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IN THE SUPERIOR COURT OF GUAM

ESTATE OF MARYLEE PALOMARES, by and through MARINA PALOMARES, Special Administrator; MARINA PALOMARES, as an individual, MARY LOWELL WONG, LEOMAR-VAL PALOMARES, and MARY LYNDA PALOMARES,

Plaintiffs,

vs.

GUAM MEMORIAL HOSPITAL AUTHORITY, and DOES 1 through 20, inclusive,

Defendants.

CIVIL CASE NO. CV CV 0145-26

COMPLAINT

INTRODUCTION

Plaintiffs bring this action for medical negligence and wrongful death based on the care Defendant Guam Memorial Hospital Authority ("GMHA") provided to Marylee Palomares ("Marylee") and the events that led to her death. Plaintiffs include the Estate of Marylee Palomares and her surviving family members[1]. While Marylee was a patient at the GMHA and being prepared for a procedure, GMHA staff placed her on a narrow, elevated table and left her unattended and

[1] On June 11, 2025, Marina Palomares petitioned the Superior Court of Guam for Letters of Administration as Special Administrator in *In the Matter of the Estate of Marylee Palomares*, Probate Case No. PR0096-25. On July 17, 2025, the Court appointed Marina Palomares as Special Administrator of the Estate and authorized her, among other things, to file a government claim and administer and prosecute this civil action on behalf of the Estate.

without adequate restraints despite her vulnerable condition and known propensity for erratic, uncontrolled movement. As a direct result, Marylee fell from the table, suffered a traumatic intracranial hemorrhage, underwent unsuccessful emergency surgery, and died on May 19, 2025.

JURISDICTION AND VENUE

1. This Court is vested with jurisdiction pursuant 7 GCA §§ 3105 and 4104, and the Government Claims Act, Title 5 GCA, Chapter 6, including 5 GCA §§ 6208 and 6209.

2. Plaintiffs timely submitted written government claims, arising from the matters alleged herein, to the appropriate Claims Officer on August 13, 2025, as follows: (a) Marina Palomares, on behalf of the Estate, (b) Marina Palomares, as an heir; (c) Leomar-Val Palomares, as an heir; (d) Mary Lowell Wong, as an heir; and (e) Mary Lynda Palomares, as an heir. Each claimant complied with the requirements of Title 5 GCA, Chapter 6, including Article 2.

3. More than six (6) months have elapsed since presentation of the claims, without written rejection. Plaintiffs are therefore authorized to institute this action against Defendant for money damages pursuant to 5 GCA § 6208(b).

4. Venue is proper because the acts and omissions giving rise to this action occurred in Guam, at or in connection with care provided at GMHA, and Defendant operates and maintains its principal place of business in Guam.

PARTIES

5. At all relevant times herein, Marylee Palomares ("Marylee") was a "house patient" of GMHA, i.e., she was admitted to receive care, supervision, and treatment through GMHA's hospital staff and systems, and not through a separately retained private physician directing her day-to-day hospital care.

6. Plaintiff Estate of Marylee Palomares (the "Estate") is represented by its court-appointed Special Administrator, Marina Palomares.

7. Plaintiff Marina Palomares is Marylee's natural mother, a resident of Guam, and an heir within the meaning of 7 GCA § 12109(b).

8. Plaintiff Mary Lowell Wong is Marylee's natural sister, a resident of California, and an heir within the meaning of 7 GCA § 12109(b).

9. Plaintiff Leomar-Val Palomares is Marylee's natural brother, a resident of Guam, and an heir within the meaning of 7 GCA § 12109(b).

10. Plaintiff Mary Lynda Palomares is Marylee's natural sister, a resident of California, and an heir within the meaning of 7 GCA § 12109(b).

11. Defendant GMHA is a public corporation and autonomous instrumentality of the Government of Guam that owns and operates the Guam Memorial Hospital ("GMH"). By providing care for Marylee through its employees, agents, and contractors, the GMHA is responsible for their acts and omissions as alleged.

12. Plaintiffs are ignorant of the true names and capacities of Defendants sued as DOES 1 through 20, inclusive, and therefore sue these Defendants by fictitious names. Plaintiffs will amend this Complaint to allege their true names and capacities when ascertained.

13. Each DOE defendant was an employee, agent, contractor, or representative of the GMHA and/or otherwise legally responsible for the events alleged herein. All acts and omissions were committed within the course and scope of such relationship(s) and the GMHA is legally responsible for them under applicable principles of agency and *respondeat superior*.

FACTUAL HISTORY

14. On January 10, 2025, Marylee was admitted as an inpatient at the GMHA for weakness and generalized swelling that subsequently led to the initiation of hemodialysis.

15. During her hospitalization at the GMHA, Marylee contracted bacterial infections multiple times, complicated by an embolic stroke to her brainstem and renal failure. Marylee suffered one or more strokes while at the GMHA that resulted in severe neurological impairments.

16. GMHA's staff knew, or in the exercise of reasonable care should have known, that Marylee was nonverbal, bedbound, and had limited voluntary control of her body.

17. GMHA physicians and nurses expressly documented that Marylee experienced uncontrolled movements, recording observations of decorticate and decerebrate posturing, and reflexive twitching upon stimulation — each of which is a recognized manifestation of involuntary neurological motor activity beyond a patient's voluntary control.

18. GMHA's staff knew, or in the exercise of reasonable care should have known, that because of Marylee's severe neurological deficits and documented total dependence upon staff, she required continuous and uninterrupted assistance and close supervision for her basic physical safety.

19. GMHA's staff knew, or in the exercise of reasonable care should have known, that because of her profound encephalopathy, unpredictable reflexive twitching, and total physical dependency, Marylee was a known high-fall-risk and completely incapable of protecting or bracing herself.

20. Reasonable hospital care under these circumstances required heightened fall precautions, close monitoring, and continuous physical protection of Marylee from foreseeable injury while she was in the care, custody, and control of the GMHA.

21. On May 5, 2025, Marylee was scheduled to undergo a permacath placement procedure in connection with her dialysis access.

22. Due to her documented profound encephalopathy, aphasia, and non-verbal status, Marylee was incapable of consenting to the procedure herself.

23. At approximately 7:15 a.m., on May 5, 2025, GMHA personnel contacted Marylee's sister and authorized representative, Mary Lowell Wong, to obtain verbal consent for the permacath placement procedure.

24. During the same phone call, GMHA personnel told Mary Lowell Wong that Marylee would be the first case of the morning and would be returned safely to her room between 9:30 and 9:45am.

25. After consent was obtained, GMHA personnel transported Marylee from her hospital room to the Interventional Radiology ("IR") department, to be prepared for the permacath placement.

26. Upon arrival at the IR department, GMHA staff placed Marylee on a narrow, elevated procedure/exam table that was approximately 36 to 42 inches (3 to 4 feet) in height.

27. Because of her documented profound encephalopathy, totally bedbound status, and classification as requiring "maximum assist" for all mobility and activities of daily living, multiple GMHA personnel were required to physically lift and transfer Marylee from the gurney onto the narrow, elevated table.

28. At the time she was placed on the table, GMHA personnel knew, or in the exercise of reasonable care should have known, that Marylee was actively taking Eliquis, a blood thinner prescribed to prevent further strokes, which made her vulnerable to life-threatening bleeding in the event of physical trauma.

29. Despite her total physical dependency, her known fall-risk status, and her heightened risk for severe bleeding, GMHA personnel failed to implement appropriate fall precautions and safety measures after placing Marylee on the narrow, elevated table.

30. Once on the table, instead of using secure straps or reliable medical restraints, GMHA staff merely placed small, plastic lateral support "slides" underneath each of Marylee's shoulders, utilizing no additional securing devices.

31. Upon information and belief, the small lateral support slides are fabricated from clear plastic specifically for use during X-ray imaging because their transparency is intended to avoid interference with the X-ray. However, by design, the lateral supports are completely unanchored and unfixed to the narrow, elevated table, and rely solely on compression between the table surface and a patient's body weight to remain in place.

32. Because Marylee was a lightweight patient, weighing approximately 100 to 110 pounds, the small lateral supports were inadequately secured and could easily shift, fall aside, or slide out of place, rendering them insufficient to protect an incapacitated patient from falling from a narrow, elevated table.

33. Compounding their failure to properly secure her, GMHA personnel also failed to provide continuous attendance, supervision, and physical monitoring of Marylee after placing her on the narrow, elevated table.

34. After placing Marylee unsecured on the narrow, elevated table, the two GMHA staff members who were in the room with her — a registered nurse and a technician — inexplicably turned their backs on Marylee to prepare for the procedure.

35. Shortly after the GMHA staff turned their backs, leaving Marylee unsupervised and without physical support, a loud "thud" was heard. This was later documented by GMHA physicians in Marylee's medical records as an "unassisted fall".

36. GMHA personnel found Marylee on the hard floor of the procedure room, having fallen approximately 3 to 4 feet from the narrow, elevated table. Her fall was unwitnessed.

37. After missing an initial call at 7:40 a.m., Mary Lowell Wong was informed by telephone at approximately 9:20 a.m. by Jeffrey D. Shay, MD ("Dr. Shay"), an interventional radiology specialist at the GMHA, that Marylee had suffered an unwitnessed fall while in the hospital's care, custody, and control.

38. As a direct and proximate result of the fall, Marylee sustained catastrophic, irreversible neurological injuries, including a large traumatic intracranial hemorrhage which required an immediate emergency neurosurgical decompressive craniotomy.

39. At approximately 10:10 a.m., Marylee was rushed into the GMHA operating room in a desperate attempt by the neurosurgeon to relieve the massive pressure, bleeding, and brain herniation caused by her unwitnessed fall.

40. During the time that Marylee was in surgery, Dr. Shay spoke with Marylee's family members.

41. In the room where Marylee's unwitnessed fall occurred, Dr. Shay demonstrated how the unsecured plastic lateral supports were supposed to work.

42. Dr. Shay admitted his suspicion that Marylee had not been properly placed in the center of the narrow, elevated table, causing her to fall off the right side of the table, and opined that the plastic lateral supports were inadequate to secure Marylee due to her small size and compromised physical condition.

43. On May 6, 2025, Kwasi Nyame, M.D. ("Dr. Nyame") a neurosurgeon at the GMHA, met with Marylee's family and explained that her intercranial bleed was so large that it had shifted half of Marylee's brain hemisphere to one side, and that while he was able to stop the "main" bleeds, the area of Marylee's brain that was compressed had died.

44. Following the traumatic intracranial bleeding and the desperate, emergent decompressive surgery, Marylee never again regained consciousness, suffering persistent neurologic devastation. She remained trapped in an unresponsive coma, tragically characterized by fixed and dilated pupils, decerebrate posturing, and a complete absence of brainstem reflexes.

45. On May 17, 2025, GMHA personnel, led by intensive care physician Garrett Britton, D.O. ("Dr. Britton"), held a meeting with Marylee's family and delivered the devastating news that

there was no improvement in Marylee's condition. Dr. Britton confirmed that Marylee had no respiratory drive, lacked a cough or gag reflex, and was completely non-responsive to pain.

46. On May 19, 2025, after her family was forced to make the agonizing decision to transition to comfort-focused measures, Marylee's life support was discontinued.

47. Two weeks after her unwitnessed 3 to 4 foot fall from a narrow, elevated exam/procedure table, Marylee tragically died at 4:39 p.m. on May 19, 2025.

48. GMHA's death summary states Marylee's primary cause of death as "traumatic intracerebral hemorrhage".

49. Throughout Marylee's prolonged hospitalization, her family members maintained a close, loving, and involved relationship with her. They each actively monitored her daily care, maintained constant contact with GMHA staff, and fiercely advocated for her safety and well-being, making the hospital's sudden and entirely preventable abandonment of Marylee all the more devastating to her surviving loved ones.

FIRST CAUSE OF ACTION
PROFESSIONAL NEGLIGENCE / MEDICAL MALPRACTICE
(By Estate of Marylee Palomares against Defendants)

50. The Estate repeats and realleges the preceding paragraphs as though fully set forth in this cause of action.

51. At all relevant times, Marylee was a highly vulnerable, bedbound, house patient entirely in GMHA's care, custody, and control.

52. The GMHA, through its employees, agents, and contractors, undertook to provide Marylee with hospital and nursing care, supervision, and physical protection while she was being prepared for, and awaiting, a permacath placement procedure.

53. The GMHA and its employees, agents, and contractors owed Marylee a duty to exercise the level of care, skill, prudence, supervision, and diligence ordinarily possessed and exercised by reasonably careful hospitals, nurses, technicians, and other health care providers under similar circumstances in Guam, including the heightened duty to implement appropriate fall precautions and physically protect a totally dependent, high-fall-risk patient from foreseeable harm.

54. The GMHA breached its duty of care to Marylee by acts and omissions including, but not limited to, the following:

a. Failing to appropriately assess, identify, communicate, and implement adequate fall-risk precautions for a known high-fall-risk, nonverbal, neurologically impaired patient with documented uncontrolled, reflexive movements;

b. Placing Marylee on a narrow, elevated exam/procedure table without securing her with appropriate straps, rails, fixed barriers, positioning aids, or other reliable protective measures reasonably required under the circumstances;

c. Leaving Marylee entirely unattended and unsupported while she was positioned on a narrow, elevated surface, despite her known inability to protect or brace herself and her need for continuous physical assistance and supervision;

d. Failing to monitor Marylee consistent with her critical condition while she was awaiting and being prepared for a procedure;

e. Failing to ensure adequate staffing, coordination, and supervision for procedure workflow, resulting in Marylee being left unprotected on a narrow, elevated surface while GMHA staff turned their backs to her;

f. Utilizing unsecured plastic "slides" as lateral supports that relied upon a lightweight patient's body weight for compression, rendering them completely inadequate to secure Marylee from falling;

g. Failing to timely document, investigate, and appropriately respond to Marylee's unwitnessed fall in a manner consistent with hospital standards and patient-safety requirements, including preserving and communicating accurate information and documentation about how the fall occurred.

55. GMHA's failure to secure, supervise, monitor, and protect Marylee when placing her on the narrow, elevated table — especially because she was a known high-fall-risk patient with documented profound encephalopathy and total physical dependency — was the direct, proximate, and substantial factors in causing her unassisted fall.

56. GMHA's breach of the standard of care directly caused Marylee's traumatic intracerebral hemorrhage, brain herniation, subsequent neurologic devastation, and ultimately her death.

57. Marylee's unwitnessed and unassisted 3 to 4 foot fall from the narrow, elevated table to the hard floor, and her subsequent catastrophic injuries are events that do not ordinarily occur in the absence of negligence.

58. Because Marylee was incapacitated, and the procedure room, the narrow, elevated table, and the inadequate restraints were under the exclusive management and control of the GMHA and its personnel, the negligence of the Defendants is inferred under the evidentiary doctrine of *res ipsa loquitur*.

59. Marylee's injuries required immediate emergency medical treatment and caused Marylee to suffer pain, prolonged neurologic devastation, medical and related expenses, and damages prior to her death.

60. The Estate seeks judgment against Defendants for medical negligence damages in an amount to be determined according to proof at trial, together with allowable costs, pre-judgment and post-judgment interest, and such further relief as the Court deems just and proper.

SECOND CAUSE OF ACTION
WRONGFUL DEATH
(By Marina Palomares against Defendants)

61. Marina Palomares ("Marina") repeats and realleges the preceding paragraphs as though fully set forth in this cause of action.

62. Marylee's tragic and preventable death was directly and proximately caused by the wrongful acts, gross negligence, and omissions of the GMHA, through its employees, agents, and contractors, as alleged in this Complaint.

63. As Marylee's natural mother, Marina is an heir within the meaning of 7 GCA § 12109(b) and is entitled to maintain this wrongful death action pursuant to 7 GCA § 12109(a)–(b).

64. Prior to her hospitalization, Marylee was a single woman who lived at home with her elderly mother, Marina, and maintained an independent life. Marylee and Marina shared a close and bonded relationship, residing under the same roof where they provided each other with mutual care, daily companionship, and essential household support, including shopping, cooking, cleaning and other daily tasks.

65. When Marylee first arrived at the GMHA emergency department on January 10, 2025, Marina personally accompanied her daughter to the hospital and visited her daily throughout her hospitalization, evidencing her constant presence and devotion to her daughter's well-being.

66. As a direct, legal, and proximate result of GMHA's wrongful conduct and the resulting death of her daughter, Marina sustained profound and permanent damages recoverable under Guam law.

67. Because they shared a home and daily life prior to this preventable tragedy, Marina suffered the devastating loss of Marylee's household services and financial support, as well as the irreplaceable loss of her daughter's love, companionship, comfort, care, assistance, protection, affection, society, and moral support.

68. Marina seeks judgment against Defendants for wrongful death damages in an amount to be determined according to proof at trial, together with allowable costs, pre-judgment and post-judgment interest, and such further relief as the Court deems just and proper.

THIRD CAUSE OF ACTION
WRONGFUL DEATH
(By Mary Lowell Wong against Defendants)

69. Plaintiff Mary Lowell Wong ("Mary Lowell") repeats and realleges the preceding paragraphs as though fully set forth in this cause of action.

70. Marylee's tragic and preventable death was directly and proximately caused by the wrongful acts, gross negligence, and omissions of the GMHA, acting through its employees, agents, and contractors, as alleged in this Complaint.

71. As Marylee's sister, Mary Lowell is an heir within the meaning of 7 GCA § 12109(b) and is entitled to maintain this wrongful death action pursuant to 7 GCA § 12109(a)–(b).

72. Mary Lowell shared a deep, loving, and lifelong bond with her sister. As a registered nurse, Mary Lowell acted as Marylee's primary designated spokesperson and fierce medical advocate throughout her hospitalization at the GMHA.

73. Mary Lowell was in constant communication with GMHA's staff regarding her sister's care and condition. Despite working full-time and taking care of her own family in California, Mary Lowell sought to obtain daily reports from day shift and night shift nurses, frequently calling multiple times each day considering the time difference and availability of GMHA nurses.

74. Mary Lowell spoke with each of Marylee's various specialists (nephrologist, infectious disease, etc.) while she was hospitalized at the GMHA, and with every physician assigned to her care – who changed every one to two weeks. Marylee's continuity of care was fragmented with each new doctor who sometimes was not vested in her long-term care, but instead, getting through their one-week hospital rotation.

75. Mary Lowell was "on-call" daily and in all necessary moments, always feeling anxious if Marylee's doctors would remember or would be reminded to call her with any and all updates.

76. Mary Lowell has endured profound grief and extreme anger over the loss of her sister that was completely preventable; especially because Marylee was making progress just weeks before her unwitnessed fall. Mary Lowell was not prepared for the lack of care and foresight on the part of GMHA staff to ensure her sister's safety.

77. Mary Lowell last saw her sister the night before she was scheduled to have the permacath placement procedure. When Marylee cried, Mary Lowell assured her it was a simple procedure and reminded her that she had had a permacath placed in the past. Marylee trusted Mary Lowell. She nodded her head and stopped crying.

78. Mary Lowell feels she let down her sister, since she was the person who gave the verbal consent for the procedure that ultimately resulted in Marylee's death. It was Mary Lowell who GMHA staff called at 7:15 a.m. on the morning of May 5, 2025, to obtain verbal consent for the permacath procedure, and it was Mary Lowell who suffered the shock of receiving a phone call just two hours later informing her that her sister had fallen approximately 3 to 4 feet onto the hard floor resulting in an unsurvivable brain bleed. Mary Lowell relives those heart-wrenching moments every day; she is heartbroken beyond words.

79. As a direct, legal, and proximate result of GMHA's wrongful conduct and the resulting death of her sister, Mary Lowell sustained profound and permanent damages recoverable under Guam law.

80. Mary Lowell has suffered the devastating and irreplaceable loss of her sister's love, companionship, comfort, care, assistance, affection, society, and moral support.

81. Mary Lowell seeks judgment against Defendants for wrongful death damages in an amount to be determined according to proof at trial, together with allowable costs, pre-judgment and post-judgment interest, and such further relief as the Court deems just and proper.

FOURTH CAUSE OF ACTION
WRONGFUL DEATH
(By Leomar-Val Palomares against Defendants)

82. Plaintiff Leomar-Val Palomares ("Leomar-Val") repeats and realleges the preceding paragraphs as though fully set forth in this cause of action.

83. Marylee's tragic and preventable death was directly and proximately caused by the wrongful acts, gross negligence, and omissions of the GMHA, acting through its employees, agents, and contractors, as alleged in this Complaint.

84. As Marylee's brother, Leomar-Val is an heir within the meaning of 7 GCA § 12109(b) and is entitled to maintain this wrongful death action pursuant to 7 GCA § 12109(a)–(b).

85. Leomar-Val, his wife Annie, and their three children shared a strong and loving familial bond with Marylee. Marylee adored Leomar-Val's children; she loved and helped raise them as if they were her own.

86. Leomar-Val and his wife and children spent countless hours at Marylee's bedside, communicating with her, raising her spirits and motivation, assisting with activities of daily living, diligently keeping her updated on her condition and on news about the world around her, and helping her perform physical therapy exercises – all in the hopes of her improvement, ultimate recovery, and better quality of life. They were encouraged by Marylee's gradual and steady progress.

87. Leomar-Val, and his wife and children, were suddenly devastated and heartbroken when they were informed of Marylee's unwitnessed fall, especially knowing that Marylee was helpless and had no way to prevent the fall and protect herself.

88. As a direct, legal, and proximate result of GMHA's wrongful conduct and the resulting death of his sister, Leomar-Val sustained profound and permanent damages recoverable under Guam law.

89. Because Leomar-Val, and his wife and children, shared a constant and close relationship with Marylee prior to this preventable tragedy, Leomar suffered the devastating loss of Marylee's love, companionship, comfort, care, assistance, protection, affection, society, and moral support.

90. Leomar-Val seeks judgment against Defendants for wrongful death damages in an amount to be determined according to proof at trial, together with allowable costs, pre-judgment and post-judgment interest, and such further relief as the Court deems just and proper.

FIFTH CAUSE OF ACTION
WRONGFUL DEATH
(By Mary Lynda Palomares against Defendants)

91. Plaintiff Mary Lynda Palomares ("Mary Lynda") repeats and realleges the preceding paragraphs as though fully set forth in this cause of action.

92. Marylee's tragic and preventable death was directly and proximately caused by the wrongful acts, gross negligence, and omissions of the GMHA, acting through its employees, agents, and contractors, as alleged in this Complaint.

93. As Marylee's sister, Mary Lynda is an heir within the meaning of 7 GCA § 12109(b) and is entitled to maintain this wrongful death action pursuant to 7 GCA § 12109(a)–(b).

94. Mary Lynda and her three sons shared a strong and loving familial bond with Marylee.

95. Mary Lynda is Marylee's youngest sister and was only 6 years old when their father died. Marylee was Mary Lynda's connection to memories of their father, and her sons connection to their grandfather.

96. Mary Lynda and her children were devastated and heartbroken when they was informed of Marylee's unwitnessed fall. Mary Lynda still feels disbelief because she was unable to arrive in Guam before Marylee's death; she did not think that a permacath procedure would result in Marylee's death.

97. As a direct, legal, and proximate result of GMHA's wrongful conduct and the resulting death of Marylee, Mary Lynda sustained profound and permanent damages recoverable under Guam law.

98. Mary Lynda has suffered the devastating and irreplaceable loss of her sister's love, companionship, comfort, care, assistance, affection, society, and moral support.

99. Mary Lynda seeks judgment against Defendants for wrongful death damages in an amount to be determined according to proof at trial, together with allowable costs, pre-judgment and post-judgment interest, and such further relief as the Court deems just and proper.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, and each of them, as follows:

1. For general and special damages;
2. For special damages, including medical and related expenses incurred as a result of the injuries sustained on May 5, 2025, and through the date of Marylee Palomares' death;
3. For damages in favor of the Estate pursuant to 19 GCA § 31104;
4. For wrongful death damages in favor of the Maylee Palomares' heirs pursuant to 7 GCA § 12109;
5. For funeral and burial expenses;
6. For attorney's fees and costs of suit as allowed by law;
7. For pre- and post-judgment interest; and

8. For such other and further relief as the Court deems just and proper.

Respectfully submitted this 25th day of March 2026.

LAW OFFICES OF MINAKSHI V. HEMLANI, P.C

By: _____

NICHOLAS TYLER LOCH, Esq.
Counsel for Plaintiffs