A REPORT TO CLIENTS & ATTORNEYS VOLUME 13, NUMBER 2

# **Negligence by property** management company results in \$12 million award to boy's family

### Nine-vear-old bicyclist killed by driver whose vision was blocked by overgrown hedge.

The Daily Business Review, May 2, 2013, edition, published a lead article for its "Verdicts & Settlements" report on an automobile negligence and premises liability case tried by SDSBS attorneys Greg Barnhart, Karen Terry, and Matt Schwencke. In January 2011, nine-year-old Andrew Connor Curtis was spending the weekend with his father, Andre Kovacs, in Jupiter, Florida. The two went for a bike ride along U. S. Highway One, with Andrew following his father. At the intersection of U.S. Highway One and the Villas on the Green complex, a minivan driven by Helen Bygel made a lawful stop at a stop sign, and proceeded to pull out into traffic to make a right hand turn. The vehicle missed Mr. Kovacs but struck and killed Andrew.

Mr. Kovacs and Andrew's mother, Tracy Curtis, filed civil actions against the driver, Helen Bygel, Villas on the Green Townhouse Association, Villas on the Green Condominium Association, and the property management



dential settlement with the parents prior to trial.

At trial, the SDSBS attorneys called a traffic safety engineering expert to the stand to testify that visual obstructions were present at the exit of the facility that violated the law. These obstructions consisted of a hedge bordering the property that was twice the height allowed by the Code (Continued on page fifteen.)

## Ignored or disabled ventilator alarm results in death

#### Nurse was incapable of performing **CPR** in effort to revive infant.

In 2009, Adam and Betty Crandall (not their real names) were newlyweds, looking forward to an active, exciting life together. The couple settled in Florida and began planning for a family. Unfortunately, Betty had a blocked fallopian tube that required surgical repair which prevented her from becoming pregnant naturally. The couple elected to do in vitro fertilization. Shortly after starting the procedure, they learned that they were pregnant with triplets. Topping that news, they learned soon after that they were having quadruplets. They were overjoyed.

In Betty's second trimester, she began to show signs of early labor. She was admitted to a hospital and told that the babies' births were pending and that the babies would not survive. Betty was advised to accelerate labor to prevent infection. Determined to save her babies, Betty refused advanced labor. She was on complete bed rest for months. Although one child was stillborn at 23 weeks, the other three babies were born at 25 weeks and survived. Because they were very premature, the babies - a boy named David, and sisters Ellie and Faith (not their real names) - were ventilator-dependent and required extensive care in a neonatal intensive care unit. At nine months of age, the three babies were (Continued on page seventeen.)

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# Ignored or disabled ventilator alarm results in death

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allowed to go home. Requiring aroundthe-clock nursing care, home ventilators, and monitors, the babies' discharge dates were staggered to prevent overwhelming the parents.

The hospital provided the Crandalls with references to several home health-care agencies. The couple eventually selected XYZ Pediatric Care, Inc. (not its real name) to provide round-the-clock home nursing for the three children. The parents were assured that the company would provide top quality infant care to meet each baby's needs. The agreement worked well for the first several weeks. Then Betty began finding some of the night nurses sleeping on the job. Betty reported this to the company and refused to allow those nurses back into her home.

The last baby to be discharged from the hospital was Faith, mostly because her condition was more complicated than those of her siblings. Faith had been diagnosed with periventricular leukomalacia (a type of brain injury that affects infants), although the extent of any disability caused by that condition had yet to be determined. Ellie and Faith were in separate cribs, in the same room, with the nurse's station between the two cribs. Baby David was off the ventilator and sleeping in his parents' room. For more than a week after arriving home, Faith thrived, responding to family attention and smiling. On the evening of February 25, 2010, Jane Doe (not her real name), a licensed practical nurse assigned by XYZ Pediatric Care to work the night shift (7:00 pm to 7:00 am) was on duty. Checking on her two baby girls before bedtime, Betty noticed that Faith's pulse oximeter (a device used to continuously monitor pulse and blood oxygenation)

had been turned off. The nurse admitted to turning the monitor off, and Betty directed her to turn it back on. The oximeter was attached to Faith's toe and secured with a Velcro fastener and a sock. Both the oximeter and the baby's ventilator were equipped with alarms so that if the baby stopped breathing, the alarm would sound. In addition to this protection, the nurse was required by contract to monitor the children throughout the night and keep a close eye on each of them

At some point that night, Faith stopped breathing. Either the nurse turned the alarm off again, or she ignored it. She failed to recognize that the baby was in crisis until it was too late – the baby was cold, blue, and unresponsive. The nurse panicked and started screaming and trying ineffectively to administer cardiopulmonary resuscitation, but she

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was confused and inept. Betty told the nurse to use the AMBU bag to resuscitate the baby, but the nurse could not work the equipment properly and, eventually, in frustration, threw it across the room against the wall. Betty began to administer CPR to Faith until the emergency paramedics arrived. The baby was transported to the hospital. Her body temperature had dropped to 80 degrees. The hospital doctors told Adam and Betty that their baby girl was dead.

The police investigation eventually found that the ventilator's alarm had been disabled. All other functions of the ventilator and pulse oximeter were working fine. The nurse had claimed in statements to the police that the ventilator and pulse oximeter were "faulty," yet she had never filed a complaint about the equipment to anyone prior to the baby's death. They also disclosed that the nurse had been on duty at another residence, several years before, when a baby had stopped breathing and died while in her care. XYZ Pediatrics had not informed the Crandalls of this incident. Faith's autopsy revealed no evidence of a seizure, heart attack, or other cause related to her underlying health condition.

The parents sought representation by SDSBS attorneys Chris Searcy and Sia Baker-Barnes in an effort to hold the nurse and her employer responsible for their reckless disregard of the life and safety of their baby, Faith. Despite a vigorous defense raised by the defendants, including their reliance on nursing notes indicating that baby Faith was checked on an hour before the incident, arguments that the machines were faulty, and that baby Faith was so severely premature that she would not have survived anvway, attorneys Searcy and Barnes were able to prove that the circumstantial evidence demonstrated that the baby was neglected and that her death could have, and should have, been avoided. The parties engaged in mediation and eventually reached a confidential settlement.