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| DOCKET NO.: (X10) UWY-CV15-6029965-S | : | COMPLEX LITIGATION |
| ANTHONY DIAZ; BRUCE SYPNIEWSKI ; AND DAISY A. GMITTER | : | J.D. OF WATERBURY |
| V. | : | AT WATERBURY |
| GRIFFIN HEALTH SERVICES CORP., ET AL. | : | AUGUST 2, 2017 |

**SECOND AMENDED COMPLAINT**

## INTRODUCTION

Plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter bring this action on their own behalves, and on behalf of all other persons similarly situated, pursuant to Connecticut General Statutes §§ 52-104 and 52-105 and Practice Book §§ 9-7 and 9-8, against defendants Griffin Health Services Corporation and The Griffin Hospital (collectively, "Griffin"), for damages arising from Griffin's negligence and common law recklessness.

## THE PARTIES

1. Plaintiff Anthony Diaz is a resident of Ansonia, Connecticut.

2. Plaintiff Bruce Sypniewski is a resident of Derby, Connecticut.

3. At all times relevant to this matter, plaintiff Daisy A. Gmitter was a resident of Beacon Falls, Connecticut.

4. At all times referenced herein, Griffin Health Services Corporation was a Connecticut corporation, which owned and operated as its subsidiary, The Griffin Hospital, a public hospital located in Derby, Connecticut. Defendants Griffin Health Services Corporation and the Griffin Hospital are hereinafter, collectively referred to as "Griffin."

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**STATEMENT OF FACTS**

5. At all times relevant to this action, Griffin represented that patients treated at Griffin Hospital would be provided with appropriately trained and competent health care providers and other personnel, adequate facilities and equipment, and appropriate diagnoses, therapies and treatments, so as to provide care and treatment in accordance with applicable standards of care.

6. In order to provide appropriate care and treatment of its patients, Griffin was required to allow services to be rendered only by physicians and other health care providers and staff who had the appropriate skill, education, training, expertise, and competence.

7. In order to ensure that patients received proper care, Griffin established and enforced a system of administration, management, control and oversight including a governing body (responsible for patient care), medical directors, hospital administrators, other administrators, a medical staff, executives, committees, and other staff; through this system, Griffin was responsible for establishing, implementing, and enforcing rules, regulations, by-laws, protocols, guidelines and standards of care regarding every aspect of Griffin Hospital's operation, including: the proper treatment of patients; the training, qualifications, and duties of health-care providers; lines of responsibility and authority with regard to patient care; the oversight and management of clinical care; maintenance of facilities; and, information services, including the creation, maintenance, and availability of hospital records and patient information.

8. In order to ensure that patients received proper care, Griffin created, organized, managed, directed and oversaw Griffin Hospital medical staff; Griffin supervised, monitored and

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managed the care and treatment of patients, to ensure that each patient received care that was in accordance with the applicable standard of care.

9. Furthermore, in order to ensure that Griffin Hospital patients received proper care and treatment, Griffin was required to train, supervise, oversee and direct their employees and agents, including their residents, and to ensure that all patient care complied with the applicable standards of care, guidelines, policies, protocols and rules and regulations.

10. At all times mentioned herein, the physician employees, agents, and/or servants of Griffin were acting within the scope of their authority, agency, and/or employment in their treatment and care of plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter and in furtherance of the interest of Griffin.

11. At all times mentioned herein, Griffin employed physicians specializing in internal medicine, gastroenterology, endocrinology and other fields necessary to treat patients admitted to Griffin Hospital upon the condition that such physicians comply with all established and applicable rules and regulations.

12. At all times mentioned herein, Griffin employed pharmacists to treat patients admitted to Griffin Hospital upon the condition that such pharmacists comply with all established and applicable rules and regulations.

13. At all times mentioned herein, Griffin employed nurses, physician assistants and employees, agents and/or servants to treat patients admitted to Griffin Hospital upon the condition that such nurses, physician assistants, and employees, agents and/or servants comply with all established and applicable rules and regulations.

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14. In approximately May, 2009, plaintiff Anthony Diaz was admitted to Griffin Hospital.

15. At the time of plaintiff Anthony Diaz's admission to Griffin Hospital in May, 2009, Anthony Diaz was an insulin-dependent diabetic.

16. During plaintiff Anthony Diaz's May, 2009, admission at Griffin Hospital, employees, agents and/or servants of Griffin prescribed and administered insulin to Anthony Diaz using a multi-dose insulin pen.

17. During plaintiff Anthony Diaz's May, 2009, admission at Griffin Hospital, he was injected with insulin from a multi-dose insulin pen.

18. In approximately January, 2012, plaintiff Anthony Diaz was admitted to Griffin Hospital. During his admission at Griffin Hospital in January, 2012, employees, agents and/or servants of Griffin prescribed and administered insulin to Anthony Diaz.

19. In approximately February, 2014, plaintiff Anthony Diaz was admitted to Griffin Hospital. During his admission at Griffin Hospital in February, 2014, employees, agents and/or servants of Griffin prescribed and administered insulin to plaintiff Anthony Diaz.

20. In approximately February, 2014, plaintiff Bruce Sypniewski was admitted to Griffin Hospital.

21. During plaintiff Bruce Sypniewski's February, 2014, admission at Griffin Hospital, employees, agents and/or servants of Griffin prescribed and administered insulin to Bruce Sypniewski using a multi-dose insulin pen.

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22. During plaintiff Bruce Sypniewski's February, 2014, admission at Griffin Hospital, he was injected with insulin from a multi-dose insulin pen.

23. In approximately April, 2012, plaintiff Daisy A. Gmitter was admitted to Griffin Hospital.

24. During plaintiff Daisy A. Gmitter's April, 2012, admission at Griffin Hospital, employees, agents and/or servants of Griffin prescribed and administered insulin to Daisy A. Gmitter using a multi-dose insulin pen.

25. A multi-dose insulin pen is an injector device that contains a multi-dose vial, or cartridge, of insulin designed to allow for the delivery of multiple doses of insulin to a single patient.

26. Multi-dose insulin pens are intended for single patient use only and are not intended to be used on multiple patients.

27. Multi-dose insulin pens utilize a retractable, single-use, disposable needle that attaches to the insulin pen allowing reuse of the pen-like injector with a new sterile safety needle for each use.

28. Even when using a new needle for the multi-dose insulin pen, the cartridge can be contaminated through the backflow of blood or skin cells from one patient, and thus could potentially transmit an infection if used on another patient.

29. Griffin Hospital began using multi-dose insulin pens in approximately September, 2008.

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30. From approximately September, 2008, through approximately May 7, 2014, Griffin Hospital prescribed and administered insulin through the use of multi-dose insulin pens to over 3,100 patients, including plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter.

31. From approximately September, 2008, through May 7, 2014, employees, agents and/or servants of Griffin continuously and improperly used multi-dose insulin pens by using a single multi-dose insulin pen on multiple patients.

32. From approximately September, 2008, through May 7, 2014, employees, agents and/or servants of Griffin continuously and improperly used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed.

33. From approximately September, 2008, through May 7, 2014, employees, agents and/or servants of Griffin continuously and improperly drew insulin from a multi-dose insulin pen prescribed for a specific patient into a separate insulin syringe and then administered that insulin to another patient.

34. From approximately September, 2008, through May 7, 2014, employees, agents and/or servants of Griffin continuously and improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients.

35. At least eleven (11) employees, agents and/or servants of Griffin improperly used multi-dose insulin pens on multiple patients, used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed, drew insulin from a multi-dose insulin pen prescribed for a specific patient into a separate insulin syringe and then

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administered that insulin to another patient and/or removed the patient identification label affixed to a multi-dose insulin pen prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients.

36. Griffin and/or its employees, agents and/or servants had a continuing practice of improperly using multi-dose insulin pens, as described in Paragraphs 31 through 35 above and Paragraph 60 of the First Count, Paragraph 60 of the Fourth Count, and Paragraph 60 of the Sixth Count, beginning in approximately September, 2008 through approximately May 7, 2014.

37. On or about May 16, 2014, Griffin Hospital issued a press release alerting patients of Griffin Hospital that Griffin Hospital identified improper use of the multi-dose insulin pens which exposed patients to disease transmission.

38. On or about May 16, 2014, Griffin Hospital's President and CEO, Patrick Charmel, sent a correspondence to over 3,100 patients of Griffin Hospital, including plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter, notifying them that they were administered insulin through multi-dose insulin pens, that Griffin Hospital identified misuse of those insulin pens and that, as a result, blood-borne infections such as the hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) may have been transmitted.

39. As a result of the misuse of multi-dose insulin pens by Griffin and/or its employees, agents and/or servants, Griffin offered free testing for HBV, HCV and HIV to all patients for whom an insulin pen was ordered during their hospitalization on or after September

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1, 2008 through May 7, 2014. Griffin also strongly encouraged those patients, described herein, to be tested within thirty (30) days of receiving the letter.

40. On or about May 16, 2014, Griffin announced publicly that it and/or its employees, agents and/or servants had misused the multi-dose insulin pens since approximately September, 2008 by using multi-dose insulin pen cartridges intended for single patient use for more than one patient.

41. The May 16, 2014 correspondence did not notify patients that Griffin's employees, agents and/or servants also misused multi-dose insulin pens by drawing insulin from unsealed insulin pens prescribed for other patients into separate insulin syringes which was then administered to other patients.

42. The May 16, 2014 correspondence did not notify patients that Griffin's employees, agents and/or servants also improperly used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed.

43. The May 16, 2014 correspondence did not notify patients that Griffin's employees, agents and/or servants also improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients.

44. Plaintiff Anthony Diaz did not learn of the misuse of the multi-dose insulin pens at Griffin Hospital or of his risk for contracting blood-borne infections such as HBV, HCV and/or HIV until on or about May 16, 2014.

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45. Soon after receiving notice of the misuse of multi-dose insulin pens at Griffin Hospital, plaintiff Anthony Diaz went to Griffin Hospital to be tested for HBV, HCV and HIV as offered by Griffin Hospital in the May 16, 2014 correspondence, which required blood to be drawn from Anthony Diaz.

46. Plaintiff Bruce Sypniewski did not learn of the misuse of the multi-dose insulin pens at Griffin Hospital or of his risk for contracting blood-borne infections such as HBV, HCV and/or HIV until on or about May 16, 2014.

47. Soon after receiving notice of the misuse of multi-dose insulin pens at Griffin Hospital, plaintiff Bruce Sypniewski went to Griffin Hospital to be tested for HBV, HCV and HIV as offered by Griffin Hospital in the May 16, 2014 correspondence, which required blood to be drawn from Bruce Sypniewski.

48. Plaintiff Daisy A. Gmitter did not learn of the misuse of the multi-dose insulin pens at Griffin Hospital or of her risk for contracting blood-borne infections such as HBV, HCV and/or HIV until on or about May 16, 2014.

49. After receiving notice of the misuse of multi-dose insulin pens at Griffin Hospital, plaintiff Daisy A. Gmitter went to Griffin Hospital to be tested for HBV, HCV and HIV as offered by Griffin Hospital in the May 16, 2014 correspondence, which required blood to be drawn from Daisy A. Gmitter.

50. Griffin Hospital performed the testing free of charge.

51. Upon information and belief no patients admitted to Griffin Hospital who received insulin from multi-dose insulin pens between approximately September, 2008 and May

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7, 2014, learned of the misuse of the multi-dose insulin pens at Griffin Hospital or of their risk of contracting blood-borne infections such as HBV, HCV and/or HIV until on or about May 16, 2014.

**CLASS ACTION ALLEGATIONS**

52. The Plaintiffs bring this action individually and on behalf of all other persons similarly situated. The class consists of all patients of Griffin Hospital between September 1, 2008 and May 7, 2014, for whom a multi-dose insulin pen was prescribed, who received notice of the misuse of multi-dose insulin pens at Griffin Hospital between September 1, 2008 and May 7, 2014, and who were subsequently tested for HBV, HCV and/or HIV.

53. The exact number of members of the Class identified and described herein is not known at this time, but it is estimated that there are in excess of 3,100 members. The precise determination of the number of Class members is possible only through information within the exclusive control of Griffin.

54. The claims of the Plaintiffs, who are representative of the Class herein, are typical of the claims of the Class in that the claims of all members of the Class, including the Plaintiffs, depend upon Griffin's and/or its employees', agents' and/or servants' practices in administering insulin from multi-dose insulin pens to insulin dependent diabetics admitted to Griffin Hospital from approximately September, 2008 through May 7, 2014, receipt of notice of the misuse of multi-dose insulin pens at Griffin Hospital from approximately September, 2008 through May 7, 2014, and subsequent testing for HBV, HCV and/or HIV.

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55. There is no conflict between the individuals named as Plaintiffs and other members of the Class with respect to this Action or with respect to the Claims for Relief herein set forth.

56. The named Plaintiffs are the representative parties for the Class and will fairly and adequately protect the interests of the Class. The Attorneys for the Plaintiffs are experienced and capable in the field of Civil Litigation, have successfully represented claimants in other litigation, including class action litigation, and will actively conduct and be responsible for the claims of the Plaintiffs and those of the Class herein.

57. This Action is properly maintained as a Class Action and the prosecution of separate actions by individual members of the Class would create a risk of varying adjudications with respect to individual members of the Class and might establish incompatible standards of conduct for Griffin. Further, the prosecution of separate actions by individual members of the Class would create a risk of adjudications with respect to individual members of the Class which might, as a practical matter, be dispositive of the interest of other members not parties to the adjudications, or would substantially impair or impede their ability to protect their interest. Upon information and belief, the members of the Plaintiffs class are unaware of their rights to prosecute this action and may not have the means or resources to secure legal assistance to do so, except for inclusion within the Class.

58. This Action is properly maintained as a Class Action insomuch as the questions of law and fact common to the members of the Class predominate over any questions affecting only

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individual members, and a Class Action is superior to other available methods for the fair and efficient adjudication of the controversy.

59. There are common questions of law and fact in this Action that relate to and affect the rights of each members of the Class and the relief sought is common to the entire class. Griffin and/or its employees, agents and/or servants misused multi-dose insulin pens between approximately September, 2008 and May 7, 2014. Each member of the Class was a patient at Griffin Hospital at some time between September, 2008 and May 7, 2014 for whom a multi-dose insulin pen was prescribed. Each member of the Class received notice of the misuse of multi-dose insulin pens at Griffin Hospital between approximately September, 2008 and May 7, 2014. Each member of the Class was subsequently tested for HBV, HCV and/or HIV.

**FIRST COUNT: Plaintiff Anthony Diaz as to all Defendants (Negligence)**

1.–59. Paragraphs 1 through 59 of this Complaint are hereby incorporated as Paragraphs 1 through 59 of this, the First Count.

60. Griffin and/or its employees, agents and/or servants were negligent and thereby caused injury to plaintiff Anthony Diaz and all members of the Class in that Griffin and/or its employees, agents and/or servants failed to provide the required appropriate and acceptable care, skill and treatment as follows:

a. Griffin and/or its employees, agents and/or servants failed to properly administer insulin to patients using a multi-dose insulin pen;

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b. Griffin and/or its employees, agents and/or servants improperly used a multi-dose insulin pen on multiple patients;

c. Griffin and/or its employees, agents and/or servants failed to put in place the appropriate policies, procedures, rules and/or guidelines to ensure that multi-dose insulin pens were not used on multiple patients;

d. Griffin and/or its employees, agents and/or servants knew or should have known that there was a practice of using multi-dose insulin pens on multiple patients yet failed to take any steps to remediate that problem;

e. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering multi-dose insulin pens to patients;

f. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor those employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering insulin;

g. Griffin and/or its employees, agents and/or servants failed to properly warn and/or otherwise notify those employees, agents and/or servants of Griffin responsible for prescribing, administering and/or delivering multi-dose insulin pens to patients of the risks of using a single pen on multiple patients;

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h. Griffin and/or its employees, agents and/or servants failed to ensure that single patient use insulin pens were labelled as such once removed from the original packaging and/or that nursing staff followed infection control practices;

i. Griffin and/or its employees, agents and/or servants improperly drew insulin from insulin pens prescribed for other patients into separate insulin syringes which they then administered to other patients;

j. Griffin and/or its employees, agents and/or servants failed to make available the proper and appropriate medications prescribed and/or necessary for patient care;

k. Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed;

l. Griffin and/or its employees, agents and/or servants improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients;

m. Griffin and/or its employees, agents and/or servants failed to ensure that the system for distribution of pertinent information, including but not limited to United States Food and Drug Administration's ("FDA") alerts and/or Centers for Medicare & Medicaid Services ("CMS") Survey & Certification ("S&C") alerts, related to the use of insulin pens was effective;

n. Griffin and/or its employees, agents and/or servants improperly stored insulin pens prescribed for specific patients in other patients' medication drawers;

o. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of FDA alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the March 2009 FDA warning relating to potential "backwash" related to insulin pens; and,

p. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of CMS S&C alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the May 2012 CMS S&C letter identifying that insulin pens are meant for use by a single patient and must never be used for more than one patient; and,

61. As a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Anthony Diaz and all members of the Class required and in the future may require additional medical monitoring and treatment until such time as plaintiff Anthony Diaz and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

62. As a further result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Anthony Diaz and all members of the Class suffered emotional distress, anguish and anxiety from the time they first learned of



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Griffin's and/or its employees', agents' and/or servants' continuing wrongful conduct as aforesaid, until such time as plaintiff Anthony Diaz and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

63. Pursuant to Connecticut General Statutes § 52-190a, Plaintiffs' counsel has attached as Exhibit A to this Complaint, a copy of plaintiff's counsel's certificate of reasonable inquiry in support of this action, along with a redacted written and signed opinion of a similar health care provider, as defined in Connecticut General Statutes § 52-184c.

**SECOND COUNT: Plaintiff Anthony Diaz as to all Defendants (Common Law Recklessness)**

1.–63. Paragraphs 1 through 63 of the First Count are hereby incorporated as Paragraphs 1 through 63 of this, the Second Count.

64. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that multi-dose insulin pens are meant for single patient use and that they should never be used on multiple patients.

65. The package insert for the insulin pens used by Griffin Hospital clearly indicated that insulin pens were meant for single-patient use.

66. The package insert for the insulin pens used by Griffin Hospital clearly noted that the insulin pens should never be shared between patients even if the needle is changed and that sharing poses a risk of transmission of blood-borne pathogens.

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67. Griffin and/or its employees, agents and/or servants were aware of the risk of substantial harm to others at Griffin Hospital which would be created by its recklessness in the aforesaid respects.

68. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using multi-dose insulin pens on multiple patients could cause transmission of serious blood-borne pathogens.

69. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using a multi-dose insulin pen prescribed for a specific patient on another patient for which that insulin pen was not prescribed could cause transmission of serious blood-borne pathogens.

70. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that drawing insulin from multi-dose insulin pens into a separate syringe which was then administered to another patient could cause transmission of serious blood-borne pathogens.

71. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that removing patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administering insulin from that same multi-dose insulin pen to other patients could cause transmission of serious blood-borne pathogens.

72. The actions of Griffin and/or its employees, agents and/or servants were reckless in that they injected patients with insulin from a multi-dose insulin pen that had been used on

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another patient; misused multi-dose insulin pens by drawing insulin from unsealed insulin pens prescribed for other patients into separate insulin syringes which was then administered to other patients; misused insulin pens prescribed for a specific patient on patients for which that insulin pen was no prescribed; and/or improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients, with knowledge of the serious danger involved in that decision or with knowledge of facts which would disclose such danger to a reasonable person.

73. Griffin Hospital's reckless conduct was a substantial factor in causing the aforesaid injuries and damages to plaintiff Anthony Diaz and all members of the Class in that Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens as described herein even though it knew or should have known that such conduct posed a serious risk of injury to plaintiff Anthony Diaz and all members of the Class.

**THIRD COUNT: Negligent Infliction of Emotional Distress as to all Defendants**

***COUNT STRICKEN BUT JUDGMENT NOT ENTERED PURSUANT TO PRACTICE BOOK SECTION 10-44***

**FOURTH COUNT: Plaintiff Bruce Sypniewski as to all Defendants (Negligence)**

1.–59. Paragraphs 1 through 59 of this Complaint are hereby incorporated as Paragraphs 1 through 59 of this, the Fourth Count.

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60. Griffin and/or its employees, agents and/or servants were negligent and thereby caused injury to plaintiff Bruce Sypniewski and all members of the Class in that Griffin and/or its employees, agents and/or servants failed to provide the required appropriate and acceptable care, skill and treatment as follows:

a. Griffin and/or its employees, agents and/or servants failed to properly administer insulin to patients using a multi-dose insulin pen;

b. Griffin and/or its employees, agents and/or servants improperly used a multi-dose insulin pen on multiple patients;

c. Griffin and/or its employees, agents and/or servants failed to put in place the appropriate policies, procedures, rules and/or guidelines to ensure that multi-dose insulin pens were not used on multiple patients;

d. Griffin and/or its employees, agents and/or servants knew or should have known that there was a practice of using multi-dose insulin pens on multiple patients yet failed to take any steps to remediate that problem;

e. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering multi-dose insulin pens to patients;

f. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor those employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering insulin;

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g. Griffin and/or its employees, agents and/or servants failed to properly warn and/or otherwise notify those employees, agents and/or servants of Griffin responsible for prescribing, administering and/or delivering multi-dose insulin pens to patients of the risks of using a single pen on multiple patients;

h. Griffin and/or its employees, agents and/or servants failed to ensure that single patient use insulin pens were labelled as such once removed from the original packaging and/or that nursing staff followed infection control practices;

i. Griffin and/or its employees, agents and/or servants improperly drew insulin from insulin pens prescribed for other patients into separate insulin syringes which they then administered to other patients;

j. Griffin and/or its employees, agents and/or servants failed to make available the proper and appropriate medications prescribed and/or necessary for patient care;

k. Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed;

l. Griffin and/or its employees, agents and/or servants improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients;

m. Griffin and/or its employees, agents and/or servants failed to ensure that the system for distribution of pertinent information, including but not limited to

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United States Food and Drug Administration's ("FDA") alerts and/or Centers for Medicare & Medicaid Services ("CMS") Survey & Certification ("S&C") alerts, related to the use of insulin pens was effective;

n. Griffin and/or its employees, agents and/or servants improperly stored insulin pens prescribed for specific patients in other patients' medication drawers;

o. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of FDA alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the March 2009 FDA warning relating to potential "backwash" related to insulin pens; and,

p. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of CMS S&C alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the May 2012 CMS S&C letter identifying that insulin pens are meant for use by a single patient and must never be used for more than one patient.

61. As a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Bruce Sypniewski and all members of the Class required and in the future may require additional medical monitoring and treatment until such time as plaintiff Bruce Sypniewski and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

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62. As a further result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Bruce Sypniewski and all members of the Class suffered emotional distress, anguish and anxiety from the time they first learned of Griffin's and/or its employees', agents' and/or servants' continuing wrongful conduct as aforesaid, until such time as plaintiff Bruce Sypniewski and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

63. Pursuant to Connecticut General Statutes § 52-190a, Plaintiffs' counsel has attached as Exhibit A to this Complaint, a copy of plaintiff's counsel's certificate of reasonable inquiry in support of this action, along with a redacted written and signed opinion of a similar health care provider, as defined in Connecticut General Statutes § 52-184c.

64. Plaintiffs' counsel has also appended to this Complaint, a copy of the order from the Superior Court, Judicial District of Ansonia-Milford, dated May 11, 2017, extending the Statute of Limitations by ninety days.

**FIFTH COUNT: Plaintiff Bruce Sypniewski as to all Defendants (Common Law Recklessness)**

1.–64. Paragraphs 1 through 64 of the Fourth Count are hereby incorporated as Paragraphs 1 through 64 of this, the Fifth Count.

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65. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that multi-dose insulin pens are meant for single patient use and that they should never be used on multiple patients.

66. The package insert for the insulin pens used by Griffin Hospital clearly indicated that insulin pens were meant for single-patient use.

67. The package insert for the insulin pens used by Griffin Hospital clearly noted that the insulin pens should never be shared between patients even if the needle is changed and that sharing poses a risk of transmission of blood-borne pathogens.

68. Griffin and/or its employees, agents and/or servants were aware of the risk of substantial harm to others at Griffin Hospital which would be created by its recklessness in the aforesaid respects.

69. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using multi-dose insulin pens on multiple patients could cause transmission of serious blood-borne pathogens.

70. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using a multi-dose insulin pen prescribed for a specific patient on another patient for which that insulin pen was not prescribed could cause transmission of serious blood-borne pathogens.

71. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that drawing insulin from multi-dose insulin pens into a separate

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syringe which was then administered to another patient could cause transmission of serious blood-borne pathogens.

72. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that removing patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administering insulin from that same multi-dose insulin pen to other patients could cause transmission of serious blood-borne pathogens.

73. The actions of Griffin and/or its employees, agents and/or servants were reckless in that they injected patients with insulin from a multi-dose insulin pen that had been used on another patient; misused multi-dose insulin pens by drawing insulin from unsealed insulin pens prescribed for other patients into separate insulin syringes which was then administered to other patients; misused insulin pens prescribed for a specific patient on patients for which that insulin pen was no prescribed; and/or improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients, with knowledge of the serious danger involved in that decision or with knowledge of facts which would disclose such danger to a reasonable person.

74. Griffin Hospital's reckless conduct was a substantial factor in causing the aforesaid injuries and damages to plaintiff Bruce Sypniewski and all members of the Class in that Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens as

described herein even though it knew or should have known that such conduct posed a serious risk of injury to plaintiff Bruce Sypniewski and all members of the Class.

**SIXTH COUNT: Plaintiff Daisy A. Gmitter as to all Defendants (Negligence)**

1.–59. Paragraphs 1 through 59 of this Complaint are hereby incorporated as Paragraphs 1 through 59 of this, the Sixth Count.

60. Griffin and/or its employees, agents and/or servants were negligent and thereby caused injury to plaintiff Daisy A. Gmitter and all members of the Class in that Griffin and/or its employees, agents and/or servants failed to provide the required appropriate and acceptable care, skill and treatment as follows:

a. Griffin and/or its employees, agents and/or servants failed to properly administer insulin to patients using a multi-dose insulin pen;

b. Griffin and/or its employees, agents and/or servants improperly used a multi-dose insulin pen on multiple patients;

c. Griffin and/or its employees, agents and/or servants failed to put in place the appropriate policies, procedures, rules and/or guidelines to ensure that multi-dose insulin pens were not used on multiple patients;

d. Griffin and/or its employees, agents and/or servants knew or should have known that there was a practice of using multi-dose insulin pens on multiple patients yet failed to take any steps to remediate that problem;



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e. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering multi-dose insulin pens to patients;

f. Griffin and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor those employees, agents and/or servants of Griffin responsible for prescribing, administering and delivering insulin;

g. Griffin and/or its employees, agents and/or servants failed to properly warn and/or otherwise notify those employees, agents and/or servants of Griffin responsible for prescribing, administering and/or delivering multi-dose insulin pens to patients of the risks of using a single pen on multiple patients;

h. Griffin and/or its employees, agents and/or servants failed to ensure that single patient use insulin pens were labelled as such once removed from the original packaging and/or that nursing staff followed infection control practices;

i. Griffin and/or its employees, agents and/or servants improperly drew insulin from insulin pens prescribed for other patients into separate insulin syringes which they then administered to other patients;

j. Griffin and/or its employees, agents and/or servants failed to make available the proper and appropriate medications prescribed and/or necessary for patient care;

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k. Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens prescribed for a specific patient on patients for which that insulin pen was not prescribed;

l. Griffin and/or its employees, agents and/or servants improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients;

m. Griffin and/or its employees, agents and/or servants failed to ensure that the system for distribution of pertinent information, including but not limited to United States Food and Drug Administration's ("FDA") alerts and/or Centers for Medicare & Medicaid Services ("CMS") Survey & Certification ("S&C") alerts, related to the use of insulin pens was effective;

n. Griffin and/or its employees, agents and/or servants improperly stored insulin pens prescribed for specific patients in other patients' medication drawers;

o. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of FDA alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the March 2009 FDA warning relating to potential "backwash" related to insulin pens; and,

p. Griffin and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of CMS S&C alerts and

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warnings relating to the use of multi-dose insulin pens, including but not limited to the May 2012 CMS S&C letter identifying that insulin pens are meant for use by a single patient and must never be used for more than one patient.

61. As a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Daisy A. Gmitter and all members of the Class required and in the future may require additional medical monitoring and treatment until such time as plaintiff Daisy A. Gmitter and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

62. As a further result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct as aforesaid, plaintiff Daisy A. Gmitter and all members of the Class suffered emotional distress, anguish and anxiety from the time they first learned of Griffin's and/or its employees', agents' and/or servants' continuing wrongful conduct as aforesaid, until such time as Daisy A. Gmitter and all members of the Class are reasonably medically certain as to whether they were infected with HBV, HCV and/or HIV as a result of Griffin's and/or its employees', agents' and/or servants' continuing course of wrongful conduct.

63. Pursuant to Connecticut General Statutes § 52-190a, plaintiff's counsel has attached as Exhibit A to this Complaint, a copy of plaintiff's counsel's certificate of reasonable inquiry in support of this action, along with a redacted written and signed opinion of a similar health care provider, as defined in Connecticut General Statutes § 52-184c.

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64. Plaintiffs' counsel has also appended to this Complaint, a copy of the order from the Superior Court, Judicial District of Ansonia-Milford, dated May 11, 2017, extending the Statute of Limitations by ninety days.

**SEVENTH COUNT: Plaintiff Daisy A. Gmitter as to all Defendants (Common Law Recklessness)**

1.–64. Paragraphs 1 through 64 of the Sixth Count are hereby incorporated as Paragraphs 1 through 64 of this, the Seventh Count.

65. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that multi-dose insulin pens are meant for single patient use and that they should never be used on multiple patients.

66. The package insert for the insulin pens used by Griffin Hospital clearly indicated that insulin pens were meant for single-patient use.

67. The package insert for the insulin pens used by Griffin Hospital clearly noted that the insulin pens should never be shared between patients even if the needle is changed and that sharing poses a risk of transmission of blood-borne pathogens.

68. Griffin and/or its employees, agents and/or servants were aware of the risk of substantial harm to others at Griffin Hospital which would be created by its recklessness in the aforesaid respects.

69. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using multi-dose insulin pens on multiple patients could cause transmission of serious blood-borne pathogens.

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70. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that using a multi-dose insulin pen prescribed for a specific patient on another patient for which that insulin pen was not prescribed could cause transmission of serious blood-borne pathogens.

71. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that drawing insulin from multi-dose insulin pens into a separate syringe which was then administered to another patient could cause transmission of serious blood-borne pathogens.

72. At all times mentioned herein, Griffin and/or its employees, agents and/or servants knew or should have known that removing patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administering insulin from that same multi-dose insulin pen to other patients could cause transmission of serious blood-borne pathogens.

73. The actions of Griffin and/or its employees, agents and/or servants were reckless in that they injected patients with insulin from a multi-dose insulin pen that had been used on another patient; misused multi-dose insulin pens by drawing insulin from unsealed insulin pens prescribed for other patients into separate insulin syringes which was then administered to other patients; misused insulin pens prescribed for a specific patient on patients for which that insulin pen was no prescribed; and/or improperly removed patient identification labels affixed to multi-dose insulin pens prescribed for a specific patient and then administered insulin from that same multi-dose insulin pen to other patients, with knowledge of the serious danger involved in

that decision or with knowledge of facts which would disclose such danger to a reasonable person.

74. Griffin Hospital's reckless conduct was a substantial factor in causing the aforesaid injuries and damages to plaintiff Daisy A. Gmitter and all members of the Class in that Griffin and/or its employees, agents and/or servants improperly used multi-dose insulin pens as described herein even though it knew or should have known that such conduct posed a serious risk of injury to plaintiff Daisy A. Gmitter and all members of the Class.

WHEREFORE, plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter and all members of the Class claim monetary damages against the defendants Griffin Health Services Corporation and The Griffin Hospital.

WHEREFORE, with respect to the Second, Fifth and Seventh Counts, plaintiffs Anthony Diaz, Bruce Sypniewski and Daisy A. Gmitter and all members of the Class claim common law punitive damages against the defendants Griffin Health Services Corporation and The Griffin Hospital.

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THE PLAINTIFF

BY: _____

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## CLAIM FOR RELIEF

WHEREFORE, the plaintiffs pray on their own behalves and on behalf of all others similarly situated that the Court grant the following relief:

1. That the Court certify this action as a class action on behalf of plaintiff and all individuals similarly situated;
2. Compensatory damages in an amount in excess of fifteen thousand ($15,000.00) dollars, exclusive of interest and costs;
3. Common law punitive damages; and,
4. Such other relief in law or equity as the Court deems appropriate.

THE PLAINTIFF

BY: _____

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## CERTIFICATE

I hereby certify that a reasonable inquiry has been made, as permitted by the circumstances, and this inquiry has given rise to a good faith belief on my part that grounds exist for an action against named defendants **Griffin Health Services Corporation** and **The Griffin Hospital**. Pursuant to Connecticut General Statutes § 52-190a, copies of the redacted written and signed opinions of a similar health care providers, as defined in Connecticut General Statutes § 52-18ac, are attached as Exhibit A.

ERNEST F. TEITELL

**REGISTERED NURSE'S OPINION**
**PURSUANT TO C.G.S. SECTION 52-190a**
**(NOT SUBJECT TO GENERAL DISCLOSURE)**

I am a registered nurse, National League of Nursing Certified Nurse Educator, and have functioned in the role of an Assistant Clinical Professor at a School of Nursing of an academic institution within the last year. I additionally hold a Doctor of Nursing Practice degree and am familiar with the standard of care for the practice of nursing and for the practice of administering insulin to patients in a hospital setting. I have been a licensed nurse since 1992, and have worked as a nurse in a hospital setting since 1992. I have been a certified nurse educator since 2007 and have worked as clinical nurse educator since 2004. As such, I am qualified to opine on the duties and the standard of care of nurses and of those health care workers who administer insulin to patients in the Eastern United States.

I have reviewed Griffin Hospital's letter and packet mailed to patients on May 16, 2014, and documents provided pursuant to a Freedom of Information Request. Based on my review of these records, it is my opinion that there is evidence of medical negligence on the part of Griffin Hospital, including its nurses, employees, agents and/or servants responsible for administering insulin to patients at Griffin Hospital. Said negligence is as follows:

1. Griffin Hospital and/or its employees, agents and/or servants failed to properly administer insulin to patients using a multi-dose insulin pen;

2. Griffin Hospital and/or its employees, agents and/or servants improperly used a multi-dose insulin pen on multiple patients;

3. Griffin Hospital and/or its employees, agents and/or servants failed to put in place the appropriate policies, procedures, rules and/or guidelines to ensure that multi-dose insulin pens were not used on multiple patients;

4. Griffin Hospital and/or its employees, agents and/or servants knew or should have known that there was a practice of using multi-dose insulin pens on multiple patients yet failed to take any steps to remediate that problem;

5. Griffin Hospital and/or its employees, agents and/or servants failed to properly train, educate, supervise and monitor employees, agents and/or servants of Griffin Hospital responsible for prescribing, administering and delivering insulin to patients;

6. Griffin Hospital and/or its employees, agents and/or servants failed to properly warn and/or otherwise notify those employees, agents and/or servants of Griffin Hospital responsible for prescribing, administering and/or delivering multi-dose insulin pens to patients of the risks of using a single pen on multiple patients;

7. Griffin Hospital and/or its employees, agents and/or servants improperly drew insulin from insulin pens prescribed for other patients into separate insulin syringes which they then administered to other patients; and,

8. Griffin Hospital and/or its employees, agents and/or servants failed to advise, distribute, educate and train its employees, agents and/or servants of FDA alerts and warnings relating to the use of multi-dose insulin pens, including but not limited to the March 2009 DFA warning relating to potential "backwash" related to insulin pens.

The opinions stated here are based on the information available to me at this time. Should other information and evidence become available, I reserve the right to supplement and/or amend this opinion.

REDACTED