IN THE CIRCUIT COURT OF THE 20TH JUDICIAL CIRCUIT OF FLORIDA, IN AND FOR LEE COUNTY

GENERAL JURISDICTION DIVISION

NICOLE SCHELL and JOHN SCHELL III, her spouse,

Plaintiffs,

v.

ERIC VENSEL, M.D., RADIOLOGY REGIONAL CENTER, P.A., DAWN MEIER, LM, JESSLYN ROMERO, RN, FAMILY BIRTH SERVICES, INC d/b/a FAMILY BIRTH CENTER OF NAPLES, ANNALIESE K. HAGGARTY, SM, and HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC.,

Defendants.
_____/

Case No: 23-CA-009865

THIRD AMENDED COMPLAINT FOR DAMAGES AND DEMAND FOR JURY TRIAL

Plaintiffs, NICOLE SCHELL and JOHN SCHELL III, her spouse, by and through their undersigned counsel, hereby file this Third Amended Complaint against Defendants, RADIOLOGY REGIONAL CENTER, P.A., ERIC VENSEL, M.D, FAMILY BIRTH SERVICES, INC. d/b/a FAMILY BIRTH CENTER OF NAPLES, DAWN MEIER, LM, JESSLYN ROMERO, RN, ANNALIESE K. HAGGARTY, SM, and HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC. and all allegations being of fact extant at all times pertinent hereto allege that:

HALBERG & FOGG, PLLC, ATTORNEYS AT LAW
4440 PGA BLVD. SUITE 306 PALM BEACH GARDENS, FL 33410 ● TEL. (561) 616-3000

GENERAL ALLEGATIONS AND IDENTIFICATION OF THE PARTIES

1. This is an action for damages in excess of the jurisdictional limits of this court.

2. Venue is proper in Lee County, Florida, in accordance with §47.011 Fla. Stat. as one or more of the Defendants do business and the events giving rise to this action occurred therein.

3. Plaintiffs, NICOLE SCHELL and JOHN SCHELL III, her spouse, at all times material hereto, were and are residents of the State of Florida.

4. Defendant, RADIOLOGY REGIONAL CENTER, P.A. (hereinafter referred to as "RADIOLOGY REGIONAL"), is and was a radiology center Lee County, Florida, providing radiological care and services to its patients in Lee County, Florida, and is vicariously liable for any negligent acts of its agents, apparent agents, servants, and/or employees, who rendered care to NICOLE SCHELL.

5. Defendant, ERIC VENSEL, M.D. (hereinafter referred to as "DR. VENSEL"), is and was a radiologist who was acting as an agent, apparent agent, servant and/or employee of RADIOLOGY REGIONAL at the time he read and interpreted films for patient NICOLE SCHELL, including, but not limited to the April 22, 2021, obstetrical ultrasound, while she was a patient of RADIOLOGY REGIONAL.

6. Defendant, FAMILY BIRTH SERVICES, INC. d/b/a FAMILY BIRTH CENTER OF NAPLES. (hereinafter referred to as "BIRTH CENTER"), is and was a birthing center in Naples, Florida, providing birthing care and treatment to its patients in Naples, Florida, is vicariously liable for any negligent acts of its agents, apparent agents, servants, and/or employees,

who rendered care to NICOLE SCHELL, and who was acting as an agent, apparent agent, servant, and/or employee of HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC. at the time it provided care and treatment to patient NICOLE SCHELL.

7. Defendant, DAWN MEIER, LM. (hereinafter referred to as "MEIER"), is and was a licensed midwife, is vicariously liable for any negligent acts of its agents, apparent agents, servants, and/or employees, who rendered care to NICOLE SCHELL, and who was acting as an agent, apparent agent, servant and/or employee of BIRTH CENTERS and/or HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC. at the time she provided care and treatment to patient NICOLE SCHELL.

8. Defendant, JESSLYN ROMERO, RN (hereinafter referred to as "ROMERO") is and was a registered nurse who was acting as an agent, apparent agent, servant and/or employee of BIRTH CENTER at the time she provided care and treatment to patient NICOLE SCHELL.

9. Defendant, ANNALIESE K. HAGGARTY (hereinafter referred to as "HAGGARTY"), was, at all times material hereto, a student of a midwifery who was acting as an agent, apparent agent, servant and/or employee of HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC. (hereinafter referred to as the "HERITAGE MIDWIFERY") and/or MEIER.

10. Defendant, HERITAGE MIDWIFERY, is and was, at all times material hereto, a midwife training program, governed by Fla. Admin. Code. 64B24-4 and Fla. Stat. §467, with its principal place of business located in Sarasota County, Florida.

11. Defendant, MEIER, was, at all times material hereto, a midwife preceptor for Defendant's, HERITAGE MIDWIFERY, school of midwifery and was the preceptor for Defendant, HAGGARTY.

COMPLIANCE WITH CONDITIONS PRECEDENT AND FLORIDA STATUTE SECTION 766.106(2)

12. Notice of Intention to Initiate Litigation against the Defendants named in this Complaint was given and acknowledged in accordance with the requirements of Fla. Stat. §766.106(2) by either serving the Defendants named individually or by and through service to their employee, employer, agent and/or apparent agent. The Plaintiffs have complied with all of the requirements of the Department of Health, Agency for Health Care Administration. A copy of the Complaint will be sent to that entity at the time the Complaint is filed. This action is properly brought within the two years of when the alleged negligence incident occurred or within two years from the date the alleged negligent incident could have been discovered with the exercise of due diligence. Any and all conditions precedent to the filing of this lawsuit have been complied with.

CERTIFICATE OF COUNSEL

13. Through counsel's signature below, it is hereby certified, pursuant to Florida Statute §766.203, that counsel for the Plaintiffs, before filing this action, made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there was negligence in the care and treatment of NICOLE SCHELL. Such reasonable investigation has given rise to a good faith belief that grounds exist for an action against the named Defendants.

FACTS GIVING RISE TO THE CAUSE OF ACTION

14. At all times relevant hereto, NICOLE SCHELL was a 30-year-old female who was pregnant, G1 PO, with a history of moderate anemia and a patient at BIRTH CENTER since February of 2021.

15. She presented for her first visit in February of 2021. She had a familial history of cleft palate as her husband, the baby's father, has a cleft palate himself and, accordingly, that was a concern for her during this pregnancy.

16. During her March 22, 2021, visit with MEIR, at BIRTH CENTER, NICOLE SCHELL'S pregnancy was noted to be low risk despite her familial history of cleft palette disease.

17. Her prenatal ultrasounds during the course of her pregnancy took place at RADIOLOGY REGIONAL, and on April 22, 2021, she presented to RADIOLOGY REGIONAL for her 20-week obstetrical ultrasound.

18. The obstetrical ultrasound was said to contain all the necessary images to have shown the four chambers of the heart and all necessary anatomy to determine whether there were any fetal anomalies.

19. DR. VENSEL reviewed and interpreted the April 22, 2021, obstetrical ultrasound and reported no anomalies and all four chambers of the heart were visible.

20. However, the April 22, 2021, obstetrical ultrasound did not have adequate images to properly report that there were no anomalies to the mouth, nor did the ultrasound have the adequate and necessary images to properly review the four chambers of the heart.

21. Therefore, it was impossible for DR. VENSEL to accurately report that there were no anomalies because the imaging taken was not adequate for him to make those findings, and, at that time, he should have requested the imaging be redone in order for him to properly discern the possibility of fetal anomalies that this baby may have and report accordingly.

22. Nevertheless, DR. VENSEL improperly reported findings he was unable to confirm and failed to appraise NICOLE SCHELL of the inherent risks of her pregnancy, which was part and parcel of the services he was rendering for her.

23. As DR. VENSEL'S ill-informed and inaccurate reporting was the pretense for NICOLE SCHELL'S pregnancy remaining classified as low risk, NICOLE SCHELL was lulled into a false sense of security as it related to the health and safety of her and her baby. Had DR. VENSEL properly rendered services related to the obstetrical ultrasound for NICOLE SCHELL and, thus, seen and reported a cleft palette and anomaly her pregnancy would have been assessed with adequate risk and appropriate care and oversight there related would have been rendered.

24. Of note, in accordance with Fla. Stat. §467.015 a midwife can only provide care for mothers expecting to have a normal pregnancy, labor, and delivery. In the event a midwife provides care for a pregnancy that is not low risk a physician must maintain supervision for directing the specific course of medical treatment.

25. NICOLE SCHELL was not afforded her statutory protections due to DR. VENSEL'S failure to adequately render services.

26. On May 17, 2021, NICOLE SCHELL had a follow-up appointment at BIRTH

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CENTER with MEIER. It is unclear what was discussed about the April obstetrical ultrasound and if MEIER saw and reviewed the actual film or just depended on the inaccurate report by DR. VENSEL.

27. Thereafter, NICOLE SCHELL continued with her scheduled visits to BIRTH CENTER.

28. On her July 26, 2021, visit she reported heart palpitations.

29. During her August 16, 2021, visit to BIRTH CENTER, NICOLE SHELL reported to MEIER that she had 14 hours of prodromal labor with irregular contractions that had stopped that morning at or about 4:00 am before her visit. Upon information and belief, there is no record of an exam performed by MEIER to check on the baby's heartbeat and no record of an ultrasound being ordered or performed.

30. NICOLE SCHELL next returned to BIRTH CENTER four (4) days later and is seen by ROMERO on August 20, 2021.

31. At this visit, NICOLE SCHELL complained of bilateral lower extremity edema that was not resolving, as it had in the past, and expressed concerns about same. Moreover, her urine dip was positive for protein and labs were drawn related to a preeclampsia panel. She recalls her blood pressure being borderline and was told that if went higher it would be considered preeclampsia. Again, no one checked the baby's heart tones or vitals on this visit and she was sent home.

32. Subsequent thereto, in accordance with the instructions provided by BIRTH

CENTER and its practitioners, NICOLE SCHELL contacted MEIER because her blood pressure was high. As a result thereof, MEIER simply advised her to lay on her side, and that MEIER would follow up with her in the morning.

33. Then, on the morning of August 23, 2021, NICOLE SCHELL presented to BIRTH CENTER with high blood pressure. She had a vaginal exam. Inducing labor was discussed resulting in a foley bulb being inserted and NICOLE SCHELL being instructed to return home to do nipple stimulation with breast pump, to take castor oil, and to monitor her blood pressure at home every 1-2 hours.

34. On that same day of August 23, NICOLE SCHELL contacted MEIER at or around 1:20 pm to report that her water had broken with contractions of about 2 minutes apart lasting 30-45 seconds. NICOLE SCHELL reported to MEIER that the water was discolored, greenish yellowish and smelled bad, yet MEIER told her to wait at home because the contractions were not lasting long enough.

35. At about 3:20 pm on August 23, NICOLE SCHELL, again, contacted MEIER and this time reported her contractions were 2 minutes apart lasting one minute for the last half hour. A plan was made to head to BIRTH CENTER for evaluation.

36. NICOLE SCHELL arrived at BIRTH CENTER around 4:00 p.m. although the medical records note she arrived at 4:30 p.m. Along with NICOLE SCHELL, present for her delivery were her husband, JOHN SCHELL III, doula, Sabrina Hall, LPN, Damaris Valenzuela, birth assistant, HAGARTY, a midwife student, and MEIER, midwife.

37. HAGARTY was present for NICOLE SCHELL'S delivery functioning in a midwife capacity for NICOLE SCHELL as a part of the clinical learning experience required in her training program with HERITAGE MIDWIFERY.

38. At 4:45 p.m. a note is entered into her records that states the membranes were "clear" despite NICOLE SCHELL reporting earlier to the staff that her water was discolored, greenish, yellowish and smelled bad.

39. At 5:00 p.m., 5:30 p.m. and 5:45 p.m. a doppler is noted to be assessing the fetal heart tones, and it is charted that there are no accelerations or decelerations detected and these are initialed by HAGARTY, the student.

40. At 5:45 p.m., after being at BIRTH CENTER for well over an hour and a half, MEIER noted that she was unable to find the fetal heart tone via doppler. Then, at 5:50 p.m., MEIER noted she was unable to find the fetal heart tone with the doppler or the ultrasound and an ambulance was called at 5:55 p.m.

41. The ambulance arrived at 6:00 p.m. and NICOLE SCHELL arrives at North Collier Hospital at 6:08 p.m. and at 38 weeks and 4 days gestation, NICOLE SCHELL was transferred from BIRTH CENTER to North Collier Hospital for suspected intrauterine fetal demise.

42. NICOLE SCHELL underwent urgent vaginal delivery with vacuum due to the loss of heart tone of the baby with North Collier Hospital noting meconium fluids. NICOLE SCHELL'S child was born cyanotic with no heart tone, no respiratory effort, no muscle tone and a large cleft lip/palate was noted. Apgars were 0, 0, and 0, and NICOLE SCHELL'S child was

pronounced dead.

43. The absence of NICOLE SCHELL and her child receiving the adequate medical care, attention, and treatment needed during this pregnancy ultimately resulted in the death of her child.

44. Upon delivery of the baby, it was discovered that he suffered from a severe clef palate which went undiagnosed by any of the medical providers.

45. Furthermore, BIRTH CENTER by and through its staff, employees and all others who provided care to NICOLE SCHELL and her child, during these office visits failed to consider the possibility of preeclampsia in the presence of an elevated blood pressure and protein in the urine and failed to send NICOLE SCHELL for additional workup at the hospital to rule out preeclampsia as opposed to gestational hypertension during her pregnancy.

COUNT I
CLAIM AGAINST ERIC VENSEL, M.D.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 of this Third Amended Complaint as if fully asserted herein and further allege:

46. Defendant, DR. VENSEL, held himself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as medical doctor capable of providing radiology interpretation in a competent, careful, and skilled manner in accordance with the prevailing professional physician standards of care of similar physicians and like medical communities.

47. Defendant, DR. VENSEL, had a duty to provide radiological care to NICOLE SCHELL in a manner that was consistent with the applicable standard of care for similarly situated health care providers.

48. Notwithstanding this duty of care, Defendant, DR. VENSEL breached his duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing standard of care and treatment, to wit:

a. Negligently and carelessly failed to ensure that the adequate images were taken during this April 22, 2021 Ultrasound;

b. Negligently and carelessly reported that there were no anomalies to the mouth when there were not adequate images to report those findings;

c. Negligently and carelessly reported that the 4 chambers of heart were normal when there were not adequate images to report those findings;

d. Negligently and carelessly failed to request that ultrasound be redone so that appropriate views of the mouth could be seen in order to accurately report whether or not there were anomalies to the mouth;

e. Negligently and carelessly failed to request that the ultrasound be redone so that the 4 chambers of the heart could be seen in order to accurately report the radiologist's findings;

f. Negligently and carelessly reported his findings of the mouth and 4 chambers of the heart based on an ultrasound that was incomplete and did not appropriately show views of the mouth and heart for him to accurately report;

g. Negligently and carelessly failed to undertake all other reasonable efforts to

ensure that adequate care was provided and available for NICOLE SCHELL; and,

h. Failing to act reasonably under the circumstances.

49. As a direct and proximate result of the negligence of DR. VENSEL, NICOLE SCHELL was inappropriately informed about her baby's ultrasound findings preventing her from being knowledgeable of her and her unborn child's conditions and receiving adequate treatment, care, and services, accordingly. As a direct and proximate result of the negligence of DR. VENSEL, NICOLE and JOHN SCHELL'S baby received inadequate medical care and died.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, ERIC VENSEL, M.D., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT II
CLAIM AGAINST
RADIOLOGY REGIONAL CENTER, P.A.

The Plaintiffs adopt and re-allege paragraphs 1 through 49 and all sub paragraphs thereof of this Third Amended Complaint as if fully asserted herein and further allege:

50. Defendant, RADIOLOGY REGIONAL CENTER, P.A., is a radiological center providing radiological care and services to patients and held itself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a radiology center who by and through its staff and healthcare providers were capable of the duty to provide radiology care to NICOLE SCHELL in accordance with that level of care and skill which, under the circumstances,

is recognized as acceptable and appropriate by reasonably prudent similar healthcare facility by and through its healthcare providers.

51. NICOLE SCHELL was a patient of RADIOLOGY REGIONAL on, but not exclusively, April 22, 2021, when she underwent an ultrasound that was read and interpreted by ERIC VENSEL, M.D.

52. Notwithstanding this duty of care, Defendant, RADIOLOGY REGIONAL by and through its healthcare providers, including but not limited to DR. VENNSEL., breached its duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing professional standard of medical care and treatment of similar healthcare facilities, to wit:

a. Negligently and carelessly failed to ensure that the adequate images were taken during this April 22, 2021 Ultrasound;

b. Negligently and carelessly reported that there were no anomalies to the mouth when there were not adequate images to report those findings;

c. Negligently and carelessly reported that the 4 chambers of heart were normal when there were not adequate images to report those findings;

d. Negligently and carelessly failed to request that ultrasound be redone so that appropriate views of the mouth could be seen in order to accurately report whether or not there were anomalies to the mouth;

e. Negligently and carelessly failed to request that the ultrasound be redone so that the

4 chambers of the heart could be seen in order to accurately report the radiologist's findings;

f. Negligently and carelessly reported his findings of the mouth and 4 chambers of the heart based on an ultrasound that was incomplete and did not appropriately show views of the mouth and heart for him to accurately report;

g. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for NICOLE SCHELL; and,

h. Failing to act reasonably under the circumstances.

53. As a direct and proximate result of the negligence of RADIOLOGY REGIONAL, by and through its healthcare providers, including but not limited to DR. VENSEL, NICOLE SCHELL was inappropriately and inaccurately informed about her ultrasound findings preventing her from being knowledgeable of her and her unborn child's conditions and receiving adequate treatment, care, and services, accordingly. As a direct and proximate result of the negligence of DR. VENSEL, NICOLE and JOHN SCHELL'S baby received inadequate medical care and died

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, RADIOLOGY REGIONAL CENTER, P.A., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT III
CLAIM AGAINST DAWN MEIER, LM.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 of this Third Amended Complaint as if fully asserted herein and further allege:

54. Defendant, MEIER, held herself out to the public in general and to NICOLE SCHELL and JOHN SCHELL III in particular, as a licensed midwife capable of providing birthing care in a competent, careful, and skilled manner in accordance with the prevailing professional physician standards of care of similar licensed midwives in like medical communities.

55. Defendant, MEIR, had a duty to provide birthing care to NICOLE SCHELL in a manner that was consistent with the applicable standard of care for similarly situated healthcare providers.

56. Notwithstanding this duty of care, Defendant, MEIR, breached her duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing standard of care and treatment, to wit:

a. Negligently and carelessly failed to consult with a maternal fetal medicine specialist when NICOLE SCHELL discussed her concerns during her February 8, 2021, office visit regarding her family history of cleft palette, specifically the baby's father;

b. Negligently and carelessly failed to consider the possibility of preeclampsia in the presence of an elevated blood pressure and protein in the urine and send for additional testing and workup at the hospital to include lab work, non stress test and biophysical profile to rule out preeclampsia as opposed to gestational hypertension;

c. Negligently and carelessly failed to follow up and perform a 34 week ultrasound as noted on the July 26, 2021 office visit. As the office visit of August 9, 2021, indicates ultrasound to be determined;

d. Negligently and carelessly failed to appreciate, address, and review NICOLE SHELL'S presentation on her August 16, 2021, office visit. Wherein she reported that she had 14 hours of prodromal labor with irregular contractions that stopped, yet no fetal heart tones or ultrasounds were performed during this office visit to confirm fetal condition;

e. Negligently and carelessly failed to appreciate, address, and provide care for NICOLE SHELL'S bilateral extremity edema and protein traced in urine during her August 20, 2021, office visit;

f. Negligently and carelessly failed to timely admit Nicole when she presented to Family Birth Center on August 23, 2021 and the fetal heart tones at 16:45 showed no accelerations or decelerations;

g. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for the health and safety of NICOLE SCHELL and her unborn child; and,

h. Failing to act reasonably under the circumstances.

57. As a direct and proximate result of the negligence of MEIER, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical conditions were not appropriately addressed resulting in the death of her child as described above.

58. As a direct and proximate result of the negligence of MEIER, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, DAWN MEIER, L.M., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT IV
CLAIM AGAINST JESSILYN ROMERO, R.N.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 of this Third Amended Complaint as if fully asserted herein and further allege:

59. Defendant, ROMERO, held herself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a registered nurse capable of providing birthing care in a competent, careful, and skilled manner in accordance with the prevailing professional standards of care of similar registered nurses in like medical communities.

60. Defendant, ROMERO, had a duty to provide birthing care to NICOLE SCHELL in a manner that was consistent with the applicable standard of care for similarly situated healthcare providers.

61. Notwithstanding this duty of care, Defendant, ROMERO breached her duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing standard of care and treatment, to wit:

a. Negligently and carelessly failed to consult with a maternal fetal medicine specialist when NICOLE SCHELL discussed her concerns during her February 8, 2021 office visit regarding her family history of cleft palette, specifically the baby's father;

b. Negligently and carelessly failed to consider the possibility of preeclampsia in the presence of an elevated blood pressure and protein in the urine and send for additional testing and workup at the hospital to include lab work, non stress test and biophysical profile to rule out preeclampsia as opposed to gestational hypertension;

c. Negligently and carelessly failed to follow up and perform a 34 week ultrasound as noted on the July 26, 2021 office visit. As the office visit of August 9, 2021, indicates ultrasound to be determined;

d. Negligently and carelessly failed to appreciate, address, and review NICOLE SHELL'S presentation on her August 16, 2021, office visit. Wherein she reported that she had 14 hours of prodromal labor with irregular contractions that stopped, yet no fetal heart tones or ultrasounds were performed during this office visit to confirm fetal condition;

e. Negligently and carelessly failed to appreciate, address, and provide care for NICOLE SHELL'S bilateral extremity edema and protein traced in urine during her August 20, 2021, office visit;

f. Negligently and carelessly failed to timely admit Nicole when she presented to BIRTH CENTER on August 23, 2021 and the fetal heart tones at 16:45 showed no accelerations or decelerations; and

g. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for the health and safety of NICOLE SCHELL and her unborn child; and,

h. Failing to act reasonably under the circumstances.

62. As a direct and proximate result of the negligence of ROMERO, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical conditions were not appropriately addressed resulting in the death of her child as described above.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, JESSILYN ROMERO, R.N., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT V
CLAIM AGAINST FAMILY BIRTH SERVICES, INC. d/b/a FAMILY BIRTH CENTER OF NAPLES

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 and 54 through 62 and all subparagraphs thereto of this Third Amended Complaint as

if fully asserted herein and further allege:

63. Defendant, BIRTH CENTER, is a birthing center providing birthing care and services to patients and held itself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a birthing center who by and through its staff and healthcare providers were capable of the duty to provide birthing care to NICOLE SCHELL in accordance with that level of care and skill which, under the circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare facility by and through its healthcare providers.

64. NICOLE SCHELL was a patient of BIRTH CENTER throughout the course of her pregnancy. She received birthing care from the staff and healthcare providers at BIRTH CENTER, including but not limited to MEIER and ROMERO.

65. Notwithstanding this duty of care, Defendant, BIRTH CENTER by and through its healthcare providers, including but not limited to MEIER and ROMERO, breached its duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing professional standard of medical care and treatment of similar healthcare facilities, to wit:

a. Negligently and carelessly failed to consult with a maternal fetal medicine specialist when NICOLE SHELL discussed her concerns during her February 8, 2021, office visit regarding her family history of cleft palette, specifically the baby's father;

b. Negligently and carelessly failed to consider the possibility of preeclampsia in the presence of an elevated blood pressure and protein in the urine and send for additional testing and workup at the hospital to include lab work, non stress test and biophysical profile to rule out preeclampsia as opposed to gestational hypertension;

c. Negligently and carelessly failed to follow up and perform a 34 week ultrasound as noted on the July 26, 2021 office visit. As the office visit of August 9, 2021, indicates ultrasound to be determined;

d. Negligently and carelessly failed to appreciate, address, and review NICOLE SHELL'S presentation on her August 16, 2021, office visit. Wherein she reported that she had 14 hours of prodromal labor with irregular contractions that stopped, yet no fetal heart tones or ultrasounds were performed during this office visit to confirm fetal condition;

e. Negligently and carelessly failed to appreciate, address, and provide care for NICOLE SHELL'S bilateral extremity edema and protein traced in urine during her August 20, 2021, office visit;

f. Negligently and carelessly failed to timely admit Nicole when she presented to Family Birth Center on August 23, 2021, and the fetal heart tones at 16:45 showed no accelerations or decelerations;

g. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for the health and safety of NICOLE SCHELL and her unborn child; and,

h. Failing to act reasonably under the circumstances.

66. As a direct and proximate result of the negligence of BIRTH CENTER, by and through its healthcare providers, including but not limited to MEIER and ROMERO, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical conditions were not appropriately addressed resulting in the death of her child as described above.

67. As a direct and proximate result of the negligence of BIRTH CENTER, by and through its healthcare providers, including but not limited to MEIER and ROMERO, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, FAMILY BIRTH SERVICES, INC. d/b/a FAMILY BIRTH CENTER OF NAPLES, and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT VI
CLAIM AGAINST ANNALIESE K. HAGGARTY, SM

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 of this Third Amended Complaint as if fully asserted herein and further allege:

68. Defendant, HAGGARTY, held herself out to the public in general and to NICOLE SCHELL and JOHN SCHELL III in particular, as a student midwife undertaking clinical learning experiences capable of providing supervised birthing care in a competent, careful, and skilled manner in accordance with the prevailing professional physician standards of care of similar licensed midwives in like medical communities.

69. Defendant, HAGGARTY, had a duty to provide birthing care to NICOLE SCHELL in a manner that was consistent with the applicable standard of care for similarly situated healthcare providers.

70. Defendant, HAGGARTY, had a duty to not provide medical services outside of what she was legally allowed to provide in accordance with Fla. Admin. Code. 64B24-4.

71. Notwithstanding this duty of care, Defendant, HAGGARTY breached her duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing standard of care and treatment, to wit:

a. Negligently and carelessly failed to timely admit Nicole when she presented to Family Birth Center on August 23, 2021 and the fetal heart tones at 16:45 showed no accelerations or decelerations;

b. Negligently and carelessly undertaking care of NICOLE SCHELL in an unsupervised manner while at BIRTH CENTER on August 23, 2021;

c. Negligently and carelessly undertaking actions, obligations, and responsibilities outside of her scope, ability, and authorization as student of midwifery;

d. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for the health and safety of NICOLE SCHELL and her unborn child; and,

e. Failing to act reasonably under the circumstances.

72. As a direct and proximate result of the negligence of HAGGARTY, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical condition was not appropriately addressed resulting in the death of her child as described above.

73. As a direct and proximate result of the negligence of HAGGARTY, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, ANNALIESE K. HAGGARTY, SM, and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT VII
CLAIM AGAINST
HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1 through 45 and 68 through 73 and all subparagraphs thereto of this Third Amended Complaint as if fully asserted herein and further allege:

74. Defendant, HERITAGE MIDWIFERY, is an approved midwifery program as defined by Fla. Stat. §467.003(1) providing education and experience to those seeking licensure as defined by Fla. Stat. §467.003(6). As apart of said licensure, HERITAGE MIDWIFERY provides supervision and/or student practitioners in which its student practitioners function in a midwifery capacity with patients. As such, HERITAGE MIDWIFERY provides birthing care and services to patients and held itself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a healthcare program who by and through its staff, agents,

apparent agents, employees, servants, and/or healthcare providers were capable of the duty to provide birthing care to NICOLE SCHELL in accordance with that level of care and skill which, under the circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare program by and through its healthcare providers.

75. BIRTH CENTER was a facility as defined by Fla. Admin. Code. 64B24-4.001(4) where HERITAGE MIDWIFERY'S students acted as agents, apparent agents, employees, servants, and/or healthcare providers functioned in a midwifery capacity with patients on HERITAGE MIDWIFERY'S behalf.

76. NICOLE SCHELL was a patient of BIRTH CENTER throughout the course of her pregnancy. She received birthing care from the staff and healthcare providers at BIRTH CENTER, including but not limited HAGGARTY.

77. Notwithstanding this duty of care, Defendant, HERITAGE MIDWIFERY by and through its healthcare providers, including but not limited to HAGGARTY, breached its duty of care by doing or failing to do one or more of the following acts, any, some, or all of which were departures from the prevailing professional standard of medical care and treatment of similar healthcare facilities, to wit:

a. Negligently and carelessly failed to timely admit Nicole when she presented to Family Birth Center on August 23, 2021 and the fetal heart tones at 16:45 showed no accelerations or decelerations;

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b. Negligently and carelessly undertaking care of NICOLE SCHELL in an unsupervised manner while at BIRTH CENTER on August 23, 2021;

c. Negligently and carelessly undertaking actions, obligations, and responsibilities outside of her scope, ability, and authorization as student of midwifery;

d. Negligently and carelessly failed to undertake all other reasonable efforts to ensure that adequate care was provided and available for the health and safety of NICOLE SCHELL and her unborn child; and,

e. Failing to act reasonably under the circumstances.

78. As a direct and proximate result of the negligence of HERITAGE MIDWIFERY, by and through its healthcare providers, including but not limited to HAGGARTY, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical condition was not appropriately addressed resulting in the death of her child as described above.

79. As a direct and proximate result of the negligence of HERITAGE MIDWIFERY, by and through its healthcare providers, including but not limited to HAGGARTY, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT VIII
CLAIM AGAINST DAWN MEIER, LM.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1

through 45 and 68 through 73 and all subparagraphs thereto of this Third Amended Complaint as if fully asserted herein and further allege:

80. In accordance with Fla. Stat. § 467.003 Defendant MEIER, was a preceptor and clinical faculty of the Defendant, HERITAGE MIDWIFERY.

81. Through her duties as a preceptor for Defendant, HERITAGE MIDWIFERY, Defendant, MEIER, was directing, teaching, supervising, the midwifery actions of Defendant, HAGGARTY, while at BIRTH CENTER.

82. In accordance with Fla. Stat. §467.002 "it is unlawful for any person to practice midwifery in this state unless such person is licensed pursuant to the provisions of this chapter or s. 464.012." Notwithstanding, Fla. Stat. §467.207 expressly states that the Chapter 467 Fla. Stat. shall not be construed to prohibit the "practice of midwifery by students enrolled in an approved midwifery training program."

83. Accordingly, Defendant, HAGGARTY, practiced midwifery at BIRTH CENTER through the licenses of Defendant, MEIER. MEIER is vicariously responsible for the actions of HAGGARTY.

84. As such, Defendant, MEIER, provided birthing care and services to patients and held herself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a midwife who by and through her agents, apparent agents, employees, servants, and/or healthcare providers were capable of the duty to provide birthing care to NICOLE SCHELL in accordance with that level of care and skill which, under the circumstances, is recognized as

acceptable and appropriate by reasonable prudent similar healthcare providers.

85. NICOLE SCHELL was a patient of BIRTH CENTER throughout the course of her pregnancy. She received birthing care from the staff and healthcare providers at BIRTH CENTER, including but not limited HAGGARTY and MEIER.

86. Notwithstanding this duty of care, Defendant, MEIER, breached her duty of care by failing to ensure her agents, apparent agents, employees, servants, and/or medical providers' care and treatment of her patients were properly undertaken and/or supervised and/or that the students whom were practicing midwifery under her license were not acting beyond the limits of their capacity when functioning in a midwifery capacity with patients.

87. As a direct and proximate result of the negligence of MEIER, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical condition was not appropriately addressed resulting in the death of her child as described above.

88. As a direct and proximate result of the negligence of MEIER, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, DAWN MEIER., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

COUNT IX
CLAIM AGAINST
HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC.

The Plaintiffs re-allege and reaffirm each and every allegation contained in paragraphs 1

through 45, 54 through 58, 68 through 73, and 80 through 88 and all subparagraphs thereto of this Third Amended Complaint as if fully asserted herein and further allege:

89. Defendant, HERITAGE MIDWIFERY, is an approved midwifery program as defined by Fla. Stat. §467.003(1) providing education and experience to those seeking licensure as defined by Fla. Stat. §467.003(6). As part of said licensure, HERITAGE MIDWIFERY provides supervision, through clinical faculty, and/or student practitioners in which its clinical faculty and student practitioners function in a midwifery capacity with patients. As such, HERITAGE MIDWIFERY provides birthing care and services to patients and held itself out to the public, in general, and to NICOLE SCHELL and JOHN SCHELL III, in particular, as a healthcare program who by and through its staff, agents, apparent agents, employees, servants, and/or healthcare providers were capable of the duty to provide birthing care to NICOLE SCHELL in accordance with that level of care and skill which, under the circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare programs by and through its healthcare providers.

90. BIRTH CENTER was a facility as defined by Fla. Admin. Code. 64B24-4.001(4) where HERITAGE MIDWIFERY'S students acted as agents, apparent agents, employees, servants, and/or healthcare providers functioned in a midwifery capacity with patients on HERITAGE MIDWIFERY'S behalf.

91. NICOLE SCHELL was a patient of BIRTH CENTER throughout the course of her pregnancy. She received birthing care from the staff and healthcare providers at BIRTH CENTER,

including but not limited HAGGARTY and MEIER.

92. Notwithstanding this duty of care, Defendant, HERITAGE MIDWIFERY breached its duty of care by failing to ensure its student's clinical learning experience was being properly undertaken and/or supervised, failing to ensure that its clinical faculty and/or preceptor was acting within the standard of care in accordance with the prevailing professional physician standards of care of similar licensed midwives in like medical communities, and/or failing to ensure that its students were not acting beyond the limits of their capacity when functioning in a midwifery capacity with patients.

93. As a direct and proximate result of the negligence of HERITAGE MIDWIFERY, NICOLE SCHELL was not provided adequate care, properly managed, and/or her medical condition was not appropriately addressed resulting in the death of her child as described above.

94. As a direct and proximate result of the negligence of HERITAGE MIDWIFERY, Plaintiffs make the below listed claims for damages.

WHEREFORE, the Plaintiffs demand judgment for damages against Defendant, HERITAGE SCHOOL OF MIDWIFERY AND NATURAL HEALTH SCIENCES, INC., and a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

CLAIMS FOR DAMAGES FOR ALL COUNTS

95. As a direct and proximate result of the negligence of the Defendants that caused the injuries of NICOLE SCHELL, the Plaintiffs set forth below the listed claims.

CLAIM ON BEHALF OF NICOLE SCHELL

96. As a direct and proximate result of the negligence of the Defendants that caused the injuries to NICOLE SCHELL, the Plaintiff, NICOLE SCHELL, has in the past and will in the future continue to suffer:

a. Mental pain and suffering;

b. Value of medical expenses related to this claim.

97. The Plaintiff's injuries are either permanent or continuing in nature and the Plaintiff will suffer the aforementioned losses and impairment in the future.

WHEREFORE, the Plaintiff, NICOLE SCHELL, demands judgment for damages against the Defendants and demands a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

CLAIM ON BEHALF OF JOHN SCHELL

98. As a direct and proximate result of the negligence of the Defendants that caused the injuries to NICOLE SCHELL, her spouse, JOHN SCHELL, has in the past and will in the future continue to suffer:

a. Mental pain and suffering;

WHEREFORE, the Plaintiff, JOHN SCHELL, demands judgment for damages against the Defendants and demands a trial by jury of all issues so triable by law and such other relief this Court may deem appropriate.

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4440 PGA BLVD. SUITE 306 PALM BEACH GARDENS, FL 33410 ● TEL. (561) 616-3000

DEMAND FOR JURY TRIAL

The Plaintiffs NICOLE SCHELL and JOHN SCHELL, her spouse, demand trial by jury of all issues triable as of right by jury.

DATED, this ___ day of April, 2025.

Respectfully submitted,

HALBERG & FOGG, PLLC
Barristers Building
1615 Forum Place Suite 3-B
West Palm Beach, FL 33401
PH: (561) 616-3000
FAX: (561) 688-0775
service@halberglaw.com

/s/ Ryan A. Fogg
BY: _____
RYAN A. FOGG., ESQ. (68773)
BASIL D. SABBAK, ESQ. (1004390)