2012 WL 4293891 (Cal.Super.) (Trial Motion, Memorandum and Affidavit)
Superior Court of California.
San Mateo County

Pauline GOGOL, an individual, by and through her Guardian Ad Litem Jennifer Gogol, an individual, Plaintiff,

v.

MILLS-PENINSULA HEALTH SERVICES, a California Corporation dba Mills-Peninsula Skilled Nursing; and Does 1-100, inclusive, Defendants.

No. CIV 509469.
June 18, 2012.

**Trial Brief of Defendant Mills-Peninsula Health Services, Inc. dba Mills-Peninsula Skilled Nursing**

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Trial Date: June 18,2012

Time: 9:00 a.m..

Complaint filed: November 2, 2011

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## I. INTRODUCTION

This is a medical malpractice action [1] involving an 85 year old woman who dislocated her hip and fractured her acetabulum (the hip socket) under circumstances which remain unknown. At the time plaintiff was recovering from elective hip surgery which had been performed at Mills Peninsula Medical Center, and she was at the Mills Peninsula Skilled Nursing facility, next door to the main hospital. Both are operated by defendant Mills Peninsula Health Services (MPHS).

The cross-defendants employed sitters who were assigned to plaintiff during the approximately 18 hour period when it is suspected plaintiff sustained her injury. To date no one has admitted any knowledge of what happened, and plaintiff herself is too demented to provide any insight to what happened.

## II. FACTS

On June 7, 2011 Pauline Gogol was admitted to Mills Peninsula Medical Center to undergo elective hip surgery. At the time she was living alone in a condominium on the second floor of a complex which was only accessible by stairs. Her sister Jennifer, 10 years younger, lived next door. Neither has ever married. While plaintiff was living independently at the time, it was noted by her sister that she was becoming "forgetful."

The surgery was performed by orthopedic surgeon Paul Hazelrig M.D. This was a total hip replacement, which involved placing a hip socket prosthesis (acetabulum) and a femoral stem component. The surgery itself was uneventful, but in the post-operative period Ms. Gogol had significant confusion. While this is not necessarily unusual in **elderly** patients, her confusion persisted. Because of her confusion she was not able to meaningfully participate in physical therapy at the hospital, and the decision was made to transfer her to the Mills Peninsula Skilled Nursing unit for longer-term rehabilitation.

Plaintiff was admitted to Mills Peninsula Skilled Nursing (MPSN) on June 10, 2011. On the day of her admission the physical therapy assessment included the following observation: "Patient may need 24 hour support at home if cognition does not improve."

On June 11 she became increasingly restless and agitated, and out of concern for her safety the nurses contacted her primary care physician, Dr. Young, and got an order to put her in a posey vest. When she calmed down they asked Dr. Young for an order for a sitter.

Over the next two weeks plaintiff's progress was very slow. The primary impairment was her cognitive difficulties. Patients recovering from hip replacement surgery have to follow certain precautions to avoid dislocating the hip, which can easily occur in the first month following a surgery like this. While the optimistic plan at the time of her admission was for plaintiff to go home with assistance from her sister, with her slow recovery it was becoming increasingly apparent this was likely unduly optimistic. On June 24 the Occupational Therapist noted: "Progressing slower than anticipated toward goals due to impaired cognition (does not follow through with hip precautions) will need 24/7 care for safety with hip precautions with bed mobility, functional transfers and ADLs."

June 25, 2011 was a Saturday. Dr. Young saw her that morning and noted "Her only complaint of pain is right calf pain with ambulation." Later that morning she had a session of physical therapy. She was able to walk 60 ft x 2, but for the Safety section of her note the therapist noted "Poor-patient unable to recite total hip precautions; has a tendency to internally rotate at hip throughout activities." In her assessment the therapist noted "Patient is not safe."

At 4:00 p.m. that afternoon restorative nursing aide Edgardo Dosayla ambulated plaintiff. Her sister was present for this session. His note says:

"Patient was ambulated with front wheeled walker and followed by wheelchair. Sister followed patient during ambulation for encouragement. Patient tolerated ambulation well."

The PM shift starts at 3:30. The PM shift sitter on June 25, Divina Lara, was from RNS. The night shift started at 11:30 p.m. The night shift sitter was Ursula Bell of MGA. The day shift started at 7:30. The day shift sitter on June 26, Mirasol Oradio, was from RNS. There were no reports from any of the sitters of any untoward events or incidents involving plaintiff.

Just before noon on June 26 plaintiff was seen by Dr. Young. In his note he says: “She doesn't feel well today. She walked twice yesterday, but complains of more right leg pain today. She is slightly more confused.” A little over an hour later the physical therapist came to see plaintiff. She noted Ms. Gogol was confused, and was in obvious pain when she tried to get her to stand. She attempted to page Dr. Young, but he did not return the page. Her plan was to follow up with Dr. Hazelrig the next day for a possible x-ray.

Later that afternoon Jennifer Gogol came to visit her sister. When she refused to get up Jennifer asked the nurse to call Dr. Young. She did so, and Dr. Young returned the page this time. He was advised the sister was concerned about a possible dislocation. In response he ordered a hip x-ray. He did not order it on a stat basis. This was just before 6 p.m. on a Sunday. For the x-ray to be done an x-ray tech from the acute hospital would have to bring a portable x-ray machine to the SNF. The regular techs were off duty as of 6 p.m., and since the study was not ordered on a stat basis, per the routine it was deferred until the next morning.

The x-ray done on the morning of June 27 revealed the plaintiff's hip to be dislocated. Accordingly, she was transferred back to the hospital, and later that day Dr. Hazelrig took her to surgery. His initial intention was to do a closed reduction. However, he could not get the hip back in, and so had to do an open procedure. During the surgery he learned she also had a fracture of the acetabulum. Because the repair of the acetabulum was beyond Dr. Hazelrig's expertise, he did a Girdlestone procedure, which involved removing the implants.

After a few days in the acute care hospital plaintiff went to the other Mills Peninsula SNF, MPEC. In late August she went to a board and care facility.

She was re-admitted to Mills Peninsula in November for revision hip surgery. By this time she had been referred to Dr. Philip Krueger, an orthopedic surgeon. On November 16, 2011 Dr. Krueger performed a revision total hip replacement. This procedure went as planned, and after several days in the hospital, plaintiff went back to a SNF for rehabilitation. She was discharged on January 4 to her Board and Care facility. She continued to receive outpatient physical therapy, and when Jennifer Gogol was deposed on February 22, 2012 she testified her sister was at the same stage in her recovery as she had been on June 25, 2011.

On March 1, 2012 plaintiff saw Dr. Young at his office because of lightheadedness. He noted she was walking 4 times per day with a front wheeled walker at the Board and Care facility, and felt her cognitive status was improved. He ordered several tests to further evaluate her lightheadedness.

On or about March 4, 2012 plaintiff had a fall at her Board and Care facility. She reportedly was in a wheel chair, and on her own decided to get up and walk to her bed. While doing so she got lightheaded, fell, and broke her distal femur, just above her knee. This injury has been treated without surgery, with a brace. She was non-weight bearing for a period of six weeks, and is currently on 50% weight bearing status.

## III. RELEVANT MICRA PROVISIONS

In 1975 the State of California enacted the Medical Injury Compensation Reform Act (MICRA). The MICRA statutes apply to any action arising from professional negligence claimed against a licensed health care provider. In *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 192 the Supreme Court said the following regarding the application of the MICRA statutes:

“We recognize that in the medical malpractice context, there may be considerable overlap of intentional and negligent causes of action. Because acts supporting a negligence cause of action might also support a cause of action for an intentional tort, we have not limited application of MICRA provisions to causes of action that are based solely on a “negligent act or omission” as provided in these statutes. To ensure that the legislative intent underlying MICRA is implemented, we have recognized

that the scope of conduct afforded protection under MICRA provisions (actions “based on professional negligence”) must be determined after consideration of the purpose underlying each of the individual statutes.”

The relevant statutes define the term “health care provider” as:

“Health care provider” means any person licensed or certified pursuant to Division (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider...”

Acute care hospitals like Mills Peninsula Health Services fall within this definition, as do nurses, Certified Nursing Assistants, and other professionals who were involved in plaintiff's care.

**A. Civil Code §3333.1**

Civil Code §3333.1 abrogates the collateral source rule, and provides that third party payors cannot assert liens against professional negligence claims against health care providers. This statute states:
(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(c) For the purposes of this section:

(1) “Health care provider” means any person licensed or certified pursuant to

Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licer the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider;

(2) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

While plaintiff is Medicare eligible, she participates in a Medicare HMO. Medicare has already confirmed no payments have been made by Medicare itself. Instead, all of plaintiff's medical care has been covered by the HMO coverage she has. This

constitutes a contract to pay for services, in accordance with Civil Code §3333.1(a), and so the provisions of Civil Code §3333.1 apply. Accordingly, the defense is entitled to put on evidence of the payments for plaintiff's past and future medical care.

**B. Civil Code §3333.2**

Civil Code §3333.2 caps the recovery of general damages at $250,000 in any action arising from professional negligence:
(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000).

(c) For the purposes of this section:

(1) “Health care provider” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider;

(2) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. (Emphasis added)

An in limine motion has been filed to preclude any reference to this statute in front of the jury. In the event of a verdict with general damages in excess of $250,000 the court is requested to reduce the award to $250,000 prior to the entry of judgement.

**C. Code of Civil Procedure §667.7**

Code of Civil Procedure §667.7 mandates that a court must, in any case in which future special damages equal or exceed $50,000, reduce the judgement to a periodic payment judgment when requested by the defendant:
(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b) (1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

(e) As used in this section:

(1) “Future damages” includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) “Periodic payments” means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) “Health care provider” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider.

(4) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(f) It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment. (Emphasis added)

In *American Bank & Trust v. Community Hospital* (1994) 36 Cal.3d 359, the Supreme Court found C.C.P. §667.7 to be constitutional. In so holding, the court found the fundamental goal of the periodic payment judgment is to match losses with compensation as the losses occur. In achieving this fundamental goal, the court held the trial court is to be guided by the evidence of future damages introduced at trial:

"In structuring a periodic payment schedule, in light of the statutory objective providing compensation sufficient to meet the needs of an injured plaintiff... for whatever period is necessary [citation omitted], the court will of course necessarily be guided by the evidence of future damages introduced at trial..." (Id. at 377.)

To facilitate the implementation of a periodic payment judgment it is only necessary for the jury to award a gross value for the future damages. This concept was explained by the court in *Hrimnak v. Watkins* (1995) 38 C.A.4th 964, 974:
"When a party properly invokes §667.7, '... the [trial court] must fashion the periodic payments based on the gross amount of future damages.' [citation omitted] This is because if a present value is periodisized, a plaintiff might not be fully compensated for his or her future losses; the judgment in effect would be discounted twice: first by reducing the gross amount to present value and second by deferring payment [citation omitted].

... The proper approach, however, is for the jury to determine the gross amount of future damages and for the court to structure a periodic payment schedule based upon that amount." [citation omitted] This approach more accurately reflects future damages, is more in tune with respective roles of the jury and the court in implementing §667.7, and does not implicate the problem of interest being awarded on periodic payments that are not yet due.

"In structuring a periodic payment schedule under Section 667.7, a trial court is guided by the evidence of future damages introduced at trial." (*Salgado v. County of Los Angeles* (1998) 19 Cal.4th 629, 639, internal quotation marks omitted.) The court begins with the gross economic damages awarded by the jury, and then determines both the timing and the amount of periodic payments consistent with the both the evidence at trial, and the purpose of the statute. (*Holt v. Regents of University of California* (1999) 73 Cal.App.4th 871, 877-878).

"The fundamental goal [of periodic payments] is to attempt to match losses with compensation to ensure that money paid to an injured plaintiff will in fact be available when the plaintiff incurs the anticipated expenses or losses in the future." (*Salgado*, supra, 19 Cal.4th at 639, internal quotation marks omitted.) Pursuant to the statute, a periodic payment judgement is required to identify the amount of the payments, the frequency, the duration, and to whom the payments should be made.

To allow for proper implementation of §667.7 the defendant will submit a special verdict form which delineates past and future special and general damages. To give the court and the parties adequate time for post-verdict hearings on periodic payments, Mills Peninsula Health Services requests that the court stay entry of judgment should there be a verdict in plaintiff's favor in excess of $50,000 for future special damages, pending a determination regarding future periodic payments.

## IV. ELDER ABUSE

Plaintiff's first cause of action is for **elder abuse**. Claims for dependent adult **abuse** arise under Welfare & Institutions Code § 15600 et seq. Welfare & Institutions Code § 15610.07 defines "**abuse** of an **elder** or dependent adult" as either the following:
"(a) Physical **abuse**, neglect, financial **abuse**, abandonment, isolation, abduction, or treatment with resulting physical harm, or pain, or mental suffering.

(b) The deprivation by a care custodian of goods or services that are necessary to avoid the physical harm or mental suffering."

The term "care custodian" is defined in Welfare & Institutions Code § 15610.17 as follows:
"Care custodian" means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for **elders** or dependent adults, including members of the support staff and maintenance staff:

(a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code ....

A lengthy list of agencies and entities which can be considered care custodians follows. It is not disputed MPHS is a facility listed under Health and Safety Code § 1250.

**A. Elder Abuse Remedies**

The remedies available for **elder abuse** claims are listed in Welfare & Institutions Code § 15657, which states:
Where it is proven by clear and convincing evidence that a defendant is liable for physical **abuse** as defined in Section 15610.63, or neglect as defined in Section 15610.57, and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this **abuse**, the following shall apply, in addition to all other remedies otherwise provided by law:

(a) The court shall award to the plaintiff reasonable attorney's fees and costs. The term "costs" includes, but is not limited to, reasonable fees for the services of a conservator, if any, devoted to the litigation of a claim brought under this article.

(b) The limitations imposed by Section 377.34 of the Code of Civil Procedure on the damages recoverable shall not apply. However, the damages recovered shall not exceed the damages permitted to be recovered pursuant to subdivision (b) of Section 3333.2 of the Civil Code.

(c) The standards set forth in subdivision (b) of Section 3294 of the Civil Code regarding the imposition of punitive damages on an employer based upon the acts of an employee shall be satisfied before any damages or attorney's fees permitted under this section may be imposed against an employer. (Emphasis added)

As set forth in the statute, plaintiff's burden of proof in seeking heightened remedies under the **Elder Abuse** Act is that of clear and convincing evidence. This burden of proof applies to liability, and causation. In *Perlin v. Fountain View Management* (2008) 163 Cal.App.4th 657, 664 the court said:

> "Liability" under section 15657 includes as an element "causation," which, as all elements of liability, must be proved by clear and convincing evidence for purposes of an award of attorney fees. [citation omitted.]"

The evidence in this case falls far short of what is necessary for plaintiff to meet the clear and convincing burden of proof to establish liability and causation for **elder abuse** damages. For an **elder abuse** claim a plaintiff can pursue a claim of neglect or physical **abuse**. Plaintiff here is pursuing a neglect theory of recovery. The law is clear that neglect is different than negligence, and simply showing there was a breach of the standard of care is insufficient to establish a prima facie case of neglect.

**B. Neglect**

Welfare & Institutions Code § 15610.57 defines the term "neglect" in the context of **elder abuse** as follows:
(a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an **elder** or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(2) The negligent failure of an **elder** or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or **abused** for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

(5) Failure of an **elder** or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance **abuse**, or chronic poor health.

In *Delaney v. Baker* (1999) 20 Cal.4th 23, the Supreme Court addressed the difference between professional negligence and **elder abuse** in the context of neglect. The issue in *Delaney v. Baker* was whether the heightened remedies of the **Elder Abuse** Act could be obtained in an action against a health care provider. While the court held **elder abuse** could be alleged against a health care provider, the court also held the statutory framework of Welfare & Institutions Code § 15600 should not apply to situations involving mere professional negligence; the Supreme Court held something more egregious is necessary:
"In order to obtain the remedies available in section 15657, a plaintiff must demonstrate by clear and convincing evidence that defendant is guilty of something more than negligence; he or she must show reckless, oppressive, fraudulent or malicious conduct. The latter three categories involve " 'intentional,' " " 'wilful,' " or " 'conscious' " wrongdoing of a " 'despicable' " or " 'injurious' " nature. [Citations omitted]. " 'Recklessness' " refers to a subjective state of culpability greater than simple negligence, which has been described as a " 'deliberate disregard' " of the " 'high degree of probability' " that an injury will occur [citation omitted]. Recklessness, unlike negligence, involves more than " 'inadvertence, incompetence, unskillfulness, or failure to take precautions' " but rather rises to the level of a " 'conscious choice of a course of action ... with knowledge of the serious danger to others involved in it.' " [Citation omitted]. (20 Cal.4th, at page 31-32, emphasis added).

"Section 15657.2 can therefore be read as making clear that the acts proscribed by section 15657 do not include acts of simple professional negligence, but refer to forms of **abuse** or neglect performed with some state of culpability greater than mere negligence." (20 Cal.4th, at page 32)

In *Delaney* the court went on to explain the difference between what could constitute professional negligence, as opposed to the type of neglect required to establish **elder abuse**, as follows:
"This difference in focus can be clarified by considering the differing types of conduct with which section 15657 and MICRA are concerned. As discussed, section 15657 concerns "neglect" "physical **abuse**" and "fiduciary **abuse**." Former section 15610.57 defines neglect as "the negligent failure of any person having *the care or custody of an* ***elder*** *or a dependent adult* to exercise that degree of care which a reasonable person in a like position would exercise. Neglect includes, but is not limited to, all of the following: [P] (a) Failure to assist in personal hygiene, or in the provision of food, clothing or shelter. [P] (b) Failure to provide medical care for physical and mental health needs ... [P] (c) Failure to protect from health and safety hazards. [P] (d) Failure to prevent malnutrition." (Italics added.) Thus, neglect within the meaning of former section 15610.57 appears to cover an area of misconduct distinct from "professional negligence" In section 15657.2: "neglect" as defined in former section 15610.57 and used in section 15657 does not refer to the performance of medical services in a manner inferior to " 'the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing' " ( *Flowers v. Torrance Memorial Hospital Medical Center, supra,* 8 Cal. 4th at p. 998), but rather to the failure of those responsible for attending to the basic needs and comforts of **elderly** or dependent adults, regardless of their professional standing, to carry out their custodial obligations. It is instructive that the statutory definition quoted above gives as an example of "neglect" not negligence in the

undertaking of medical services but the more fundamental "[f]ailure to *provide* medical care for physical and mental health needs." (Emphasis added; cal.4th, at p. 34

Thus, for negligent care to equate with "neglect" there must be a showing of an absence of care, i.e. a "failure" to provide care. Negligently provided care, by itself, cannot equate with **elder abuse**. For each type of "neglect" there has to be a failure to provide care, hygiene, shelter, etc. In the present case, there is no dispute the necessary care was provided to plaintiff. There is no allegation there was an absence of care. What plaintiff alleges is that a sitter somehow allowed plaintiff to be injured, and did not report this injury. This cannot factual claim cannot support a claim of **elder abuse**.

In *Carter v. Prime Healthcare Paradise Valley LLC* (2011) 198 Cal.App.4th 396 the court followed up on the ruling in *Delaney v. Baker* to further explain what can and cannot constitute neglect. Procedurally, *Carter v. Prime Healthcare Paradise Valley LLC* was an appeal following the trial court's sustaining of a demurrer to **elder abuse** and "wrongful misconduct" causes of action, without leave to amend. Factually, the case arose from the plaintiff's decedent Roosevelt Grant hospitalization at the defendant hospital, as well as a separate skilled nursing facility. The plaintiff alleged the decedent was "continually neglected" by being kept wet and cold for extended periods of time, which led to pneumonia, as well as the development of pressure ulcers to the decedent's back and buttocks. Plaintiff also alleged the documentation of the pressure sores were fraudulently and falsely maintained.

The plaintiff alleged the decedent died as a result of the defendant's conduct, which was characterized as reckless, willful, and done with "deliberate indifference and conscious disregard for the health, safety and well-being" of the decedent. The trial court ruled the allegations of the complaint did not constitute "neglect" under the **Elder Abuse** Act, that there is no separate cause of action for "wilful misconduct," and that plaintiff's claims amounted to no more than claims of professional negligence. The Court of Appeal affirmed. In so doing, the Court of Appeal held that a plaintiff seeking enhanced remedies under the **Elder Abuse** Act must plead and prove, by clear and convincing evidence:
1. The Defendant had responsibility for meeting the basic needs of the **elder** or dependent adult, such as nutrition, hydration, hygiene or medical care.

2. The Defendant knew of conditions that made the **elder** or dependent adult unable to provide for his or her own basic needs.

3. The Defendant denied or withheld goods or services necessary to meet the **elder** or dependent adult's basic needs, either with knowledge that injury was substantially certain to befall the **elder** or dependent adult, or with conscious disregard of the high probability of such injury. (Emphasis added, 198 Cal. App.4th, at p. 406-407)

In the present case there will be no evidence an care was denied or withheld. As previously noted, in *Delaney v. Baker, supra*, the Supreme Court held that "neglect" in this context equates with a complete absence of care, rather than providing care in a negligent manner. Thus, in the context of hospital care plaintiff's burden is to show an *absence* of care, which caused plaintiff harm, both of which need to proven by clear and convincing evidence; if the defendants provided care, but did so in a negligent manner, this does not rise to the level of"neglect." Further, the "neglect" has to be a result of recklessness, or a conscious disregard of the health and safety of plaintiff. Plaintiff's expert has testified to several breaches of the standard of care. Each involves the manner in which care was provided, rather than an absence of care.

In *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, the Supreme Court revisited the issue of dependent adult **abuse** claims against health care providers. This time, the focus was on whether Code of Civil Procedure § 425.13 (regarding punitive damages) applied to claims of dependent adult **abuse**. In assessing why Code of Civil Procedure § 425.13 does not apply to claims for dependent adult **abuse** the Supreme Court noted:
"While " 'minimally culpable defendants are often charged with intentional torts' " [citations omitted] supporting punitive damage claims, **elder abuse** triggering the Act's heightened remedy provisions entails by its major egregious conduct [citations

omitted]. And while in the medical malpractice context " 'there may be considerable overlap of intentional and negligent causes of action' " [citation omitted], no such overlap occurs in the **Elder** **Abuse** Act context, where the legislature expressly has excluded ordinary negligence claims from treatment under the Act [citations omitted].

In order to obtain the Act's heightened remedies, a plaintiff must allege conduct essentially equivalent to conduct that would support recovery of punitive damages." (32 Cal.4th, at p. 789-790; emphasis added.)

Plaintiff will not be able to state a prima facie case of neglect by clear and convincing evidence. Plaintiff claims she either fell out of bed, or fell from a standing position while being assisted by the sitter. Either way she only could have gotten back to bed with the assistance of the sitter. MPHS provided her with a sitter for safety, and if plaintiff's theory of injury is correct, at worst the claim is one for negligent care, not an absence of care.

**C. There Is No Fraud Which Can Support an Elder Abuse Claim**

It is plaintiff's contention that there is some sort of conspiracy which has prevented the true facts of her injury from being known. Plaintiff's counsel has suggested that this conspiracy some how gives rise to a fraud cause of action. However, this claim is missing a significant, and necessary element of fraud: detrimental reliance.

In *Carter v. Prime Healthcare Paradise Valley LLC* there was also a fraud claim asserted by plaintiff, specifically with regard to notations put in the medical record about medications administered, which plaintiff claimed had not been given. In rejecting this claim The *Carter* court said:
"Although neglect that is fraudulent may be sufficient to trigger the enhanced remedies available under the **Elder** **Abuse** Act [citations omitted], without detrimental reliance, there is no fraud [citations omitted]." (Emphasis added; 198 Cal. App.4th, at p. 409)

There will be evidence at trial that any of the employees or agents said anything to plaintiff or her sister which could be considered knowingly false, and for which there was detrimental reliance. Accordingly, to the extent plaintiff seeks to base her **elder** **abuse** claim on fraud, this claim will also be the subject of a nonsuit motion.

**D. Employer Liability for Elder Abuse**

For an employer like MPHS, damages for **elder** **abuse** cannot be awarded by just showing an employee was guilty of neglect. To the contrary, as set forth in Welfare & Institutions Code § 15657(c) the plaintiff must make the same showing as that required by Civil Code §3294(b) for punitive damages against an employer. Civil Code §3294(b) states:

> (b) An employer shall not be liable for damages pursuant to subdivision (a), based upon acts of an employee of the employer, unless the employer had advance knowledge of the unfitness of the employee and employed him or her with a conscious disregard of the rights or safety of others or authorized or ratified the wrongful conduct for which the damages are awarded or was personally guilty of oppression, fraud, or malice. With respect to a corporate employer, the advance knowledge and conscious disregard, authorization, ratification or act of oppression, fraud, or malice must be on the part of an officer, director, or managing agent of the corporation.

Thus, for the plaintiff's prima facie case she must show that a managing agent of MPHS either (1) knew about the unfitness of a particular employee who recklessly caused plaintiff harm, and employed that person with a conscious disregard of the rights and safety of others; (2) authorized or ratified the wrongful conduct (i.e. reckless failure to provide any care to plaintiff);

or, (3) was himself or herself guilty of oppression, fraud or malice with regard to plaintiff. Plaintiff has no such evidence, let alone clear and convincing evidence. Indeed, plaintiff's complaint does not even allege a managing agent of MPHS has any culpability, as is required. No one who could be deemed a managing agent has been deposed. In *White v. Ultramar* (1992) 21 Cal.4th 563, 577 the court said a managing agent for purposes of Civil Code §3294(b) is someone who exercises "substantial discretionary authority over decisions that ultimately determine corporate policy." Plaintiff has not deposed any employee of MPHS who meets this definition, and even those with some management responsibility have testified they had no knowledge of the unfitness of any of the sitters.

After plaintiff's opening statement, the defendants will seek leave for the court to consider a motion for nonsuit on the **elder abuse** claim. The elimination of this claim will drastically reduce the time necessary for trial.

**E. There Cannot Be a Claim for Non-MICRA Custodial Negligence.**

It was suggested by plaintiff's counsel at the settlement conference that even if the burden of proof for heightened remedies cannot be met, the negligence claim at issue would not be governed by MICRA. This argument is not supported by the case law, and is contrary to the **elder abuse** act itself.

In *Covenant Care, Inc. v. Superior Court*, supra, the Supreme Court said:
"It is true that statutory **elder abuse** includes "neglect as defined in Section 15610.57" (Welf. & Inst. Code, § 15657), which in turn includes negligent failure of an **elder** custodian "to provide medical care for [the **elder's**] physical and mental health needs" (id., § 15610.57, subd. (b)(2)). But as we explained in *Delaney*, "neglect" within the meaning of Welfare and Institutions Code section 15610.57 covers an area of misconduct distinct from "professional negligence." As used in the Act, neglect refers not to the substandard performance of medical services but, rather, to the "failure of those responsible for attending to the basic needs and comforts of **elderly** or dependent adults, regardless of their professional standing, to carry out their custodial obligations." ( Delaney, supra, 20 Cal.4th at p. 34.) Thus, the statutory definition of "neglect" speaks not of the undertaking of medical services, but of the failure to provide medical care. (Ibid.) Notably, the other forms of **abuse**, as defined in the Act--physical **abuse** and fiduciary **abuse** (Welf. & Inst. Code, § 15657)--are forms of intentional wrongdoing also distinct from "professional negligence." (*Delaney*, supra, at p. 34.)

As we determined in *Delaney*, if the neglect (or other **abuse**) is reckless or done with oppression, fraud, or malice, "then the action falls within the scope of [Welfare and Institution Code] section 15657 and as such cannot be considered simply 'based on ... professional negligence' .... That only these egregious acts were intended to be sanctioned under section 15657 is further underscored by the fact that the statute requires liability to be proved by a heightened 'clear and convincing evidence' standard." (*Delaney*, supra, 20 Cal.4th at p. 35.)." (Emphasis added; 32 Cal.4th 771, 783)

Further, Welfare and Institutions Code § 15657.2 says:

> Notwithstanding this article, any cause of action for injury or damage against a health care provider, as defined in Section 340.5 of the Code of Civil Procedure, based on the health care provider's alleged professional negligence, shall be governed by those laws which specifically apply to those professional negligence causes of action. (Emphasis added)

By operation of the statute, if a claim against a health care provider for **elder abuse** fails to meet the burden of proof for heightened remedies, the claim is rendered one for professional negligence, for which the MICRA provisions apply. Any contrary argument would render this statute a nullity.

Dated: June 18, 2012

SHEUERMAN, MARTINI & TABARI

<<signature>>

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Footnotes

1 The complaint also includes a cause of action for **Elder** **Abuse**, which will be the subject of a nonsuit motion.

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