IN THE SUPREME COURT OF MISSISSIPPI

NO. 2007-CA-00852

JAMES A. NEELY AND GENEVA NEELY,
INDIVIDUALLY AND AS HEIRS-AT-LAW
AND THE WRONGFUL DEATH
BENEFICIARIES OF JAMES A. NEELY,
DECEASED, APPELLANTS

Versus

NORTH MISSISSIPPI MEDICAL CENTER, INC.
AND JOHN DOES 1-5 APPELLEES

Appeal from the Circuit Court of Lee County, Mississippi

BRIEF OF APPELLANTS

Dale Danks, Jr., Esq. [redacted]
DANKS, MILLER, HAMER & CORY
213 S. Lamar Street, Suite 100
Jackson, MS 39201

Pieter Teeuwissen, Esq.
Post Office Box 16787
Jackson, MS 39236

Michael B. Gratz, Jr., Esq. [redacted]
GRATZ & GRATZ, P.A.
312 N. Green Street
Tupelo, MS 38804

ATTORNEYS FOR APPELLANTS

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the Justices or Judges of this Court may evaluate possible disqualification or recusal.

1. James E. Neely, Decedent.

2. James A. Neely, son and wrongful death beneficiary of James E. Neely.

3. Geneva Neely, wife and wrongful death beneficiary of James E. Neely.

4. Attorneys for the Neely Beneficiaries:

   (a) Dale Danks, Jr., of Jackson, Mississippi;

   (b) Pieter Teeuwissen, of Jackson, Mississippi;

   (c) Michael B. Gratz, Jr., of Tupelo, Mississippi.

5. North Mississippi Medical Center, Inc., Defendant.

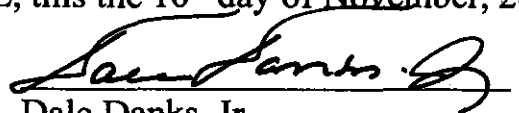
6. North Mississippi Health Services, Inc., Defendant.

7. Attorneys for the Medical Center Defendants:

   (a) John G. Wheeler, of Tupelo, Mississippi;

   (b) Mitchell, McNutt, and Sams, of Tupelo, Mississippi.

SO CERTIFIED BY ME, this the 16th day of November, 2007.



Dale Danks, Jr.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

MISCELLANEOUS

STATEMENT OF ISSUES

Did the Circuit Court err in granting summary judgment to Defendants on grounds that Plaintiffs did not submit an affidavit from their expert witness, when (a) Plaintiffs had timely designated an expert witness and fully disclosed her proposed testimony, (b) Defendants did not seek to depose Plaintiffs' expert, and (c) Defendants did not proffer any affidavit to meet their initial burden of showing there were no genuine issues of material fact as to the standard of care?

STATEMENT OF THE CASE

Procedural History

James E. Neely died on November 4, 2001. On May 9, 2002, his wife, Geneva Neely, and his son, James A. Neely ("the Neely Beneficiaries") filed this action in the Circuit Court of Lee County, Mississippi against North Mississippi Medical Center, Inc., and North Mississippi Health Services, Inc. ("the Medical Center"). (CP 5). The Complaint pled causes of action for negligence, gross negligence, breach of contract, and breach of warranty. The Medical Center answered the complaint on July 10, 2002 (CP 19). Discovery commenced (CP 33-130, 133-143), and the case was set for trial on November 9, 2005 (CP 132).

On September 16, 2005, the Medical Center filed a motion for summary judgment (CP 146). The motion argued that "[t]he plaintiffs have failed to identify or otherwise designate a competent health care expert to support their theories of medical negligence . . . In accord with Rule 4.04 of the Uniform Circuit and County Court Rules, the plaintiffs' deadline to identify trial experts expired 60 days in advance of the trial setting – September 9, 2005." CP 148.

The motion for summary judgment also argued that "[t]he plaintiffs in this case cannot establish a *prima facie* case of liability against NMMC and NMMS unless they are able to prove the existence of a duty on behalf of said defendants to conform to specific applicable standards of care, a failure to conform to such

standard(s), and cognizable damages as a proximate result of any alleged breach of duty . . . . The plaintiffs herein lack expert medical proof of the requisite elements of their alleged cause(s) of action against NMMC and NMHS and in the absence of such proof, no genuine issue of material fact exists for trial, and said defendants are entitled to judgment as a matter of law." (CP 149-50).

Significantly, however, the Medical Center's motion for summary judgment did not attach any affidavit from any expert retained by the Medical Center.

On September 26, 2005, the Neely Beneficiaries filed their Designation of Expert Witness, designating Ann McFarland Limbach, R.N., as an expert witness. (CP 164-69). The Designation gave an extremely detailed discussion of Ms. Limbach's qualifications and opinions regarding the death of James Neely.

That same day, September 26, 2005, the Neely Beneficiaries responded to the Medical Center's motion for summary judgment (CP 170). The response stated that Ms. Limbach had sent plaintiffs' counsel the information needed for the Rule 4.04 designation on September 2, 2005, but that at that time, counsel were heavily involved in the City of Jackson's response to Hurricane Katrina (CP 171). Affidavits of both Jackson counsel were attached in support of these averments (CP 176; CP 179). The response noted that the expert designation was contemporaneously filed, and represented that the Neely Beneficiaries did not

object to a trial continuance to allow the designation to be timely under Rule 4.04 (CP 172).

With respect to the Medical Center's second argument for summary judgment, the Neely Beneficiaries pointed out that "[i]n this case . . . Defendants have not submitted any expert testimony of their own to show that there is no genuine issue of material fact as to the breaches of duty alleged by Plaintiffs in the Complaint . . . . Thus, while summary judgment might be allowed where the defendant has expert testimony and the plaintiff does not, it does not follow that summary judgment must be granted where the defendants do not even proffer expert testimony of their own." (CP 173)

On September 28, 2005, the Medical Center responded to the Neely Beneficiaries' filings by filing a motion to strike the Plaintiff's designation of experts (CP 182).

On October 5, 2005, the Circuit Court signed an Agreed Order of Continuance that continued the November 9, 2005 trial setting and instructed the parties to "enter a scheduling order setting forth applicable deadlines." (CP 192)

From October 5, 2005, until August 1, 2006, the Medical center made no effort to depose the Neely Beneficiaries' expert witness.

On August 1, 2006, the Circuit Court set the Medical Center's motions for hearing. It also ordered all supplementation of discovery to be completed by August 31, 2006. (CP 193)

On August 3, 2006, the Medical Center filed its Designation of Expert Witnesses. It designated one witness, Suzy Bishop, R.N., on the standard of care, and further designated any of the decedent's treating physicians and nurses (CP 195).

Again, however, the Medical Center submitted no sworn testimony from its experts with respect to the standard of care.

On October 23, 2006, the Circuit Court heard arguments on the Medical Center's motions. (Tr. 1-19).

On October 30, 2006, the Neely Beneficiaries submitted an affidavit from Ms. Limbach that stated verbatim (albeit under oath) the same opinions as were set forth the year before in her expert designation. (CP 236).

On November 21, 2006, the Circuit Court entered final summary judgment for the Medical Center (CP 242). The Court held that "[i]t is the opinion of this Court that the viability of the plaintiffs' claims of health care negligence is dependent upon production by the plaintiffs of evidence from a competent health care expert identifying and articulating the applicable standard(s) of care of the

hospital defendants under the circumstances at issue, breach thereof, and proximate causation of Mr. Neely's death." (CP 244-45)

The Circuit Court acknowledged that an affidavit from Ms. Limbach had been filed on October 30, 2006, but did not consider same, because it was filed after the hearing on the Medical Center's motion for summary judgment (CP 245-46).

A motion to alter, amend, or reconsider the order granting summary judgment was timely filed by the Neely Beneficiaries on December 1, 2006 (CP 247). This motion was denied by the Court on April 23, 2007 (CP 285).

The Neely Beneficiaries filed a timely Notice of Appeal on May 7, 2007. CP 286.

Statement of Facts

The following facts come from the Neely Beneficiaries' Designation of Expert Witness (CP 164-69) and the Affidavit of Ms. Limbaugh, their expert (CP 236-41):

James E. Neely was a 54 year old African American male admitted to North Mississippi Medical Center on November 2, 2001 with the diagnosis of Left Scrotal Mass. According to the admission history and physical, he was transferred from the Houston, Mississippi Emergency Department because of swelling and pain in the left hemiscrotum. The social history noted that the patient smoked a

pack of cigarettes a day and drank a pint of whiskey a day. The neurological assessment states that the patient has a history of seizure disorder under control with Dilantin and that he occasionally has dizzy spells.

The medical record contains four pages of Nursing Care Plan Data. One of the first Outcome/Goals documented was that "patient has safe environment during hospitalization, evaluate daily." This is consistent with the functions of the Registered Nurse as set forth in the rules and regulations of the Mississippi Board of Nursing, which include "assessing the patient's needs, formulating a nursing diagnosis," and "organizing, administering and supervising the implementation and evaluation of a written nursing care plan for each patient." It is also consistent with the functions of the Licensed Practical Nurse under the Board's regulations. Both the RN and the LPN have the duty of observing, recording and reporting to the appropriate person the signs and symptoms which may indicate changes in the patient's condition.

The Registered Nurses responsible for the nursing care of Mr. Neely failed to comply with these regulations as evidenced by the lack of any plan addressing the issue of Mr. Neely's alcohol consumption and his abrupt withdrawal of same. For example, the nurses did not document how they planned to provide any such plan of safety, considering that the patient was not only ambulatory, but had left the nursing unit twice prior to the final time that resulted in his death. There was

also no plan of care documented to address potential problems from increased anxiety due to not being allowed to smoke given that, until November 1, 2001, the patient routinely drank a pint of whiskey a day.

This patient had a significant potential for alcohol withdrawal and delerium tremens (DTs), an acute toxic state that follows a prolonged period of drinking followed by a sudden withdrawal. Alcohol withdrawal delirium is a serious complication and is life threatening. Symptoms can begin as early as 4 hours after reduction of alcohol intake and usually peaks at 24 to 48 hours, but may last up to 2 weeks. Symptoms, which may occur independently or in combination, are shakes, seizures and hallucinations. The patient may exhibit anxiety or fear and should be closely observed by the nursing staff.

Basic nursing knowledge is that an alcoholic is going to go into DTs in the hospital if they don't have access to alcohol. The nurses should have noted signs or symptoms of DTs so that the doctor could have ordered appropriate medication in a timely fashion. By the time the neurologist arrived on November 4 and began ordering medication for this problem, it was already too late.

The nursing notes are very limited on this issue and indicate that both the Rns and LPNs failed in the duties set forth above. On November 3, at 13:30 they state, "Making rounds, noticed patient was not in room . . . checked floor . . . patient found in main hall on 1st floor." This is followed by a note at 16:15 that he

was off floor and found in the smoking area. There was no documented assessment of the patient after either of these trips off the nursing unit and no documented nursing intervention other than telling him to stay in his room.

Moreover, the nursing staff failed to assess the reason for the patient leaving the unit, nor did they provide any nursing intervention for this problem. Further, they did not notify the treating physician of these absences. Even if the nursing staff took actions not found in the medical records, their failure to properly communicate any assessments or interventions limited the knowledge of other members of the healthcare team to reliance upon verbal communication, which in many instances was second hand.

The nursing staff also failed to properly document the administration of the medications ordered by the physicians. On November 4, 2001, two doses of Dilantin were documented at 20:00, giving rise to possible Dilantin overdose and adverse effects.

Further, the nursing staff failed to follow the physician's orders for medication administration. The Toradol 30mg ordered to be given every 6 hours was only given one time, on November 4 at 19:00. At 19:30 on November 4, there is no reason given for the failure to administer the Demerol 50-75 mg or Vistaril 25 mg that had been ordered.

Inc. v. City of Ocean Springs, 562 So. 2d 103, 106 (Miss. 1990); *see also Shaw v. Burchfield*, 481 So. 2d 247, 252 (Miss. 1985); *Brown v. Credit Center, Inc.*, 444 So. 2d 358, 362 (Miss. 1983).

This burden must meet the standards of Rule 56(e) – that is, the movant must attach materials that would be admissible at trial, to demonstrate the lack of any triable issue of fact. *Smith v. H.C. Bailey Companies*, 477 So. 2d 224, 233 (Miss. 1985); *Palmer v. Biloxi Regional Medical Center, Inc.*, 564 So. 2d 1346, 1355 (Miss. 1990); *Dailey v. Methodist Medical Center*, 790 So. 2d 903 (Miss. Ct. App. 2001).

The Medical Center did not do so. It mistakenly assumed, and led the Circuit Court to believe, that a defendant need only file a motion with the bare allegation that "the plaintiff cannot prove his/her case without expert testimony" to shift the burden of production to the non-movant. That has never been the law. *Dailey, supra.*

Summary judgment was erroneously granted in this case; the judgment should be reversed and the case remanded for trial.

LAW AND ARGUMENT

The Circuit Court Erred in Granting Summary Judgment Where the Medical Center Submitted No Summary Judgment Evidence to Demonstrate the Absence of a Genuine Issue of Material Fact

Rule 56 of the Mississippi Rules of Civil Procedure, which incorporates the Federal Rules' provisions for summary judgment, is now a rule with which this Court and the Bar is well familiar. The rule provides that pre-trial judgment may be entered on a party's motion "if the pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." M.R.C.P. 56(c). This Court conducts *de novo* review of the Circuit Court's grant of summary judgment. *Burton v. Choctaw County*, 730 So. 2d 1, 3 (Miss. 1997).

In this case, however, the Circuit Court was misled by the Medical Center about what a moving party must file to satisfy its initial burden on the motion. The Court thus granted summary judgment despite the fact that the Medical Center did not file any admissible evidence demonstrating the absence of genuine issues of material fact.

The Medical Center's motion had originally been based on Uniform Rule 4.04; the argument was that the Neely Beneficiaries had not filed a designation of expert witnesses within sixty days of the November 9, 2005 trial date. CP 148.

But the Circuit Court, in an order expressly agreed to by the Medical Center, had continued that trial date and ordered new deadlines to be set. CP 192. Moreover, in its August 1, 2006 Order, the Circuit Court extended the discovery period until August 31, 2006. CP 193. With the trial date and discovery deadline thus postponed, the Neely Beneficiaries' September 26, 2005 Designation of Expert Witnesses (CP 164), listing Ann Limbach, R.N., as their expert and giving a detailed disclosure of her opinions, was timely filed. Thus, the Medical Center could not rely on Rule 4.04 as a basis for summary judgment.

Moreover, in the eleven months between the filing of the Designation and the August 31, 2006 discovery deadline, the Medical Center had made **no effort** to depose Ms. Limbach. Where a party claims that its opponent has not provided sufficient information about potential expert testimony in its discovery responses, the complaining party must seek clarification or supplementation of the responses, or request leave to depose the expert. *Palmer v. Volkswagen of America, Inc.*, 905 So. 2d 564 (Miss.Ct.App. 2003); *Caracci v. International Paper Company*, 699 So. 2d 546 (Miss. 1997); *Nichols v. Tubb*, 609 So. 2d 377 (Miss. 1992). The Medical Center's motion to strike the designation of Ms. Limbach was therefore without merit.

The Medical Center insisted, however, that its motion for summary judgment could still be granted. It persuaded the Circuit Court that a defendant

relief by the strengths of his own showing, not by the defects in his opponent's showing." *Id.* at 233. The "summary judgment evidence" filed with the motion must meet the standards of M.R.C.P. 56(e). *Id.*

Thus, "[a]lthough the moving party need not negate the elements of its opponent's case, the moving party must show an absence of facts and cannot simply assert in a conclusory manner that the nonmoving party has no evidence to support its case." Jackson, *supra*, at §11:19 at page 11-32 & n.12, *citing Quay v. Archie L. Crawford and Shippers Exp., Inc.*, 788 So. 2d 76 (Miss.Ct.App. 2001).

In this case, all that the Medical Center relied upon in its motion was (1) its own declaration of expert witness and (2) the Neely Beneficiaries' failure to provide an affidavit from their expert. That was the exact situation in *Dailey v. Methodist Medical Center*, 790 So. 2d 903 (Miss. Ct. App. 2001).

The Court of Appeals reversed summary judgment in *Dailey*, among other reasons, because the defendants did not submit any competent summary judgment evidence to meet its initial burden of production. The appellate court explained:

> What the [circuit] court apparently failed to realize is that the defendants never presented any affidavits from Drs. Bennett and Thigpen. The document elevated to the level of competent, credible affidavits was the defendants' disclosure of expected testimony from their experts. Nothing was ever signed or sworn to by Drs. Bennett and Thigpen, as were the deposition testimonies of the nurses and Dr. Hume.

Id. at 916. That is to say, Court of Appeals held that the materials submitted by the defendant in *Dailey* did not meet the standards of Rule 56(e) – it must be competent evidence, admissible at trial, and either sworn to or self-authenticating. See also Miss.Unif.Cir.Cty.Ct.R. 4.03(1) (referring to "affidavits and other supporting **evidentiary** documents" to be filed with a motion for summary judgment).

Dailey, and the other cases cited above, control here. Even after the Neely Beneficiaries had designated their expert in compliance with Rule 4.04, the Medical Center went forward with its motion for summary judgment. The Medical Center then attempted to change position, arguing as if they had submitted an affidavit from their expert, and relying on the familiar cases that hold, in such situations, that the non-movant must produce sworn testimony controverting the defendant's expert. But, like the defendant in *Dailey*, the Medical Center did not submit an expert affidavit, and therefore did not qualify to gain the benefit of those authorities.

This, then, is a simple case. The Medical Center adduced no **evidence** that it met the applicable standard of care in its treatment of the decedent. The Neely Beneficiaries were thus under no obligation to provide an affidavit in opposition to the motion. The Medical Center's motion for summary judgment was erroneously granted; thus this Court should reverse that judgment and remand this case for trial.

CONCLUSION

The Neely Beneficiaries deserve their day in Court before a jury of their peers. Without doubt, the Neely Beneficiaries have expert testimony that will establish, if believed at trial, that the Medical Center breached its duties to care for James A. Neely, abandoning his care and allowing him to fall to his death after a simple operation. In this regard, the Neely Beneficiaries had exactly the same type of pleadings on file (designation of experts) as did the Medical Center. The Circuit Court erroneously granted summary judgment because the Medical Center claimed that it need not establish its right to summary judgment with evidentiary materials, but instead could simply require the plaintiffs to respond. That judgment was erroneous and should be reversed.

Respectfully Submitted,

Dale Danks, Jr., Esq. ([redacted]
DANKS, MILLER, HAMER & CORY
213 S. Lamar Street, Suite 100
Jackson, MS 39201

Pieter Teeuwissen, Esq.
Post Office Box 16787
Jackson, MS 39236

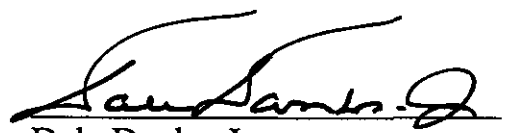
Michael B. Gratz, Jr., Esq. [redacted]
GRATZ & GRATZ, P.A.
312 N. Green Street
Tupelo, MS 38804

ATTORNEYS FOR APPELLANTS

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be mailed, via U.S. Mail, postage prepaid, a true and correct copy of the Brief of Appellants to John G. Wheeler, Attorney for Appellees, Mitchell McNutt & Sams, Post Office Box 7120, Tupelo, MS 38802-7120.

This the 16th day of November, 2007.



Dale Danks, Jr.