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\$425,000 RECOVERY

Medical Malpractice – Psychiatry – Failure of medical staff of hospital pediatric psychiatric ward to provide adequate supervision to 15-year-old patient deemed to be suicide risk after involuntary commitment – Suicide.

Nassau County, New York

This action was commenced by the estate of a 15-year-old boy who was involuntarily remanded to the defendant hospital's pediatric psychiatry ward for a full in-patient psychiatric evaluation after a Family Court hearing that followed a violent outburst at home. Upon admission, the defendant's chief pediatric psychiatrist diagnosed the boy with "Episodic Mood Disorder" and placed him on "Q:15" observation, which according to the hospital's Suicide Precautions, requires that the patient "be observed every 15 minutes by staff and monitored during all activities.

Several days into his involuntary hospital stay, the decedent told his mother that he wanted to hang himself, and such advisements were conveyed to the hospital medical staff. The attending psychiatrist changed the orders to a 1:1 suicide watch at approximately 11:00 a.m. The estate contended that shortly thereafter, the defendant's psychiatrist changed the orders back to "Q:15" monitoring and the estate maintained that the progress notes reflected that one of the reasons for the change was that "there were staffing issues" in the pediatric psychiatry ward. The orders also provided that 1:1 suicide monitoring would resume after the boy took a shower that evening.

The estate maintained that the orders were not changed that afternoon despite the boy's refusal to take prescribed medication at 12:40 p.m., entries in the chart that noted that his "mood is angry and hostile," his inability to participate in the 3:40 p.m.

group psychotherapy session because he was deemed to not be able to maintain behavioral control, his refusal to take his 5:10 medication, and a note by a nurse completing her 12 hour shift at 7:00 p.m. that the boy had refused to eat or drink anything that day. The estate further maintained that although the Patient Care Assistant in the ward responsible for monitoring the patients' evening showers was told that the decedent had "threatened to hurt himself and we should keep an extra eye on him so that he does not hurt himself."

The Patient Care Assistant permitted the decedent to walk into the boy's shower room alone, wearing and carrying hospital pants with draw strings, which the decedent used to hang himself in the shower. The hospital's suicide prevention policies otherwise directed that patients on 1:1 observation be dressed in clothes without ties for their own safety and protection. The parties' experts opined that the boy experienced about five minutes of conscious pain and suffering.

The case settled after jury selection for \$425,000.

REFERENCE

Nimir vs. Nassau University Medical Center, et al. Index no. 8943/08; Judge John M. Galasso, 01-20-12.

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