IN THE MISSISSIPPI SUPREME COURT
Case No. 2008-CA-00067

THE ESTATE OF HAMILTON PETER GUILLOTTE, BY AND THROUGH EDITH JORDAN, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF PETER GUILLOTTE

PLAINTIFF/APPELLANT

v.

DELTA HEALTH GROUP, INC.; PENSACOLA HEALTH TRUST, INC.; JOHN DOES 1 THROUGH 10; AND UNIDENTIFIED ENTITIES 1 THROUGH 10 (AS TO DIXIE WHITEHOUSE NURSING HOME)

DEFENDANTS/APPELLEES

APPEAL FROM THE SECOND JUDICIAL DISTRICT CIRCUIT COURT OF HARRISON COUNTY, MISSISSIPPI

HONORABLE JERRY O. TERRY, CIRCUIT JUDGE

BRIEF OF APPELLANT

ORAL ARGUMENT REQUESTED

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Certificate of Interested Parties

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 of the Supreme Court and/or the judges of the Court of Appeals may evaluate possible disqualification or recusal.

Appellant:
Edith Jordan, Individually and as
Administratrix Of the Estate of Peter Guillotte

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Respectfully submitted,

Estate of Hamilton Peter Guillotte, by and Through Edith Jordan, Individually and as Administratrix of the Estate of Hamilton Peter Guillotte, Deceased,

By: Susan N. Estes

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THE ESTATE OF HAMILTON PETER GUILLOTTE, BY AND THROUGH EDITH JORDAN, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF PETER GUILLOTTE — PLAINTIFF/APPELLANT

v.

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STATEMENT OF THE ISSUES

I. The Circuit Court misconstrued the holding in *Estate of Finley ex rel. Jordan v. Beverly Health and Rehabilitation,* 933 So. 2d 1026 (Miss. Ct. App. 2006) to require that a plaintiff identify by name specific caregivers that breached the standard of care in order to withstand a motion for summary judgment.

II. The Circuit Court erred in granting Defendants' motion for summary judgment despite testimony by Plaintiff's experts as to numerous acts and omissions of the Defendants' employees that directly and proximately caused Mr. Guillotte's injuries and death.

STATEMENT OF THE CASE

A. Nature of the Case

This case is a nursing-home abuse-and-neglect case.

Edith Jordan (Plaintiff) is the daughter and Administratrix of the Estate of Hamilton Peter Guillotte. Record at p. 58.[1] Plaintiff brought this action against Pensacola Health Trust, Inc.; Delta Health Group, Inc.; Dixie White House Nursing Home, Inc., Scott J. Bell; Dennis Forsythe, William Trevvett; John Does 1 through 10; and Unidentified Entities 1 through 10 (as to Dixie White House Nursing Home) for the injuries and damages sustained by Hamilton Guillotte while he was a resident of Dixie White House Nursing Home (Dixie White House). R. at 24. Plaintiff's complaint, as amended, alleges against all Defendants causes of action for negligence, medical malpractice, malice and/or gross negligence, fraud, breach of fiduciary duty, and for the wrongful death of Mr. Guillotte. R. at 24-91.

B. Course of the Proceedings Below

On December 30, 2002, Plaintiff filed the instant action against Defendants, stating claims for the injuries and damages Mr. Guillotte sustained while he was a resident of Dixie White House from approximately October 26, 2001 until September 21, 2002. R. at 123. Mr. Guillotte died on September 23, 2002. R. at 24. An Amended Complaint was filed January 17, 2003. R. at 58. Defendants filed their Answer on March 12, 2003. R. at 95.

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[1] Citations to the Record will be made as "R. at ___".

An Agreed Scheduling Order was entered on June 9, 2005, setting the trial of this matter for March 6, 2006. R. at 226. On September 29, 2005, Plaintiff served her initial disclosure of expert witnesses, identifying Dr. Timothy Hammond, Luanne Trahant, RN, and James A. Koerber, CPA, as experts Plaintiff intended to call at trial. R. at 488. Defendants designated Dr. Robert Kelly as their expert witness on January 24, 2006. R. at 570. On Defendants' Motion, the original scheduling order was continued on February 27, 2006. R. at 578. Defendants filed a supplemental designation of expert witnesses adding Victoria L. Berry, RN, and Kathy Warwick, RD, as experts on August 17, 2006. R. at 1109.

Following numerous delays involving discovery disputes and the dismissal of separate defendants Dixie White House Nursing Home, Inc., Scott Bell, William Trevvett, and Dennis Forsythe, Plaintiff's case was finally reset for trial to begin September 17, 2007, against Pensacola Health Trust, Inc. and Delta Health Group, Inc. R. 194, 541, 230, 1301, 1373, 1404, 1527, 1867.

Defendants took the depositions of Plaintiff's physician expert Dr. Timothy Hammond on July 10, 2007, and Plaintiff's nurse expert, Luanne Trahant, on July 18, 2007. R. at 1713, 2195. Plaintiff then took the deposition of Defendants' physician expert, Dr. Robert H. Kelly, on August 21, 2007. R. at 1826. Plaintiff and Defendants filed contemporaneous witness and exhibit lists on September 4, 2007, in anticipation of the September 17, 2007 trial date. R. 1858, 1861, 1864, 1867.

On August 13, 2007, Defendants moved the Circuit Court for summary judgment, asserting that Plaintiff had failed to identify the specific caregivers whose

actions or inactions fell below the standard of care. R. at 1412. On August 22, 2007, Plaintiff responded to Defendants' Motion incorporating Defendants' Responses to Plaintiff's Requests for Admissions, the depositions of Plaintiff's experts, excerpts from Mr. Guillotte's nursing home and hospital records, and time cards of Defendants' employees. R. at 1690-1822. A hearing was held on Defendants' Motion on August 24, 2007. See Separate Transcript Volume, August 24, 2007 Hearing Transcript.[2] On August 29, 2007, Plaintiff supplemented her response with the August 21, 2007 deposition testimony of Defendants' expert, Dr. Robert H. Kelly. R. at 1823. On September 18, 2007, the Circuit Court granted Defendants' Motion for Summary Judgment in a Final Judgment including findings of fact and conclusions of law. R. at 1880.

Plaintiff filed a Motion for Reconsideration or to Alter or Amend the Final Judgment on September 24, 2007, pointing the Circuit Court to two recent decisions of the Mississippi Supreme Court, *Delta Regional Medical Center v. Venton,* 964 So. 2d 500 (Miss. 2007) and *Mariner Health Care, Inc. v. Estate of Edwards ex rel. Turner,* --- So. 2d ----, 2007 WL 2670308 (Miss. 2007), and arguing that these cases strongly support the denial of Defendants' Motion for Summary Judgment and the withdrawal of the Final Judgment against the Plaintiff. R. at 2113. Following a hearing held November 30, 2007, Plaintiff's Motion was denied December 7, 2007. R. at 1331; Tr. (November 30, 2007). Plaintiff timely filed a Notice of Appeal on January 3, 2008. R. 2333.

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[2] References herein to the Transcript Volume shall be noted, "Tr. (hearing date), p. _____."

STATEMENT OF FACTS

Hamilton Guillotte, at the age of 85, was admitted to Dixie White House on October 26, 2001, from the VA Hospital. R. at 123, 1721. He remained a resident of Dixie White House until September 21, 2002. R. 24, 123. During his residency at Dixie White House, Hamilton Guillotte suffered from physical and emotional trauma, including, but not limited to: multiple falls, urinary tract infections, bronchial infections, dehydration, malnutrition, uncontrolled glucose levels, functional decline, contractures, multiple pressure sores, sepsis, and death. R. at 29, 1720, 1721, 1739, 1745, 1751, 1760, 1763. Nurse Trahant testified that Mr. Guillotte's injuries and suffering "could have been controlled by the nursing home staff." R. at 2232 (emphasis added). Instead, he suffered from severe pain that had to be controlled by Morphine patches, caused by a combination of "pressure ulcers, contractures, his arthritis, [and] being immobile." *Id.* Mr. Guillotte's quality of life was diminished by the Defendants' repeated failures to recognize what care, services, and treatment he needed. R. at 2231.

1. Malnutrition and Dehydration.

According to Plaintiff's physician expert, Dr. Timothy Hammond, Mr. Guillotte had continuing deterioration and needed nutritional parameters. Yet, "he does not have an adequate assessment and reassessment and care-plan to continue to deal with it, and he has continued malnutrition and dehydration, which is ongoing and increasing in severity." R. at 1720. Indeed, Mr. Guillotte was malnourished several months into his admission. R. at 1722. According to Dr. Hammond, "[t]hey should have been telling the doctor that his weight was still below ideal weight." R. at 1720. Yet, the

nursing home "[f]ailed to assess, reassess and make a care plan to realize they had an ongoing nutritional deficit." R. at 1723; see also, R. at 1725.

> [I]f they had acted appropriately, reassessed him and gotten adequate nutrition through the PEG tube, then it would have helped, yes. I believe it would have prevented the skin problems and he would have healed them faster, and it would have put him at less risk for the sepsis that led to his death. And the dehydration issue goes along with the nutrition issues on that.
>
> ...
>
> You do not look at nutrition alone. The nutrition and dehydration condition go together.
>
> ...
>
> This poor man is dehydrated consistently. On occasion, he's dramatically dehydrated.

R. at 1732.

Nurse Trahant describes a concerning inconsistency in the documentation regarding Mr. Guillotte's nutrition. R. at 2204. As explained by Nurse Luanne Trahant, in April, 2002, someone was charting that Mr. Guillotte was consuming 100% of his meals, yet he had to be sent to the hospital for a PEG tube to be placed due to malnourishment. R. at 2216, 2221. A review of the records cited by Ms. Trahant shows that there are no signatures by the individual charting that Mr. Guillotte was consuming 100% of his meals. R. at 1807-08, 1809, 1813. "[T]hey are documenting he's eating well in one place, and in another place, he's not eating well and he needs supplements and he needs appetite stimulants. So it is very difficult to determine based on these assessments." R. at 2221.

Similarly, individuals were responsible for providing fluids to Mr. Guillotte, yet he became dehydrated on more than one occasion. There is no documentation of his input and output prior to June 2002. Even then, the documentation does not reveal who monitored his intake and output. R. at 1818 (showing initials but no signatures for the documentation of Mr. Guillotte's intake and output in June 2002), 1841-43, 2204. Still, Nurse Trahant testified that "once they began documenting his intake and output in May and all through September, it was very evident to me that they consistently were not providing him with the amount of fluid that had been recommended by the dietition." R. at 2204. Dr. Hammond also testified that the root of Mr. Guillotte's dehydration was his not getting adequate fluid through his PEG feedings. R. at 1733. "You have to really work to get a sodium of 166, by not giving someone anywhere near adequate water." *Id.* Dr. Hammond then opined that Mr. Guillotte could have been given water through the PEG tube, "just like the hospital did." R. at 1735. "They did give him some free water . . . just not enough." R. at 1735.

2. Glucose Control.

Mr. Guillotte had Type II diabetes. R. at 1744. Yet, according to Dr. Hammond, "[t]hey don't get the job done and the patient's diabetic control gets worse over time, not better, for the periods that we have documentation. There is one period we do not." R. at 1745. Dr. Hammond opined, "[t]hey don't have to manage it, they just have to know they have a problem and ask for help." R. at 1746.

3. Contractures.

Dr. Hammond was critical of the fact that the hospital records document Mr. Guillotte's contractures before the nursing home even seems to realize they exist. R. at 1739, 1750-51, 1754, 1757. According to Dr. Hammond, the nursing home "needed to document why their documentation of contractures, or rather of range of motion and voluntary movement is so different to the hospital." R. at 1757.

It is clear that at times restorative therapy was not given, yet it is unclear from the records who should have given the restorative therapy. Thus, it would be impossible for Plaintiff's expert to know specifically which individual breached the standard of care. R. at 1756, 1758, 1772, 2216. Yet, according to Dr. Hammond, the ceasing of physical therapy after May 30 suggests the physician was not getting the information he needed. R. at 1756.

Dr. Hammond and Nurse Trahant both opined that the onset and progression of contractures could have been delayed with appropriate therapy. R. at 1758, 2216. According to Nurse Trahant, "Mr. Guillotte would have benefited from being picked back up by restorative in June. There were no documented reasons why they couldn't pick him up." R. at 2215. Indeed, Nurse Trahant testified that Mr. Guillotte's mobility and pain "could have been addressed appropriately by the staff through interventions." R. at 2218 (emphasis added). "[A]s he started developing changes, the staff didn't change or intervene appropriately as they had in the past." *Id.*(emphasis added). In nurse Trahant's opinion, restorative range of motion exercises would have prevented his contractures, improved circulation, and decreased his pain. R. at 2216.

4. Skin Lesions.

Mr. Guillotte's skin lesions also were not consistently or reliably documented. On the same day, Mr. Guillotte is noted in one document as having 10 lesions and in another document 7 lesions are recorded. R. at 1763, 1770. The nursing home documentation is conflicting—internally and conflicting with what the wound care center in the hospital reported. R. at 1763. Given this conflicting documentation, Dr. Hammond wondered, "[h]ow can you look after lesions when you have conflicting reports of how many there are and where they are?" R. at 1765. "I think it is very hard to adequately deal with lesions when you are uncertain how many there are, what they are and what the status is." R. at 1769.

Luanne Trahant agreed. She was unable to decipher the nurses' notes with regard to whether comprehensive skin assessments were done. There were no body audits prior to February 2002. The documentation was "very incomplete and very much below standard as far as keeping up with his skin condition." This violated Defendants' own policy as well as the standard of care. R. at 2201-02.

Nurse Trahant further discussed the facility's awareness of Mr. Guillotte's risk for pressure ulcers, care planning for this risk initially, and then failing to assess or reassess him after he returned from the hospital in April and failing to document turning and repositioning. R. at 2220-21. Clearly, in referring to the "facility", Ms. Trahant is referring to Defendants' employees. However, she is more specific, stating the "CNA's record there is either no documentation or inconsistent documentation for turning or how often they're turning." R. at 2221.

Nurse Trahant specifically stated that the reasons Mr. Guillotte developed wounds were: "he did not receive enough hydration", "he was losing important nutritional elements", "the turning and positioning during that time was poorly documented." R. at 2222-23. Further, the staff failed "to change the plan to address his nutritional problems or skin problems." R. at 2231.

Dr. Hammond explained that he was not critical of specific dressings or wound care. "There are many ways to approach these wounds... They didn't have to know what to do, again, they just have to know they are in trouble and ask for help." R. at 1767. Yet, "they don't adequately document that they are aware of that." R. at 1767. Indeed, Dr. Hammond considered the treatment sheets "essentially uninterpretable." R. 1770. Yet Dr. Hammond opined that, with appropriate nutrition and adequate hydration, more likely than not, these wounds would not have developed. R. at 1767.

5. Multiple Falls.

Mr. Guillotte suffered from numerous falls at Dixie White House. He was found lying on the floor on at least five occasions, the last fall resulting in a contusion to his left forehead. R. at 1751, 1753. According to Dr. Hammond, "[t]hey didn't do anything that prevented the outcome of the return falls." R. at 1752. Indeed, "the pattern of being found on the floor and not making new interventions, particularly with the wheelchair, does breach the standard of care... All I see is a recurrent pattern where they do not adequately address it." R. at 1752; see also, R. at 1653. Dr. Hammond explained that Mr. Guillotte "should not be put in a situation where he was likely to fall... There are a variety of ways of going about it, and I would not criticize them for which ones they

did, but they need to assess, reassess and care-plan to make sure they deal with it." R. at 1753.

6. Recurrent Infections.

Mr. Guillotte suffered from recurrent infections, including three episodes of urosepsis, urinary tract infections, and some secondary elements of pneumonia while at Dixie White House. R. at 1760. According to Dr. Hammond, Mr. Guillotte's malnutrition and dehydration predisposed him to infections. R. at 1762.

With regard to Mr. Guillotte's urinary tract infections, Nurse Trahant testified that "the hygiene practices of the staff were not well documented in the records." R. at 2227. She felt that it "would have been important for the staff to evaluate . . . if taking out the catheter affected any of the wounds or the ability to take care of those wounds." R. at 2227 (emphasis added).

Nurse Trahant stated plainly that it was the staff's responsibility to inform the doctor of Mr. Guillotte's condition, but the staff failed to assess his bladder function and failed to notify the doctor. R. at 2229.

7. Documentation Deficiencies.

With regard to each of the injuries sustained by Mr. Guillotte, Dr. Hammond was critical of the staff's failure to accurately assess, reassess, care plan and advise the physician with regard to the ongoing issues. R. at 1739 (dehydration), 1745 (diabetes), 1746 (diabetes), 1751 (falls), 1753 (falls), 1765 (skin lesions), 1767 (skin lesions), 1762 (urinary infections). Indeed, "[t]he home had a responsibility to be more aggressive about calling and updating the physician." R. at 1745. Dr. Hammond views this failure

a "pattern." R. at 1746. The pattern was evident in documentation that was not only internally inconsistent, but was "essentially uninterpretable"—"[h]ow can you know what you are treating?" R. at 1763, 1770, 1771.

A review of Mr. Guillotte's chart during his final admission to Dixie White House shows that although there are initials, many of which are illegible, no one signed the Medication Administration Record in order to delineate who provided or failed to provide the care at issue and as ordered by the dietician. R. at 1784-1801. This Medication Administration Record is the entire record for Mr. Guillotte's final admission to Defendants' facility.

Defendants concede that the chart is incomplete. They refused to admit that all care provided to Mr. Guillotte is contained in Mr. Guillotte's chart, or that the names or observations of all of Mr. Guillotte's caregivers are identified in his chart. R. 1705-06. When asked to admit that Mr. Guillotte's caregivers did not document their observations each time they answered his call light, Defendants answered that to the extent Mr. Guillotte's call light was used, "Defendants would admit that, most likely, each and every observation made when answering the call light was not documented." R. at 1708.

Dr. Hammond testified that he believed these failures were the result of a staffing problem... "it's not only the physician, skilled nursing should know it, a nutritionist seeing these, a dietician seeing these should know. So there are a number of professionals involved that should see this and say, 'We have a problem.'" R. at 1734-35.

8. A Systemic Pattern.

Dr. Hammond did not identify by name the specific caregivers that breached the standard of care. "What I see is a systematic pattern. There are a large number of people involved and a number of them are recurrent." R. at 1773. Even if he tried to identify specific caregivers, most of the caregiver names on the chart are illegible. R. at 1772, 1773. Further, care is sometimes "given by a team and they do not all document what they do because the team leader does the documentation." R. at 1772. For those caregivers who did not chart, it would be impossible to determine if they violated the standard of care. R. at 1772.

Still, Dr. Hammond testified that "whatever caregiver was either documenting the record for those specific instances... then that would be the respective caregiver who fell below the standard of care." R. at 1772. "I think it is a systemic failure, meaning that there are many individuals that breached the standard of care, all right? And that they share a responsibility with the home." R. at 1774. "It is a matter of the chain of command. Each person is charged to give the right information up the chain of command... The chain of command failed, and that happened several times." R. at 1774. Moreover, he opined that the physicians would not have done what they did if they had gotten the information they needed. R. at 1771.

> I think the major problem is a systemic failure of the home. The home is not monitoring the care and doesn't have the policies and procedures in place to assess, reassess and deliver a care plan.
>
> ...

> But if you are asking me was there one nurse in particular, there were many nurses and many staff who did not manage to convey adequate information.

R. at 1775.

In addition to the substantial testimony provided by Plaintiff's experts regarding the impossibility of reading the illegible names, initials, and signatures on Mr. Guillotte's chart, not to mention the complete absence of documentation on many occasions, Defendants' own expert testified that he was unable to ascertain the individual names of the caregivers at issue.

Dr. Robert Kelly agreed that identifying specific nurses or caregivers was often impossible given the poor documentation. For example, Dr. Kelly testified that there was no record of any specific aide turning or repositioning Mr. Guillotte from the month of October 2001 until April 2002, at which time Mr. Guillotte had already developed pressure sores. R. at 1833, 1838. In fact, the only time Dr. Kelly could find a name was in June 2002, and he was unable to determine exactly what the name was. R. at 2271. Similarly, Dr. Kelly could not identify who monitored the intake and output of Mr. Guillotte's fluids from October 2001- May 2002. R. at 1841-42. For the month of June, the specific identity of nurses still cannot be identified. Instead, "it would be generic by the nurses." R. at 1843.

Dr. Kelly admitted that there was evidence that, even when specific caregivers were listed, the records were neither reliable nor complete. R. at 1848-51, 1854-55. Dr. Kelly testified:

ARGUMENT

I. STANDARD OF REVIEW.

This Court applies a *de novo* standard of review to the grant of summary judgment by a trial court. *Leffler v. Sharp*, 891 So. 2d 152, 156 (Miss. 2004). It is well settled that summary judgment shall be granted only 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." Miss. R. Civ. P. 56(c); *Saucier ex rel. Saucier v. Biloxi Reg'l Med. Ctr.*, 708 So. 2d 1351, 1354 (Miss. 1998). "All motions for summary judgment should be viewed with great skepticism, and if [a court] is to err, it is better to err on the side denying the motion. *Mississippi Livestock Producers Ass'n v. Hood*, 758 So. 2d 447, 450 (Miss. Ct. App. 2000) (citing *Ratliff v. Ratliff*, 500 So. 2d 981, 981 (Miss. 1986)). "If there is doubt as to whether or not a fact issue exists, it should be resolved in favor of the non-moving party." *Id.*

As the moving party, Defendants had the burden of demonstrating that there is no genuine issue of material fact in existence, while Plaintiff, as the non-moving party, should have been given the benefit of every reasonable doubt. *Moss v. Batesville Casket Co., Inc.*, 935 So. 2d 393 (Miss. 2006) (citing *Tucker v. Hinds County*, 558 So. 2d 869, 872 (Miss. 1990)). "The evidence is viewed in the light most favorable to the party opposing the motion." *Stallworth v. Sanford*, 921 So. 2d 340, 341-42 (Miss. 2006) (citing *Davis v. Hoss*, 869 So. 2d 397, 401 (Miss. 2004)). When the evidence in this matter is viewed under this standard, it is clear that Defendants' motion should have failed, as Plaintiff

established that genuine issues of material fact exist. *See Partin v. North Mississippi Medical Center, Inc.*, 929 So. 2d 924, 933 (Miss. Ct. App. 2005).

Plaintiff submits that the Circuit Court of Harrison County's decision granting summary judgment in favor of the Defendants should be reversed and the case should be remanded so that Plaintiff may proceed to trial with her cause of action.

II. THE CIRCUIT COURT ERRED IN GRANTING SUMMARY JUDGMENT TO DEFENDANTS.

A. *Finley* is Distinguishable.

The Circuit Court relied entirely on the Mississippi Court of Appeals' decision in *Estate of Finley ex rel. Jordan v. Beverly Health and Rehabilitation*, 933 So. 2d 1026 (Miss. Ct. App. 2006) in granting Defendants' Motion for Summary Judgment. R. at 1880-83.

In *Finley*, the defendants proposed request for admissions "asking the plaintiff to admit or deny whether each individual caregiver acted within the standard of care." *Finley*, 933 So. 2d at 1028. In *Finley*, the plaintiff objected, but essentially admitted that none of the defendants' employees breached the standard of care. *Id.* Thereafter, the defendants filed a motion to determine the sufficiency of the plaintiff's answers after which the court found the answers to be insufficient and ordered the plaintiff to amend her answers. *Id.* Only after amendment and a motion to deem the answers admitted did the trial court rule that the plaintiff had admitted that none of the defendants 'employees had breached the standard of care. *Id.*

The Court of Appeals held that the trial court did not abuse its discretion in finding the nursing home's requests for admissions deemed admitted due to

unresponsive amended responses submitted by the plaintiff. *Id.* These are not the facts presented in the case at bar.

Plaintiff agrees that *Finley* stands for the proposition that absent evidence that caregivers neglected a resident and directly or proximately caused the resident harm, summary judgment is appropriate. Yet, in response to Defendants' discovery requests, completely inapposite to the situation in *Finley*, Plaintiff provided fifty-five names of caregivers that breached the standard of care. R. at 1466-68. Further, Plaintiff's experts testified in their depositions as to numerous acts and omissions of the Defendants' employees that directly and proximately caused Mr. Guillotte's injuries and death. Plaintiff's experts have acknowledged, as did Defendants' own expert, that they are unable to ascertain all of the names of the Defendants' employees who breached the standard of care. Yet, this does not discount the many breaches identified by Plaintiff's experts.

Defendants' attempt to turn this case into *Finley* was without merit. The matter at bar is factually distinctive and legally distinguishable. The Circuit Court erred when it failed to recognize the critical distinctions.

1. The disputed discovery request is an interrogatory.

First, Defendants' motion was not based on an admitted request for admission as in *Finley*, but instead was based on one interrogatory, propounded in April 2003, which reads:

> In your Complaint you allege the Defendants failed to discharge their obligations of care to Hamilton Peter Guillotte resulting in catastrophic injuries, etc. including those conditions detailed in the subparagraphs thereunder. As to each allegation, please specifically state the following:

(a) Each action or inaction which you contend supports your allegations;

(b) The name, address and telephone number of each individual you contend supports each allegation; and

By way of request for production please produce a copy of any document you contend supports each allegation.

R. at 1454. Plaintiff responded to Defendants' Interrogatory in February 2004 by stating that discovery was incomplete at that time and that Plaintiff's experts would provide testimony based on a review of Mr. Guillotte's medical records. R. at 1455-56. This interrogatory is substantially different from the discovery propounded in the *Finley* case.

Defendants and the Circuit Court fault Plaintiff for failing to supplement her responses in the interim. R. at 1882. Yet, this blame was misplaced. Notably, Defendants waited until August 14, 2007, the month before trial was scheduled to begin, before it moved to compel additional or more responsive answers in regard to this information. R. at 1527. Certainly, a motion to compel was the proper process, as there is no "motion to deem an interrogatory admitted." Further, Defendants waited nearly two years after Plaintiff's experts were identified to depose them. R. at 1599, 2195. Not more than seventeen days after Plaintiff's experts' depositions, Plaintiff supplemented her response to Defendants' interrogatory based, in part, on her experts' testimony. R. at 1463. Unlike *Finley*, Plaintiff never admitted that none of Defendants' employees breached the standard of care.

Moreover, Plaintiff's initial designation of these fifty-five caregivers was not an untimely supplement to a dated interrogatory. Instead, Plaintiff's initial designation was a timely response to new discovery propounded by Defendants in May 2007. R. at 1466. Indeed, Defendants waited until May 24, 2007, to propound their Consolidated Second Set of Interrogatories, Requests for Production, and First Requests for Admission, which included a single request for admission similar to the requests in *Finley*. R. at 2312.[3] In response to that Request for Admission, Plaintiff first designated the fifty-five caregivers who could be identified from the records. However, Plaintiff noted that many of the entries were illegible. R. at 1459-62.

Plaintiff's initial response to Defendants' 2003 interrogatory was clear that expert testimony was needed to fully respond to the interrogatory—yet Defendants chose not to depose Plaintiff's experts until July 2007. Although not acknowledged by the Circuit Court, the information requested by Defendants was not readily available or apparent to Plaintiff. In fact, Plaintiff filed motions to compel staffing discovery from Defendants on three separate occasions. R. at 194, 541, and 1404. In her supplemental interrogatory response, Plaintiff referenced her recent response to the Request for Admission, as well as the depositions and testimony of her experts regarding breaches of the standard of care. According to Dr. Hammond, "whatever caregiver was either documenting the record for those specific instances... then that would be the respective caregiver who fell below the standard of care." R. at 1772.

[3] The certificate of service on this discovery request incorrectly notes the date as May 24, 2006. However, the designation of 2006 is in error. Defendants' Consolidated Second Set of Interrogatories, Requests for Production, and First Requests for Admission were filed May 25, 2007, as noted by the Circuit Court's Case History List. R. at 15.

Defendants characterize Plaintiff's list of caregivers as a "laundry list." R. at 1414. However, such list is consistent with and supported by the testimony of her experts and is as extensive as Defendants' poor documentation will allow. Plaintiff and her experts' affirmative identification in this case of "many individuals that breached the standard of care" stands in direct contradiction to the plaintiff's deemed admission that *none* of defendants' employees had breached the standard of care in *Finley*. R. at 1773.

2. Plaintiff's expert testimony is sufficient.

Unlike *Finley*, Plaintiff has never asserted that none of Defendants' employees have breached the standard of care. Plaintiff's experts have testified that Mr. Guillotte suffered injuries due to numerous breaches in the standard of care at Defendants' facility, referring to Defendants' employees as "staff", "they", "the facility", etc. Just as "the hospital" or any other inanimate object cannot provide care, neither can "the facility." As clarified by Dr. Hammond, "it is the people who breached the standard of care." R. at 1774. Indeed, his and Nurse Trahant's statements that "they" and "staff" and "facility" breached the standard of care are clearly references to the individuals that provided care to Mr. Guillotte.

Further, as testified by Plaintiff's and Defendants' experts, the nursing home record provided to the Plaintiff and maintained by Defendants makes the task of naming each breaching caregiver impossible. R. at 1772-75, 1784-1801, 1833, 1838, 1841-43, 1845, 1847-51, 1854-55, 2271, 2276. On many occasions, the individuals responsible

for providing Mr. Guillotte's care and treatment on a daily basis are unidentified or their signatures or initials are illegible. *Id.*

The Circuit Court incorrectly held that pursuant to *Finley, supra,* summary judgment must be granted because Plaintiff did not specifically identify each employee of Defendants that breached the standard of care. R. at 1882. In so doing, the Circuit Court incorrectly held Plaintiff and her experts to an unnecessary and impossible standard, as Plaintiff and her experts are operating off of information provided by Defendants, Mr. Guillotte's nursing home chart, that is full of inaccuracies, mistakes, and is simply missing important information. As Defendants admitted in responses to requests for admissions propounded by the Plaintiff, "all care providers are required to provide care that meets the standard of care." R. at 1707. Defendants further admitted that their employees are required to report neglect as well as document negligence, yet no documentation of neglect or evidence of neglect is documented. R. at 1707-08.

Even without the names of specific caregivers who provided care on each shift, Plaintiff's experts clearly testified as to the breaches of care that occurred. When Dr. Timothy Hammond was asked specifically if it would be possible to identify somebody who deviated from the standard of care when that caregiver's identity is not indicated in Mr. Guillotte's records, Dr. Hammond clearly responded, "No, sir." R. at 1772.

Dr. Hammond's testimony continued:

> Q. Regarding what should or should not have been done for Mr. Guillotte regarding his care and the outcome thereof, correct?
>
> A. Yes.

Q. And whatever caregiver was wither documenting the record for those specific instances which you either charted or discussed, then that would be the respective caregiver who fell below the standard of care?

A. Yes.

Q. And for the ones that are not indicated anywhere in the chart who failed to delivery that care, you would never be able to identify that person?

A. No, sir.

***

A. There are so many—because there are so many nurses involved and so many staff, I didn't specifically look at he specific caregivers. What I see is a systematic pattern. There are a large number of people involved and a number of them are recurrent.

***

A. Most of the names are illegible.

R. at 1772-73.

In answers to Plaintiff's discovery, Defendants conclusively established that even they are unable to determine who provided care to Mr. Guillotte on specific occasions. For example, when asked to admit that a caregiver named P. Pryor did not provide care and/or treatment to Hamilton Guillotte during his residency at Dixie White House, Defendants responded, "Based upon information and belief, admitted." R. at 1704. However, a cursory review of Defendants' own records for Mr. Guillotte indicates that what appears to be a P. Pryor charting as having provided care on numerous occasions from April through August 2002. R. at 1805, 1806. If this individual is not "P. Pryor", then both parties are unable to identify who this particular individual is.

Defendants dispute that it is "impossible to determine the signature of the author"-- though they concede that "some of the signatures in Mr. Guillotte's nursing home chart may be difficult to read." R. at 1707. Plaintiff submits that some of the signatures are, in fact, impossible to read. R. at 1802-03, 1811, 1815.

Illegible entries are only part of the problem. A number of critical entries in Mr. Guillotte's activities of daily living (ADL's) contain no signatures of the staff providing the care, or responsible for providing care, nor do they contain the signatures of the nurses supervising the individuals providing or failing to provide care. R. at 1782-1803. Defendants' expert, Dr. Robert Kelly, agreed that identifying specific nurses or caregivers was often impossible given the poor documentation. R. at 1833, 1838, 1841-42. Instead, the identity "would be generic by the nurses." R. at 1843.

Even when specific caregivers are listed in the records, those records are not always reliable information of care provided. R. at 1848-51, 1854-55. Defendants deny that there are instances in the record where care was documented in Mr. Guillotte's chart that was not actually provided. R. at 1706. Yet, Plaintiff has discovered several inaccuracies that prove Defendants' response to be incorrect. First, Mr. Guillotte's chart indicates that care was provided to him in the month of June 2001, even though Mr. Guillotte was not admitted until October of that year. R. at 1808. More disturbingly, the chart for June 2001 has a "31st" day written in, despite the fact that June has only thirty days. *Id.* Similarly, care is charted as having been provided on a day when Mr. Guillotte was not in the nursing home but was in fact in the hospital. R. at 1809-12,

1820. Further, an employee charted that she provided care to Mr. Guillotte when her timecard shows that the employee was on vacation at the time. R. at 1813-17.

It was error for the Circuit Court to require Plaintiff to identify each employee who breached the standard of care when such a task is unnecessary and impossible based on the Defendants' own record keeping. Even Defendants' own expert was unable to identify individual caregivers. Yet, according to Dr. Kelly, "it does not matter-- it does not trouble me." R. at 1845, 1847. As succinctly put by Dr. Kelly, "I don't see a need for it." R. at 1847.

The issues involved in this matter are non-delegable nursing home duties. As such, they cannot be transferred, and Plaintiff's experts have provided testimony that proper care was not given to Mr. Guillotte. As stated above, this is not the case in *Finley, supra,* where the Court determined that there was an admission that *none* of the caregivers breached the standard of care. Plaintiff's experts have testified regarding numerous breaches of the standard of care. It is both unnecessary and impossible for Plaintiff to specify the individuals responsible for each and every single breach, as Defendants' own records are insufficient and inaccurate in this regard. For each of these reasons, the Circuit Court's order should be reversed and Plaintiff's cause of action reinstated.

3. The Circuit Court's holding is an overbroad extension of *Finley.*

In granting Defendants' Motion for Summary Judgment, the Circuit Court extended *Finley* beyond the language in the opinion. The Circuit Court recites that, "as in *Finley,* Plaintiff alleges Guillotte's death resulted from omissions in his treatment and

not from a breach of duty by any particular employee." R. at 1882. This is an accurate description of the factual situation in *Finley*, not the case at bar.

The Circuit Court incorrectly concluded that Plaintiff's medical experts "will not be providing testimony at trial regarding specific acts or omissions of the Defendants' employees and whether or not said acts or omissions were a proximate cause of Guillotte's injuries and/or death." R. at 1882. Contrary to the Circuit Court's finding, Plaintiff's experts did testify in their depositions as to numerous, specific acts and omissions of the Defendants' employees that directly and proximately caused Mr. Guillotte injuries and death. Admittedly, both Plaintiff's and Defendants' experts were unable to ascertain all of the names of the Defendants' employees who breached the standard of care. However, the specific naming of the employees is not required by Mississippi precedent.

Moreover, the Circuit Court's conclusion, "[w]ithout such expert medical testimony, Plaintiff cannot survive a motion for summary judgment" is an incorrect statement of the law and an unreasonable extension of *Finley*. R. at 1882. Instead, the *Finley* Court wrote:

> If [the plaintiff's] theory of liability was truly that no employee had ever breached the standard of care, and that Beverly had negligently contributed to Finley's death, then the response should have been a firm admission that none of the caregivers listed had breached the standard of care, and other evidence should have been produced to show that, regardless, Finley suffered an untimely demise due to a lack of adequate care.

Finley, 933 So. 2d at 1032. The Plaintiff in this matter does not assert that no employee ever breached the standard of care. On the contrary, prior to the Circuit Court's grant

of summary judgment, Plaintiff provided evidence through expert testimony of numerous breaches by Defendants' employees.

It is well settled that summary judgment shall be granted by a court only 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." Miss. R. Civ. P. 56(c); *Saucier ex rel. Saucier v. Biloxi Reg'l Med. Ctr.*, 708 So. 2d 1351, 1354 (Miss. 1998). "If there is doubt as to whether or not a fact issue exists, it should be resolved in favor of the non-moving party." *Mississippi Livestock Producers Ass'n v. Hood*, 758 So. 2d 447, 450 (Miss. Ct. App. 2000). When the evidence in this matter is viewed under this standard, it is clear that the Circuit Court erred, as Plaintiff has established that genuine issues of material fact exist. *See Partin v. North Mississippi Medical Center, Inc.*, 929 So. 2d 924, 933 (Miss. Ct. App. 2005).

B. Two Recent Opinions by the Mississippi Supreme Court Support Reversal of the Circuit Court's Decision.

On September 13, 2007, the day after the Circuit Court signed the Final Judgment, but before it was filed with the Clerk, the Mississippi Supreme Court handed down its decisions in *Delta Regional Medical Center v. Venton*, 964 So. 2d 500 (Miss. 2007) and *Mariner Health Care, Inc. v. Estate of Edwards ex rel. Turner*, --- So. 2d ----, 2007 WL 2670308 (Miss. 2007). Both of these cases strongly support the reversal of the Final Judgment against the Plaintiff. Neither *Edwards* nor *Venton* limits or overrules *Finley*. Instead, these opinions confirm what expert testimony is necessary to defeat a motion for summary judgment and support Plaintiff's assertion that the expert testimony in

this matter is sufficient not only to survive summary judgment but also to sustain an award at trial.

1. *Venton*, 964 So. 2d 500 (Miss. 2007).

In *Venton*, the Mississippi Supreme Court affirmed a verdict in a case against Delta Regional Medical Center in which a patient developed a decubitus ulcer while at the hospital and died shortly after transfer from the hospital to a rehabilitation facility. The son of the patient filed suit against the hospital and "ten unnamed staff members." *Venton*, 964 So. 2d 500, 503 (Miss. 2007). The "unnamed" staff members were apparently dismissed from the suit, as the judgment in *Venton* was against the hospital defendant, Delta Regional Medical Center. *Id.*

Following a bench trial, the trial judge in *Venton* found "by a preponderance of the evidence that negligent acts and/or omissions of the nursing staff and other employees and personnel of [the hospital] in failing to adequately turn and reposition Hattie Venton, and in failing to provide proper hydration, were proximate contributing causes of the skin breakdown, decubitus ulcer development, regression and the death of Hattie Venton." *Id.*

Under the standard set forth by the Supreme Court in *Venton, supra*, Dr. Hammond and Nurse Trahant's testimony in this matter is clearly sufficient to establish that genuine issues of material fact exist. Indeed, the expert testimony discussed by the Mississippi Supreme Court in *Venton* is similar to the expert testimony in this case.

The plaintiff's nurse expert, Loureen Downes, testified in *Venton*:

> [T]he standard of care in prevention of bedsores mandates turning a patient at least every two hours. She pointed to medical records which

> showed that even after the pressure sore was diagnosed, Venton was not turned for periods ranging from three to upward of eight hours.

Id., at 505. Similarly, in the case at bar, Plaintiff's nurse expert, Luanne Trahant, testified that Mr. Guillotte was not turned and repositioned sufficiently both before and after he developed decubitus ulcers. R. at 2222.

In *Venton,* Downes also testified to the standard of care in keeping a patient properly hydrated:

> Downes pointed to medical records which revealed that Venton's fluid intake as controlled by the staff of DRMC was far less than what was prescribed by her doctors, and grossly inadequate to meet her hydration needs.

Venton, 964 So. 2d at 505. Nurse Trahant in the case at bar testified that Defendants' staff failed to provide the hydration recommended by the dietician, which led to urinary tract infections and dehydration that required hospitalization. R. at 2204. Nurse Trahant testified that once "they" [clearly Defendants' employees] began documenting Mr. Guillotte's intake and output in May and all through September, "it was very evident to me that they consistently were not providing him with the amount of fluids that had been recommended by the dietitian." R. at 2204.

Additionally, in *Venton,* one of the plaintiff's experts, Dr. Verdery, testified that nutrition is essential in the maintenance of skin integrity, especially in older people who are immobile, and that Venton's malnutrition while at the hospital contributed to the development of her decubitus ulcer. *Venton,* 964 So. 2d at 505. Similarly, both Nurse Trahant and Dr. Hammond testified that Mr. Guillotte was not properly assessed and

that he was not provided with sufficient nutrition which led to the development and worsening of his ulcers. R. at 1765, 2221.

The Mississippi Supreme Court held in *Venton* that the plaintiff sufficiently established the element of breach. In regard to causation, the *Venton* Court stated that Dr. Verdery's testimony that Venton's wound "was a result of lack of proper hydration, nutrition, and turning on behalf of DRMC employees" and further that the bedsore caused Venton's death was substantial and credible evidence sufficient for the trial judge to have found in favor of the plaintiff. *Venton,* 964 So. 2d at 506 (emphasis added). Similarly, Plaintiff's medical expert in this matter, Dr. Timothy Hammond, testified that there was a failure to assess, reassess, and care plan and treat Mr. Guillotte's nutrition and hydration status and needs, and that these failures led to Mr. Guillotte developing decubitus ulcers. R. at 1763-64, 1765. Dr. Hammond also testified that Mr. Guillotte was unable to extend him limbs due to severe contractures. R. at 1739, 1750-51, 1754. Dr. Hammond testified that Mr. Guillotte suffered dehydration and sepsis which ultimately contributed to his death. R. at 1721. Dr. Hammond also testified, "They should have worked out that somebody was so horribly dehydrated and transferred [him] earlier or intervened." R. at 1739.

Plaintiff's experts testified that numerous employees of the Defendants breached the applicable standard of care. Dr. Hammond explained,

> I think it is a systematic failure, meaning that there are many individuals that breached the standard of care. And that they share a responsibility with the home. But it is essentially the home which is failing to deliver the standard of care... I think there are a lot of individuals that breached the standard of care.

R. at 1774 (emphasis added). Dr. Hammond did express difficulty naming these employees based on the illegibility and nonexistence of the medical records. However, Defendants' own expert, Dr. Robert Kelly, testified in his deposition that he, too, was unable to ascertain the names of the individuals providing or supposed to be providing care to Mr. Guillotte and that this did not matter to him. R. at 1833, 1838, 1841-43, 1845-47,1855.

Under the standard set forth by the Supreme Court in *Venton, supra,* Dr. Hammond and Nurse Trahant's testimony is clearly sufficient to establish that genuine issues of material fact exist. There is simply no precedent, including *Finley, supra,* that requires naming the individual caregivers that breached the standard of care in order to maintain a negligence cause of action in Mississippi. Thus, this Court should reverse the Circuit Court's decision granting summary judgment.

2. *Edwards*, 2007 WL 2670308 (Miss. 2007).

In *Edwards,* the Mississippi Supreme Court examined a nursing home case handled by the same law firm that represents the Plaintiff in this matter. Although the Court ultimately reversed the jury verdict in favor of the plaintiff for other reasons, the Court specifically examined the denial of a motion for judgment notwithstanding the verdict and the testimony of the testifying expert, Dr. Kenneth Olson. *Edwards,* --- So. 2d ----, 2007 WL 2670308 at *2.

In *Edwards,* Dr. Olson testified that the defendants "breached the standard of care in failing to monitor Mr. Edward's nutritional needs and bowel movements, in failing to recommend intravenous feeding, known as 'TPN feeding,' to the center's medical

director, and in not recommending that Edwards be transferred to a multiple-specialty facility to address his worsening condition." *Id.* "He further opined that the failure of the nursing home to recommend the TPN treatment was a contributing cause of Edwards's death." *Id.*

The Mississippi Supreme Court held:

> Dr. Olson's testimony was sufficient to present a prima facie case for the liability of Greenwood Health. . . . He testified to a causal nexus between the actions of Greenwood Health and Edwards's death.

Id. at *2-3.

Dr. Olson did not specifically name the caregivers who breached the standard of care, rather he identified the breaches themselves, just like Plaintiff's experts have done in this case. The Mississippi Supreme Court found Dr. Olson's testimony to be sufficient, stating: "While he did not rule out the possibility that other parties were liable, his testimony that the negligence of Greenwood Health contributed to Edwards's death is sufficient to establish proximate cause." *Id.*

The Supreme Court's analysis of the expert testimony in *Edwards* is persuasive. The *Edwards* Court noted that in *Finley,* the Court of Appeals held that "generalized testimony of short-staffing that does not show a casual nexus between staffing and a plaintiff's injuries is not probative to the question of liability." *Id.* (citing *Finley*). Plainly, "generalized testimony [by nursing assistants] of short-staffing" is not the issue in the matter at bar. Instead, as in *Edwards,* Plaintiff's experts have testified to numerous specific breaches that directly caused Mr. Guillotte's injuries. That they will not also testify as to the names of every caregiver that fell below the standard of care is

not fatal to Plaintiff's case. Having met her burden of establishing that material facts exist, the Circuit Court of Harrison County erred in granting summary judgment in favor of the Defendants.

CONCLUSION

The expert testimony provided by Dr. Timothy Hammond and Nurse Luanne Trahant and the legal standard established by the Mississippi Supreme Court in *Venton* and *Edwards, supra,* establish that the testimony in this case is sufficient for Plaintiff to continue her cause of action.

Plaintiff respectfully requests that the Court reverse the Circuit Court of Harrison County's grant of summary judgment in favor of the Defendants, remand the case for trial, and for all other relief, both general and specific, to which she is entitled.

Respectfully submitted,

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By and through Edith Jordan, Individually
and as Administratrix of the Estate of
Hamilton Peter Guillotte

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CERTIFICATE OF FILING

I hereby certify that I, Susan Nichols Estes, counsel for the Plaintiff/Appellant, on this 7th day of July, 2008, deposited with Federal Express, with delivery prepaid via Priority Next Day Delivery, to be delivered to the Mississippi Supreme Court Clerk's Office, the following original documents and copies:

The original and five (5) copies of the above Appellant's Brief.
The original and five (5) copies of Appellant's record excerpts.

This certificate of filing is made pursuant to Rule 25(a) of the Mississippi Rules of Appellate Procedure.

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I hereby certify that a true and correct copy of the foregoing was served by First Class Mail on the following, this 7th day of July, 2008:

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CERTIFICATE OF VIRUS-FREE COMPUTER DISK

I certify that the computer disk accompanying this brief has been scanned and is virus free.

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IN THE MISSISSIPPI SUPREME COURT
Case No. 2008-CA-00067

THE ESTATE OF HAMILTON PETER GUILLOTTE, BY AND THROUGH EDITH JORDAN, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF PETER GUILLOTTE — PLAINTIFF/APPELLANT

v.

DELTA HEALTH GROUP, INC.; PENSACOLA HEALTH TRUST, INC.; JOHN DOES 1 THROUGH 10; AND UNIDENTIFIED ENTITIES 1 THROUGH 10 (AS TO DIXIE WHITEHOUSE NURSING HOME) — DEFENDANTS/APPELLEES

Certificate of Interested Parties

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 of the Supreme Court and/or the judges of the Court of Appeals may evaluate possible disqualification or recusal.

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I hereby certify that a true and correct copy of the foregoing was served by First Class Mail on the following, this 28th day of July, 2008:

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