

MENTAL HEALTH**Negligent Treatment — Wrongful Death****Son killed himself at facility;
father blamed inpatient care**

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| VERDICT | Defense |
| CASE | Valentin Gonzalez Sr. v. Penn Mar Therapeutic Center, No. KC051107 |
| COURT | Superior Court of Los Angeles County, Pomona, CA |
| JUDGE | Bruce Minto |
| DATE | 6/2/2009 |
| PLAINTIFF ATTORNEY(S) | Antonio H. Rodriguez (lead), Law Offices of Antonio Rodriguez, Los Angeles, CA (Valentin Gonzalez Sr.) Delia Flores, Solo practitioner, Wilmington, CA (Valentin Gonzalez Sr.) |
| DEFENSE ATTORNEY(S) | Raymond L. Blessey, Taylor Blessey LLP, Los Angeles, CA |

FACTS & ALLEGATIONS On Jan. 6, 2006, plaintiff's decedent Valentin Gonzalez Jr., 27, an auto mechanic, was taken off life support and pronounced dead, one week after he had hanged himself at Penn Mar Therapeutic Center, an acute psychiatric facility in El Monte.

On Dec. 11, 2005, Gonzalez was admitted to LAC-USC Medical Center on an involuntary hold due to being a danger to himself. Twenty-four hours later, he was transferred to White Memorial Medical Center, where his involuntary hold was extended to 14 days.

On Dec. 22, he was discharged from WMMC on Thorazine and instructed to follow-up with outpatient psychological counseling.

On Dec. 28, while driving home with his father from a hearing regarding a bankruptcy matter, Gonzalez pulled a knife and threatened to kill himself. His father testified that he had to struggle with his son to take the knife away and thwart the suicide attempt. Later that same day, Gonzalez obtained a knife from the kitchen and went into the bathroom; the father intervened and struggled with his son to prevent him from hurting himself. The father called the police, and Gonzalez was taken to LAC-USC on an involuntary hold due to being a danger to himself and to others. Approximately 24 hours later, the hospital made plans to transfer Gonzalez to another facility due to the unavailability of inpatient beds.

On Dec. 29, Gonzalez transferred to Penn Mar. The charge nurse saw him that evening and obtained orders from the on-call psychiatrist. The physician orders included placing Gonzalez on a "q 15 minute" suicide watch.

On Dec. 30, at approximately 9:30 a.m., the attending psychiatrist interviewed and examined Gonzalez, and found him

to be calm, cooperative, and denying suicidal ideation. His differential diagnoses included rule out paranoid schizophrenia and major depression with a psychotic component; the doctor ordered the administration of Zyprexa, an anti-psychotic medication, that evening.

An unlicensed social worker interviewed Gonzalez that morning, and noted that he was agitated and responding to internal stimuli, and that he was fairly cooperative and denied suicide ideation.

Around noon that day, the shift nurse interviewed Gonzalez and documented that he was mostly withdrawn and isolated, but without suicidal ideation and agitation.

A family member of Gonzalez's called the social worker at about 3 p.m. and reported that Gonzalez was hearing voices that were urging him to kill himself. The social worker claimed that she reported the call to the charge nurse; the social worker did not, however, document the call, contrary to her normal custom and practice. In addition, the charge nurse denied that he was informed about the call.

The psychology technician — who saw Gonzalez via a head count every 15 minutes at 3:15, 3:30, 3:45 and 4 p.m. — stated that his behavior was not unusual or concerning. At approximately 3:50 p.m., Gonzalez approached the staff member who had been assigned to room checks and inquired about the identity of the staff members assigned to head count and room checks.

At approximately 4:15 p.m., just prior to completing her head count rounds, the psychology technician realized that she had not accounted for Gonzalez. She went to his room and found him in the bathroom hanging from the inside of the door, with a sheet tied around his neck and affixed to the top of the door. She summoned the assistance of several other staff members who commenced CPR immediately. Paramedics came to the facility and transported Gonzalez to an acute care hospital for further evaluation and treatment.

On Jan. 6, 2006, Gonzalez was declared brain dead and taken off life support. He was pronounced dead shortly thereafter.

Gonzalez's father sued Penn Mar, alleging medical malpractice and wrongful death based on negligent inpatient psychiatric care.

The plaintiff argued that Gonzalez was at high risk for suicide and that he was a guarded patient with poor insight and judgment; as a result, his ongoing denial of suicidal ideation should not have been taken seriously. He argued that Gonzalez would not have hung himself if Penn Mar had implemented a heightened level of suicide precaution, such as one-to-one observation or line-of-sight observation.

The plaintiff psychiatry expert opined that the attending psychiatrist failed to assess Gonzalez adequately for suicide risk factors and that Penn Mar should have implemented one-to-one observation or line-of-sight observation.

The plaintiff psychiatric nursing expert opined that Penn Mar fell below the standard of care in numerous ways, including the use of support staff that was inadequately trained and inappropriately supervised.

Penn Mar argued that its care and treatment were within the applicable standard at all times and that the care at issue was not a substantial factor leading to Gonzalez's death.

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The defense psychiatry expert opined that there is no single risk factor or set of risk factors that can predict reasonably which inpatient will attempt suicide, or when the attempt is likely to occur. He opined that Gonzalez's clinical presentation, including his denial of suicide ideation, placed him at a relatively low risk of imminent suicide; therefore, it was appropriate and well within the standard of care to place him on an every-15-minute watch.

INJURIES/DAMAGES *death; loss of society*

Gonzalez lost his life.

His father — Valentin Gonzalez Sr., 64, an auto mechanic — sought approximately \$14,000 in funeral and burial expenses, and at least \$300,000 in general damages.

RESULT The jury returned a defense verdict, finding that Penn Mar was not negligent.

DEMAND None
OFFER Waiver of costs

INSURER(S) Hudson Insurance Co. for Penn Mar

TRIAL DETAILS Trial Length: 8 days
Trial Deliberations: 75 minutes
Jury Vote: 12-0

**PLAINTIFF
EXPERT(S)** Mace Beckson, M.D., psychiatry,
Los Angeles, CA
Denise K. Rounds, R.N., psychiatric
nursing, Huntington Beach, CA

**DEFENSE
EXPERT(S)** Lester M. Zackler, M.D., psychiatry,
Sherman Oaks, CA

EDITOR'S NOTE This report is based on information that was provided by defense counsel. Plaintiff's counsel did not respond to the reporter's phone calls.

—Joseph Falso