COMMONWEALTH OF MASSACHUSETTS

NORFOLK, ss. SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO. 2682CV00071

PATRICK W. CLANCY, Individually and as the Personal Representative of the Estates of CORA MARIE CLANCY, DAWSON WILLIAM CLANCY, and CALLAN PATRICK CLANCY,

Plaintiff,

v.

JENNIFER A. TUFTS, M.D., REBECCA H. JOLLOTTA, C.N.P., ASTER MENTAL HEALTH INC., AND SOUTH SHORE HEALTH SYSTEM, INC.

Defendants.

COMPLAINT AND JURY DEMAND

INTRODUCTION

This is an action for wrongful death brought by Patrick Clancy ("Patrick"), individually and as the personal representative of the Estates of his deceased children, Cora Marie Clancy, Dawson William Clancy, and Callan Patrick Clancy ("Plaintiff"). Patrick's wife, Lindsay Clancy ("Lindsay"), is alleged to have murdered Cora, Dawson and Callan. Prior to the alleged murder, Lindsay sought medical treatment for her anxiety and increasingly poor and deteriorating mental health condition. As alleged herein, the treatment of her providers—Jennifer A. Tufts, M.D. ("Dr. Tufts"), Rebecca H. Jollotta, C.N.P. ("Nurse Jollotta"), Aster Mental Health Inc. ("Aster"), and South Shore Health System, Inc. ("South Shore Health") (collectively, "Defendants")—exacerbated her mental health struggles. Indeed, the bevy of diverse and powerful medications

they misprescribed coupled with their abject failure to appropriately monitor Lindsay resulted in Lindsay's mental health deteriorating to the point of suicidal ideation and requiring in-patient care. Ultimately, Defendants' negligent treatment of Lindsay, including their complete failure to recognize and address the radical erosion of her mental health, resulted in tragedy, namely, allegations that Lindsay took the lives of her children. If Defendants had not acted negligently, and rather had provided adequate care, it is more likely than not that Patrick and Lindsay's children would still be alive today.

PARTIES

1. Cora Marie Clancy was a five-year-old child at the time of her death, and lived with her parents, Patrick and Lindsay Clancy, in Duxbury, Plymouth County, Massachusetts.

2. Dawson William Clancy was a three-year-old child at the time of his death, and lived with his parents, Patrick and Lindsay Clancy, in Duxbury, Plymouth County, Massachusetts.

3. Callan Patrick Clancy was an eight-month-old baby at the time of his death, and lived with his parents, Patrick and Lindsay Clancy, in Duxbury, Plymouth County, Massachusetts.

4. Plaintiff Patrick W. Clancy is Cora, Dawson, and Callan's dad and the personal representative of the Estate of Cora M. Clancy, the Estate of Dawson W. Clancy, and the Estate of Callan P. Clancy (collectively, the "Estates"). He was appointed personal representative of the Estates on December 3, 2025, in Plymouth Probate Court Dockets PL25P1826EA, PL25P1827EA, and PL25P1828EA, respectively. Patrick Clancy was, at the time of his children's death, a resident of Duxbury, Plymouth County, Massachusetts.

5. Defendant Jennifer A. Tufts, M.D. is a psychiatrist registered to practice medicine in the Commonwealth of Massachusetts with a usual place of business in Braintree, Norfolk County, Massachusetts.

6. Defendant Rebecca H. Jollotta, C.N.P. is a certified nurse practitioner registered to practice medicine in the Commonwealth of Massachusetts with a usual place of business in Weymouth, Norfolk County, Massachusetts.

7. Defendant Aster Mental Health Inc. is a Massachusetts professional corporation with a principal place of business at 325 Wood Road, Suite 209, Braintree, Norfolk County, Massachusetts.

8. Defendant South Shore Health System, Inc. has a principal place of business of 55 Fogg Road, South Weymouth, Norfolk County, Massachusetts.

JURISDICTION AND VENUE

9. This Court has jurisdiction over Defendants under G.L. c. 223A, §§ 2 and 3 because they either reside in Massachusetts, have a principal place of business in Massachusetts, and/or their actions and inactions that caused Cora, Dawson, and Callan's death took place in Massachusetts.

10. Venue is proper in this Court pursuant to G.L. c. 223, § 1 because the Defendants each have a principal place of business in Norfolk County.

FACTS

A. The Clancy Family

11. In January 2023, Patrick and Lindsay Clancy were living in Duxbury, Massachusetts with their three children, Cora, Dawson, and Callan.

12. Patrick and Lindsay had married in December 2016 and settled in Duxbury. Patrick worked in telecommunications, while Lindsay began her career as a nurse, working at

Massachusetts General Hospital ("MGH"). She soon became a nurse in the MGH labor and delivery unit.

13. Patrick and Lindsay had always intended to have children, and soon after getting married, began to grow their family.

14. They had their first baby, Cora, on December 24, 2017 and their second baby, Dawson, on September 30, 2019. Lindsay experienced some anxiety following the birth of each of her first two children, which worsened as she got closer to returning to work each time. She was able to overcome her anxiety both times, however, through exercise, a healthy diet, meditation, socializing and, following Dawson's birth, several therapy sessions.

15. Patrick and Lindsay jumped into parenthood and worked together to provide the best possible environment to raise their children. In order to spend more time at home with her children, Lindsay began working part time night shifts in the MGH labor and delivery unit.

16. During her shifts, Lindsay remained attentive to her children and was known to monitor Cora and Dawson on baby monitors while they slept.

17. Nonetheless, Lindsay's career remained important to her. She remained passionate about nursing and having a career also allowed her the chance to get out of the house and interact with other people.

18. Lindsay became pregnant with the couple's third child several years later, and gave birth to a baby boy, Callan, on May 26, 2022.

19. Both Patrick and Lindsay took parental leave following Callan's birth, with Patrick's leave scheduled for 12 weeks and Lindsay's leave scheduled for 18 weeks.

20. The family spent their leave together, visiting extended family, the local beach and pool, and enjoying time together at home.

21. Lindsay repeatedly told Patrick how happy she was and how much she loved their new baby. Her actions echoed her voiced sentiments. Lindsay appeared extremely happy. She was enthusiastic and energetic, and returned to exercising—something that had always been important to her—shortly after giving birth Callan. Patrick and Lindsay ran two 5k road races, one in July and a second in September. Life was idyllic for the Clancys.

B. Patrick's Return to Work and Lindsay's Impeding Return to Work

22. Patrick returned to work approximately 12 weeks after Callan was born and, while he was able to work from home, for the first time Lindsay was challenged with taking care of their three children single-handedly during the weekdays.

23. Lindsay was also faced with her own return to work at the end of September 2022. Previously, the time period leading to the end of her parental leave had been a difficult time for Lindsay and had resulted in anxiety.

24. Lindsay began to experience stress and anxiety in September 2022 toward the end of her maternity leave. Nonetheless, she continued to socialize with friends and continued to go to events and trips with her family.

25. Because of her anxiety and impending return to work however, Lindsay decided to seek psychiatric treatment.

C. Lindsay's Medical Treatment

26. To address her anxiety, Lindsay sought psychiatric care with Dr. Tufts from Aster. Dr. Tufts is a psychiatrist at Aster who, according to Aster's website, specializes in post-traumatic stress disorder and trauma-related disorders, mood disorders, anxiety,

obsessive compulsive disorder, ADHD, substance abuse, women's mental health, and perinatal and postpartum psychiatry.

27. Lindsay decided to extend her maternity leave in the hopes of improving her mental health.

28. Dr. Tufts treated Lindsay from on or about September 15, 2022 through on or about January 23, 2023. During that time, Dr. Tufts prescribed Lindsay a variety of different medications but failed to monitor her reactions to those medications or attend to her worsening psychiatric condition.

29. Lindsay's first appointment with Dr. Tufts was on September 15, 2022. That day, Dr. Tufts diagnosed Lindsay with chronic generalized anxiety disorder and chronic adjustment disorder with depressed mood.

30. When Lindsay first began treatment, she was hesitant about taking prescription medications. Nonetheless, on September 15, 2022, Dr. Tufts prescribed Lindsay sertraline (also known as "Zoloft").

31. Lindsay did not initially take the medication but by October 3, 2022 Lindsay told Dr. Tufts that she was "'on the verge of taking medication' but wants to try therapy first."

32. Lindsay began taking the prescribed Zoloft by mid-October. One week after starting the medication and increasing the dose as prescribed, however, on October 20, 2022, she reported to Dr. Tufts that she felt "awful," was experiencing insomnia due to the medication increase, did not want to eat, was feeling more depressed, was crying all day, experiencing mental fog, and was terrified to start something new. Indeed, she explained that her anxiety had gotten worse than it was before she began taking medication, felt it was difficult to differentiate between how she felt before taking the medication, experienced over

night racing thoughts and was "paranoid of getting suicidal thoughts, something bad happening, doesn't want to be alone." This reaction to a relatively low dose of the medication was atypical, and should have prompted Dr. Tufts to assess why Lindsay reacted in this way. Among other things, she should have conducted testing of blood plasma levels of medication. Dr. Tufts failed to do so.

33. Lindsay's condition deteriorated through the fall. Among other things, she experienced increasingly bad insomnia, anxiety, and depression. Instead of working to identify the source of Lindsay's condition, Dr. Tufts attempted to treat Lindsay's symptoms, adding medications to treat her anxiety and depression.

34. By the end of October and into November 2022, Lindsay was still hopeful about the future and about returning to her baseline. For example, on October 31, 2022, Lindsay reported to her therapist, a colleague of Dr. Tufts, that she was hoping to return to work soon, which she hoped would decrease her depression symptoms.

35. By mid-November, however, her insomnia had become so bad that she was sleeping approximately only three (3) hours per night. Lindsay's insomnia became so severe that on November 16, 2022, she went to the emergency room for treatment. She was prescribed another medication, trazodone, however it was not effective.

36. In an attempt to assist her daughter-in-law, on November 20, 2022, Patrick's mother, a nurse at South Shore Health, contacted Julie Paul, CNM/CNP ("Nurse Paul") of The Perinatal Behavioral Health Program of South Shore Health and asked her to reach out to Lindsay.

37. Nurse Paul did so, and Lindsay reported that the trazadone she had been prescribed had not been effective in helping her sleep, even when taking a 150 MG dosage.

Lindsay reported that she was "[v]ery frustrated and scared" and afraid of being on medication long term. She told Nurse Paul that she was feeling "very overwhelmed. Starting having racing thoughts – constantly thinking…experiencing extreme insomnia. Averaging 3 hours per night…very frustrated and scared."

38. On November 21, 2022, Nurse Paul prescribed Lindsay fluoxetine HCL 10 MG (also known as "Prozac"). Lindsay was describing symptoms suggesting mania, such as racing thoughts, extreme insomnia, frustration and feeling scared. At this point, again, lab work should have been performed in order to ensure that Lindsay was metabolizing the medications she was being prescribed at a normal rate. However, no lab work was done.

39. Two days later, Lindsay reported to Nurse Paul that she was "feeling disconnected and out of it today. Feeling a bit spacey. This has happened a few times in the last couple months." Shortly afterwards, on November 25, 2022, Nurse Paul prescribed Lindsay three different medications, zolpidem tartrate (also known as "Ambien"), mirtazapine (also known as "Remeron"), and clonazepam (also known as "Klonopin").

40. The medications did not help Lindsay. On November 28, 2022 Lindsay reported to Nurse Paul that she was continuing to struggle with sleep, "still feels disoriented, forgetful, not connected to her body" … "when she wakes up she is feeling 'hung over'. Petrified that she is becoming 'addicted to benzos'. Feels like she is in a panic state right now."

41. The next day, on November 29, 2022, Lindsay began treating with Nurse Paul's colleague, Nurse Jollotta. Nurse Jollotta is a Certified Nurse Practitioner with the South Shore Health Perinatal Behavioral Health Program.

42. That day, Lindsay told Nurse Jollotta that she was "getting physically depend[ent] on benzos in order to sleep." She further reported feeling "completely overwhelmed" and that her "[m]ind is constantly running." She also reported "[f]eeling afraid as if something awful might happen: Several days" in the past two weeks. On November 30, 2022, Nurse Jollotta prescribed Lindsay quetiapine fumarate (also known as "Seroquel") for the first time.

43. Lindsay quickly reported the negative impact this medication had on her mental health. She told Nurse Jollotta's South Shore Health Perinatal Behavioral Health Program coworker, Latiesha Dukes LMHC ("Ms. Dukes"), with whom she began receiving therapy, that she had "an addiction to Ativan, and that is why she can't sleep." She reported weight loss, a lack of appetite, panic attacks, and a feeling of numbness. She also reported for the first time that she had suicidal ideation.

44. On or about December 5, 2022, Lindsay reported to Ms. Dukes that she had experienced intrusive thoughts of wanting to die and had contacted ASPIRE Crisis support, an emergency service for those at risk of self-harm, over the weekend. Patrick joined the visit with Nurse Paul and reported to her that Lindsay's anxiety had become significantly worse since starting psychiatric medications.

45. The following day, Lindsay attended an appointment with Nurse Jollotta During the appointment, Lindsay reported that she was sleeping only about three (3) hours per night, felt completely overwhelmed, and that her mind was constantly running. The symptoms presented by Lindsay caused Nurse Jollotta to ask her if she was having thoughts of harming herself or her children. Lindsay denied having such thoughts but again reported, however, "[f]eeling afraid as if something awful might happen" almost every day.

46. Lindsay also reported that she believed that her ongoing symptoms were connected to the medication she was being prescribed, and that immediately after being prescribed a stronger dose of Zoloft, she did not sleep for 48 hours and was not tired.

47. In response, Nurse Jollotta prescribed an additional medication to Lindsay, diazepam (also known as "Valium").

48. On December 9, 2022, Patrick called Nurse Jollotta's office, asked for a call back, and made clear to Nurse Jollotta's office that it was "fairly urgent." When Patrick and Lindsay spoke to Nurse Jollotta, they advised her that Lindsay was still experiencing panic and suicidal ideation. Nurse Jollotta advised Lindsay to continue taking the medication Nurse Jollotta had prescribed.

49. Lindsay continued to experience suicidal ideation throughout December.

50. She continued to seek help, through Nurse Jollotta, her therapist, and, in mid-December, the emergency department at Massachusetts General Hospital. During this time period, Lindsay reported having persistent thoughts of suicide. She also reached out to Dr. Tufts, who prescribed her an additional medication, lamotrigine (also known as "Lamictal").

51. Further seeking help, on December 20, 2022, Lindsay admitted herself into a day hospital program at Women & Infants Hospital intended for patients with post-partum depression. While at Women & Infants Hospital, Lindsay reported that she started having passive suicidal ideation immediately after starting Seroquel, prescribed by Nurse Jollotta on November 30, 2022.

52. At Women & Infants Hospital, Lindsay reported, among other things, heart palpitations, severe depression, a feeling of numbness, that her life was "becoming a disaster,"

that she could not "feel fear," and that she was "[w]orried that she [wa]s 'messed up beyond repair.'" She also reported a general inability to function.

53. Women & Infants Hospital determined that Lindsay's mental health issues were likely due to overmedication and misdiagnosis and that its day program was therefore not appropriate for her. Women & Infants Hospital reached out to Nurse Jollotta to discuss Lindsay's care, but Nurse Jollotta failed to respond to them.

54. Lindsay's condition continued to deteriorate, and on January 1, 2023, Lindsay admitted herself to McClean Hospital as a result of suicidal ideation. She remained at McClean until January 5, 2023.

55. Lindsay returned to treatment with Dr. Tufts the following day, on January 6, 2023. Dr. Tufts diagnosed Lindsay with "chronic" "major depressive disorder, single episode, moderate." She recorded that Lindsay's psychiatric condition was "Deteriorating" and that her medication was not effective. Despite her poor condition, Dr. Tufts met with Lindsay for only 17 minutes. Dr. Tufts met with Lindsay for another 17 minutes three days later.

56. On or about January 12, 2023, Lindsay reported to Dr. Tufts that she was "still feeling a very low mood, no motivation, and just very depressed. This has been going on for months now and I am getting desperate for something that would work quickly to get me out of this depressed state."

57. Four days later, during another 17-minute visit on January 16, 2023, Dr. Tufts reported Lindsay's mood to be depressed and her affect depressed and flat, writing that Lindsay's "mood is still very low, no motivation, numb. Able to force self out of bed – take care of basics eating. Concentration fine. Caring for baby/bonding 'feels forced.' No [suicidal ideation]."

58. Lindsay had a final appointment with Dr. Tufts on January 23, 2023. During that 17-minute appointment, Lindsay reported that she was "a little more anxious +heart racing," and that she was "[n]oticing more AM anxiety." Dr. Tufts recorded that Lindsay's "[m]ood [wa]s the same flat/anxious," that Lindsay has "[n]o motivation, numb," and that she "[h]as to force herself up, out of the house." Lindsay's "Sleep" and "Medication Efficacy" were "Poor," her "Insight" was poor, and her "Psychiatric Condition Generally" was "Unchanged."

D. <u>January 24, 2023</u>

59. Lindsay has been accused of killing Cora, Dawson and Callan while Patrick was briefly out of the family home on the evening of January 24, 2023. Cora and Dawson died that same day and Callan succumbed to his injuries and died on January 27, 2023.

60. According to medical records, Lindsay did so because she "started hearing a compelling and unrecognizable singular male voice that told her 'this is your last chance' and that she had to 'take them with [her.]'" She also reported that "the voice indicated to her that she should die, that this is her last chance, and that her children would suffer if she was gone." Lindsay then cut her wrists and neck and jumped out of a second-floor window in her home. She fell approximately 20 feet to the ground below and suffered traumatic spinal cord injuries. She is now paralyzed below the sternum.

E. <u>Dr. Tufts' and Nurse Jollotta's Treatment of Lindsay Fell Below the Standard of Care</u>

61. Dr. Tufts and Nurse Jollotta, and through them their employers Aster and South Shore Health, were aware that Lindsay was experiencing suicidal ideation and a critically deteriorating psychiatric condition while in their care and failed to take reasonable steps to properly treat her.

62. The standard of care required Dr. Tufts and Nurse Jollotta to take reasonable steps to appreciate the full extent of Lindsay's psychiatric condition so that they could provide adequate treatment to her. This required them to, among other things, meet Lindsay for appointments in person so that they could adequately assess her behavior in its totality. Often a patient is unable to voice her condition or fully describe her mental state. Under such circumstances, it is crucial to assess the patient's body language to more accurately assess the patient's condition. It is also important for a psychiatric prescriber to explore the patient's reported symptoms and ask follow-up questions to fully assess the patient for signs of concern, particularly because patients do not always know what is important to report. The standard of care requires that psychiatric prescribers fully document these assessments in their notes, both for themselves and to communicate this information to other members of the care team. Further, the standard of care requires a prescriber to meet with a patient frequently enough and for a long enough time to continuously assess the patient's condition, particularly where the patient is prescribed medication and has an adverse reaction to or negative side effects to the medication.

63. Dr. Tufts and Nurse Jollotta regularly met with Lindsay via video conference rather than assessing her in person. Doing so provided them with an incomplete picture of Lindsay's condition, as they did not have the ability to fully assess Lindsay's body language. Moreover, the visits were too short to fully assess Lindsay's condition. Indeed, in the weeks before January 24, 2024, Dr. Tufts' appointments with Lindsay were only 17 minutes long despite her acknowledging that Lindsay's mood was depressed and that her affect was depressed and flat. These appointments were particularly inadequate where Lindsay had experienced a deteriorating condition since at least October 2022, had reported experiencing

passive suicidal ideation since starting Seroquel in early December 2022, and was hospitalized at McLean Hospital for suicidal ideation in January 2023.

64. The standard of care also required Dr. Tufts and Nurse Jollotta to assess and monitor a patient who had an unusual, unexpected or unfavorable reaction to medication, such as side effects or a lack of response. A simple way to do so was to order blood plasma levels of medication in order to determine whether the patient was a slow metabolizer, and thus more drastically impacted by a medication than she otherwise would be, or on the contrary, whether the medication simply was not working, either indicating that the patient might need a higher dose for it to be effective (if she was a fast metabolizer) or that the patient might have an underlying medical condition that needed to be treated. The standard of care required Dr. Tufts and Nurse Jollotta to look at the lab results in conjunction with the patient's symptoms in order to properly assess her condition. Indeed, the standard of care is to start low and go slow, meaning to begin a medication at a minimal level and slowly increase the dosage over time to allow the provider to better assess the impact of the drug upon the patient.

65. Dr. Tufts and Nurse Jollotta failed to do so. Despite having immediate adverse side effects as a result of the medications that she was prescribed, neither Dr. Tufts nor Nurse Jollotta ever conducted any testing, including blood plasma levels of medication, to determine why Lindsay was having an adverse reaction—including to early, low dosages of medication prescribed to her. Instead, both Dr. Tufts and Nurse Jollotta added and accelerated medications in an ad hoc manner that did not follow the "start low and go slow" principle, radically increasing the risks to Lindsay, without ever taking the necessary steps to determine the cause of Lindsay's adverse reactions, much less acknowledge the severity of the adverse reactions she was experiencing. Dr. Tufts and Nurse Jollotta's inaction, including their failure

to conduct testing to determine whether the medications they were prescribing to Lindsay, and the frequency and dosage in which they were prescribing them, fell below the standard of care and caused Lindsay's symptoms to worsen.

66. The standard of care also required Dr. Tufts and Nurse Jollotta to coordinate care between and among themselves and other providers. A patient is often seen by multiple clinicians, and it is vital that all treating clinicians are aware of what treatment the other is providing so that they can effectively work together to treat the patient. Here, Dr. Tufts and Nurse Jollotta were part of a treatment team that, among other things, included themselves, Lindsay's therapists, and the hospitals that she visited and was admitted to. Among other things, Lindsay and Patrick reported to certain of these providers, for example Ms. Dukes, their concerns regarding the prescriptions that Lindsay had been given, yet there is no indication in her medical records that Dr. Tufts and Nurse Jollotta ever coordinated her care and treatment. Dr. Tufts and Nurse Jollotta's failure to coordinate Lindsay's care with other providers amounted to a breach of the standard of care.

67. Given Lindsay's documented deteriorating condition, the standard of care required Dr. Tufts and Nurse Jollotta to seek more information regarding Lindsay's condition including from those around her every day, specifically, her family members. Lindsay was the primary caregiver for her three children, all five years of age and under. Nonetheless, Lindsay reported being unable to function on a daily basis and reported that she was sleeping only a few hours a night—which alone can result in psychosis. Despite these clear warning signs, Dr. Tufts and Nurse Jollotta failed to reach out to the individuals with whom Lindsay interacted on a daily basis in order to gain further information regarding her condition and the severity of her condition. This information would have been crucial in understanding the full nature of

Lindsay's condition, particularly where Lindsay herself repeatedly told Dr. Tufts and Nurse Jollotta that the medications were not effective and that she was experiencing suicidal ideation.

68. Finally, the standard of care required Dr. Tufts and Nurse Jollotta to understand and appreciate the risk that Lindsay would hurt not only herself but her children. As prescribers who specialized in perinatal and postpartum mental health issues, the standard of care required Dr. Tufts and Nurse Jollotta to be aware of and understand current studies and developments in their field. It is well-known that there is a risk that a patient suffering from mental health disorders following pregnancy pose a risk of injuring or even killing either themselves and/or their children.

69. Lindsay's condition was serious and deteriorating. She reported that she was "[f]eeling afraid as if something awful might happen" regularly and that "Caring for baby/bonding 'feels forced.'" Nurse Jollotta recognized the risk and asked Lindsay multiple times if she had any intent to harm her children. Lindsay's statements, general condition, and symptoms demonstrated that her children were at risk if Dr. Tufts and Nurse Jollotta failed to properly treat her.

70. Defendants knew or should have known that she presented a real, clear, and present danger of harm to herself and her young children.

71. Dr. Tufts and Nurse Jollotta, who were charged with Lindsay's care and, despite clear warnings, failed to take appropriate action consistent with the standard of care and in failing to do so more likely than not, directly and proximately caused Lindsay to take the lives of her children on January 24, 2023, as is alleged. Indeed, it is more likely than not that, had Dr. Tufts and Nurse Jollotta met the standard of care, they would have appreciated

the severity of Lindsay's mental health condition. Further, it is more likely than not that, had Dr. Tufts and Nurse Jollotta appreciated the severe nature of Lindsay's mental health condition, they would have altered their treatment plans to properly treat Lindsay and, more likely than not, Lindsay would not have harmed or killed Cora, Dawson, and Callan, as is alleged. Dr. Tufts' and Nurse Jollotta's failure to comply with the standard of care more likely than not resulted in the deaths of the Clancys' three children.

COUNT I

Wrongful Death

(Plaintiff against All Defendants)

72. Plaintiff repeats and realleges the allegations contained above as if fully set forth herein.

73. Patrick Clancy, as Personal Representative of the Estates of Cora, Dawson, and Callan, brings this Count in accordance with G.L. c. 229, § 2 for the negligence of Defendants in causing the deaths of Cora, Dawson, and Callan.

74. All Defendants owed Lindsay, Cora, Dawson, and Callan a duty to exercise reasonable skill and attention in their care and treatment of Lindsay.

75. Defendants failed to exercise reasonable skill and attention in caring for Lindsay.

76. Defendants' conduct deviated from accepted standards of medical practice.

77. As a direct and proximate result of the negligence of Defendants, Cora, Dawson, and Callan are dead.

78. Further, the acts and omissions of Defendants also constituted gross negligence and a reckless indifference to the health, safety and welfare of Lindsay and her children and

showed reckless disregard for the consequences which Defendants knew or should have known could result from their acts or omissions.

79. Cora, Dawson, and Callan are survived by their father, Patrick, who has suffered damages as a result of their death, including, without limitation, services, protection, care, assistance, society, companionship, comfort, guidance, counsel, advice and consortium. Patrick has also incurred funeral and burial expenses, and other damages as a result of Cora, Dawson, and Callan's deaths.

80. As a result of the foregoing, Patrick and his heirs are entitled to recover damages and punitive damages from Defendants in an amount to be determined at trial.

COUNT II

Conscious Pain and Suffering Pursuant to G.L. c. 229, § 6

(Plaintiff against All Defendants)

81. Plaintiff repeats and realleges the foregoing allegations as if fully set forth herein.

82. As a direct and proximate result of their negligence, recklessness, and gross negligence, Defendants caused Cora, Dawson, and Callan to endure horrific conscious pain and suffering.

COUNT III

Violations of the Health Insurance Portability and Accountability Act ("HIPAA")

(Plaintiff against South Shore Health)

83. Plaintiff repeats and realleges the foregoing allegations as if fully set forth herein.

84. On January 15, 2026, South Shore Health disclosed to Plaintiff that on November 17, 2025 it had discovered that a South Shore Health employee had inappropriately accessed Patrick, Cora, Dawson, and Callan's medical records.

85. South Shore Health's employee's inappropriate access of Patrick's and his children's medical records amounts to a violation of the Health Insurance Portability and Accountability Act.

86. As a direct and proximate result of HIPAA, South Shore Health caused Plaintiff damages in an amount to be determined at trial.

WHEREFORE, Plaintiff prays that this Honorable Court:

a. enter judgment in their favor on Counts I through III;

b. award damages, including punitive damages, as allowed by law for the wrongful deaths of Cora Marie Clancy, Dawson William Clancy, and Callan Patrick Clancy, their conscious pain and suffering, and all other damages permitted by law, plus interest at the rate of 12% per annum from the date of this Complaint, plus costs and attorneys' fees; and

c. grant such other and further relief as this Court deems just and appropriate.

THE PLAINTIFF DEMANDS A TRIAL BY JURY

Respectfully submitted,

PATRICK W. CLANCY, Individually and as the Personal Representative of the Estates of CORA MARIE CLANCY, DAWSON WILLIAM CLANCY, and CALLAN PATRICK CLANCY,

By his attorneys,

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