UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

ELBERT FRY, KATHLEEN KELLY-LYON,CHRISTINE CANTON, ELLEN BROWNSTEIN, PATRICIA JACKSON, LINDA GREGORY and VIRGINIA SANCHEZ, *Plaintiffs,* *-against-* ALISON OVERSETH, SENATOR CHRIS HARRIS, DR. GEORGE BELLER, DR. ROSEMARIE ROBERTSON, MR. JOSEPH CASTLE, THE HON. DEAN TRAFELET and THE HON. RICHARD COHEN, Individually And In Their Capacities As Trustees Of The Wyeth Settlement Trust, THE WYETH SETTLEMENT TRUST Formerly Known As The American Home Products Settlement Trust *Defendants.*	COMPLAINT CIVIL ACTION No.: DEMAND FOR TRIAL BY JURY

To The Above Named Defendants:

Plaintiffs ELBERT FRY, KATHLEEN KELLY-LYON, CHRISTINE CANTON, ELLEN BROWNSTEIN, PATRICIA JACKSON, LINDA GREGORY and VIRGINIA SANCHEZ, by their attorneys, NAPOLI, KAISER BERN & ASSOCIATES, LLP, as and for a Verified Complaint, alleges the following, at all times hereinafter mentioned, upon information and belief:

PARTIES

1. Plaintiffs are "beneficiaries" of the Wyeth Settlement Trust formerly known as the American Home Products Settlement Trust ("the Trust"), who have filed claims for settlement benefits based upon the results of echocardiograms performed and interpreted by "qualified cardiologists".

2. Plaintiff Elbert Fry, a resident of Gallatin, Missouri, is a beneficiary of the Wyeth Settlement Trust who has filed a claim for Matrix Benefits and has been approved by the Trust for a matrix payment. He is 66 years old and was diagnosed in 2001 by an AHP Screening echocardiogram as having trace mitral regurgitation. In 2002, a subsequent echocardiogram demonstrated moderate mitral regurgitation and an ejection fraction of 48%.

3. Plaintiff Fry's claim was audited by an AHP Settlement Trust auditing cardiologist, and was approved for payment of matrix level damages; the AHP Settlement Trust agreed to pay his A-Matrix benefit on or about September 11, 2002. The AHP Settlement Trust denied payment of his B Matrix benefits on October 15, 2003 due to the fact that his claim had been attested to by Dr. Linda Crouse.

4. Plaintiff Fry was served with a Medical Practices Questionnaires by the AHP Settlement Trust, and has been directed that the 18-page detailed questionnaire must be *personally* filled out by the physician who attested to the plaintiffs' claims under the Trust and submitted to the Trust no later than December 18, 2003 or his claim – already supported by the AHP Settlement Trust's auditor as medically legitimate -- will not be further considered.

5. Plaintiff Fry has also been notified by the Trust that, although his claims have been approved they will not be paid as a result of ongoing inquiries in connection with the so-called Claims Integrity Program (CIP) related to his attesting physician, Dr. Linda Crouse.

6. Plaintiff KATHLEEN KELLY-LYON, a 57 year old resident of Port Jefferson Station, New York, was diagnosed in August of 2001 with mild-to-moderate

mitral regurgitation. Subsequent echocardiograms by two different cardiologists in November 2001 and December 2002, demonstrated moderate mitral regurgitation and mild aortic insufficiency.

7. Plaintiff Kelly-Lyon has been served Medical Practices Questionnaires by the AHP Settlement Trust, and has been directed that an 18-page detailed questionnaire must be *personally* filled out by the physician who attested to the plaintiffs' claims under the Trust.

8. Plaintiff Kelly-Lyon has further been advised that those questionnaires must be returned to the Trust no later than December 15, 2003 or her claims will not be processed through audit.

9. Plaintiff Kelly-Lyon's attesting physician signed more than 20 Green Forms and because plaintiff is represented by counsel . The AHP Settlement Trust has designated her claim as likely being meritless – without a completed audit – due solely to the fact that her attesting physician signed more than 20 Green Forms and because plaintiff is represented by counsel . As a result, the AHP Settlement Trust has wrongfully put her claim behind others in the line for processing to completeness for audit.

10. Plaintiff Linda Gregory is a resident of Allentown, Pennsylvania. She is a 49 year old patient diagnosed in 2001 with severe mitral regurgitation and mild aortic insufficiency. A subsequent echocardiogram performed in 2002 by another physician confirmed that diagnosis.

11. Notwithstanding her diagnosis, plaintiff Gregory's claim has been designated as likely meritless – without a completed audit – due solely to the fact that her attesting physician signed more than 20 Green Forms and because plaintiff is represented by

counsel. As a result, the AHP Settlement Trust has wrongfully put her claim behind others in the line for processing to completeness for audit.

12. Plaintiff Ellen Brownstein is a 57 year old resident of Monterey, California who underwent a 1997 echocardiogram that revealed moderate aortic insufficiency and severe mitral regurgitation. A subsequent echocardiogram in 1998 demonstrated mild-to-moderate levels of aortic insufficiency and mitral regurgitation. A 2000 echocardiogram demonstrated mild-to-moderate aortic insufficiency and mitral regurgitation. A 2001 echocardiogram performed by Dr. Mueller demonstrated moderate aortic insufficiency and severe mitral regurgitation.

13. During the September 2002 hearings before the District Court, plaintiff Brownstein's claim was among the 78 claims deemed "medically unreasonable" on the testimony of AHP Trust expert witness Dr. John Dent. Pursuant to the Court's resulting order, plaintiff Brownstein withdrew her initial claim, and underwent yet another echocardiogram by her California physician, Dr. Lowenbraun, who diagnosed moderate aortic insufficiency and moderate mitral regurgitation.

14. Upon the re-echo results by Dr. Lowenbraun, plaintiff Brownstein re-submitted her claim to the AHP Settlement Trust for audit.

15. The AHP Settlement Trust has designated plaintiff Brownstein's claim as likely being meritless – without a completed audit – due solely to the fact that her attesting physician signed more than 20 Green Forms and because plaintiff is represented by counsel. As a result, the AHP Settlement Trust has wrongfully put her claim behind others in the line for processing to completeness for audit.

16. Plaintiff CHRISTINE CANTON is a 53 year old resident of Miami, Florida who was diagnosed in 2001 with moderate aortic regurgitation and moderate mitral regurgitation. After her claim was designated as "medically unreasonable" in September 2002 during the hearings held before the Hon. Harvey Bartle, III that resulted in that Court's pretrial order 2640 (*see In re Diet Drugs fenfluramine/phentermine /Dexfenfluramine) Products Liability Litigation*, 236 F. Supp. 445 [E.D. Pa. 2002]), plaintiff Canton underwent a subsequent echocardiogram with another physician (Dr. Stahl) that demonstrated moderate mitral regurgitation and mild aortic insufficiency with left atrial enlargement. Her claim, supported by this new echocardiogram, was re-submitted to the AHP Trust, pursuant to PTO 2640, on May 3, 2003.

17. The AHP Settlement Trust has designated plaintiff Canton's claim as likely being meritless – without a completed audit – due solely to the fact that her attesting physician signed more than 20 Green Forms and because plaintiff is represented by counsel. As a result, the AHP Settlement Trust has wrongfully put her claim behind others in the line for processing to completeness for audit.

18. Plaintiff PATRICIA JACKSON is a 55 year old resident of Kansas City, Missouri. In March, 2002, Ms. Jackson underwent an echocardiogram by Dr. Crouse that revealed severe mitral regurgitation and aortic insufficiency. After her claim was designated as "medically unreasonable" in September 2002 during the hearings held before the Hon. Harvey Bartle, III that resulted in that Court's pretrial order 2640 (*see In re Diet Drugs fenfluramine/phentermine/Dexfenfluramine) Products Liability Litigation*, 236 F. Supp. 445 [E.D. Pa. 2002]), plaintiff Jackson underwent a subsequent

echocardiogram with another physician (Dr. Stahl) that demonstrated moderate mitral regurgitation and mild aortic insufficiency with an ejection fraction of <60%.

19. Notwithstanding the findings on subsequent evaluation, plaintiff Jackson's claim has been designated as likely meritless – without a completed audit – due solely to the fact that her attesting physician signed more than 20 Green Forms and because plaintiff is represented by counsel. As a result, the AHP Settlement Trust has wrongfully put her claim behind others in the line for processing to completeness for audit.

20. Plaintiff Virginia Sanchez is a 53 year old resident of Shirley, New York. In 1997, she was diagnosed with moderate mitral regurgitation. In March 2002, plaintiff Sanchez underwent a subsequent echocardiogram that diagnosed moderate Aortic regurgitation and severe mitral regurgitation. In April 2003, a third echocardiogram performed by the AHP Trust was read as showing mild aortic regurgitation and mild-to-moderate mitral regurgitation.

21. Plaintiffs CHRISTINE CANTON and VIRGINIA SANCHEZ filed green forms with the Settlement Trust. They did not present Level I, II, III, IV and V claims that were initially filed by a claimant without counsel (*i.e.*, on a *pro se* basis) and that are still handled on a *pro se* basis.

22. Plaintiffs CHRISTINE CANTON and VIRGINIA SANCHEZ did not present Level I claims.

23. Plaintiffs CHRISTINE CANTON and VIRGINIA SANCHEZ did not present Level II claims attested to by physicians who have attested to fewer than 20 Matrix claims.

24. Plaintiffs CHRISTINE CANTON and VIRGINIA SANCHEZ did not present Level II claims with both a Pink Form and a Green Form filed before February 15, 2002.

25. Because plaintiffs CHRISTINE CANTON and VIRGINIA SANCHEZ do not fit the Trust's prioritization scheme, their cases are not being processed by the AHP Settlement Trust.

26. No provision has been made for addressing or reinstating those claims in the event the attesting physician refuses to cooperate with the demand for the Medical Practices Questionnaire.

27. Defendant the AHP Settlement Trust [the "Trust"] is a judicially approved Trust that receives settlement funds from Wyeth ("Wyeth") (formerly known as American Home Products Corporation) pursuant to the NATIONAL CLASS ACTION SETTLEMENT AGREEMENT WITH AMERICAN HOME PRODUCTS, INC., ["Settlement Agreement"].

28. The Trust, created under the laws of Delaware, has its principal place of business in Philadelphia, Pennsylvania. The Trust processes and reviews claims for settlement benefits deriving from the federal multi-district litigation ["MDL 1203"] arising from plaintiffs' claims against Wyeth for their injuries developed secondary to their ingestion of Wyeth's diet drug products (*fenfluramine*, trade name "Pondimin" and *dexfenfluramine*, trade name "Redux") and disburses settlement funds to those who qualify for benefits.

29. On February 25, 2000, seven Trustees were appointed by the United States District Court of the Eastern District of Pennsylvania to administer and operate the Trust, all of whom still remain as trustees.

30. The Court appointed Trustees have a fiduciary responsibility to represent the class. Those Trustees are: Alison Overseth, Senator Chris Harris, Dr. George Beller, Dr. Rosemarie Robertson, Mr. Joseph Castle, The Hon. Dean Trafelet and The Hon. Richard Cohen. Further, the Court appointed Trustees to oversee the Trust at the suggestion and recommendation of class Counsel and AHP.

31. Defendant Trustee Joseph Castle is a citizen and resident of Pennsylvania.

32. Defendant Trustee George A. Beller, M.D. is a citizen and resident of Virgina.

33. Defendant Trustee The Honorable Richard S. Cohen is a citizen and resident of New Jersey.

34. Defendant Trustee The Honorable Chris Harris is a citizen and resident of Texas.

35. Defendant Trustee Allison Overseth is a citizen and resident of New York,

36. Defendant Trustee Rose-Marie Robertson, M.D. is a citizen and resident of Tennessee.

37. Defendant Trustee the Honorable Dean M. Trafelet is a citizen and resident of Illinois.

BACKGROUND

THE SETTLEMENT AGREEMENT

38. Wyeth and Class Counsel entered into the NATIONAL CLASS ACTION SETTLEMENT WITH AMERICAN HOME PRODUCTS, INC., ["Settlement Agreement"] on November 17, 1999. The Settlement Agreement was intended to provide a comprehensive set of benefits and remedies and was applicable to all individuals in the

United States who had ingested either Pondimin and or Redux. The fiduciary duties of the trustees are set forth in the Trust Agreement, at Article VI.

39. The Trustees are deemed, according to the governing documents, fiduciaries with a duty to protect the interests of the claimants herein.

40. Given the wholly ineffectual administration of the claims process thus far, with repeated audits of claims, waffling auditors' opinions, non-payment of legitimate claims and refusal of the Trust to comply with the clear directives of this Court, the Trustees have breached those fiduciary duties time and time again.

41. The Settlement Agreement provided different types of benefits including, specifically, "Matrix Level Benefits" for those individuals who demonstrated certain types of injuries including but not limited to moderate mitral valve regurgitation in conjunction with any one of several "complicating factors" as described in the Settlement Agreement.

42. According to the Trust Agreement, the Board of Trustees' powers are deemed

> *fiduciary* powers to be exercised in a *fiduciary capacity to accord each of the partie*s to the Settlement Agreement their rights and to enforce their obligations thereunder and otherwise to carry out the provisions and purposes thereof. Each Trustee shall carry out his or her fiduciary obligations in accordance with his or her own judgment, subject in all cases to the terms and conditions of this Trust Agreement and the Settlement Agreement.

See Trust Agreement, at p. 4, ¶3.02.

43. In its Memorandum And Pretrial Order No. 1415, the District Court wrote that:

> The audit *procedure requires those responsible for administration of the settlement* to gather all medical records relevant to the audited claim and forward them to a highly qualified *independent* board certified cardiologist who is responsible for making a determination as to

> whether or not there was a reasonable medical basis for the representations made by any physician in support of the claim. [citation omitted]. If the auditing cardiologist makes the determination that there was a reasonable medical basis to support the class member's claim *and there is no substantial evidence that fraud was committed* in connection with the claim, *the claim is to be allowed*. Id. If not, those responsible for the administration of the settlement are required to apply to the court for relief. Id.

See Pretrial Order 1415 at pp. 52-53, (emphasis added).

44. Notwithstanding that language from the pretrial order, and similar passages therein, as well as other statements by this Court about the timely payment of claims and the unbiased and independent opinions of Trust auditors, the Trustees have consistently failed to follow this directive.

45. Specifically, the Trustees have utterly failed to carry out their duties, including but not limited to the following:

a. The trustees have negligently failed to act prudently and expeditiously in setting up the Claims Resolution Facility;

b. Incompetent selection of an interim claims administrator;

c. Selection of Robert Mitchell as Managing Director of a 4.5 Billion Dollar Trust, when, *inter alia*, Mr. Mitchell has no previous experience managing any trust; has no claims experience and limited legal experience;

d. The trustees sought the employment of a managing consultant firm to advise them as to the deployment of the Claims Resolution Facility, a task that Trustees with the requisite ability and experience for the Trustee position should be competent to achieve without such assistance. Seeking such outside assistance, in the opinion of the moving parties, underscores the trustees' apparent lack of ability and skill required to administer this trust fund;

e. The Trustees' failure to perform any claims forecast, to predict the number of, and type of claims and the work force necessary to properly administer those claims.

The result of this failure is the Trust's continuing inability to manage the workload and a chronic inability to allocate resources;

f. Failure to meet claims processing deadlines;

g. Failure to meet minimum processing requirements, including but not limited to an inability to open the mail on a timely basis;

h. Failure to implement the 100% audit resulting in the Trust's inability to establish an audit program that meets the standards set out in the Settlement Agreement, thereby stripping claimants of the rights and benefits for which they bargained under the Settlement Agreement;

i. Failure to distribute the settlement funds to eligible class members on a timely basis notwithstanding the Trust's mandate, as emphasized by this Court, to effect speedy resolution of Diet Drug Claims,

j. The Trustees have thus far failed to take any effective action toward the creation of an operational claims resolution process;

k. Failure to perform an adequate background check on physician auditors to make sure those auditors are medically competent and free of bias; Failure to notify the class that there was, and remains, a danger that the Trust will run out of funds;

l. And other acts of misfeasance and improprieties.

46. The Trustees, defendants herein, owe a fiduciary duty to the beneficiaries of the AHP Settlement Trust, including the plaintiffs herein.

47. Defendant Trust and the defendant Trustees have informed the Plaintiffs herein and similarly situated class members that their claims for Matrix Benefits will not be further processed and/or paid due to an ongoing "investigations" of thirteen qualified physicians and a civil action filed against one attesting physician, Linda Crouse, M.D.

48. Defendant Trust and the Trustees of the trust have informed the Plaintiffs herein and similarly situated class members that their claims for Matrix Benefits will not be further processed and/or paid due to the CIP program and Prioritization Scheme.

49. The CIP was developed as part of an overall scheme developed by the defendants, Class Counsel and Wyeth to deny legitimate claimants benefits under the National Settlement Agreement. The "Prioritization Scheme" is one part of that scheme which was also developed in conjunction with Wyeth and Class Counsel.

50. The CIP and "Prioritization Scheme" are a reaction by the defendants to the Motion to Remove the Trustees and its detailed account of defendants' utter failures in fulfilling its duties as fiduciaries.

51. Defendants' reaction is part of a two-step process defendants designed and developed with their "Special Counsel" which eliminates valid and legitimate claimants by first re-prioritizing claims and then to, second, contest the basis of each beneficiaries claims through the use of "medical practices questionnaires" (MPQs) in an attempt to eliminate each and every claim that remains. This is known as the "Prioritization Scheme."

52. The CIP is an integral part of the defendants' scheme by which defendants have prioritized claims to pay those claimants chosen by defendants without regard for the requirements of the Settlement Agreement and/or their fiduciary duties.

53. On October 23, 2003, The trust and defendants detailed their scheme on the Trust's official website stating:

> October 23, 2003 -- The Trust has adopted a policy about the order in which completed Matrix Level Benefit claims will be referred to the medical audit process. The Trust has already stated its policy that Matrix Level III, IV and V

> claims will receive expedited advancement and referral to medical audit, as announced in the Trust's Operations Plan of August 2003. In addition, the following kinds of completed claims will be given priority:
>
> - Level I, II, III, IV and V claims that were initially filed by a claimant without counsel (i.e., on a pro se basis) and that are still handled on a pro se basis;
> - Level I claims;
> - Level II claims attested to by physicians who have attested to fewer than 20 Matrix claims; and
> - Level II claims with both a Pink Form and a Green Form filed before February 15, 2002.

54. Additional claimant-beneficiaries' claims have been "frozen" under the CIP because of the Trust's demand for the completion of a Medical Practices Questionnaire.

55. The MPQ is not mentioned, suggested or contained in the Settlement Agreement as a requirement for the processing of requests for Matrix Benefits. The additional requirement of the MPQ constitutes a material change to the contract (the Settlement Agreement) negotiated between the parties.

56. The requirement of presenting a completed MPQ has not appeared in any of the six amendments to the National Settlement Agreement. The additional requirement of the MPQ constitutes a material change to the contract (the Settlement Agreement) negotiated between the parties.

57. The MPQ was devised by defendants to empower the Trustees to pick and choose who would get receive benefits under the National Settlement Agreement.

58. The defendants have acted with disparate treatment in processing the claims of this quasi-judicial trust.

59. These "investigations" are a ruse by which the Trust has seen fit to unilaterally decide who it wants to pay out of the National Settlement Fund. Such treatment amounts to disparate treatment by the defendants of legitimate class members, including, particularly, the plaintiffs herein.

60. Defendants have agreed, through their special counsel, that among the 16,000 claimant-beneficiaries singled out by Defendants, those 16,000 people include legitimate claimants signed by these thirteen qualified physicians.

61. An unspecified amount of claimants fall within the Prioritization Scheme.

62. Defendants have agreed that among those claimants who are not included in the list of claimants who Matrix benefits will be processed there are legitimate claimants whose benefits have not been processed or paid.

63. Defendants are aware and the Court in charge of the Wyeth Settlement Trust has stated repeatedly that the Trust is a "limited fund". "The funds contributed by Wyeth, though large are finite." *See In re: Diet Drugs (Fenfluramine, Phentermine and Dexfenfluramine) Products Liability Litigation*, 236 F. Supp.2d 445, 462 (E.D. Pa 2002).

64. Plaintiffs now have their claims frozen.

65. Plaintiffs are no longer having their claims processed and/or paid.

66. At the same time that these claims are frozen the Trust continues to process other claimants' claims, thus depleting the pool of funds available to process the plaintiffs' claims, and rendering it unlikely that the claimants will ever be compensated for their injuries.

67. The claims that have been and continue to be processed by the Trust have been handpicked by the Trustees for processing. In fact, Wyeth, filed a Form 8-K with

the Securities and Exchange Commission, entitled "Report Of Unscheduled Material Events Or Corporate Changes" on October 22, 2003. That report, *inter alia,* outlined the "priority" by which claims are processed by the Trust. In relevant part, Wyeth's 8-K report stated:

> The settlement trust has also adopted a program to prioritize the handling of those matrix claims that it believes are least likely to be illegitimate. Under the plan, claims under Levels III, IV and V will be processed and audited on an expedited basis. (Level III covers claims for heart valve disease requiring surgery to repair or replace the valve, or conditions of equal severity. Levels IV and V cover complications from, or more serious conditions than, heart valve surgery.) The policy will also prioritize the auditing of, inter alia, Level I claims, all claims filed by a claimant without counsel (i.e., on a pro se basis) and Level II claims substantiated by physicians who have attested to 20 or more fewer matrix claims.

68. In the October 22, 2003 8-K filing, Wyeth also acknowledges:

> Even if substantial progress is made by the trust, through its Integrity Program, or other means, in reducing the number of illegitimate matrix claims, a significant number of claims which proceed to audit might be interpreted as satisfying the matrix eligibility criteria, notwithstanding the fact that the claimants may not in fact have serious heart valve disease. If so, matrix claims found eligible for payment after audit may exceed the $3.75 billion cap of the settlement fund.

69. Defendants have full knowledge that the so-called "priority" claims alone will exhaust the limited fund available to compensate legitimate claimants.

70. Defendants' establishment of the so-called "Integrity Program" is a sham designed by the defendants to eliminate legitimate claims, claimants and class members without any due process protections for those the Settlement Agreement was originally designed to benefit.

71. By eliminating and/or freezing certain claims, the frozen legitimate claims will never receive the benefits of the Settlement Agreement.

72. Defendants have thereby chosen to benefit one group of claimants at the expense of another group of claimants. Such actions are a direct violation of defendants' fiduciary duties to all class members who are also their beneficiaries.

73. The Settlement Agreement determines the order in which claims are to be processed and paid. What was envisioned was processing based upon the date a claim was deemed complete. This FIFO ("first in-first out") process has been abandoned by the defendants without any order from the Court approving it.

74. Any order the Court would issue that would put one class of claimant above that of another class of claimant would violate the Constitution and case law interpreting class action settlements.

75. Defendants have failed to protect the interests of these legitimate claimants in any way whatsoever.

76. Defendants have failed to protect the interests of these plaintiffs in any way whatsoever.

77. Defendants have failed to account for the depletion of the limited fund to protect those claimants such as plaintiffs herein Elbert Fry, Kathleen Kelly-Lyon, Christine Canton, Ellen Brownstein, Patricia Jackson, Linda Gregory and Virginia Sanchez, by either escrowing and/or reserving the monies they are due and providing them with interest for the monies lost by the defendants' refusal to pay the benefits they are entitled.

78. In fact the defendants have gone out of their way time and time again, to take steps that intentionally and maliciously injure these claimant-beneficiaries to claimants' detriment.

79. Defendants have not seen fit to provide claimant-beneficiaries with any remedy to ensure the expeditious processing of the legitimate claims in the event the other thirteen qualified physicians do not cooperate with their investigations or complete a Medical Practices Questionnaire. The Trustees' failure to protect the interests of these beneficiaries will result in the unlawful denial of legitimate claims and constitutes a breach of the fiduciary duty the Trustees owe the class members.

80. Defendants have not seen fit to provide claimant-beneficiaries with any remedy if the funds are depleted because of defendants' Prioritization Scheme and/or CIP Program. The Trustees' failure to protect the interests of these beneficiaries will result in the unlawful denial of legitimate claims and constitutes a breach of the fiduciary duty the Trustees owe the class members.

JURISDICTION

81. The Court has original jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331 (federal question) and 28 U.S.C. §1337 (supplemental jurisdiction). The Court also has jurisdiction over this action under its continuing jurisdiction under the diet drug action.

82. Venue is proper pursuant to 28 U.S.C. §1391(b)(2) because a substantial part of the events giving rise to this action occurred in and are ongoing in this jurisdiction.

THE AHP SETTLEMENT TRUST

83. The AHP Settlement Trust [the "Trust"] was created to implement the terms of, and to distribute the benefits of the Settlement Agreement.

84. At the time the Trustees were appointed, on February 25, 2000, an interim claims administrator, Seabury & Smith, was overseeing operation of the Trust.

85. In April 2000 the Trustees first met as a group.

86. In November 2000 the Trustees became disillusioned with the performance of the interim claims administrator and made a decision to move claims processing in-house.

87. Despite the Trustees' lack of confidence in Seabury & Smith, that firm nonetheless continued to work with the Trust through January 2002.

88. The Trustees retained no consultants to assist them in transitioning from Seabury & Smith until May 2001, seven months after they had serious concerns about Seabury & Smith's performance.

THE APPOINTMENT AND PERFORMANCE OF ROBERT A. MITCHELL, JR. AS CHIEF EXECUTIVE OFFICER OF THE TRUST

89. The Trustees were charged with the administration and distribution of up to 3.55 billion dollars in settlement funds.

90. Following the Trustees' decision to replace Seabury & Smith, they conducted extensive interviews of potential candidates for Chief Executive Officer of the Trust.

91. In August 2001, Robert A. Mitchell, Jr. was appointed interim CEO of the Trust.

92. At the time of his appointment, Mr. Mitchell was an associate attorney at the law firm Wolf Block Schorr & Solis-Cohen, LLP, the firm that is counsel for the Trust.

93. At the time of his appointment, Mr. Mitchell had no experience as a Chief Executive Officer, nor did he have any significant supervisory experience.

94. The Trustees recognized that Mr. Mitchell had no experience but believed that they could "let him grow into the job."

95. Under Mr. Mitchell's leadership the Trust has failed to meet the processing deadlines and requirements outlined in the Settlement Agreement.

96. Under Mr. Mitchell's leadership, the Trust has experienced delays of as much as 30 days or more in even opening the mail.

97. Under Mr. Mitchell's leadership the Trust was unable to implement the Trust-run screening program in a timely manner such that it was forced to request an extension from the Court.

98. Under Mr. Mitchell's leadership the Trust has failed to implement the Court-ordered 100% audit, such that it will now take as long as forty years to process the remaining claims for Matrix benefits at the current rate those claims are being processed.

THE TRUST HAS DEMONSTRATED A BIAS ADVERSE TO ITS BENEFICIARIES

99. As fiduciaries, the Trustees serve the beneficiaries of the Trust. The Trustees have demonstrated a bias that is adverse to the interests of the beneficiaries to whom they owe a fiduciary duty.

100. One example of the Trustees' failure to properly perform their duties is the appointment of John Gottdiener, M.D., as an auditor, despite the fact that it was common

knowledge that Dr. Gottdeiner had participated in Wyeth-funded studies conducted for litigation purposes that disputed the causal association of fenfluramines and valvular disease.

101. Answering a motion to remove the Trustees, in a Memorandum in Opposition served and filed on October 31, 2003, ("AHP Settlement Trust's Memorandum of Law in Response to Motion to Discharge Trustees") the Trustees state, in relevant part,

> The Trust screens all auditors before it decides whether to retain them by requiring them to complete a questionnaire. When Dr. Gottdiener completed the questionnaire, he answered "no" to a question that asked whether he or a member of his immediate family had ever had a "consultant relationship" with AHP (Wyeth) or any other wholesaler or distributor of Phentermine products. *See* Declaration of John Gottdiener ("Gottdiener Decl. II") ¶¶13-14, Exhibit A question no. 7. The question defind "consultant relationship" as including "service as an investigator for research or clinical studies funded" by any such companies. Id.

See "AHP Settlement Trust's Memorandum of Law in Response to Motion to Discharge Trustees" at p. 23.

102. Thus, the Trustees have conceded that they have done no more than accept without question the representations made by prospective auditors, without taking any step to investigate the auditors' background and affiliations.

103. Most recently Dr. Gottdeiner was listed as an author of a study that was written, in part, by Wyeth employees.

104. The Trustees themselves have documented historical relationships with Wyeth and/or their counsel Arnold & Porter.

105. Trustee Joseph Castle was a client of Arnold & Porter.

106. Trustee Rose-Marie Robertson, M.D., is a Professor of Medicine at Vanderbilt University. Wyeth has an unrestricted educational grant program that provides generous funding for Vanderbilt University.

107. Despite the requirement that the Trustees must demonstrate undivided loyalty to the beneficiaries for whom they serve, the Trustees have authorized the implementation of a Claims Integrity Program, the requirement for which has summarily removed 16,000 claims from the pool of claims awaiting audit.

108. Despite the requirement that the Trustees must demonstrate undivided loyalty to the beneficiaries for whom they serve, the Trustees have authorized the implementation of a "Prioritization Scheme."

109. Finally, despite the requirement that the Trustees must demonstrate undivided loyalty to the beneficiaries for whom they serve, the Trustees have authorized the implementation of a "Medical Practices Questionnaire" as part of their Claims Integrity Program, the requirement for which has summarily removed 16,000 claims from the pool of claims awaiting audit.

110. The Trustees have implemented this prioritization policy without providing for any remedy for those beneficiaries whose claims may be denied because a doctor may legitimately refuse to comply with the Trust's demands.

111. The Trustees have implemented this prioritization policy without providing for any remedy for those beneficiaries whose claims will lose their place in line and will be denied benefits through no fault of their own.

THE DEFINITION OF VALVULAR HEART DISEASE UNDER THE SETTLEMENT AGREEMENT

112. To qualify for benefits under the Settlement Agreement, a class member was required to undergo an echocardiogram prior to January 3, 2003, and that echocardiogram had to have demonstrated the presence of at least mild mitral valve regurgitation and/or mild aortic valve regurgitation.

113. Matrix level benefits would be available to those class members who demonstrated at least FDA-positive regurgitation, *i.e.*, moderate or greater mitral regurgitation and/or mild or greater aortic regurgitation along with other factors as required by the Settlement Agreement.

114. The Settlement Agreement requires that the levels of valvular regurgitation be assessed quantitatively through the use of the procedures and protocols outlined in J.P. Singh, *et al*., "Prevalence and Clinical Determinants of Mitral, Tricuspid and Aortic Regurgitation (The Framingham Heart Study)," *See* American J. Cardiology, 83:897-902 (1999).

115. The parties and the Court all understood that the standards set forth in the Singh article and in the other guidelines for diagnosis under the Settlement Agreement did not comport with the methods used for diagnosing valvular heart disease in most cardiologists' clinical practice.

116. In order to determine the degree of valvular regurgitation present, a cardiologist is required to use planimetry.

117. Planimetry involves the use of a trackball or other devices to draw or trace the perimeter of a regurgitant jet on a monitor screen. Planimetry is also used to trace the left atrium.

118. In order to determine the degree of mitral regurgitation, the equation RJA/LAA (regurgitant jet area/left atrial area) is used. If the ratio is 20% or greater, the patient is determined to have moderate mitral regurgitation under the standards set in the Settlement Agreement.

119. A similar method is used to determine the severity of aortic regurgitation. JH/LVOTH (jet height/left ventricular outflow tract height). If the ratio is 10% or greater, the patient is determined to have mild aortic regurgitation under the standards set forth in the Settlement Agreement.

120. In order for a class member to submit a claim for Matrix benefits based upon a finding of moderate mitral regurgitation they also had to demonstrate a further complicating condition such as an enlarged left atrium or an ejection fraction of 60% or less.

REQUIREMENTS FOR A CLAIMANT TO FILE A MATRIX CLAIM "GREEN" FORM

121. A claim for Matrix benefits required the submission of a so-called "Green Form." A physician was required to assist in completing a 32-page "Green Form," the document that, when filed, triggered the benefit request process

122. The Green Form was submitted along with a videotape or digital disk of the claimant's echocardiogram, proof that the claimant had been prescribed the defendant's diet drug product(s), and the claimant's medical records. The claimant's physician, required to be a Level 2 board-certified cardiologist or cardio-thoracic

surgeon, would attest to the claimant's qualifying VHD (valvular heart disease) level under Settlement Agreement criteria.

123. A key benefit to class members and this Court was that this process was not subject to the exercise of discretion by the administrators of the Settlement or by any court but rather, was based on the sworn certification of claimant's board certified physician.

124. Under the Settlement Agreement, if a claimant's Green Form was properly completed, and was submitted along with the required medical documentation (including a videotape or disk of an echocardiogram), and the claimant's qualification for matrix level benefits was verified by her Level 2 cardiologist, the claimant was to be compensated.

THE TRUST IS WOEFULLY UNDERFUNDED DUE TO A GROSS UNDERSTIMATION OF POTENTIAL CLAIMS BY WYETH AND CLASS COUNSEL

125. The funding for the Trust was based upon projections provided by Wyeth and Class Counsel during the fairness hearings.

126. Based upon the predictions made by Wyeth and Class Counsel the Court assumed that the Trust was adequately funded and would be able to operate and provide benefits for up to fourteen years after final judicial approval.

127. Wyeth's funding obligations were claimed to be sufficient to pay all of the anticipated claims, both present and future.

128. Wyeth's total funding obligation for Matrix compensation was set at $2.55 billion. This was sufficient to pay approximately 6000 to 7000 full value Matrix "A" claims.

129. Based upon assumptions provided by Michael Fishbein, Esq., a member of Class Counsel, their expert Dr. Samuel J. Kursh, was instructed to assume that 90% of those individuals who qualified for Matrix benefits would enter the Matrix at level I, while only 10% would enter at level II, which requires a lesser degree of valvular regurgitation.

130. To qualify for level I benefits, a class member must have findings of severe mitral or aortic regurgitation.

131. To qualify for level II benefits a class member must have findings of at least moderate mitral regurgitation, accompanied by one or more other findings including an ejection fraction of 60% or less (a clinically normal finding), or others such as a mildly enlarged left atrium (a common finding in an obese population).

132. The overwhelming majority of claims filed with the Trust, greater than 90%, are matrix level II claims.

133. Less than 5% of the claims which have been filed are matrix level I claims.

134. The expected number as well as type of claims predicted was wildly inaccurate.

135. It should come as no surprise that there are thousands more legitimate claims than were projected and for which funding was provided.

136. An accepted definition of an injury caused by exposure to Pondimin and or Redux is a finding of FDA positive regurgitation. FDA positive is a finding of moderate or greater mitral regurgitation or a finding of mild or greater aortic regurgitation.

137. It is assumed that approximately 6 million people were exposed to Pondimin and or Redux.

138. Class Counsel's expert, Steven Goodman. M.D., M.H.S., Ph.D., stated in an affidavit dated March 20, 2000, that, "[t]he risk of FDA grade Mitral regurgitation in the exposed population is 3.5% (CI 2.1% to 4.8%), with no apparent increase in the risk with duration of use."

139. Applying this conservative rate to the exposed population results in a conservative calculation that 216,000 diet drug users have been caused to sustain injuries to their mitral valves which has resulted in moderate or greater mitral regurgitation as a result of their use of these dangerous drugs.

140. With respect to injury to the aortic valve the numbers are greater.

141. The gross underestimation in the number of legitimate claims arises from a number of reasons, principally the acceptance of misleading and inaccurate data propounded by Wyeth in the course of litigation in order to minimize the recognition of the damage caused by its products.

142. The gross underestimation of the number of legitimate claims will cause the Trust to become insolvent before the legitimate claims are paid under the terms of the settlement.

143. The Trust has become aware, or should have become aware, of the fact that there were far more legitimate claims than it originally acknowledged.

144. Rather than fulfill its duties to these legitimate claimants, the Trust has participated in a scheme with Wyeth and Class Council – who have a shared financial incentive not to reveal the actual number of legitimate claims and the fact that the Trust

will inevitably become insolvent well before claimants are paid – to shift the blame for the large number of claims submitted to the Trust.

145. Specifically, they have actively sought to create the false and misleading impression that the claims result from fraudulent submissions.

146. The Trust's failure to bring to the attention of the Court and of the claimants the fact that it was under funded, and its failure to characterize accurately the reasons it is under funded, constitutes a breach of the trustees' fiduciary duties.

147. Excerpts from Trust CEO Robert Mitchell's October 28, 2003 Deposition support plaintiffs' claims that the Trust has not dealt in an appropriate fashion with these plaintiffs as it is required to do:

a. Trust CEO Robert Mitchell, Jr. has confirmed that "pro se claims have been designated as receiving priority" for "advancement into audit." *See* Mitchell Dep., at p. 27;

b. Trust CEO Robert Mitchell, Jr. has admitted in sworn deposition testimony that the Trust has *not* "made a determination that all claims of one particular category are reliable or not." *See* Mitchell Dep., at p. 32. He confirmed that "there may, indeed, be legitimate claims that that fall outside [its] priority scheme." *Id.* at 75;

c. Trust CEO Robert Mitchell, Jr. has admitted that in electing to participate in the Trust rather than opting out, claimants were never "told they would be given less priority in processing" based on these newly adopted criteria. *See* Mitchell Dep., at p. 40; *see also id.* 41-42, 44;

d. Trust CEO Robert Mitchell, Jr. has confirmed that, inexplicably, *pro se* claimants whose physicians attested to more than 20 Green Forms and because plaintiff is represented by counsel but who are not subject to the MPQ receive *priority* treatment, while identically situated represented claimants are sent to the back of the queue. *See* Mitchell Dep., at pp. 44-45. Indeed, if a represented claimant is *completely ready for audit*, he or she must await the completion of the

audit process for all of those claimants to whom the Trust has unilaterally given "priority." *Id.* at 91;

e. Trust CEO Robert Mitchell, Jr. has admitted that the Trust doesn't even know whether it has enough money to pay admittedly legitimate claims. *See* Mitchell Dep., at pp. 60, 66;

f. Trust CEO Robert Mitchell, Jr. has admitted that the Trust doesn't have any realistic projection of what percentage of claims will be deemed legitimate after audit. *See* Mitchell Dep., at pp. 64, 67;

g. Trust CEO Robert Mitchell, Jr. has confirmed that the Trust does not intend to process claims "in the order that they were filed," but rather will apply its new Priority Scheme. *See* Mitchell Dep., at p. 73; *see also id.* at 74-75.

148. Because the Settlement Agreement provides expressly that claims will be processed based on the date the completed claim is received, these re-prioritizations constitute an impermissible material alteration to the Settlement Agreement to the detriment of the plaintiffs.

THE AUDIT SYSTEM

149. As a deterrent against fraud the Trust had been permitted to designate 5% of the submitted claims for audit. In addition Wyeth was permitted to designate an additional 10% of the claims for audit.

150. As a response to what it viewed as an inordinate number of Matrix benefit claims that exceeded the projections made at the time of the fairness hearings, the Court ordered that 100% of all claims be audited by the Trust.

151. The Settlement Agreement intended that the auditors give deference to the opinion of the attesting physician and that claim could only be denied if it lacked a "reasonable medical basis."

152. Following the implementation of the 100% audit the Court approved the Trust's Auditing Cardiologist Training Course.

153. The Trust's Auditing Cardiologist Training Course instructs the auditor *not to rely on the "Green Form" protocol* in evaluating a claimant's medical condition. In the "Overview of Auditor Review Process," the auditor is told from the outset "[a]s you would *in your clinical practice,* you must review the materials submitted to assess a claimant's medical condition."

154. Auditors are not required to do planimetry or to provide alternate measurements of the regurgitant jet; rather, they are instructed to visually assess, or "eyeball" the jet and offer their opinion as to the extent of the valvular injury demonstrated.

155. "Eyeballing" results in a subjective qualitative assessment of the regurgitant jet rather than an objective and quantitative assessment as was required by the Settlement Agreement.

THE TRUSTEES FAILED TO IMPLEMENT THE 100% AUDIT ORDERED BY THE COURT

156. Upon information and belief there are 83,500 claimants who have filed claims for Matrix benefits.

157. During the hearings that resulted in the Court's order for a 100% audit in November 2002, the Trust assured the Court that it would be able to audit 2000 claims per month beginning in January 2003.

158. The Trust audited no claims in January 2003.

159. The Trust audited no claims in February 2003.

160. The Trust audited no claims in March 2003.

161. The Trust audited only 83 claims in April 2003.

162. The Trust audited only 93 claims in May 2003.

163. The Trust audited only 120 claims in June 2003.

164. The Trust audited only 192 claims in July 2003.

165. The Trust audited on 223 claims in August 2003.

166. At the current rate it will take the Trust nearly forty (40) years to complete the review of the claims currently pending.

COURT APPROVED PROCEDURE NO. 4

167. On March 26, 2003 the Court entered Pretrial Order 2805 which approved the implementation of Court Approved Procedure No. 4, "CAP No. 4."

168. CAP No. 4 required any class member who wished to pursue a claim for Matrix "A" Benefits to provide additional records or an additional certification by a physician, which ruled out the presence of reduction factors, which would otherwise preclude the payment of full Matrix Benefits.

169. CAP No. 4 permitted a class-member to consult with a physician, who would obtain a "medical history for the purposes of diagnosis and treatment of a person suspected of having valvular heart disease."

170. The physician is then required to complete a verification under the penalty of perjury verifying the information contained therein.

171. The purpose of CAP No. 4 was to address concerns regarding the medical histories, which formed part of the Green Form.

172. Payment of Matrix "A" benefits are not to be made unless a class member complies with CAP No. 4.

MOTION TO REMOVE THE TRUSTEES

173. On or about July 18, 2003 attorneys representing approximately 15,000 class members filed a motion with the District Court seeking the removal of the AHP Trustees.

174. The motion sought the removal of the Trustees on various grounds including incompetence, negligence and breach of fiduciary duty as outlined *supra*.

CLAIMS INTEGRITY PROGRAM

175. On August 4, 2003, the Trust filed a motion with the Court requesting approval for its new Operations Plan, included therein was a description of the purposes and plans for what the Trustees' described as the Claims Integrity Program, "CIP".

176. The CIP was ostensibly created in order to detect and remove fraudulent claims from the Trust.

177. As outlined in the Operations Plan, the CIP will consist of many elements including the use of a *Medical Practices Questionnaire* "MPQ," *Claims Integrity Hotline*, *Investigations* and *Recovery Actions*.

178. Upon information and belief the various aspects of the CIP including the contents of the MPQ were enacted by the Trust with the cooperation and assistance of counsel representing Wyeth.

179. In particular Wyeth reviewed the MPQ and suggested certain areas of inquiry to representatives of the Trustees including their Special Counsel.

MEDICAL PRACTICES QUESTIONNAIRE

180. The MPQ consists of 18 pages and 39 questions that must be answered in their entirety by the class members' Green Form attesting physician. The physician is directed that he or she must answer the questions without any assistance and that the form itself must be "PERSONALLY COMPLETED BY THE QUALIFIED PHYSICIAN WHO CERTIFIED THE GREEN FORM".

181. The MPQ requests information that was and is not part of what is required by the Green Form.

182. The Trustees' Special Counsel, Richard Scheff, Esq., has stated that it will take a physician approximately twenty (20) minutes to complete each MPQ.

183. Others have stated that it will take anywhere from 1-2 hours.

184. The instructions for the MPQ further state:

> THE TRUST WILL NOT DECIDE WHETHER OR NOT TO SUBMIT THE CLAIM IDENTIFIED ABOVE FOR FURTHER EVALUATION (INCLUDING THE COURT–MANDATED AUDIT) UNTIL THE TRUST HAS RECEIVED AND ANAYLZED YOUR RESPONSES TO THIS QUESTIONNAIRE. UPON RECEIPT OF THE QUESTIONNAIRE, THE TRUST MAY REQUEST ADDITIONAL INFORMATION. THE DEADLINE FOR RESPONSE IS DECEMBER 15, 2003.

185. As a result the processing of any claim that is subject to the requirement of the MPQ is now stayed.

186. On or about August 16, 2003, the Trust served approximately 16,000 MPQ's directed to 13 physicians. This resulted in the removal of 16,000 claims from the processing queue.

187. Assuming each of the 13 physicians has received approximately 1000 MPQ's it is estimated that it would take anywhere 300 to 2000 hours for each physician to complete the MPQ's so that the claims of 16,000 claimants could resume processing.

188. It is impossible for the MPQ's to be completed by December 15, 2003; there are simply not enough hours in a day. Three hundred hours represents seven and one-half weeks of continuous work by cardiologists, who have otherwise active clinical practices, devoted to nothing other than filling out the newly required forms.

189. Despite the fact that -- given this unduly burdensome demand -- physicians are unlikely to ever complete and provide the MPQ's or at the very least are unlikely to be able to comply with the December 15, 2003 deadline, the Trustees have not provided for any remedy should an otherwise legitimate claimant's claim be withdrawn from the processing queue for no other reason other than a physician has failed to provide the MPQ.

190. The Trustees have a fiduciary obligation to protect the rights and interests of their beneficiaries, and that fiduciary obligation is utterly abrogated by the actions taken by the Trust in designing the Medical Practices Questionnaire and the impossible deadlines and requirements to comply therewith. The Trustees' willful failure to provide a remedy constitutes a blatant breach of their fiduciary duty.

THE PRO SE COMPLETENESS CAP PROGRAM

191. Defendants have also implemented the "Pro Se Completeness Program" designed by defendants to assist in the "Prioritization Scheme" to deny the legitimate claimants herein and others similarly situated their Matrix benefits.

192. Defendants' proposed program for processing the pro se claims will essentially give those claimants preferential treatment as compared with those claimants represented by counsel.

193. Pursuant to the Claims Integrity Program, the Trust is holding the processing of all claims subject to the December 15, 2003 deadline for the submission of the medical practices questionnaire. Thereafter, it is not unreasonable to assume that further lengthy delays will accrue as the questionnaires are reviewed and further investigation and/or audits take place.

194. This essentially means that the claimants who are represented by counsel, whose attesting physicians are being required to fill out the lengthy medical practices questionnaire, will not likely see any movement in the processing of their claims until late into 2004, if ever.

195. By contrast, under the proposed plan for the *pro se* claimants, Class Counsel Claims Office ["CCCO"] will assist the pro se claimants in completing their claims. See Proposed Court Approved Procedure related to the Pro Se Claim Completeness Assistance Program ["Proposed Pro Se Claims Program"], at ¶2, "Scope of this Procedure." Upon completion of the claim, or determination by Class Counsel that the claim is complete, "Class Counsel will notify the Trust of the completed Claim, and the Trust will place the Claim in the Audit Queue for further processing in accordance with the Settlement Agreement and Rules for the Audit of Matrix Claims." *See* Proposed *Pro Se* Claim Program, at ¶ 6.

196. At this point in the procedure, the *pro se* claim that has been placed "in the Audit Queue" has effectively leapfrogged over the attorney-represented claimants in the quest for compensation of the claimants' diet drug-induced injuries.

197. There is no basis for such disparate treatment and implementing a program that essentially mandates that *pro se* claimants will be processed and, correspondingly, paid before their represented co-claimants.

198. Class members cannot be subjected to the sort of disparate treatment created by the proposed Pro Se Completeness Program; the interests of one group of class members -- in this case, those class members represented by counsel -- cannot suffer to satisfy the interests of other -- in this case, unrepresented -- class members. The disparate treatment has not ended with the Pro Se Completeness Program but continues to implemented at every turn by defendants.

199. The Prioritization Policy was recently detailed by the Trust on its website. On October 23, 2003, the Trust adopted a policy under which completed Matrix Level Benefit claims will be referred to the medical audit process. The Trust has already stated its policy that Matrix Level III, IV and V claims will receive expedited advancement and referral to medical audit, as announced in the Trust's Operations Plan of August 2003.

200. In addition, the following kinds of completed claims will be given priority:

- Level I, II, III, IV and V claims that were initially filed by a claimant without counsel (*i.e.*, on a *pro se* basis) and that are still handled on a *pro se* basis;
- Level I claims;
- Level II claims attested to by physicians who have attested to fewer than 20 Matrix claims; and

- Level II claims with both a Pink Form and a Green Form filed before February 15, 2002.

201. Upon information and belief, there are only approximately 800 claims for matrix level II benefits that were attested to by physicians who had signed fewer than 20 Green Forms.

202. As the Seventh Circuit held in reversing a district court's approval of a class action settlement where some class members received better deals than others, "convenience and expediency cannot justify the disregard of the individual rights of even a fraction of the class," even when the settlement's "defect may affect only a small portion" of the class. Such a settlement is "fundamentally unfair" and cannot stand. Oswald v. General Motors Corp. (In re General Motors Corp. Engine Interchange Litig.), 594 F.2d 1106, 1133-1134 (7th Cir.), *cert. denied*, 444 U.S. 870 (1979); *see also* Hanlon v. Chrysler Corp., 150 F.3d 1011, 1027 (9th Cir. 1998) (there should be "no disparate treatment between class members"); In re American Family Enters., 256 B.R. 377, 395, 424 (D.N.J. 2000) ("It is axiomatic that all Class Members possessing similar claims must be treated equally, and that preferential treatment . . . is impermissible.").

203. The Pro Se Completeness Program and Prioritization Policy, as currently proposed, are the ultimate act of disloyalty to the claimants that Class Counsel and the defendants herein purport to defend and support in this litigation; allowing one group of class members, those not represented by counsel, to benefit from preferential and expedited processing procedures on their claims.

204. Perhaps the most troubling aspect of the proposed "Pro Se Completeness Program" are sections 13 and 14, seeking a prohibition of liability for any negligence, omissions or mishandling of a pro se claimants' submission by Trust.

205. Certainly, the law is well settled that a fiduciary cannot limit his liability for negligence in the discharge of fiduciary duties.

206. Neither Class Counsel, nor, apparently, the Trust, have offered any explanation or argument as to why they should be able to do so here except in the absence of a showing of recklessness.

207. The Trust has limited funds available to pay the 83,500 Matrix claims now pending before it.

208. The Trust's last report published on October 21, 2003 reveals that there is perhaps one billion dollars remaining to pay Matrix claims. That is enough money to pay approximately 2,500 claims.[1]

209. While the Trust has not published or made available any data concerning the projected audit pass rate of claims, in support of the joint motion to suspend the payment of matrix benefits jointly filed last September by Wyeth and Class Counsel, the parties relied upon a review of the pending claims conducted by Dr. Arthur Weyman who concluded that approximately 30% of the claims would pass audit.

210. Taking even the number of claims processed to completion awaiting audit as opposed to the total number of Matrix claims which have been filed, (*i.e.*, 37,322 vs. 83,500), and applying the Weyman-projected audit pass rate of 30%, this Court can reasonably anticipate that 11,996 claimants will qualify for Matrix payments from the pool of completed claims. *That is approximately four times as many claims as the Trust can pay.*

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[1] In its last report the Trust reported that it had paid 1.039 billion dollars to 2,625 claimants. Simple arithmetic reveals that the average matrix claim is paid $395,809.52

211. The Trust has never issued a statement to the class members regarding the potential of fund insolvency.

CLASS MEMBERS SUBJECT TO THE MEDICAL PRACTICES QUESTIONNAIRE ARE PREJUDICED DUE TO IMPENDING FUND INSOLVENCY

212. The 16,000 class members whose claims have been removed from the processing queue due to the service of the MPQ have not been afforded any protection by the Trustees to preserve the funds that would pay their claims.

213. Though the 16,000 claims have been removed from processing, the Trust states that it plans to audit approximately 1000 claims per month.

214. Given an audit pass rate of 30% as per Weyman, the Trust will process and pay Matrix benefits to 2,400 claimants over the next eight months, resulting in fund insolvency.

215. It is unlikely that there will be any funds available to pay any of the 16,000 claims that have been removed from the processing queue upon their return should there be compliance with the MPQ.

216. The Trustees' knowing and willful actions prejudice the claims of their beneficiaries and thus constitute a breach of the fiduciary duties owed those beneficiaries.

THE TRUSTEES' REFUSAL TO PAY MATRIX BENEFITS TO THOSE WHO HAVE MET THE REQUIREMENTS IS A BREACH OF THEIR FIDUCIARY DUTIES

217. Plaintiff Elbert Fry has complied with all of the requirements of the Settlement Agreement.

218. Plaintiff Elbert Fry's claim was audited and found to qualify for Matrix benefits.

219. That plaintiff has complied with the requirements of CAP No.4.

220. That plaintiff had been informed by the Trust that the claim would be paid Matrix benefits.

221. The Trust has since informed Mr. Fry that:

> While this claim has been approved by an auditor for payment, the Trust will not make payment until it has investigated the circumstances of the acquisition for the echocardiogram and resolved certain legal issues related to the recent civil actions filed against Dr. Crouse.

222. Though the legal action filed against Dr. Crouse could take years to resolve, no provision has been made to protect the interests of the beneficiaries affected by the Trustees' actions.

223. The refusal to pay Matrix benefits to otherwise qualified beneficiaries constitutes a breach of the fiduciary duty the Trustees owe those beneficiaries.

AS AND FOR A FIRST CAUSE OF ACTION –
BREACH OF FIDUCIARY DUTY

224. The plaintiffs and those similarly situated repeat, reallege and reiterate each and every one of the allegations set forth in paragraphs enumerated as "1" through "223," inclusive, *supra*, as if fully set forth herein.

225. As fiduciaries, the Trustees owe a duty of undivided loyalty to the beneficiaries of the Trust including the plaintiffs herein.

226. The Defendants' failure to pay the meritorious claim submitted by Elbert Fry is a breach of the fiduciary duty owed Elbert Fry.

227. Defendants' determination to develop a scheme to prioritize claims, the "Prioritization Scheme," to deny class members matrix benefits is a breach of duty to

Kathleen Kelly-Lyon, Ellen Brownstein, Patricia Jackson, Linda Gregory, Christine Canton, and Virginia Sanchez.

228. As a result of the Trustees' breach of fiduciary duty, Elbert Fry, Kathleen Kelly-Lyon, Ellen Brownstein, Patricia Jackson, Linda Gregory, Christine Canton, and Virginia Sanchez have been damaged and seek compensatory and punitive damages in an amount to be determined by a jury.

AS AND FOR A SECOND CAUSE OF ACTION – BREACH OF CONTRACT

229. The plaintiffs and those claimants similarly situated repeat, reallege and reiterate each and every one of the allegations set forth in the paragraphs enumerated "1" through "228", inclusive, as if fully set forth herein.

230. The Tentative Determination Letter signed and executed by Elbert Fry constituted a valid contract.

231. Plaintiff Elbert Fry properly executed said contract and conformed to all of the terms of the contract.

232. The Final determination letter sent to Plaintiff Elbert Fry by the Trust and the acceptance of that determination forwarded by Elbert Fry to the Trust constituted a valid contract.

233. Elbert Fry performed and conformed to all of the terms of that contract.

234. The Trustees' refusal to pay Elbert Fry's claims notwithstanding the contract formed by the Final Determination Letter and Elbert Fry's acceptance thereof constitutes the Trustees' breach of their contracts with Elbert Fry.

235. As a result of the Trustees' breach of contract, Elbert Fry has been damaged in the sum of his matrix amount of $431,224.00.

236. As a result of the defendants' breach of contract, Elbert Fry has lost the value of interest on the monies he was due to receive beginning on and continuing from the time when his payment was to be made and continuing into the future.

WHEREFORE, Plaintiffs pray for a judgment against these Defendants herein for:

1. Compensatory damages for lost monies and interest as a direct result of defendants "prioritizing" of claims and incidental and consequential damages in an amount to be determined by a jury;
2. Punitive damages in an amount sufficient to punish Defendants and to deter the conduct complained of in the future;
3. Interest on the damages according to law;
4. Attorneys' fees and the costs and disbursements of this lawsuit; and,
5. Any other and further relief as the Court deems just, proper, and equitable.

JURY TRIAL DEMANDED

Plaintiffs demand a trial by jury of all claims asserted in this Complaint.

Dated: November 4, 2003
Philadelphia, PA

Respectfully submitted,

NAPOLI, KAISER BERN & ASSOCIATES, LLP

By: _____

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