Senior Assistance

CASE IN FOCUS: Fearing a jury's reaction to testimony about a nursing-home resident whose calls for help were allegedly ignored, the defense settled a case for $2.2 million — one of the largest reported elder-abuse settlements in history.

BY DIANE TAYLOR

In the early morning hours of Nov. 15, 1998, 74-year-old Lorraine Konblett became extremely ill. A resident at Channel Islands Gardens, an Oxnard board-and care-facility, Konblett repeatedly summoned for help, but her calls went unanswered. Not until the next morning — when Konblett was found lying on the floor, covered in her own vomit — did the staff realize that she was in medical distress.

At that point they summoned an ambulance and took Konblett to the hospital, but their actions came too late, according to some. Konblett was diagnosed with aspirated pneumonia, which was purportedly caused by the aspiration of vomit into her lungs. Two months later Konblett, who had lapsed into a coma after the incident and never regained consciousness, died from multiorgan system failure.

"Individuals who have decisions to make about placing family members in similar facilities need to be made aware that there is horrific abuse and neglect taking place in these residential care facilities," says William M. Berman, who represented Konblett's daughter, Sheila Schlichter, in a Ventura Superior Court action she filed against Channel Islands.

WILLIAM M. BERMAN — "It was very important to both me and my client that the facts of this case be exposed publicly. ... Hopefully, public disclosure will lead to reform so that our elders are provided with the care that they need and deserve."

Berman, a San Diego sole practitioner, filed the lawsuit under California's Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA). In most cases, the amount of noneconomic damages in these cases is capped at $250,000 in accordance with the provisions of the Medical Injury Compensation Reform Act. However Berman contended that MICRA was not applicable to this situation because Channel Islands was a residential care facility, not a skilled nursing facility.

His argument was apparently persuasive. On Sept. 3, the case settled for $2.2 million — one of the largest settlement figures ever reported in an elder-abuse case. As part of the agreement, Schlichter demanded that the names in the case remain public.

"Hopefully, public disclosure will lead to reform so that our elders are provided with the care that they need and deserve," Berman says.

Robert C. Reback, a partner at Manhattan Beach's Reback, Hulbert, McAndrews & Kjar, represented Channel Islands in this action. He denies that Konblett's death was caused by the Nov. 15 incident, because she had been diagnosed with pneumonia several days before the incident.

Additionally, Reback says that Konblett's death did not stem from pneumonia, but complications from other diseases, and the plaintiffs would have had some "serious causation hurdles" if the case had gone to trial.

Still, they had testimony that caused Reback some concern. One of the cases' key pieces of evidence dealt with the shift supervisor ordering staff to tie up Konblett's emergency call cord. Additionally, a staff member pushed Konblett's wheelchair away from the bed, so she could not reach it, and unplugged her telephone.

"The plaintiff could have convinced the jury that she suffered emotional distress as a result. A jury may have been angered by this one caretaker's actions, which could have led to a steamroller of animus against my corporate client and ultimately to an unfavorable verdict," Reback says. "It was thus in the best interest of my client not to take this kind of risk with a jury and to resolve the matter."

Another concern was the state in which Konblett was found. After she was discovered by a care giver the next morning, he reported her condition to the shift supervisor, who allegedly told the staff member to leave her on the floor, and tend to the other residents first. Additionally, the care giver said that his supervisor already knew Konblett was on the floor, and he also knew that she had been there all night.

The care giver did not heed his supervisor's orders, and attempted to help Konblett. When he realized that he could not do that by himself, he asked another shift supervisor for assistance. She allegedly told him that she was too busy, and he finally convinced another staff member to help him get Konblett off the floor and into the shower. Then he noticed that Konblett was having trouble breathing. He again notified his supervisor, who allegedly failed to respond.

After he got her out of the shower and dressed, the care giver wheeled Konblett to the supervisor's desk, and berated her for not helping him. After the supervisor finally looked at Konblett, she called an ambulance.

If the case had gone to trial, both sides were prepared to offer testimony from pulmonary specialists. The defense witness held that Konblett's aspirated pneumonia

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SIDEBAR

Type: Elder abuse

Settlement: $2.2 million

Case/Number: *Schlichter v. CIG Oxnard Inc. d/b/a Channel Islands Gardens / CIV 186122*

Court/Date: Ventura Superior / Sept. 3, 1999

Judge/Department: Henry Jay Walsh / Dept. 33

Attorneys: Plaintiff — William M. Berman (Law Offices of William M. Berman, San Diego)
Defendant — Robert C. Reback (Reback, Hulbert, McAndrews & Kjar, Manhattan Beach); Mark Schreiber (Law Offices of Mark Schreiber, Encino)

Experts: Plaintiff — Michael E. Kalafer, pulmonologist, San Diego; Tracy Albee, R.N., Tracy, Calif.
Defendant — Michael J. Lieber, pulmonologist, Los Angeles

Photo by Tom Kurtz

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was caused by a series of small aspiration events that occurred well before that evening, and that her clinical presentation at the hospital that morning was not consistent with only three to four hours of aspiration.

Alternatively, the plaintiff's expert witness stated that the staff's failure to check on Konblett for several hours, combined with her inability to use the call system to summon help, led to a severe aspiration event and to aspiration pneumonia.

As additional evidence of the facility's liability, the plaintiffs cited a report prepared by the California Department of Social Services, which was notified of Konblett's condition after she was rushed to the emergency room. After interviewing Channel Island's staff, the state investigator found that the facility was in violation of Title 22 of the California Code of Regulations by not having an appropriate plan to meet Konblett's needs, especially with regard to her safety and in protecting her from falling out of bed.

The report also noted that Konblett could not summon help when she was feeling sick on Nov. 15, because her emergency cord had been wrapped around the signal device so she could not reach it. Given the dried condition of the vomit found on Konblett's face and hair, the report continued, it was "evident that the resident had been unattended too long."

The report concluded that even though Konblett may have often misused the emergency call system, it was "improper for someone to make it inaccessible to her" and rather "should have been fixed to her bed so that it would always be available to her."

The defense does not agree with the report's conclusions. One of their expert witnesses, a pulmonologist and critical care specialist, stated in a declaration that "it was not medically necessary for this patient to have a 'call button' available to her during the night of Nov. 14-15, 1998 ... [because] there [was] no evidence that the patient suffered from acute illness at that time."

Additionally, he stated that if Konblett had required the use of a call button due to an acute condition, her treating physician would have hospitalized her. The call button, the expert concluded, merely served as a "convenience" and was "in no way medically necessary."

Still, proving the defense's case may have been a challenge, especially when the staff members' testimony was coupled with the department of social services' report.

Besides mentioning that it was "improper" to take away Konblett's ability to get help, the report cited the fact that Konblett's family paid Channel Islands an additional $450 a month to ensure that she would get extra care, attention and monitoring. However, the report concluded, the center actually failed to meet Konblett's basic needs and did "nothing extra" for her.