's experience at the REI Clinic on September 5, 2017 and June 9, 2020 as prepared by her attorneys. The summary indicates that Ms. Dubrovsky reported pain during the retrieval procedure on September 5, 2017 despite the administration of four doses of IV fentanyl (50 mcg each).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone and her employer(s)/principal(s). The (1) severity of the pain reported by Viktoria Dubrovsky despite 200 mcg of purported fentanyl administration documented by Nurse Monticone on September 5, 2017, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Dubrovsky with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Monticone administrated adulterated fentanyl to Ms. Dubrovsky on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Monticone to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Lynn Economopoulos received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Economopoulos underwent oocyte retrievals while under the care of anesthesiologist Dr. Marcelle E. Blessing, MD and Dr. Elena N. Gutman, MD, whom I was informed are employees, agents or apparent agents of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Blessing and Dr. Gutman, whom I understand are also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Lynn Economopoulos underwent an oocyte retrieval at the clinic.
- The medical records Lynn Economopoulos, who was treated at the Yale REI Clinic in Orange, CT on August 17, 2020, September 9, 2020, October 14, 2020and November 1, 2020, which reflect that Ms. Economopoulos received fentanyl during her oocyte retrieval procedures.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the fentanyl that was administered to Ms. Economopoulos during her retrievals were most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

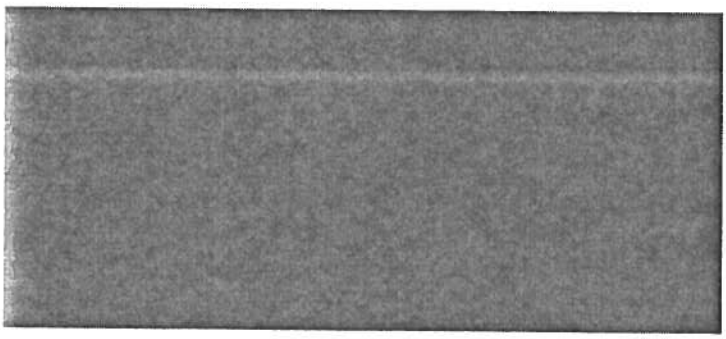
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Lynn Economopoulos. This case involves the care that was provided to Lynn Economopoulos by the following nurses and on the specified listed dates during egg retrieval procedures:

- Maureen Pothier, Registered Nurse, on June 19, 2019 and on August 17, 2019
- Patrick Welch, Registered Nurse, on November 16, 2019
- Aparajitha Srinivasan, Registered Nurse, on January 27, 2020

This care was provided during the period that Nurse Donna Monticone, also a Registered Nurse, was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply. As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Lynn Economopoulos, which documented Nurse Maureen Pothier's involvement with her care during a June 19, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Charles Collins ordered Nurse Pothier

to administer fentanyl 25 mcg every few minutes, as needed. Nurse Pothier documented that she administered four 25 mcg doses of fentanyl and two 50 mcg doses of fentanyl.

- The medical records of Lynn Economopoulos, which documented Nurse Maureen Pothier's involvement with her care during a August 17, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Valerie Flores ordered Nurse Pothier to administer fentanyl 25 mcg every few minutes, as needed. Nurse Pothier documented that she administered two 25 mcg doses of fentanyl and three 50 mcg doses of fentanyl.

- The medical records of Lynn Economopoulos, which documented Nurse Patrick Welch's involvement with her care during a November 16, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Amanda Nicole Kallen ordered Nurse Welch to administer fentanyl 25 mcg every few minutes, as needed. Nurse Welch documented that she administered two 25 mcg doses of fentanyl and three 50 mcg doses of fentanyl.

- The medical records of Lynn Economopoulos, which documented Nurse Aparajitha Srinivasan's involvement with her care during a January 27, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Charles Collins ordered Nurse Srinivasan to administer fentanyl 25 mcg every few minutes, as needed. Nurse Srinivasan documented that she administered five 25 mcg doses of fentanyl and one 50 mcg dose of fentanyl.

- A brief summary of Ms. Economopoulos's experiences at the REI Clinic on June 19, 2019, August 17, 2019, November 16, 2019 and January 27, 2020 as prepared by her attorneys. The summary indicates that Ms. Economopoulos reported horrific pain during the retrieval procedures on June 19, 2019 despite the administration of four 25 mcg doses and two 50 mcg doses of fentanyl, and on August 17, 2019 despite the administration of two 25 mcg doses and three 50 mcg doses of fentanyl, and on November 16, 2019 despite the administration of two 25 mcg doses and three 50 mcg doses of fentanyl, and on January 27, 2020 despite the administration of five 25 mcg doses and one 50 mcg dose of fentanyl.

- Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Pothier, Nurse Welch, Nurse Srinivasan and their employer(s)/principal(s). The (1) severity of the pain reported by Ms. Economopoulos despite the aforementioned fentanyl administration on June 19, 2019 documented by Nurse Pothier, and the aforementioned fentanyl administration on August 17, 2019 by Nurse Pothier, and the aforementioned fentanyl administration on November 16, 2019 by Nurse Welch, and the aforementioned fentanyl administration on January 27, 2020 by Nurse Srinivasan, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Economopoulos with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and

constitutes a deviation from the standard of care. Moreover, if Nurse Pothier, Nurse Welch and Nurse Srinivasan administrated adulterated fentanyl to Ms. Economopoulos on the above mentioned dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally a deviation from the standard of care for Nurse Pothier, Nurse Welch and Nurse Srinivasan to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Lisa Funaro received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Funaro underwent an manual vacuum aspiration while under the care of anesthesiologist Dr. Jeremy Adam Dennis, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Dennis, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Lisa Funaro underwent an manual vacuum aspiration at the clinic.
- The medical records Lisa Funaro, who was treated at the Yale REI Clinic in Orange, CT on July 24, 2020, which reflects that Ms. Lacobelle received fentanyl during her manual vacuum aspiration procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Funaro on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

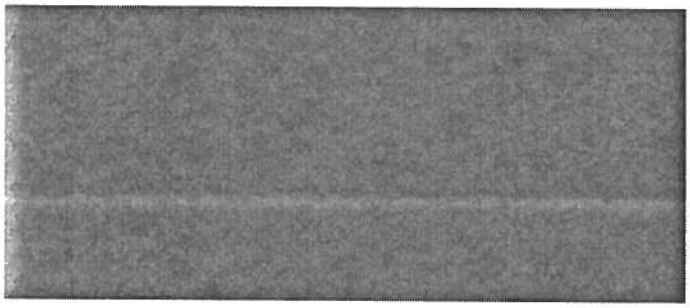
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Kathleen Garrison received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Garrison underwent an oocyte retrieval while under the care of anesthesiologist Dr. Anitha Kilari, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Kilari, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Kathleen Garrison underwent an oocyte retrieval at the clinic.
- The medical records Kathleen Garrison, who was treated at the Yale REI Clinic in Orange, CT on August 19, 2020, which reflects that Ms. Garrison received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Garrison on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

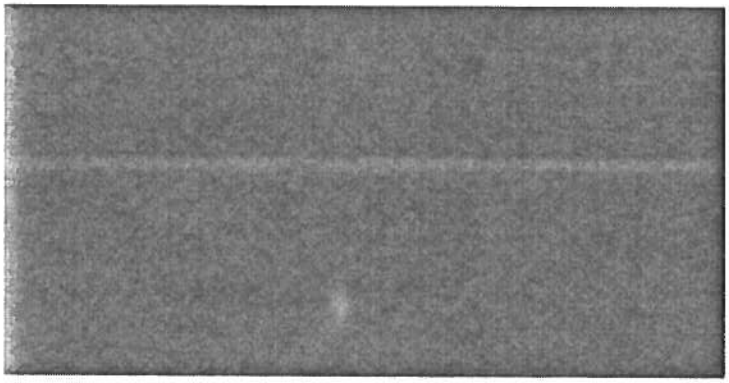
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Kathleen Garrison. This case involves the care that was provided to Kathleen Garrison by the following nurse and on the specified listed dates during an egg retrieval procedure:

- Susan Kornitsky, Registered Nurse, on October 22, 2019

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Kathleen Garrison, which documented Nurse Susan Kornitsky's involvement with her care during a October 22, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Pasquale Patrizio ordered Nurse Kornitsky to administer fentanyl 25 mcg every few minutes, as needed. Nurse Kornitsky documented

that she administered four doses of IV fentanyl (25 mcg each for four doses) in the perioperative period.

- A brief summary of Ms. Garrison's experience at the REI Clinic on October 22, 2019 and June 9, 2020 as prepared by her attorneys. The summary indicates that Ms. Garrison reported pain during the retrieval procedure on October 22, 2019 despite the administration of four doses of IV fentanyl (25 mcg each dose).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Kornitsky, Nurse Monticone and their employer(s)/principal(s). The (1) severity of the pain reported by Kathleen Garrison despite 100 mcg of purported fentanyl administration documented by Nurse Kornitsky on October 22, 2019, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Garrison with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Kornitsky administrated adulterated fentanyl to Ms. Garrison on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Kornitsky to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Stacey Glennon. This case involves the care that was provided to Stacey Glennon by the following nurses and on the specified listed dates during egg retrieval procedure:

- Maureen Pothier, Registered Nurse, on September 12, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

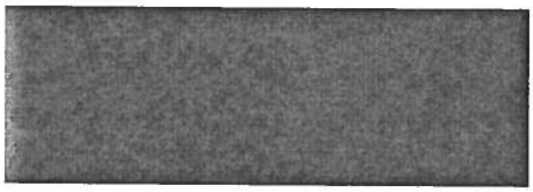
- The medical records of Stacey Glennon, which documented Nurse Maureen Potheir's involvement with her care during a September 12, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Reshef Tal ordered Nurse Pothier to administer fentanyl 25 mcg every few minutes, as needed. Nurse Pothier documented that she administered three doses of IV fentanyl (50 mcg each dose) in the perioperative period.

- A brief summary of Ms. Glennon's experience at the REI Clinic on September 12, 2020 as prepared by her attorneys. The summary indicates that Ms. Glennon reported pain during the retrieval procedure on September 12, 2020 despite the administration of three doses of IV fentanyl (50 mcg each).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Pothier and their employer(s)/principal(s). The (1) severity of the pain reported by Stacey Glennon despite 150 mcg of purported fentanyl administration documented by Nurse Pothier on September 12, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Glennon with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law. and constitutes a deviation from the standard of care. Moreover, if Nurse Pothier administrated adulterated fentanyl to Ms. Glennon on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Pothier to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Bianca Goglas. This case involves the care that was provided to Bianca Goglas by the following nurse and on the specified listed date during an egg retrieval procedure:

- Jenna Barolli, Registered Nurse, on August 8, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Bianca Goglas, which documented Nurse Jenna Barolli's involvement with her care during a August 8, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Barolli to administer fentanyl 25 mcg every few minutes, as needed. Nurse Barolli documented that she administered three doses of IV fentanyl (50 mcg each dose) in the perioperative period.

- A brief summary of Ms. Goglas's experience at the REI Clinic on August 8, 2020 as prepared by her attorneys. The summary indicates that Ms. Goglas reported pain during the retrieval procedure on August 8, 2020 despite the administration of three doses of IV fentanyl (50 mcg each).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Barolli and their employer(s)/principal(s). The (1) severity of the pain reported by Bianca Goglas despite 150 mcg of purported fentanyl administration documented by Nurse Barolli on August 8, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Goglas with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Barolli administrated adulterated fentanyl to Ms. Goglas on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Barolli to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Caroline Gruenbaum received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Gruenbaum underwent an oocyte retrieval while under the care of anesthesiologist Dr. Robert Chow, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Chow, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stored at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Caroline Gruenbaum underwent an oocyte retrieval at the clinic.
- The medical records Caroline Gruenbaum, who was treated at the Yale REI Clinic in Orange, CT on September 18, 2020, which reflects that Ms. Gruenbaum received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Gruenbaum on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

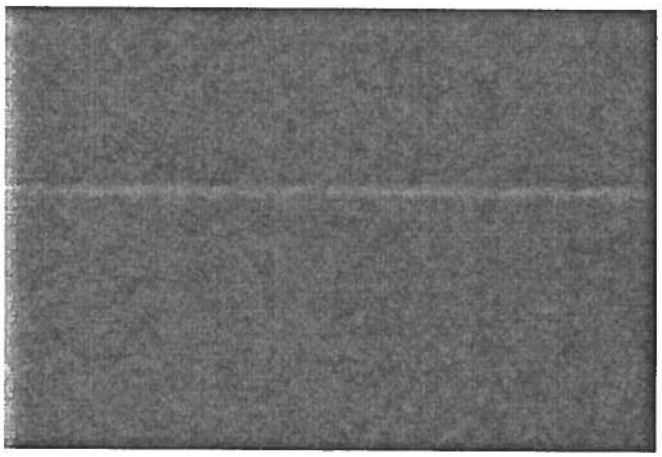
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Cristina Harris received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Harris underwent an oocyte retrieval while under the care of anesthesiologist Dr. Alena S. Rady, DO, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Rady, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Cristina Harris underwent an oocyte retrieval at the clinic.
- The medical records Cristina Harris, who was treated at the Yale REI Clinic in Orange, CT on September 23, 2020 which reflects that Ms. Harris received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Harris on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stores at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

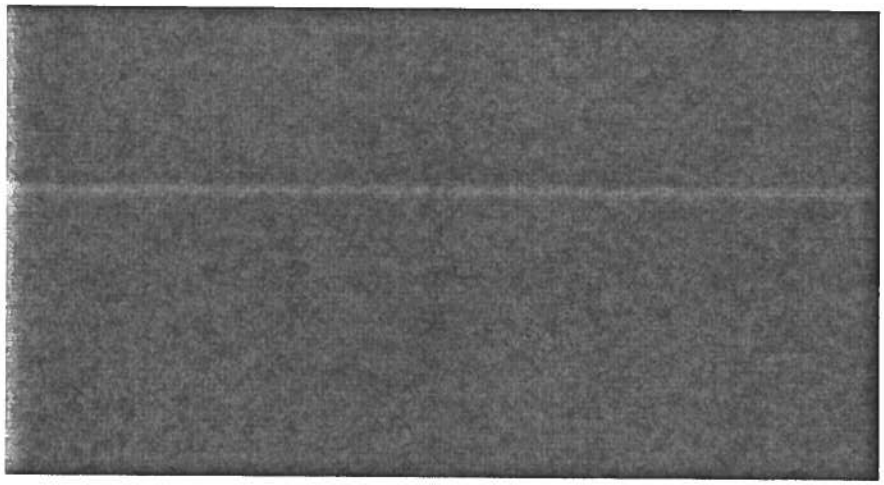
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Chelsea Harry received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Harry underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jeremy Adam Dennis, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Dennis, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Chelsea Harry underwent an oocyte retrieval at the clinic.
- The medical records Chelsea Harry, who was treated at the Yale REI Clinic in Orange, CT on October 19, 2020, which reflects that Ms. Harry received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Harry on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

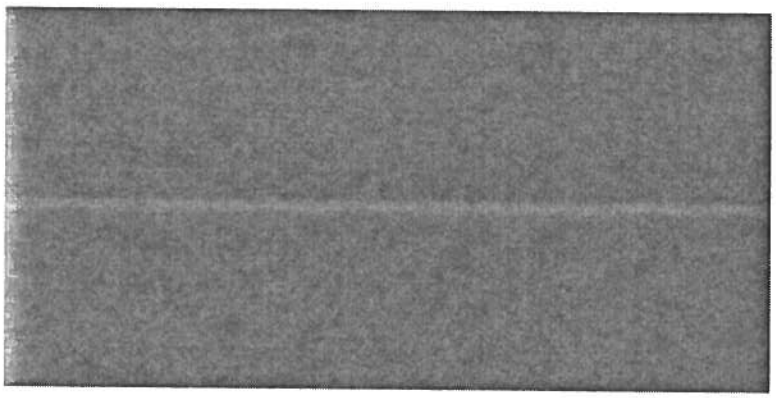
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Krystina Henderson received at the Yale REI Clinic a fertility clinic in New Haven, CT in 2020. At the REI Clinic, Ms. Henderson underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jill Zafar, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Zafar, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Krystina Henderson underwent an oocyte retrieval at the clinic.
- The medical records Krystina Henderson, who was treated at the Yale REI Clinic in Orange, CT on June 23, 2020, which reflects that Ms. Henderson received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 50 mcg of fentanyl that was administered to Ms. Henderson on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

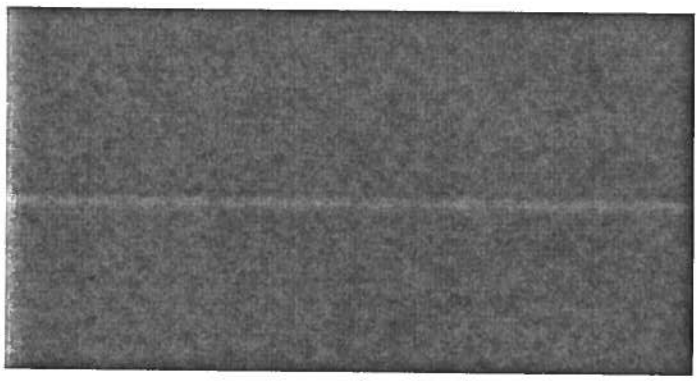
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Anne Hering received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Hering underwent an oocyte retrieval while under the care of anesthesiologist Dr. Robert Chow, MD, and Dr. Trevor Banack whom I was informed are employees, agents or apparent agents of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Robert Chow, and Dr. Trevor Banack whom I understand are also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Anne Hering underwent an oocyte retrieval at the clinic.
- The medical records Anne Hering, who was treated at the Yale REI Clinic in Orange, CT on August 4, 2020 and October 2, 2020 which reflect that Ms. Hering received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Hering on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

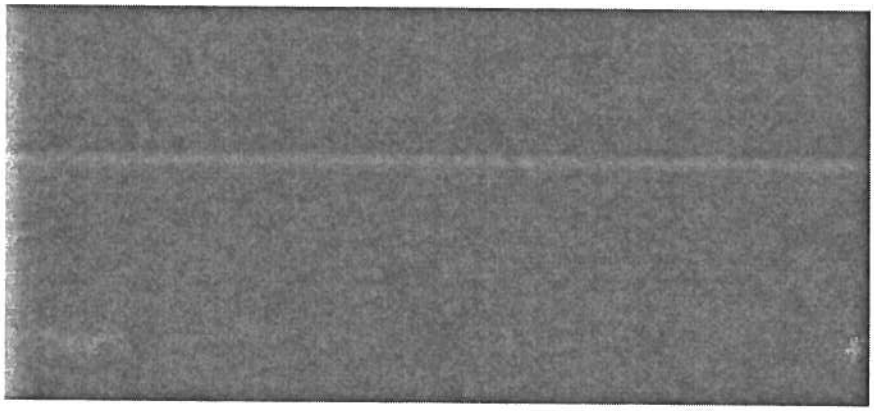
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Janine Herr received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Herr underwent an oocyte retrieval while under the care of anesthesiologist Dr. Robert Chow, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Chow, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stored at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Janine Herr underwent an oocyte retrieval at the clinic.
- The medical records Janine Herr, who was treated at the Yale REI Clinic in Orange, CT on October 6, 2020, which reflects that Ms. Herr received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Herr on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

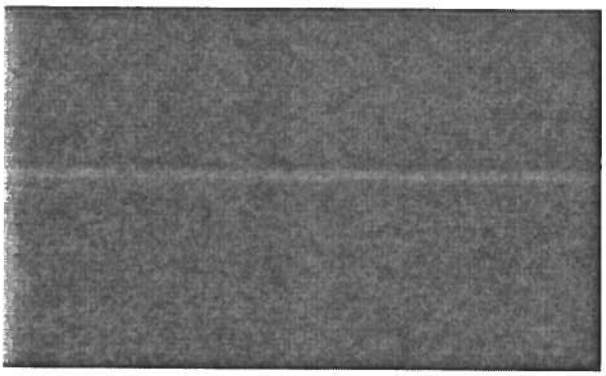
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Michelle Kelly received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Kelly underwent a manual vacuum aspiration while under the care of anesthesiologist Dr. Robert Chow, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Chow, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Michelle Kelly underwent an oocyte retrieval at the clinic.
- The medical records Michelle Kelly, who was treated at the Yale REI Clinic in Orange, CT on September 14, 2020, which reflects that Ms. Kelly received fentanyl during her manual vacuum aspiration procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Kelly on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

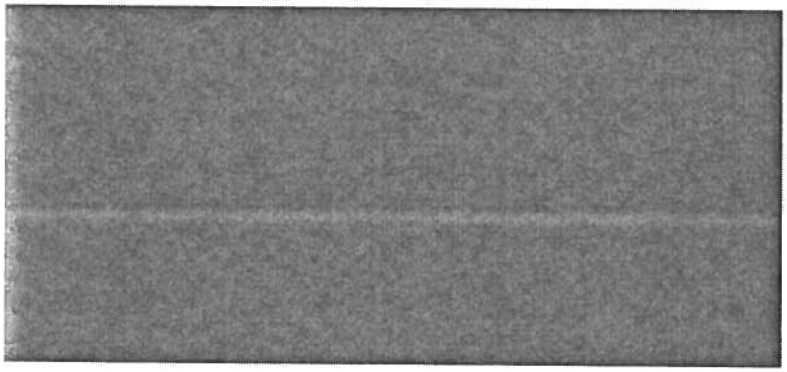
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Jessica Lacobelle received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Lacobelle underwent an oocyte retrieval while under the care of anesthesiologist Dr. Robert Chow, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Chow, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Jessica Lacobelle underwent an oocyte retrieval at the clinic.
- The medical records Jessica Lacobelle, who was treated at the Yale REI Clinic in Orange, CT on August 20, 2020, which reflects that Ms. Lacobelle received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Lacobelle on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

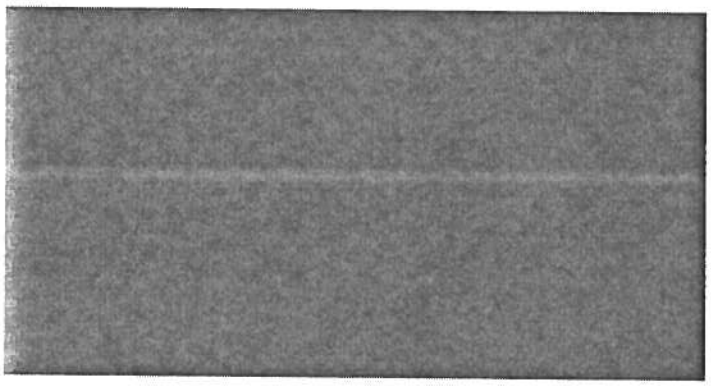
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Caitlin Peterson received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Peterson underwent an oocyte retrieval while under the care of anesthesiologist Dr. Jinlei Li, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Li, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Caitlin Peterson underwent an oocyte retrieval at the clinic.
- The medical records Caitlin Peterson, who was treated at the Yale REI Clinic in Orange, CT on July 3, 2020, which reflects that Ms. Peterson received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Peterson on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

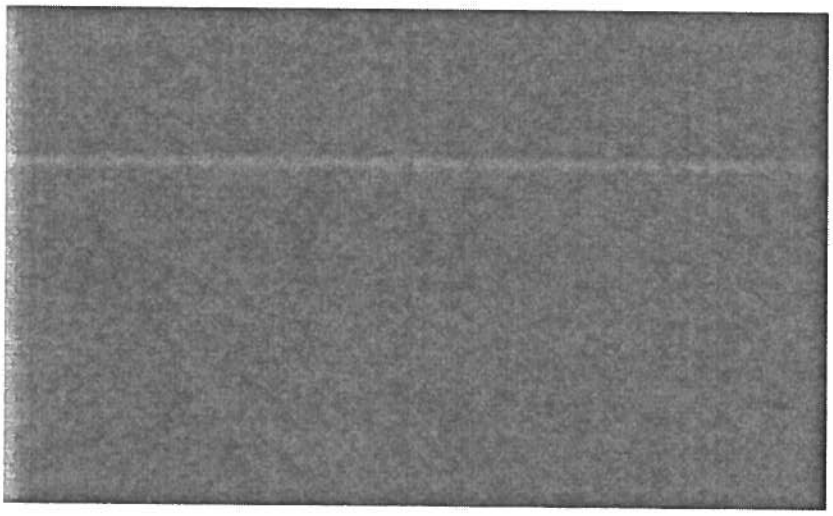
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Lindsay Rodriguez received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Rodriguez underwent a manual vacuum aspiration while under the care of anesthesiologist Dr. Jinlei Li, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Li, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Lindsay Rodriguez underwent an oocyte retrieval at the clinic.
- The medical records Lindsay Rodriguez, who was treated at the Yale REI Clinic in Orange, CT on September 24, 2020, which reflects that Ms. Rodriguez received fentanyl during her manual vacuum aspiration procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Rodriguez on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

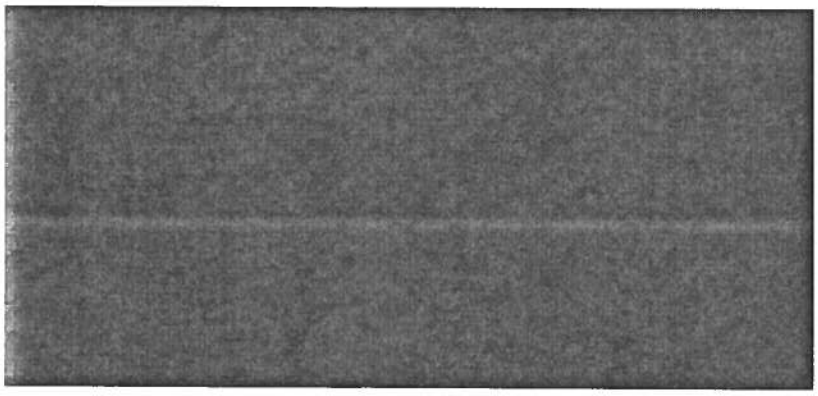
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Lauren Rosenberg received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Rosenberg underwent oocyte retrievals while under the care of anesthesiologist Dr. Elena N. Gutman, MD and Dr. Jill Zafar, MD, whom I was informed are employees, agents or apparent agents of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr.Gutman and Dr. Zafar, whom I understand are also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Lauren Rosenberg underwent an oocyte retrieval at the clinic.
- The medical records Lauren Rosenberg, who was treated at the Yale REI Clinic in Orange, CT on June 15, 2020 and August 27, 2020 which reflect that Ms. Rosenberg received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the fentanyl that was administered to Ms. Rosenberg during her retrievals were most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

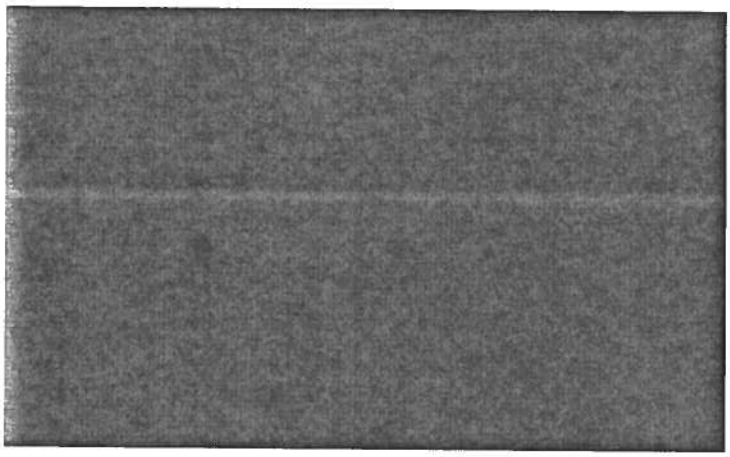
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Lauren Rosenberg. This case involves the care that was provided to Laura Rosenberg by the following nurses and on the specified listed dates during an egg retrieval procedure:

- Susy Ferreira, Registered Nurse, on February 3, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Lauren Rosenberg, which documented Nurse Susy Ferreira's involvement with her care during a February 3, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Ferreira to administer fentanyl 25 mcg every few minutes, as needed. Nurse Ferreira documented

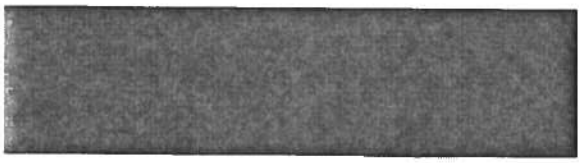
that she administered four doses of IV fentanyl (50 mcg each dose) in the perioperative period.

- A brief summary of Ms. Rosenberg's experience at the REI Clinic on February 3, 2020; June 15, 2020 and August 27, 2020 as prepared by her attorneys. The summary indicates that Ms. Rosenberg reported pain during the retrieval procedure on February 3, 2020 despite the administration of four doses of IV fentanyl (50 mcg each dose).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Ferreira and their employer(s)/principal(s). The (1) severity of the pain reported by Lauren Rosenberg despite 200 mcg of purported fentanyl administration documented by Nurse Ferreira on February 3, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Rosenberg with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Ferreira administrated adulterated fentanyl to Ms. Rosenberg on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above then it was additionally deviations from the standard of care for Nurse Ferreira to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Nataliya Sostin. This case involves the care that was provided to Nataliya Sostin by the following nurses and on the specified listed dates during egg retrieval procedure:

- Donna Monticone, Registered Nurse, on February 4, 2020
- Sarah Van Benschoten, Registered Nurse, on October 3, 2020

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, <u>admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period</u>. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

- The medical records of Nataliya Sostin, which documented Nurse Donna Monticone's involvement with her care during a February 4, 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Pasqual Patrizio ordered Nurse Monticone to administer fentanyl 50 mcg every few minutes, as needed. Nurse Monticone documented

that she administered five doses of IV fentanyl (50 mcg each dose) in the perioperative period.

- The medical records of Nataliya Sostin, which documented Nurse Sarah Van Benschoten;s involvement with her care during an October 3. 2020 egg retrieval procedure. Specifically, the records indicate that Dr. Pasqual Patrizio ordered Nurse Monticone to administer fentanyl 25 mcg every few minutes. as needed. Nurse Van Benschoten documented that she administered four doses of IV fentanyl (50 mcg each dose) in the perioperative period.
- A brief summary of Ms. Sostin's experience at the REI Clinic on February 4, 2020 and October 3, 2020 as prepared by her attorneys. The summary indicates that Ms. Sostin reported pain during the retrieval procedure on February 4. 2020 despite the administration of five doses of IV fentanyl (50 mcg each dose) and reported pain during the retrieval procedure on October 3, 2020 despite the administration of four doses of IV fentanyl (50 mcg each dose).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Van Benschoten and their employer(s)/principal(s). The (1) severity of the pain reported by Nataliya Sostin despite 250 mcg of purported fentanyl administration documented by Nurse Monticone on February 4, 2020, and despise 200 mcg of purported fentanyl administration documented by Nurse Monticone on October 3, 2020, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. Sostin with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Van Benschoten administrated adulterated fentanyl to Ms. Sostin on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Van Benschoten to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,

WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Rebecca Tulin received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Tulin underwent an oocyte retrieval while under the care of anesthesiologist Dr. Anitha Kilari, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Kilari, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stored at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Rebecca Tulin underwent an oocyte retrieval at the clinic.
- The medical records Rebecca Tulin, who was treated at the Yale REI Clinic in Orange, CT on August 18, 2020, which reflects that Ms. Tulin received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Tulin on this date was most likely adulterated by RN Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

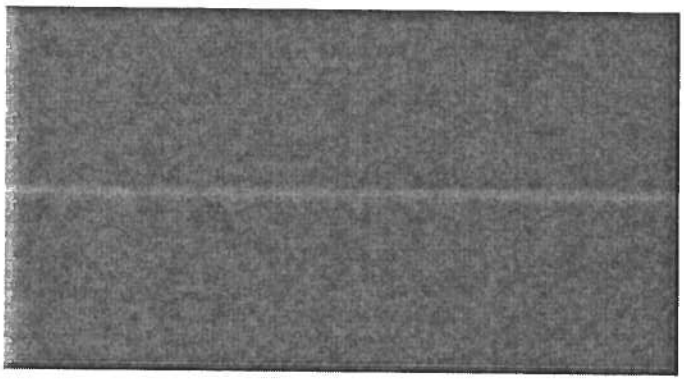
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Camise Turner-Evans received at the Yale REI Clinic a fertility clinic in Orange, CT in 2020. At the REI Clinic, Ms. Turner-Evans underwent an oocyte retrieval while under the care of anesthesiologist Dr. Donna-Ann Thomas, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Thomas, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Camise Turner-Evans underwent an oocyte retrieval at the clinic.
- The medical records Camise Turner-Evans, who was treated at the Yale REI Clinic in Orange, CT on July 22, 2020, which reflects that Ms. Turner-Evans received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Turner-Evans on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

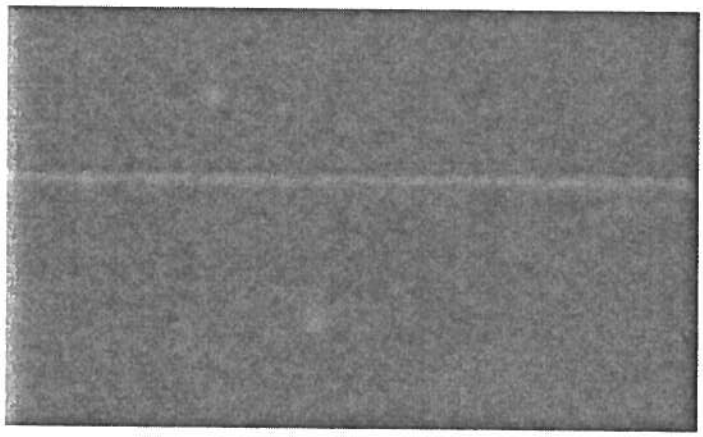
(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
[NOT SUBJECT TO GENERAL DISCLOSURE]

Dear Attorney Fitzpatrick:

Thank you for asking me to review the case of Maria McNamara. This case involves the care that was provided to Maria McNamara by the following nurses and on the specified listed date during the egg retrieval procedure:

- Susy Ferreira, Registered Nurse, on August 1, 2019

The above-listed care was also provided during the period that Nurse Donna Monticone was employed at the REI Clinic and had access to the REI Clinic's fentanyl supply.

As you know, I am a Registered Nurse trained and experienced in this same discipline (nursing), which resulted from my active involvement in the practice or teaching of medicine (nursing) within the five-year period before the incident giving rise to this claim. As you are aware, I am also licensed to practice nursing in the State of Virginia and the District of Columbia, which you informed me requires the same or greater qualifications than the appropriate regulatory agency of the State of Connecticut.

As part of my prelitigation review of this matter, I relied on the following materials:

- The United States' May 18, 2021 Sentencing Memorandum. This Memorandum documented how Nurse Monticone replaced fentanyl with saline, knowing that saline (water) would be administered to patients instead of fentanyl, a potent analgesic. It additionally detailed how fentanyl stored at the Yale REI Clinic (Orange Location) was left unsecured so that "Ms. Monticone was able to access it at time without swiping her card." This document states that Nurse Monticone, in fact, admitted to tampering with 75% of all fentanyl administered at the clinic during a five month period. In other words, *at least* 75% of all fentanyl administered to REI Clinic patients during this period contained either no pain medication, or a subtherapeutic dose of pain medication.

- The report of Attorney Fitzpatrick that dozens of women who were treated prior to this admitted diversion period have contacted the law firm of Koskoff Koskoff & Bieder with reports of excessive pain despite fentanyl administration at the Long Wharf site of the REI clinic, at a time while Donna Monticone worked at the Yale REI Clinic. *See* Sentencing Memorandum at 1-2 (documenting employment between February 29, 2016 and December 1, 2020).

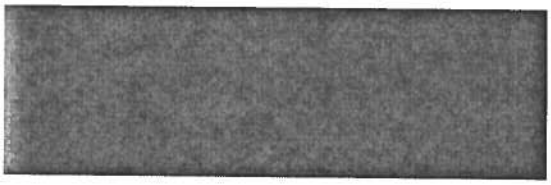
- The medical records of Maria McNamara, which documented Nurse Susy Potheir's involvement with her care during a August 1, 2019 egg retrieval procedure. Specifically, the records indicate that Dr. Stephen Collins ordered Nurse Ferreira to administer fentanyl 25 mcg every few minutes, as needed. Nurse Ferreira documented that she administered four doses of IV fentanyl (50 mcg each dose) in the perioperative period.

- A brief summary of Ms. McNamara's experience at the REI Clinic on August 1, 2019 as prepared by her attorneys. The summary indicates that Ms. McNamara reported pain during the retrieval procedure on August 1, 2019 despite the administration of four doses of IV fentanyl (50 mcg each dose).

Based on my review of the above, it is my opinion that there is evidence of medical negligence on the part of Nurse Monticone, Nurse Ferreira and their employer(s)/principal(s). The (1) severity of the pain reported by Maria McNamara despite 200 mcg of purported fentanyl administration documented by Nurse Ferreira on August 1, 2019, combined with (2) Nurse Monticone's admitted diversion of fentanyl at the REI Clinic in 2020 and (3) reports of excessive pain raised by other women at the REI Clinic (both Orange and Long Wharf), collectively provide the plaintiff with a good faith basis to believe that Nurse Monticone replaced the fentanyl that was ordered to be administered to Ms. McNamara with saline (water). Nurse Monticone's substitution was a violation of physician orders, violation of federal law, and constitutes a deviation from the standard of care. Moreover, if Nurse Ferreira administrated adulterated fentanyl to Ms. McNamara on the above dates from one or more vials that exhibited signs of adulteration as suggested by the above – then it was additionally deviations from the standard of care for Nurse Ferreira to administer the fentanyl without first checking the fentanyl vials for evidence of tampering.

The opinion stated herein is based on the information available to me at this time. Should other information or evidence become available, I reserve the right to support and/or amend this opinion.

Sincerely,



WRITTEN OPINION
PURSUANT TO C.G.S., SECTION 52-190a
NOT SUBJECT TO GENERAL DISCLOSURE

Dear Attorney Fitzpatrick,

Thank you for asking me to review this potential case against Yale University. This case involves care that Chendan Cui-Laughton received at the Yale REI Clinic—a fertility clinic—in Orange, CT in 2020. At the REI Clinic, Ms. Cui-Laughton underwent an oocyte retrieval while under the care of anesthesiologist Dr. Marcelle E. Blessing, MD, whom I was informed is an employee, agent or apparent agent of Yale University.

As you are aware, I am board certified as a specialist in anesthesiology by the American Board of Anesthesiology, like Dr. Blessing, whom I understand is also board-certified as an anesthesiologist by the American Board of Anesthesiology, trained and experienced in the medical specialty of anesthesiology, and/or held themselves out as a specialist in anesthesiology. Specifically, I am trained and experienced in the administration of anesthesia and analgesia in a surgical setting.

I have read and reviewed the following records as part of my review of this matter:

- The United States' May 18, 2021, Sentencing Memorandum of Donna Monticone, which detailed Nurse Monticone's admitted diversion of approximately 75% of fentanyl stores at the Yale REI Clinic in Orange, CT during a five-month period in 2020 when Chendan Cui-Laughton underwent an oocyte retrieval at the clinic.
- The medical records Chendan Cui-Laughton, who was treated at the Yale REI Clinic in Orange, CT on October 27, 2020, which reflects that Ms. Cui-Laughton received fentanyl during her oocyte retrieval procedure.

From this review, it is my opinion that there is a good faith basis to support negligence on the part of the defendant, Yale University, Yale-New Haven Hospital, and/or its employees, agents, and apparent agents.

Based on the available records, the 100 mcg of fentanyl that was administered to Ms. Cui-Laughton on this date was most likely adulterated by Nurse Monticone, whom admitted to diverting 75% of all fentanyl stored at Yale between June 2020 and October 2020.

Fentanyl vials come from the pharmaceutical manufacturer with factory applied DEA Schedule II labeling and safety seals, including a circumferential label and a snap off cap assembly covering the rubber diaphragm through which a needle/syringe is placed in order to extract the liquid vial contents. It is, by design, physically impossible to remove the liquid contents of the fentanyl vial without deliberately and purposefully breaking/destroying the factory applied safety seal which covers the rubber diaphragm.

Therefore, the criminal withdrawal of schedule II liquid fentanyl by Nurse Monticone from factory sealed vials required Nurse Monticone to violate and destroy the multi-faceted factory applied safety seals to each vial of fentanyl from which she withdrew contents.

Even if Nurse Monticone criminally attempted to cover her tracks with glue or some other amateur/primitive method, in my expert opinion she would not be able to fully recreate the factory generated and applied safety seals.

Furthermore, in my expert opinion, any trained anesthesiologist in the United States- as part of his/her standard of care pre-procedure evaluation and preparation for the administration of anesthesia - would have and should have recognized the amateur reconstruction of the safety seal and thereby the deliberate tampering of any fentanyl vial which in fact, had been previously tampered with by Nurse Monticone. To reiterate, it would be impossible for Nurse Monticone to replicate/clone the exact safety seal system applied by the pharmaceutical manufacturer at the factory. In the same manner that other health care devices have readily recognizable tamper evident seals to ensure sterility, all intravenous medications administered by anesthesiologists - including fentanyl - are safety sealed both to prevent adulteration and diversion and to ensure sterility before administration. It would be negligent for an anesthesiologist to administer a medication such as fentanyl where there has been evident signs of violation of the sterility/safety seal.

Therefore, once a fentanyl vial exhibited visible signs of tampering, it was a deviation from the standard of care for any anesthesiologist:

(1) to fail to recognize the obvious signs of vial tampering before proceeding with the administration of adulterated fentanyl as an integral component of the anesthetic regimen.

(2) to administer contents from a compromised vial, either personally or by directing any other health care provider involved in the procedure to administer the contents from a tampered fentanyl vial.

(3) to fail to report signs of medication vial tampering to a supervisor and/ or any other appropriate pharmaceutical control official at Yale University.

The opinion stated herein is based on the information available to me at this time. Should other information and evidence become available, I reserve the right to support and/or amend this opinion.

EXHIBIT

A

PETITION TO THE CLERK : SUPERIOR COURT

JENNIFER ACAMPORA AND
ANY OTHER PLAINTIFFS
YET TO BE IDENTIFIED : JUDICIAL DISTRICT
: OF FAIRFIELD

v. : AT BRIDGEPORT

YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees :
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees :
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees :
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees :
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees :
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees :
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees :
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED :

OFFICE OF THE CLERK
SUPERIOR COURT
2021 APR 14 A 8:02
FILED AT BRIDGEPORT
FAIRFIELD
STATE OF CONNECTICUT

: APRIL 14, 2021

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **JENNIFER ACAMPORA** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **JENNIFER ACAMPORA by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Jean Lorusso

Asst. Clerk

Dated at Bridgeport, Connecticut, this 14th day of April, 2021.

EXHIBIT

B

PETITION TO THE CLERK	:	SUPERIOR COURT
COLLEEN BAUM AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	APRIL 14, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 APR 14 A 8:02
JUDICIAL DISTRICT
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **COLLEEN BAUM** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **COLLEEN BAUM by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Asst. Clerk

Dated at Bridgeport, Connecticut, this 14th day of April, 2021.

EXHIBIT
C

PETITION TO THE CLERK	:	SUPERIOR COURT
ANGELA CORTESE AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	MARCH 31, 2021

OFFICE OF THE CLERK SUPERIOR COURT 2021 APR -1 A 8:50 JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT STATE OF CONNECTICUT

OFFICE OF THE CLERK SUPERIOR COURT 2021 MAR 32 A 8:17 JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **ANGELA CORTESE** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **ANGELA CORTESE by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at Bridgeport, Connecticut, this 1 day of April, 2021.

EXHIBIT
D

PETITION TO THE CLERK	:	SUPERIOR COURT
CHENDAN CUI-LAUGHTON AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	APRIL 14, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 APR 14 A 8:02
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CHENDAN CUI-LAUGHTON** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CHENDAN CUI-LAUGHTON by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Asst. Clerk

Dated at Bridgeport, Connecticut, this 14th day of April, 2021.

EXHIBIT

E

PETITION TO THE CLERK	:	SUPERIOR COURT
LYNN ECONOMOPOULOS AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	JULY 26, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 JUL 26 PM 4:59
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **LYNN ECONOMOPOULOS** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **LYNN ECONOMOPOULOS by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Jenn Larusso

Asst. Clerk

Dated at Bridgeport, Connecticut, this 26th day of July, 2021.

NOTICE TO COUNSEL

Your Motion for Automatic Extension of the Statute of Limitations pursuant to C.G.S. 52-190a(b) has been granted as indicated on the order on the attached petition. Please serve and return the original of the Motion with the writ, summons and complaint IF AND WHEN YOU BRING SUIT. At that time a civil entry fee will be collected. This office will retain a copy of your motion for three months from the date it was granted.

Chief Clerk
Superior Court

8/90

EXHIBIT

F

PETITION TO THE CLERK	:	SUPERIOR COURT
LISA FUNARO AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	FEBRUARY 7, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 FEB -7 P 3:30
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **LISA FUNARO** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **LISA FUNARO by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at Bridgeport, Connecticut, this 10th day of February 2022.

EXHIBIT

G

PETITION TO THE CLERK	:	SUPERIOR COURT
CRISTINA HARRIS AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES	:	
AS YET TO BE DETERMINED	:	SEPTEMBER 1, 2021

2021 SEP -1 PM 4:24
JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT STATE OF CONNECTICUT
FILED OF THE CLERK SUPERIOR COURT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CRISTINA HARRIS** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CRISTINA HARRIS by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

9/1/21

Dated at _____, Connecticut, this _____ day of September, 2021.

EXHIBIT

H

PETITION TO THE CLERK	:	SUPERIOR COURT
CHELSEA HARRY AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: : :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	MARCH 31, 2021

OFFICE OF THE CLERK SUPERIOR COURT 2021 APR -1 A 8:50 JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT STATE OF CONNECTICUT

OFFICE OF THE CLERK SUPERIOR COURT 2021 MAR 31 A 8:17 JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CHELSEA HARRY** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CHELSEA HARRY by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at Bridgeport, Connecticut, this 1 day of April, 2021.

EXHIBIT

I

PETITION TO THE CLERK	:	SUPERIOR COURT
ANNE HERING AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	SEPTEMBER 1, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 SEP -1 PM 4:25
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **ANNE HERING** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **ANNE HERING by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

Granted

BY THE COURT

Clerk

9/1/21

Dated at _____, Connecticut, this _____ day of September, 2021.

EXHIBIT

J

PETITION TO THE CLERK	:	SUPERIOR COURT
LINDSAY RODRIGUEZ, ANTHONY RODRIGUEZ AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	DECEMBER 7, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 DEC -7 P 1:15
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **LINDSAY RODRIGUEZ** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **LINDSAY RODRIGUEZ by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

1st Asst Clerk

Dated at Bridgeport, Connecticut, this 7th day of December, 2021.

EXHIBIT

K

PETITION TO THE CLERK	:	SUPERIOR COURT
JESSICA BARAJAS AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	SEPTEMBER 15, 2021

2021 SEP 15 A 10:04

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **JESSICA BARAJAS** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **JESSICA BARAJAS by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

9/16/21

Dated at _____, Connecticut, this _____ day of September, 2021.

EXHIBIT

L

PETITION TO THE CLERK	:	SUPERIOR COURT
KATHLEEN GARRISON AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	JULY 22, 2021

2021 JUL 22 A 3:52

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **KATHLEEN GARRISON** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **KATHLEEN GARRISON by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

Granted

BY THE COURT

_____

Clerk

7/22/21

Dated at _____, Connecticut, this _____ day of July, 2021.

EXHIBIT

M

PETITION TO THE CLERK	:	SUPERIOR COURT
JESSICA LACOBELLE, JEROME LACOBELLE, III AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	FEBRUARY 7, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 FEB -7 P 3: 30
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **JESSICA LACOBELLE** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **JESSICA LACOBELLE by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

_____

Clerk

Dated at Bridgeport, Connecticut, this 10th day of February 2022.

EXHIBIT

N

PETITION TO THE CLERK	:	SUPERIOR COURT
CAITLIN PETERSON AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	SEPTEMBER 1, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 SEP -1 PM 4:25
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CAITLIN PETERSON** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CAITLIN PETERSON by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

9/1/21

Dated at _____, Connecticut, this _____ day of September, 2021.

EXHIBIT

O

PETITION TO THE CLERK	:	SUPERIOR COURT
LAUREN ROSENBERG AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	JUNE 11, 2021

2021 JUN 11 P 4:52

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **LAUREN ROSENBERG** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **LAUREN ROSENBERG by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Asst. Clerk

Dated at Bridgeport, Connecticut, this 11th day of June, 2021.

EXHIBIT

P

PETITION TO THE CLERK	:	SUPERIOR COURT
KRYSTINA HENDERSON AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES	:	
AS YET TO BE DETERMINED	:	JULY 22, 2021

2021 JUL 22 A 3:52

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **KRYSTINA HENDERSON** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **KRYSTINA HENDERSON by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

_____

Clerk

7/22/21

Dated at _____, Connecticut, this _____ day of July, 2021.

EXHIBIT

Q

PETITION TO THE CLERK	:	SUPERIOR COURT
MICHELLE KELLY AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	JUNE 11, 2021

2021 JUN 11 P 4:52

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **MICHELLE KELLY** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **MICHELLE KELLY by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Jen Lorusso

Asst. Clerk

Dated at Bridgeport, Connecticut, this 11th day of June, 2021.

EXHIBIT

R

PETITION TO THE CLERK	:	SUPERIOR COURT
CRISTINE DEVOE, JAMES DEVOE AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	APRIL 8, 2022

2022 APR -8 PM 12:05
FILED
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT
CLERK
COURT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CRISTINE DEVOE** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CRISTINE DEVOE by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or

employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at BRIDGEPORT, Connecticut, this 8TH day of April 2022.

EXHIBIT
S

PETITION TO THE CLERK	:	SUPERIOR COURT
REBECCA TULIN AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES	:	
AS YET TO BE DETERMINED	:	SEPTEMBER 15, 2021

2021 SEP 15 A 10: 03

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **REBECCA TULIN** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **REBECCA TULIN by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

Granted

BY THE COURT

Clerk 9/16/21

Dated at _____, Connecticut, this _____ day of September, 2021.

EXHIBIT

T

PETITION TO THE CLERK	:	SUPERIOR COURT
JANINE HERR AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	JULY 22, 2021

2021 JUL 22 A 3:52

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **JANINE HERR** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **JANINE HERR by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

Granted

BY THE COURT

_____

Clerk

7/22/21

Dated at _____, Connecticut, this _____ day of July, 2021.

EXHIBIT

U

PETITION TO THE CLERK	:	SUPERIOR COURT
CAROLINE GRUENBAUM AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	APRIL 8, 2022

2022 APR -8 PM 12:07
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT
CLERK
SUPERIOR COURT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CAROLINE GRUENBAUM** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CAROLINE GRUENBAUM by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees; YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their**

servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at BRIDGEPORT, Connecticut, this 8TH day of April 2022.

EXHIBIT

V

PETITION TO THE CLERK	:	SUPERIOR COURT
CAMISE TURNER-EVANS AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	JULY 1, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 JUL -2 AM 8:09
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **CAMISE TURNER-EVANS** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **CAMISE TURNER-EVANS by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Asst Clerk

Dated at Bridgeport, Connecticut, this 2nd day of July, 2021.

EXHIBIT
W

PETITION TO THE CLERK	:	SUPERIOR COURT
LAURA CZAR AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	FEBRUARY 7, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 FEB -7 P 3:29
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **LAURA CZAR** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **LAURA CZAR by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at Bridgeport, Connecticut, this 10th day of February 2022.

EXHIBIT

X

PETITION TO THE CLERK	:	SUPERIOR COURT
JOHANNA D'ADDARIO AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	SEPTEMBER 28, 2021

2021 SEP 28 AM 10: 47
CLERK
JUDICIAL DISTRICT OF FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **JOHANNA D'ADDARIO** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **JOHANNA D'ADDARIO by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

2021 SEP 28 A 10: 44

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Asst. Clerk

Dated at Bridgeport, Connecticut, this 28th day of September, 2021.

NOTICE TO COUNSEL

Your Motion for Automatic Extension of the Statute of Limitations pursuant to C.G.S. 52-190a(b) has been granted as indicated on the order on the attached petition. Please serve and return the original of the Motion with the writ, summons and complaint IF AND WHEN YOU BRING SUIT. At that time a civil entry fee will be collected. This office will retain a copy of your motion for three months from the date it was granted.

Chief Clerk
Superior Court

8/90

EXHIBIT

Y

PETITION TO THE CLERK	:	SUPERIOR COURT
VIKTORIA DUBROVSKY, MARINA DUBROVSKY AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	FEBRUARY 7, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 FEB -7 P 3:30
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **VIKTORIA DUBROVSKY** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **VIKTORIA DUBROVSKY by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at Bridgeport, Connecticut, this 10th day of February 2022.

EXHIBIT

Z

PETITION TO THE CLERK	:	SUPERIOR COURT
STACEY GLENNON, SEAN GLENNON AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	MARCH 11, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 MAR 11 PM 12:
JUDICIAL DISTRICT OF
FAIRFIELD
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **STACEY GLENNON** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **STACEY GLENNON by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or

employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

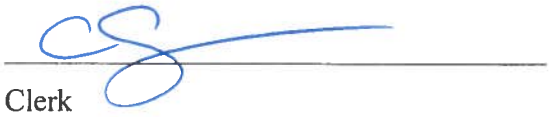
COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT



Clerk

Dated at BRIDGEPORT, Connecticut, this 11TH day of March 2022.

EXHIBIT
AA

PETITION TO THE CLERK	:	SUPERIOR COURT
BIANCA GOGLAS AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	MARCH 11, 2022

OFFICE OF THE CLERK
SUPERIOR COURT
2022 MAR 11 PM 12:
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **BIANCA GOGLAS** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **BIANCA GOGLAS by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at BRIDGEPORT, Connecticut, this 11TH day of March 2022.

EXHIBIT
BB

PETITION TO THE CLERK	:	SUPERIOR COURT
NATALIYA SOSTIN AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	: :	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	
	:	APRIL 8, 2021

OFFICE OF THE CLERK
SUPERIOR COURT
2021 APR -8 A 8:04
JUDICIAL DISTRICT OF
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **NATALIYA SOSTIN** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **NATALIYA SOSTIN by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSH KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Jean Lorenz

Asst Clerk

Dated at Bridgeport, Connecticut, this 8th day of April, 2021.

EXHIBIT
CC

PETITION TO THE CLERK	:	SUPERIOR COURT
MINGFEE CHOW-YEN, SHERMAN STIGLER AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	APRIL 8, 2022

2022 APR -8 PM 12:07
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT
THE CLERK
SUPERIOR COURT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **MINGFEE CHOW-YEN** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **MINGFEE CHOW-YEN by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees;**

YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or

employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

CS

Clerk

Dated at BRIDGEPORT, Connecticut, this 8TH day of April 2022.

EXHIBIT
DD

PETITION TO THE CLERK	:	SUPERIOR COURT
MARIA MCNAMARA, GREGORY MCNAMARA AND ANY OTHER PLAINTIFFS YET TO BE IDENTIFIED	:	JUDICIAL DISTRICT OF FAIRFIELD
v.	:	AT BRIDGEPORT
YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees	:	
YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees	:	
YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees	:	
YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants agent, apparent agents and/or employees	:	
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED	:	APRIL 8, 2022

2022 APR -8 PM 12:07
FAIRFIELD AT BRIDGEPORT
STATE OF CONNECTICUT
CLERK
COURT

Pursuant to Connecticut General Statutes Section 52-190a(b), the undersigned hereby petitions for the AUTOMATIC ninety (90) day extension of the Statute of Limitations which has not run as yet regarding the course of treatment given to **MARIA MCNAMARA** to allow reasonable inquiry to determine that there was negligence in the care and treatment of **MARIA MCNAMARA by YALE UNIVERSITY and/or their servants, agents, apparent agents and/or employees; YALE SCHOOL OF MEDICINE and/or their servants, agents, apparent agents and/or employees; YALE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY and/or their**

servants, agents, apparent agents and/or employees; YALE NEW HAVEN HOSPITAL and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN HEALTH SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN MEDICAL CENTER, INC. and/or their servants, agents, apparent agents and/or employees; YALE NEW HAVEN AMBULATORY SERVICES CORPORATION and/or their servants, agents, apparent agents and/or employees;
AND/OR ANY OTHER HEALTH CARE PROVIDERS AND THEIR SERVANTS, AGENTS AND/OR EMPLOYEES AS YET TO BE DETERMINED.

COUNSEL FOR THE PETITIONER,

JOSHUA D. KOSKOFF, ESQ.
KOSKOFF, KOSKOFF & BIEDER, P.C.
350 FAIRFIELD AVENUE
BRIDGEPORT, CONNECTICUT 06604
JURIS NO.: 410518
TELE. NO. 203-336-4421

ORDER

The foregoing Petition having been presented to the Clerk of the Court pursuant to Connecticut General Statutes § 52-190a (b), it is hereby ordered that the statute of limitations be extended for ninety (90) days.

BY THE COURT

Clerk

Dated at BRIDGEPORT, Connecticut, this 8TH day of April 2022.