BERMAN & WALTON, LLP
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Winter 2004

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Berman & Walton, LLP

Areas of Practice:

- Serious Personal Injury
- Wrongful Death
- Nursing Home Litigation
- Construction Site Accidents
- Automobile/Motorcycle
- Products Liability
- Burn Injuries
- Slip & Fall

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State of California Settles Case Involving Death of Dependent Adult at State Facility

After enduring several months of physical abuse while a resident of Lanterman Developmental Center, a state-run facility located in Southern California, Mark O., a 31-year-old developmentally disabled man, was killed by a significant blow to the abdomen. An examination of the body determined that the fatal blow was likely intentional. While it could not be determined whether the perpetrator of the fatal blow was another developmentally disabled resident or one of the facility's employees, the facility paid $950,000 to his family to settle a wrongful death lawsuit filed by *Berman & Walton, LLP*.

Mark O. with his loving parents.

Mark became developmentally disabled as an infant when he suffered brain damage caused by meningitis. He had been placed at Lanterman in February 2002 after his physical and mental health began to deteriorate in his mid 20's. He was previously a cheerful, outgoing person who, after he reached adulthood, even lived "independently" as a resident in a few other community centers. But as he grew older he became overweight, lethargic, and depressed. After consultation with his physicians and a psychologist at Lanterman, Mark's parents decided it would be in their son's best interest to place him in a facility they felt could provide the stable environment Mark needed.

The physicians and caretakers at Lanterman were convinced that, with their guidance, Mark could return to his former happy self. They believed that if they weaned Mark from his psychotropic medications and put him on a diet to lose weight, he would become a "happy camper" once more.

(Continued inside)

Workers Obtain $2,500,000 Third-Party Settlement in Propane Explosion Case

Few of us would have difficulty imagining the extreme pain and agony a person must experience after being burned in a propane explosion. Alfonzo D. and Dionicio R. were two workers at a Southern California manufacturing plant. As part of the business operation, the company utilized propane-fueled forklifts. It was during the fueling of one of these forklifts that a propane explosion occurred.

On the recommendation of defendant welding company, the plaintiffs' employer entered into a written services contract with the welding company to provide it with propane in bulk amounts. As part of this written contract, the welding company agreed to provide plaintiffs' employer with all of its required propane gas and propane equipment, and to maintain the equipment it provided. It also agreed to train the employees of the company in the safe use and hazards associated with liquid propane.

Shortly after entering into this agreement, the welding company contacted the propane company to request that it put a large 500-gallon bulk-storage propane tank upon plaintiffs' employer's property. The propane company obliged, and sent its own team to deliver and install the bulk-storage propane tank on the

(Continued inside)

When Mark was first admitted, he was placed in a room with a single roommate with whom he immediately began to have altercations. While it was unclear who initiated these altercations, it was clear that the two roommates did not get along. To resolve this issue, Mark was moved out of this first room and placed in a room with three roommates, a move that has received much criticism from doctors, medical experts and even employees of the facility.

One employee even testified in a deposition that he was surprised and "upset" that Mark was moved to a room with three roommates when it appeared he couldn't get along with a single roommate. Furthermore, the employee complained that the move — which he called "totally nuts" — placed Mark further away from the residence's main desk, making close supervision more difficult.

After Mark was moved into a larger room with three roommates, the abuse really began. Staff began to notice that Mark was sustaining unexplained injuries on his body. Over a period of six months, Mark sustained over a dozen documented instances of abuse, including severe beatings which resulted in multiple bruises and lacerations. Because of the unusually high number of incidents, Mark was placed on 15-minute bed checks during the night, and a special Interdisciplinary Team meeting was held in May, 2002. The meeting was initiated by the staff physician overseeing Mark's care, who testified that in his 20 years at the facility he had never been so concerned for the health and safety of a resident as he was for Mark's well being. His recommendation was for immediate action to transfer Mark into a residence with less violent peers.

The conclusion of all in attendance at that meeting, including a psychologist, a social worker, the Program Director and the Residence Director, was the Mark should be transferred to another program at Lanterman. Unfortunately, due to a lack of diligence, the "paperwork was lost" and the transfer was never made.

Meanwhile, for over six weeks after this meeting the abuse against Mark escalated to a point where, on June 30, 2002 he suffered a beating that left him with a bruised left ear, two swollen eyes, a swollen lower lip, a swollen left foot, and a new bruise in his groin area. Despite pleas from staff members to the Program Director and the Resident Manager, Mark's transfer to a residence with less aggressive peers was still not implemented. He continued to suffer abuse, including two more instances in July, 2002 which left him with three fractured fingers, severe bruising and a bloody mouth.

The final, fatal abuse to Mark occurred in the early morning of August 7, 2002. While performing a routine bed-check at approximately 4:45 a.m. that morning, an orderly smelled feces immediately upon entering Mark's room. Mark had soiled his sheets. After showering Mark and changing his bed linens, the orderly put Mark back in bed and went to get him a warm blanket, which he testified is something that Mark liked. When he returned to the room, he believed Mark, as well as the other residents of the room, were asleep.

The orderly testified that 3-10 minutes later one of Mark's roommates came out into the hall and was noted to be biting on his hand, something this profoundly autistic man did when he was agitated because he was unable to communicate. The orderly escorted the roommate back to the room and noticed Mark lying on the floor in the prone position, head turned to the side and breathing laboriously. The orderly yelled for medical assistance, and though a Code Blue team worked on Mark for several minutes his vital signs faded until he was pronounced dead at 5:06 a.m.

At first a treating physician believed Mark's death was caused by some cardiac event, but after an autopsy it was later determined that Mark died of blunt force trauma to the abdomen. The death was officially ruled as a homicide, but the perpetrator has never been identified.

Berman & Walton, LLP filed suit on behalf of the family last year alleging, among other causes of action, that the negligent and willful conduct of the administration and staff at the facility in failing to protect Mark fell under the provisions of what is commonly known as California's Elder Abuse and Dependent Adult Civil Protection Act. This Act was created to provide special protections for victims of abuse and neglect, including developmentally disabled adults like Mark.

Mark's family is deeply saddened by the loss of this loving, affectionate young man and his presence in their lives is sorely missed by many. His parents know that the settlement cannot bring their son back to them, nor does it excuse the facility's severe neglect of their son which enabled him to be systematically abused. However, there is hope that the administrators and staff at this facility will never again let another resident "slip through the cracks" or suffer the severe physical mistreatment Mark had to endure. ★

Did You Know?

Useful Information from California Advocates for Nursing Home Reform

Admission to a nursing facility can be a very stressful time for both the resident and the family. There are so many things to understand and address at the initial time of placement, that the process can be overwhelming.

Here are some tips to keep in mind before signing the admission agreement.

* The Code of Federal Regulations (42 CFR § 483.12) prohibits a nursing home from requiring a third party to guarantee payment as a condition of a resident's admission, expedited admission, or continued stay in the facility.

* The facility may require an individual who has legal access to a resident's available income or resources to sign a contract, without incurring personal financial liability, in order to provide the facility payment from the resident's income or resources.

* Family and friends who sign as a "Responsible Party" or "Agent" under a Power of Attorney are not personally financially liable for debts incurred, but are responsible for administering the resident's funds to the facility.

* California Health and Safety Code § 1599.69 states that the Admission contract shall state in bold capital letters of not less than 10-point type that no certified facility may require as a condition of admission, either in the contract of admission or by oral promise prior to signing the contract, that residents remain in private-pay status for a specified period of time.

Propane Explosion *(Continued)*

company's property on or around February 1998. The propane company placed the bulk-storage tank in a clearly unsafe location, in a poorly ventilated area far too close to several potential sources of ignition, including a water heater with an open flame.

The placement of the bulk-storage propane tank was not the only careless act on the part of the defendants. A greater act of negligence was defendants' failure to provide the company with the proper shut-off valve at the end of the filler hose. The valve failed to contain any mechanism to safely bleed or vent the remnant gas that normally is stuck between the small cylinder and the closed filler hose. The danger posed by that set-up is the potential for catastrophic leaks, as occurred to Alfonzo and Dionicio.

On the afternoon of April 8, 2002, Dionicio was operating one of his employer's propane-fueled forklifts, when its fuel tank became low. He drove the forklift to the large bulk-storage propane tank (the dispensing station) and started the process of refueling. Although Dionicio was trained to do this procedure, albeit minimally by a company employee and not by the welding company as per its agreement with the company, and although Dionicio had successfully completed tank refuelings over 100 times before, on this occasion all the things that could go wrong did.

After filling the tank, Dionicio closed the spit valve, and started to release the hose from the portable tank. When he did so, large amounts of propane gas began to leak at the point of connection, causing a large cloud of propane gas to accumulate around the bulk-tank, and drift toward a nearby building. Dionicio attempted to close the connection to stop the leak, but it was frozen in place by the leaking propane.

Unable to release the hose from the portable tank and unsure what to do, Dionicio immediately summoned his supervisor, Alfonzo. Alfonzo went to the area where the tanks were located, saw the propane vapor cloud and the ice around the connection. He immediately attempted to turn off the main valve at the base of the large bulk storage tank, but propane gas continued to leak from the smaller portable tank. Seconds later the propane ignited. There was a large flash fire, and both men were seriously burned. Both men were transferred via helicopter from the scene to the UCSD Medical Center Burn Unit where they both remained hospitalized for several weeks.

To this day Alfonzo and Dionicio suffer from residual pain and badly scarred skin to their hands, faces, arms and legs. Both were required to undergo numerous surgeries to repair and heal their raw flesh, and will likely need multiple surgeries in the future to minimize scarring.

Shortly after the incident, Alfonzo and Dionicio retained the services of *Berman & Walton, LLP*, to represent them in a lawsuit filed against the welding company and the propane company. Despite a strong defense mounted by the attorneys for the named defendants, the attorneys at *Berman & Walton, LLP*, were able to obtain a $2,500,000.00 settlement for the men. ★

Did you Know? *(Continued)*

* According to H & S § 1599.69, every contract of admission must clearly and explicitly state whether the facility participates in the Medi-Cal Program.

These are just some examples of Admission Agreement protections. If you have any questions about your admission agreement, please call the California Advocates for Nursing Home Reform office at (800) 474-1116 and ask to speak with a resident advocate.

Reprinted by permission of California Advocates for Nursing Home Reform. Excerpt from the March 2003 issue of the Advocate.

You Have the Right to Choose Your Own Pharmacy

Nursing facilities cannot force residents to buy medications from a specific pharmacy. California Health & Safety Code § 1320 states that nursing facilities "shall not require patients to purchase drugs, or rent or purchase medical supplies or equipment, from any particular pharmacy or other source." H & S Code § 1569.314 is the equivalent law for residential care facilities for the elderly (RCFE's).

What facilities can require is that residents and pharmacies comply with medication policies and procedures reasonably necessary for patient care or compliance with regulations.

If facilities persist in refusing medication purchases from outside pharmacies, call California Advocates for Nursing Home Reform office at (800) 474-1116 and file a complaint with your local Licensing office.

Reprinted by permission of California Advocates for Nursing Home Reform. Excerpt from the Summer 2004 issue of the Advocate

Informed Consent Prior to the Use of Restraints

Nursing homes must obtain the informed consent of the resident or resident's representative before administering psychotherapeutic drugs, physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function.

Nursing homes often use drugs like Haldol or Risperdal to control the behavior of residents. Before they can administer these chemical restraints (or any physical restraints), nursing homes must disclose to the resident all information that is material to the resident's decision whether or not to accept the restraints. Such information includes the reasons for the restraints, the risks involved, and the right to accept or refuse.

If the resident is capable of granting or withholding consent, only the resident may do so. If the resident lacks mental capacity, then the resident's representative may grant or refuse consent. Under California law, persons who may act as the resident's representative include a conservator, an agent designated under a valid power of attorney for health care, and the patient's next of kin.

For questions about informed consent, contact California Advocates for Nursing Home Reform at (800) 474-1116. Report violations of residents' informed consent rights to your district Department of Health Services, Licensing & Certification Division.

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