$20,015,000 VERDICT INCLUDING $15,000 IN PUNITIVE DAMAGES - MEDICAL MALPRACTICE - FAILURE TO MONITOR PATIENT IN INTENSIVE CARE UNIT - NURSES FAIL TO TIMELY RESPOND TO MONITOR ALARM - ALTERATION AND WITHHOLDING OF MEDICAL RECORDS - PERMANENT BRAIN INJURY TO 19-YEAR-OLD - 24-HOUR ATTENDANT CARE REQUIRED.

Philadelphia County

The plaintiff in this action was a 19-year-old male who was admitted to the defendant hospital's ICU following a purported suicide attempt.

The plaintiff alleged the defendant's nurses failed to respond to the plaintiff's bedside monitor alarm for some four to six minutes, resulting in a permanent brain injury.

The plaintiff also claimed the defendant's nurse altered the medical record and the defendant concealed the altered record.

The defendant argued that other unforeseen emergencies in the unit occupied the nurses elsewhere and they did not know the plaintiff was alarming.

The defendant denied intentionally withholding records, and the defendant's nurse contended she whited-out the medical record for accuracy.

The plaintiff suffered from allegedly self-inflicted gasoline burns and was admitted to the defendant's hospital. He was placed in a seven-bed unit with a one-to-one nurse assigned to him.

The plaintiff experienced a mucus block, he stopped breathing and his heart rate dropped. The monitor he was wearing triggered an alarm both in his room and at the defendant's central nursing station.

However, no one was at the nursing station to hear the alarm. The plaintiff claimed the monitor alarm went unanswered from four to six minutes or more.

The plaintiff's critical care expert testified it was negligent and deviated from the required standard of care for the defendant's nurses to fail to immediately respond to the plaintiff's monitor alarm.

The plaintiff's physicians testified the plaintiff sustained a permanent brain injury as a result of oxygen deprivation during the incident.

The plaintiff suffers severe short-term memory deficits and requires 24-hour attendant care, according to testimony presented.

The plaintiff currently resides in a nursing facility.

The plaintiff had just finished his freshman year at an Ivy League university at the time of his hospitalization.

Testimony indicated he had ambitions to attend medical school. The plaintiff's economist calculated the plaintiff's lost earnings as between $3 and $13 million. His life care expert testified the plaintiff will require $6 to $12 million in life care expenses for the remainder of his life. The plaintiff also claimed $600,000 in past medical expenses.

The plaintiff presented the defendant nurse's deposition testimony during which she denied she had written over any of the entries in the plaintiff's critical care flow sheet.

The nurse stated at deposition she had simply tried to make the entries darker. However, evidence showed that the nurse had actually used white-out several times in the flow chart and wrote on top of the white-out.

The plaintiff claimed the defendant's risk management department intentionally removed the altered flow chart from the original medical record and replaced it with a photocopy in which the alterations were less obvious.

Despite the plaintiff's request for the original records, this document was withheld by the defendant, according to the plaintiff's claims. The plaintiff established that the copy of the medical records sent to the defendant's

experts included a "post-it" sticker stating "original in risk management office." The copy of the records received by plaintiff's counsel did not include the "post-it" note.

The plaintiff argued that the bedside monitor to which the plaintiff was attached provided a minute-by-minute chronology of the plaintiff's medical data. However, the plaintiff contended this data was lost, because it was not printed out by the defendant's nurse within 24 hours of the incident.

The defendant argued that its nurses had other patients which they were required to attend and did not realize that the plaintiffs alarm was sounding.

Evidence showed that three nurses were assigned to cover four patients on the night in question. The defendant's nursing expert testified that the night in question presented several unforeseeable emergencies at the same time which required the nurses' attention.

The defendant's nurse testified she could not recall if she had printed the data from the plaintiffs bedside monitor following the event. She testified she whited-out portions of the critical care flow sheet because she was trying to record an accurate picture of what had happened.

The defendant denied intentionally withholding the altered flow chart and argued that the failure to produce it was inadvertent.

The defense disputed the plaintiff's loss of future wages, contending that he suffered from mental illness which would have precluded him from becoming a physician.

After a trial of 11 days, the jury found for the plaintiff in the amount of $20,015,000, including $15,000 in punitive damages. Posttrial motions are pending. The plaintiff has filed for delay damages which would increase the award to $21.6 million.