SUPREME COURT OF KENTUCKY
2009-SC-000289
(CONSOLIDATED WITH 2009-SC-000839)

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UNIVERSITY MEDICAL CENTER, INC. D/B/A UNIVERSITY OF LOUISVILLE HOSPITAL — APPELLANT/CROSS-APPELLEE

v.

APPELLANT'S BRIEF

MICHAEL G. BEGLIN, EXECUTOR OF THE ESTATE OF J.W. BEGLIN AND M.G. BEGLIN, ET AL. — APPELLEE/CROSS-APPELLANT

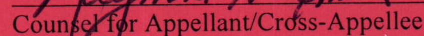
APPEAL FROM COURT OF APPEALS OF KENTUCKY
2007-CA-000018 AND 2007-CA-000133

Submitted by:
BOEHL STOPHER & GRAVES, LLP

Edward H. Stopher
Raymond G. Smith
AEGON Center, Suite 2300
400 West Market Street
Louisville, KY 40202
Phone: (502) 589-5980 / Fax: (502) 561-9400
COUNSEL FOR APPELLANT/CROSS APPELLEE

CERTIFICATE OF SERVICE

It is hereby certified that a copy of the foregoing was mailed this 10th day of May, 2010 to F. Thomas Conway, 238 South Fifth Street, 18th Floor, Louisville, KY 40202; Chadwick N. Gardner, 239 South Fifth Street, Suite 1916, Louisville, KY 40202; Honorable Charles L. Cunningham, Jr., Division Four, Jefferson Circuit Court, 700 West Jefferson Street, Louisville, KY 40202 and Samuel P. Givens, Jr., Clerk, Court of Appeals, 360 Democrat Drive, Frankfort, KY 40601. I further certify that the record on appeal was not withdrawn by the party filing this Brief.



Counsel for Appellant/Cross-Appellee

I. INTRODUCTION

This is a medical negligence case in which the trial court gave, and the Court of Appeals approved,[1] a "missing evidence" instruction even though there was no evidence that the missing document was intentionally and in bad faith destroyed or that its absence resulted in any prejudice to plaintiffs; and an instruction that permitted the jury to award punitive damages vicariously against University of Louisville Hospital because of its failure to "anticipate" conduct that had never previously occurred, and its ratification of the conduct by "fail[ing] to perform an adequate investigation."

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[1] *See* Jefferson Circuit Court Judgment entered August 4, 2006, and Court of Appeals Opinion, January 16, 2009, attached hereto as Exhibits 1 and 2.

II. STATEMENT CONCERNING ORAL ARGUMENT

Appellant/Cross-Appellee, University Medical Center, Inc., d/b/a University of Louisville Hospital ("Hospital"), believes that oral argument is vitally important in order for this Court to fully appreciate the extent to which the trial court's erroneous "missing evidence" instruction infected the jury's verdict, as well as the absence of any factual basis for the trial court's punitive damage instruction.

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VII. APPENDIX

IV. STATEMENT OF THE CASE

A. Summary of the Claims at Trial and the Court's Erroneous Instructions

It is important for this Court to appreciate at the outset the significance of the "missing evidence" and punitive damage instructions given by the trial court, the legal rationale on which they were based, and their effect on the verdict. These instructions and the absence of any evidence to justify them are at the heart of this appeal. Consequently, a brief overview of the events that gave rise to these instructions may be helpful to the Court.

This case concerns the tragic death of Jennifer Beglin ("Jennifer"). On July 14, 2003, Jennifer underwent surgery for her Crohn's disease. During surgery, Jennifer experienced a significant loss of blood that resulted in anoxic brain injury and her subsequent death when life support was withdrawn.

The fundamental factual dispute at trial was whether the surgical team or Nurse Barbara Cantrall ("Cantrall") was responsible for Jennifer not receiving a timely blood transfusion. Appellee, Michael G. Beglin ("Beglin"), contended that the surgical team either (1) negligently failed to pre-order blood in light of a previous surgery in which Jennifer had required a transfusion; or (2) the surgical team negligently delayed ordering blood when it became apparent that blood was needed. With respect to the Hospital, Beglin contended that Cantrall either (1) negligently delayed in sending a blood sample to the blood bank for typed and cross-matched blood, thus delaying the blood's arrival in the operating room ("OR"), or, (2) negligently failed to correct the doctors' misunderstanding as to when blood would be delivered to the OR.

At the conclusion of the evidence, the court gave two instructions that are the focus of this appeal. Contrary to her deposition testimony where she testified that she did

not prepare an "occurrence report" after the surgery, at trial Cantrall testified that she prepared an "occurrence report" and placed it in a bin at the front desk of the operating suite.[2] It is undisputed that if such a report was prepared, no one other than Cantrall ever saw the report and it could not be found. Beglin did not contend that the Hospital intentionally and in bad faith misplaced or destroyed the report, or that Beglin's case was prejudiced as a result of the absence of the "occurrence report." Instead, Beglin argued:

> [i]f it [occurrence report] should be in there and it isn't and it's not, you're allowed to draw an inference in your deliberations that what would have been in here is bad.[3]

In other words, Beglin encouraged the jury to hold the Hospital liable based on specuation that something in an "occurrence report" was "bad."

The trial court accepted Beglin's incorrect view of the law, and despite the absence of evidence to support a spoliation instruction, instructed the jury that it could infer that whatever was in the report was adverse to the Hospital if the jury found that the occurrence report contained:

> [m]aterial information about Ms. Beglin's surgery, and if you further find from the evidence that the University Medical Center, Inc. d/b/a University of Louisville Hospital, intentionally <u>and</u> in bad faith lost or destroyed the incident report.[4]

Instead of performing the trial court's gatekeeper function and not allowing a spoliation instruction unless there first was a judicial finding of intentional bad faith

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2 Video Recording 30-04-06VCR 037, *Michael Beglin, Executor of the Estate of Jennifer Beglin, Individually and Michael G. Beglin, Parent and Next Friend of the Minors, William Patrick Beglin and Kelly Ann Beglin v. University Medical Center, d/b/a University of Louisville Hospital, Susan Galandiuk, M.D. and Guy M. Lerner, M.D.,* Jefferson Circuit Court, C.A. 04-CI-01605 (hereinafter "VR"), VR B11: 7/19/06; 12:06:45; 12:03:05.

3 VR No. B18; 7/28/06; 17:15:00. *See also* Transcript of Trial, pp. 217, 227-228, Attorney Conway's Statement, attached hereto as Exhibit 3.

4 Transcript of Record ("TR"), Vol. 22, pp. 3251-3270 (emphasis added). *See also* Instructions Given By The Court, Jury Instruction No. 7, attached hereto as Exhibit 4.

destruction of the document, the trial court gave a "missing evidence" instruction, thereby delegating to the jury the legal decision of whether a spoliation instruction was warranted. This new procedure was fundamentally improper.

The trial court also instructed the jury that if the Hospital acted in a grossly negligent fashion "during the operation from the time blood was ordered until it was delivered" and that if the Hospital "ratified," "authorized" or "should have anticipated" "the conduct in question," it could award punitive damages.[5] It was Beglin's position that Cantrall's conduct was grossly negligent, and that by not admitting liability and by not performing a more thorough investigation following Jennifer's surgery the Hospital "ratified" Cantrall's conduct.

Because there was no evidence that punitive damages were warranted against the Hospital, and in direct violation of the court's punitive damage instruction that any gross negligence had to have occurred "during the operation from the time blood was ordered until it was delivered," Beglin's counsel argued that the missing occurrence report justified an award of punitive damages:

> I want to tell you a little bit about the punitive damages instruction ... It's your opportunity, if you so choose [to] say not in my community are you going to fail to preserve an incident report ... And if you want to deter future conduct at this institution and others and if you want to send a message, this is your opportunity.[6]

The jury awarded Beglin $3,750,000 in punitive damages.[7]

The outcome of this appeal rests upon whether evidence existed that justified the trial court's "missing evidence" and punitive damage instructions, and whether the new

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[5] TR, Vol. 22, pp. 3251-3270.
[6] VR No. B18: 7/28/06; 17:36:10.
[7] TR, Vol. 22, pp. 2379-3282.

procedure used by the trial court unfairly encouraged juror speculation and tilted the trial against the Hospital in violation of its constitutional rights. If the evidence did not warrant either of the two instructions, the Hospital was severely and irreversibly prejudiced in the eyes of the jury.

B. Jennifer's Crohn's Disease

Since 1987, Jennifer had suffered from Crohn's disease.[8] Prior to 2003, Jennifer underwent several surgeries for her condition.[9] Her most recent surgery occurred in 1998 and was performed by Dr. Susan Galandiuk ("Galandiuk").[10] During this surgery Jennifer experienced a significant loss of blood.[11] As a result, the surgical team intra-operatively ordered Jennifer's blood typed and screened in case she needed a transfusion. While Jennifer did not receive a transfusion during the operation, she did require a transfusion post-operatively.[12] In addition, shortly after being discharged from the Hospital Jennifer developed coagulopathy, an inability of her blood to clot, that resulted in Jennifer's readmission and the transfusion of four additional units of blood.[13]

Following the 1998 surgery, Jennifer's health improved. However, in 2003, she developed acute pain in the anus area.[14] Dr. Galandiuk then reevaluated Jennifer and determined that the lower part of her rectum was virtually closed off due to ulcers resulting from her Crohn's disease.[15] In order to correct the problem Jennifer decided to undergo surgery, which was scheduled for July 14, 2003.

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[8] VR No. B5: 7/11/06; 11:50:22.
[9] VR No. B5: 7/11/06; 12:06:23.
[10] VR No. B5: 11:55:05.
[11] VR No. B5: 7/11/06; 12:27:30.
[12] VR No. B5: 7/11/06; 12:24:00.
[13] VR No. B5: 7/11/06; 12:36:29.
[14] VR No. B4: 7/10/06; 12:19:44; 12:20:45.
[15] VR No. B8: 7/14/06; 14:31:27.

C. **The Hospital's Blood Bank**

U of L Hospital is a Level I trauma center.[16] It is designed to handle incidents involving massive, life threatening events.[17] The Hospital's blood bank is responsible for handling all requests for blood and blood-related services throughout the Hospital.[18] It is staffed by 15 certified, medical technologists and handles more than 17,000 specimens a year.[19] The Hospital's blood bank is regulated and regularly inspected by the American Association of Blood Banks, the College of American Pathologists, the Food and Drug Administration and the Commonwealth of Kentucky.[20]

All requests for blood from an OR are processed "stat" – "immediately and without delay."[21] The blood bank is located one floor below the operating rooms. All requests for blood from an OR are delivered to the blood bank by a runner through the front door of the blood bank.[22] Each blood specimen sent to the blood bank has an orange label with the patient's name, medical record number, the name of the person who took the sample, and the date and time the sample was taken noted on the label.[23] The minimum time required for the blood bank to type and cross-match blood is 50 minutes. It takes a minimum of 10 minutes for the blood bank to provide O-negative, emergency blood.[24]

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16 VR No. BB17: 7/27/06; 12:11:57.
17 VR No. B16: 7/26/06; 10:41:49.
18 VR No. B16: 7/26/06: 10:36:00.
19 VR No. B16: 7/26/06; 10:39:08.
20 VR No. B16: 7/26/06; 10:38:48.
21 VR No. B16: 7/26/06; 10:53:25.
22 VR No. B16: 7/26/06; 11:42:01.
23 VR No. B16: 7/26/06; 10:52:39.
24 VR No. B16: 7/26/06; 11:10:36; 11:44:29.

D. Jennifer's Surgery Begins

Jennifer, her husband, Michael, and their two children arrived at the Hospital at approximately 7:50 a.m. on July 14, 2003.[25] Jennifer's surgery, a "complete proctectomy," was scheduled for 10:00 a.m.[26] Galandiuk had decided prior to July 14, that there was no need to type and cross-match Jennifer's blood because she did not believe a transfusion would be necessary.[27]

While waiting in the pre-operative area, Jennifer spoke with Dr. Guy Lerner ("Lerner"), the chief anesthesiologist assigned to her surgery.[28] Both Jennifer and her mother told Lerner of Jennifer's bleeding history.[29] Lerner then discussed Jennifer's surgery and bleeding history with Galandiuk. They both concurred that Jennifer's 1998 clotting problem was unlikely to reoccur, even though a "re-do" surgery such as Jennifer's increases the likelihood of additional blood loss.[30]

It was expected that Jennifer's surgery would last two and a half to three hours and that she would lose approximately 400 ccs of blood.[31] Because Galandiuk was completing another surgery, Dr. Peter Deveaux ("Deveaux") began Jennifer's surgery at 5:00 p.m.[32] Among the persons present in the OR were Deveaux, Lerner, Dr. Weitzner (an anesthesiology student), and circulating nurse John Reeb. In addition, Dr. Ozan Okca

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[25] VR No. B4: 7/10/06; 12:26:44.
[26] VR No. B4: 7/10/06; 12:28:16.
[27] VR No. B5: 7/11/06; 14:15:54.
[28] VR No. B8: 7/14/06; 15:30:16.
[29] VR No. B4: 7/10/06: 15:20:11; VR No. B8: 7/14/06; 15:28:02.
[30] VR No. B8: 7/14/06; 14:34:15; 15:37:08.
[31] VR No. B8: 7/14/06; 15:38:05; VR No. B5: 7/11/06; 14:16:38.
[32] VR No. BB17: 7/27/06; 11:00:45; VR No. B5 7/11/06; 14:02:08.

("Okca"), an anesthesiologist conducting a study on surgical wound infections, was also periodically present.[33]

E. Jennifer Experiences Substantial Blood Loss

Between 6:00 and 6:30 p.m., Galandiuk entered the OR.[34] By that time, according to the anesthesia log, Jennifer had lost 500 ccs of blood.[35] Shortly before 7:00 p.m., when Dr. Weitzner's shift ended, two blood samples were drawn to check Jennifer's hematocrit and hemoglobin levels.[36] Normal hematocrit is between 36 and 44 and normal hemogloblin is between 12 and 15. Together, the two values reflect the amount of blood a person has lost.

One of the blood samples was sent to the I-Stat machine outside of the OR that the surgical team used to get an almost instantaneous hematocrit and hemoglobin reading. The other sample was sent to the Hospital's lab for a more extensive analysis.[37] The I-Stat results were obtained at 7:10 p.m. They showed that Jennifer's hematocrit level had dropped from a pre-surgery level of 43.7% to 27%.[38] Jennifer's hemoglobin had dropped from its pre-surgery level of 14.5 to 9.[39] In essence, the I-Stat results showed that Jennifer had lost a considerable amount of blood.[40]

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33 VR No. B14: 7/24/06; 15:10:26.

34 VR No. B5: 7/11/06; 14:43:50; 15:15:15.

35 VR No. B9: 7/17/06; 11:21:30; VR No. B8: 7/14/06; 14:44:07. *See also* Anesthesia Log attached hereto as Exhibit 5.

36 VR No. B9: 7/17/06; 11:18:26. Hematocrit and hemoglobin levels reflect, among other things, the amount of blood loss and the amount of blood carrying oxygen Jennifer was receiving.

37 VR No. B9: 7/17/06; 11:40:37.

38 VR No. B9: 7/17/06; 11:57:47.

39 VR No. B9: 7/17/06; 11:53:33.

40 VR No. B9: 7/17/06; 11:53:36.

When Weitzner's and the circulating nurse's shifts ended, they were replaced by Dr. Jianguo Cheng ("Cheng") and Cantrall.[41] Because of the significant decrease in Jennifer's hematocrit and hemoglobin levels, Lerner considered ordering blood. He asked Galandiuk if surgery was nearly complete. When Galandiuk responded that she did not foresee any significant, additional blood loss, Lerner decided not to order a type and cross-match of Jennifer's blood.[42] Surgery continued for over an hour and a half, and by the time it concluded Jennifer had lost approximately 2,000 ccs of blood.[43]

Between 7:30 and 8:30 p.m., Jennifer's condition deteriorated. Albumin and other blood products were ordered from the blood bank and infused into Jennifer.[44] Cantrall sent blood samples to the lab for clotting and other tests.[45] Cantrall also brought fluids into the OR that were given to Jennifer to maintain her blood pressure.[46] There is no dispute that these tests and products were timely done by Cantrall, timely processed by the blood bank and lab, and timely delivered to the OR.

F. <u>The Dispute As To When Blood Was Ordered During Jennifer's Surgery</u>

There was considerable conflict among the doctors, and between the doctors and Cantrall, as to when a sample of Jennifer's blood was drawn and sent to the blood bank for type and cross-matching. According to Cheng, the blood sample for type and cross-matching was taken between 7:45 and 7:55 p.m., shortly after Lerner returned to the OR after handling another matter and observed a decrease in Jennifer's pulse. Dr. Lerner testified that he was not in the OR when the sample was drawn, and that it was his

41 VR No. B9: 7/17/06; 11:20:50; VR B11: 7/19/06; 10:52:58.
42 VR No. B9: 7/17/06; 11:55:25.
43 VR No. B9: 7/17/06; 11:27:06.
44 VR No. B9: 7/17/06; 15:02:31.
45 VR No. B9: 7/17/06; 15:03:40.
46 VR No. B9: 7/17/06; 11:36:11.

understanding the sample was sent to the blood bank between 7:30 and 7:45 p.m.[47] In his deposition, however, Lerner testified that the blood sample was not taken and sent to the blood bank until he had returned to the OR, i.e., 7:45 p.m. or later.[48]

Lerner, Okca and Cheng did agree, however, that they made no entry in the anesthesia log as to when Lerner left the OR, when the blood sample was drawn, when it was given to Cantrall and when Lerner returned to the OR.[49] Since it takes a minimum of 50 minutes to type and cross-match blood, transfusion blood would have been available around 8:30 p.m. if Jennifer's blood sample was sent to the blood bank at approximately 7:45.

Cantrall testified at trial that the blood sample was not drawn and sent to the blood bank until approximately 8:05 p.m. According to Cantrall, Lerner first stated he needed blood at approximately 7:45 p.m..[50] She then contacted the blood bank to determine if Jennifer had a blood sample on file from which typed and cross-matched blood could be processed.[51] Cynthia Williams ("Williams"), a medical technologist with the blood bank, confirmed that she received this call from Cantrall.[52] According to Cantrall, she twice told Lerner that the blood bank needed a sample but the doctors did not draw the sample or hand it to her until 8:05 p.m.[53]

Williams testified that she typed and cross-matched Jennifer's blood.[54] Once a sample is delivered to the blood bank it is first placed in a centrifuge to separate the blood

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47 VR No. B9: 7/17/06; 14:40:38; VR No. B9: 7/17/06; 12:00:54.
48 VR No. B9: 7/17/06: 14:51:37.
49 VR No. B14: 7/24/06; 15:21:21.
50 VR No. B11: 7/19/06; 11:18:42.
51 VR No. B11: 7/19/06; 11:23:04.
52 VR B12: 7/20/06; 11:15:02.
53 VR No. B11: 7/19/06; 15:11:00.
54 VR No. B12: 7/20/06; 11:49:58.

from the blood plasma. This process takes approximately eight minutes. When the centrifugal process is completed, the medical technician enters into the computer (from the orange label) the time the sample was taken and the doctor who took it.[55]

The blood bank's computer software automatically records when information is entered. The computer recorded that at 8:20 p.m., Williams first entered the information from the label.[56] After typed and cross-matched blood is prepared, it then takes several minutes for a runner to deliver the transfusion blood to the OR. The fact that typed and cross-matched blood was delivered to the OR at approximately 8:50 p.m. supported the testimony of Cantrall that the blood specimen was not taken until about 8:05 p.m.

Testimony regarding events after 8:05 p.m. was equally conflicting. Lerner testified in his deposition that O-negative, or universal blood, was ordered at approximately 8:35 p.m, when typed and cross-matched blood did not arrive in the OR. At trial, however, Lerner testified that emergency blood was ordered around 8:25 p.m.[57] Okca testified that emergency blood was ordered between 8:15 and 8:25 p.m. Cheng could not recall when universal blood was ordered or by whom.[58] Blood bank records confirm that emergency blood was released at 8:46 p.m. and the anesthesia log reflects that the transfusion began between 8:47 and 8:50 p.m.[59]

The essence of the doctors' testimony was that typed and cross-matched blood should have been delivered to the OR by 8:30 p.m. because Jennifer's blood specimen was taken around 7:45 p.m. Moreover, Lerner testified that at approximately 8:15 p.m., Cantrall told him that transfusion blood should arrive in the OR in 10 minutes, or by 8:25

[55] VR No. B12: 7/20/06; 12:06:01.
[56] VR No. B12: 7/20/06;12:08:27.
[57] VR No. B9: 7/17/06; 12:39:40.
[58] VR No. B14: 7/24/06; 16:56:25.
[59] VR No. B9: 7/17/06; 5:19:17.

p.m.[60] Thus, it was the doctor's position that Cantrall was responsible not only for the delay in getting typed and cross-matched blood timely to the OR because she failed to send Jennifer's blood specimen to the blood bank until 8:05 p.m., but she also failed to correct the doctor's belief that typed and cross-matched blood would be ready by 8:25 to 8:30 p.m., thus delaying the doctor's decision to order emergency blood.

G. Jennifer Suffers Cardiac Arrest And Anoxic Brain Injury During Surgery

Around 8:50 p.m., Jennifer experienced a dilutional coagulopathy, which Deveaux described as a "Kool-Aid" like rush of blood loss.[61] She then suffered cardiac arrest and was given CPR.[62] Jennifer was resuscitated, the operation completed and she was sent to recovery. While it was not known at the time, Jennifer had incurred an anoxic brain injury due to lack of oxygen-carrying blood. She died on October 9, 2003, after life support was withdrawn.[63]

Immediately following surgery, Galandiuk, Okca and Lerner met with Jennifer's family. The doctors told the family that they believed that Jennifer had suffered a stroke, but never mentioned any delay in receiving blood in the OR.[64]

H. Post-Surgery Events

Within one to five hours after surgery, Lerner hand wrote a summary of events that had occurred in the OR.[65] Okca signed Lerner's summary to "confirm [its]

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60 VR No. B9: 7/17/06; 12:15:04.

61 VR No. B14: 7/24/06; 15:56:05; VR No. BB17: 7/27/06; 14:30:23.

62 VR No. BB17: 7/27/06; 14:30:23.

63 VR No.B5: 7/11/06; 16:47:26.

64 VR No. B4: 12:33:08; 15:22:24; VR No. BB: 7/21/06; 16:12:30.

65 VR No. B9: 7/17/06; 11:45:18. *See also* Dr. Lerner's Post-Surgery Report attached hereto as Exhibit 6.

accuracy."[66] Lerner and Okca's summary did not mention any delay in the surgical team receiving blood:[67]

> To sum, patient became hypotensive with low profusion, decreased end tidal CO2 and loss of Sa CO2 secondary to massive, insidious blood loss; required CPR times 5 minutes; never asystolic; spoke with family and explained all events; at this time, unsure of neurological outcome.[68]

According to Galandiuk, the day after surgery and after learning that Jennifer was having seizures, she called and talked to someone in the Hospital's Risk Management Department, whose name she could not recall, and told that person that "complications" had occurred.[69] In her interrogatory answers, Galandiuk explained that the only thing she told Risk Management was that "an intraoperative code occurred, and the patient remained in a comatose state postoperatively."[70] There was no evidence that Galandiuk told anyone at the Hospital that there was a delay in the delivery of blood from the blood bank to the OR in connection with Jennifer's surgery until after suit was filed.

I. Beglin Files Suit

On February 25, 2004, Michael Beglin, Jennifer's husband, filed suit on behalf of Jennifer's estate and her then minor children against the Hospital, Susan Galandiuk, M.D. and Guy M. Lerner, M.D.[71] After extensive discovery, the case was tried to a jury from July 7 to August 1, 2006.

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[66] VR No. B14: 7/24/06; 16:29:10.
[67] VR No. B14: 7/24/06; 16:38:36.
[68] *Id.*
[69] VR No. B5: 7/11/06; 15:52:07.
[70] VR No. B16: 7/26/06; 14:37:36.
[71] T.R., Vol. 1, pp. 1-8.

J. **The Hospital's Motion For Directed Verdict And The Court Decides To Give Instructions On Spoliation Of Evidence Without First Determining Intentional Bad Faith Destruction or Prejudice, And Punitive Damages**

At the conclusion of Beglin's case the Hospital moved for a directed verdict.[72] The trial court acknowledged that the Hospital was entitled to a directed verdict on punitive damages but nevertheless overruled the motion due to "some prior personal issue with the Court of Appeals":

> THE COURT: The other issues in terms of the punitive damages, I think you have, frankly, I think you have stronger arguments on the punitive damage. I don't hear – I have not heard what I think is gross negligence. But only because of some prior personal issue with the Court of Appeals I'm not frankly inclined to grant that motion.[73]

The Hospital renewed its motion for a directed verdict after the Hospital's proof was completed. The trial court again overruled the Hospital's motion.[74]

1. The missing occurrence report and the court's spoliation of evidence instruction

Among the forms used by the Hospital is an "Occurrence Report."[75] It is a six page, preprinted form available for use in reporting anything from a slip-and-fall, to an employee injury, to an injury to a patient. Only the "Statement of Facts" on page 1 and the block on page 3 relating to "Operating Room" had any potential pertinence to Jennifer's surgery.

Cantrall testified at trial that she completed an occurrence report at the suggestion of Elaine Strong ("Strong"), the charge nurse, after Jennifer's surgery.[76] Cantrall testified that the only information she would have recorded in the report was that CPR was

[72] VR No. BB: 7/21/06; 17:15:36.
[73] VR No. BB: 7/21/06; 17:26:24 (emphasis added).
[74] VR No. B18: 7/23/06; 10:28:09.
[75] *See* Occurrence Report form attached hereto as Exhibit 7.
[76] VR No. B11: 7/19/06; 12:06:00.

performed in the OR.[77] She acknowledged, however, that her trial testimony was not consistent with her testimony in an earlier deposition in which she had testified that she did not believe she had completed an incident report, but if she had she would have included a chronology and her perception of events that occurred during surgery.[78]

At trial, Cantrall testified that she placed the report in a bin at the front desk.[79] Strong denied that she had requested Cantrall to prepare an incident report and testified that she never saw an incident report prepared by Cantrall.[80] Other than Cantrall's trial testimony, which conflicted with her deposition testimony, no one testified that they ever saw such an incident report and there was no evidence that the report (if it existed) had been destroyed.

Even though Kentucky law requires a judicial determination of intentional bad faith and prejudice before a spoliation or missing evidence instruction may be given to a jury, Beglin's counsel did not contend that the Hospital had destroyed the report, intentionally or otherwise, or that the Hospital lost the report in bad faith, or that Beglin was prejudiced by the Hospital's inability to locate the report.

Beglin's position was that evidence of prejudice, intentional misconduct and bad faith are irrelevant in the context of a spoliation or missing evidence instruction. Beglin's position, simply stated, was that the absence of a document *per se* justifies a missing evidence instruction, and that a jury may simply infer from the absence of a document that it was "intentionally and in bad faith lost or destroyed."[81] Beglin's counsel made his

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[77] VR No. B11: 7/19/06; 12:06:46; 12:06:46.
[78] VR No. B11: 7/19/06;12:06:45.
[79] VR No. B11: 7/19/06; 12:03:35.
[80] VR No. B11: 7/19/06; 16:29:03; VR No. B16: 7/26/06; 13:46:22.
[81] T.R., Vol. 22, pp. 3251-3270.

position crystal clear when arguing to the court that Beglin was entitled to a missing evidence instruction:

> [a]nd that basically the standard in Kentucky is that if it ought to be there and it's not, you can draw an inference. And this court in its discretion can instruct the jury that if the evidence ought to be there and is missing, then the jury in its discretion is allowed to draw a negative inference and assume that the facts contained in that piece of evidence or in that incident report in this case bad – bad for the hospital.[82]

The Hospital argued that Kentucky law requires a judicial determination of intentional bad faith destruction and prejudice before a spoliation instruction may be given. The trial court, however, accepted Beglin's view of Kentucky law that simply because the occurrence report was missing, a "missing evidence" instruction was justified. Instead of making a judicial determination of bad faith destruction and prejudice, the trial court shifted this responsibility to the jury. Specifically, the court instructed the jury that it could find from the evidence that the Hospital "intentionally and in bad faith lost or destroyed the incident report":

> If you find from the evidence that an incident report was in fact prepared by Nurse Barbara Cantrell [sic] recording material information about Mrs. Beglin's surgery, and if you further find from the evidence that the University Medical Center, Inc., d/b/a University of Louisville Hospital, intentionally <u>and</u> in bad faith lost or destroyed the incident report, you may, but are not required to, infer that the information recorded in the incident report would be, if available, adverse to University Medical Center and favorable to the plaintiff.[83]

This instruction is at odds with Kentucky practice. Since no evidence was presented that in any way indicated intentional and bad faith loss or destruction of the

[82] VR No. B18: 7/28/06; 10:08:04.

[83] T.R., Vol. 22, pp. 3251-3270 (emphasis added). *See also* Exhibit 4, Instructions Given By The Court, Jury Instruction No. 8.

incident report, the instruction improperly told the jury to speculate. Similarly, no evidence was presented that Beglin was prejudiced by the unavailability of the alleged incident report, and neither the court nor the jury determined whether Beglin in fact was prejudiced in any way by the missing report. Indeed, all of the witnesses to the operation that would have been the subject of the alleged report testified at trial.

2. The court's punitive damage instruction

Beglin only requested a punitive damage instruction against the Hospital, not the doctors. It was Beglin's position that the Hospital had ratified the acts of Cantrall by both defending this lawsuit and by failing to conduct a thorough investigation following Jennifer's surgery.[84]

The day after Jennifer's surgery, Mary Jane Adams, Vice President of Compliance and Ethics at the Hospital, received a voice mail message concerning Jennifer's surgery. The voice mail was apparently from Cantrall advising that there had been a code in the OR.[85] As a result, the Director of the OR, Marty Brewer ("Brewer"), was asked to speak with her staff concerning Jennifer's surgery. After interviewing her staff, Brewer reported that she had learned nothing more than that a code occurred during surgery. No one told her there had been any delay in blood being delivered to the OR.[86]

Sally Long ("Long"), Director of Risk Management, also reviewed Jennifer's patient record, including the five page peri-operative report prepared during surgery, the anesthesia record prepared by the anesthesiologists during surgery, and the surgery

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[84] VR No. B18: 7/28/06; 10:11:39. *See* Transcript of Trial, p. 7, Attorney Conway's Statement attached hereto as Exhibit 8.

[85] VR No. B16: 7/26/06; 13:32:04.

[86] VR No. B16: 7/26/06; 13:38:59.

summary prepared by Lerner and signed by Okca immediately following surgery.[87] None of these written reports mentioned any delay in blood getting to the OR.[88] In addition, none of the doctors, Galandiuk, Lerner, Okca or Cheng orally or in writing advised the Hospital that delivery of blood from the blood bank to the OR played any part in Jennifer's condition.

The trial court nevertheless decided that it would give a punitive damage instruction, but limited the time frame for which the jury could consider the Hospital and Cantrall's conduct to "during the operation from the time blood was ordered until it was delivered" (approximately 7:45 to 8:50 according to the doctor's testimony). The court's punitive damage instruction stated, in part:

> If you find for plaintiff ... and if you are further satisfied from clear and convincing evidence that [the Hospital] acted in reckless disregard for the lives, safety or property of others, including Jennifer Beglin, during the operation from the time blood was ordered until it was delivered, you may in your discretion award punitive damages against this defendant.... To award punitive damages against [the Hospital] you also must find by clear and convincing evidence that University Medical Center (1) should have anticipated the conduct in question, or (2) that it authorized the conduct in question, or (3) that it ratified the conduct in question....[89]

Despite the language of the instruction expressly limiting the jury's consideration to events "from the time blood was ordered until it was delivered," Beglin's counsel told the jury that it should award punitive damages because of the missing occurrence report:

> I told you about the spoliation instruction. I want to tell you a little bit about the punitive damages instruction.... And it's your opportunity, if you so choose, to be the conscience of the community ... It's your opportunity, if

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[87] VR No. B16: 7/26/06; 13:34:08; 13:38:59. *See* Perio-Operative Report attached hereto as Exhibit 9.
[88] VR No. B16: 7/26/06; 13:41:53.
[89] T.R., Vol. 22, pp. 3251-3270; VR No. B18: 7/28/06; 12:48:25. *See also* Exhibit 4.

> you so choose [to] say not in my community are you going to fail to preserve an incident report ... That instruction is your opportunity to do that. And if you want to deter future conduct at this institution and others and if you want to send a message, this is your opportunity.[90]

Thus, Beglin's counsel encouraged the jury to award punitive damages based on speculation that the incident report, which may never have existed and was never seen by anyone other than Cantrall, contained something "bad for the hospital."[91]

K. <u>The Jury Verdict</u>

On August 1, 2006, the jury returned a verdict in favor of Jennifer's estate and her two children. It awarded $1,922,102.00 for the destruction of Jennifer's power to labor and earn money; $367,458.08 for medical expenses; $7,543.00 for funeral expenses; $1,500,000 for each child's loss of love, affection and Jennifer's household services; and $3,750,000 in punitive damages. The trial court subsequently overruled the Hospital's motion for JNOV and new trial.

L. <u>The Court Of Appeals Affirms The Judgment</u>

On January 16, 2009, the Court of Appeals rendered its Opinion affirming the judgment of the Jefferson Circuit Court.[92] Judge Wine issued a lengthy dissent concerning the reversible error committed by the trial court in giving the missing evidence instruction and its prejudicial effect on the jury's consideration and award of punitive damages.

The Court of Appeals' Opinion did not address the elements that must be present before a missing evidence instruction may be given. The Court of Appeals apparently believed that a trial judge does not serve as the gatekeeper in determining if a spoliation

[90] VR No. B18: 7/28/06; 17:36:10.

[91] VR No. B18: 7/28/06; 17:53:40.

[92] *See* Opinion, Exhibit 2.

instruction is warranted. Instead, according to the Court, a jury in its unfettered discretion may speculate as to whether the "hospital intentionally and in bad faith lost or destroyed the report,"[93] even where, as here, there was no evidence of intentional bad faith destruction.

The Court's Opinion was also silent as to the existence of any proof of prejudice, apparently believing that such proof is not a prerequisite for a spoliation instruction and a jury may infer prejudice simply because a document is missing. Indeed, the Court of Appeals held that the jury "was not required to weigh the evidence at all" in concluding that the Hospital "intentionally and in bad faith lost or destroyed the report."[94] This was a significant departure from prior Kentucky law, which required proof of prejudice before a spoliation instruction may be given.

Judge Wine's dissent not only found the spoliation instruction improper, resulting in a prejudicial effect upon the punitive damage award, but did so by tracing the historical roots of a missing evidence instruction. Judge Wine first correctly noted that "no one accuses the hospital or any agent of intentionally destroying the report or exercising bad faith in making the report available."[95] After tracing the history and addressing the elements of a spoliation instruction, which shows that the trial court deviated from prior Kentucky practice, Judge Wine noted that prejudice is an essential element **that must exist** before a spoliation instruction may be given. In addition, Judge Wine observed that there was no testimony or evidence from which a jury could infer that the incident report was intentionally destroyed, destroyed in bad faith or must have contained damaging information to the Hospital:

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[93] *Id.* pp. 7-8.
[94] *Id.* at 8.
[95] *Id.* at 20.

> information that the Hospital desired to withhold. There is no testimony to support that supposition. If the intent of such an instruction is to punish conduct such as intentional destruction of evidence or to fail to preserve such evidence, the remedy would not be appropriate under these circumstances. The Appellee does not show by any affirmative evidence the information contained on the post-operative form could not be obtained from any other source. To the contrary, the peri-operative log report and Cantrall's testimony supported the Appellee's contention that the blood sample had not been submitted in a timely manner.[96]

This Court granted discretionary review of the Court of Appeals' Opinion on December 10, 2009.

V. ARGUMENT

A. It Was Fundamentally Improper And Contrary To Kentucky Law And Practice For The Trial Court To Give A Missing Evidence Instruction When There Was No Evidence That The Hospital Had Intentionally And In Bad Faith Lost Or Destroyed The Incident Report Or That Beglin Was Prejudiced By Its Absence.

This error was preserved for appellate review by the Hospital's objection to the trial court giving a missing evidence instruction and its post-trial motions.[97]

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[96] *Id.* at 24-25.

[97] T.R., Vol. 22, pp. 3251-3270.

1. <u>Intentional, bad faith conduct and substantial prejudice are prerequisites to a spoliation instruction.</u>

"Spoliation" is the "intentional destruction, mutilation, alteration, or concealment of evidence."[98] The purpose of a spoliation or missing evidence instruction is to protect the rights of an adverse party where evidence has been intentionally and in bad faith destroyed that results in substantial prejudice to the ability of another to prove his claims or defenses.[99] It is "intended to prevent unfair prejudice to litigators and to ensure the integrity of the discovery process."[100]

Over the past 20 years, this Court has consistently held that a jury may only be instructed to draw an adverse inference from missing evidence where there is "deliberate destruction of evidence," "the failure to preserve or collect the missing evidence was intentional," and "substantial prejudice" has resulted to the other party.[101] Most recently, in *Fields v. Commonwealth*,[102] this Court held that the trial court did not err in refusing to give a missing evidence instruction where there was no "intentional destruction," "no other evidence of bad faith," and no prejudice.[103]

The vast majority of other jurisdictions agree with Kentucky that intentional, bad faith conduct and substantial prejudice must exist before a missing evidence instruction is

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[98] <u>Black's Law Dictionary</u>, 1437 8th Ed. 2004.

[99] *Estep v. Commonwealth*, 64 S.W.3d 805 (Ky. 2002); *Mills v. Commonwealth*, 170 S.W.3d 310 (Ky. 2005)(overruled on other grounds by *Leonard v. Commonwealth*, 279 S.W.3d 151 (Ky. 2009); <u>McCormick on Evidence</u> § 265 (6th Ed.).

[100] *Swofford v. Eslinger*, 671 F.Supp.2d 1274, 1279 (M.D.Fla. 2009)(quoting *Flury v. Daimler Chrysler Corp.*, 427 S.3d 939, 944 (11th Cir. 2005).

[101] *Monsanto Co. v. Reed*, 950 S.W.2d 811, 815 (Ky. 1997); *Estep*, 64 S.W.3d at 810; *Coulhard v. Commonwealth*, 230 S.W.3d 572 (Ky. 2007); *Tinsley v. Jackson*, 771 S.W.2d 331, 332 (Ky. 1989).

[102] 274 S.W.3d 375 (Ky. 2008).

[103] *Id*. at 415-416.

appropriate.[104] A lost or missing document is insufficient as a matter of law to warrant a spoliation instruction. For example, in *Brewer v. Dowling*, the court held that, "We will not infer spoliation or destruction of the strip – intentionally or otherwise – from the mere fact that it is missing."[105] In *Brewer v. Quaker State Oil Refining*,[106] the Third Circuit similarly expressed the rule as, "No unfavorable inference arises when the circumstances indicate that the document or article in question had been lost or accidentally destroyed."[107] And, in *Sears Roebuck & Co. v. Midcap*, the court stated that "no adverse inference arises where the evidence is lost or accidentally destroyed."[108]

McCormick on Evidence explains why bad faith is essential to any spoliation instruction:

> Of course, it is not enough to show that someone did the acts charged as obstructive. The actor must be connected to the party.... Moreover, the circumstances of the act must manifest bad faith. Mere negligence is not enough, for it does not sustain the inference of consciousness of a weak cause.[109]

It is also universally recognized that in addition to intentional, bad faith conduct, a party seeking a missing evidence instruction must demonstrate **actual harm** to his case because the document or other item is no longer available. This Court has defined that

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[104] *Park v. City of Chicago*, 297 F.3d 606 (7th Cir. 2002); *Brewer v. Dowling*, 862 S.W.2d 156 (Tex.App. 1993); *Baldridge v. Dir. of Revenue*, 82 S.W.3d 212 (Mo.App. 2002); *Phillips v. Covenant Clinic*, 625 N.W.2d 714 (Iowa 2001); *Alvariza v. Home Depot*, 240 FRD 586 (D. Colo. 2007); *Leatherwood v. Wadley*, 121 S.W.3d 682 (Tenn.Ct.App. 2003); *Sears, Roebuck & Co. v. Midcap*, 893 A.2d 542 (Del.Supr., 2006); *Aramburu v. Boeing Co.*, 112 F.3d 1398 (10th Cir. 1970); *Wal-Mart Stores, Inc. v. Johnson*, 106 S.W.3d 718 (Tex. 2003); *Veloso v. W. Betting Supply Co. Inc.*, 281 F.Supp.2d 743 (D.N.J. 2003).

[105] 862 S.W.2d at 160.

[106] 72 F.3d at 326 (3rd Cir. 1995).

[107] *Id.* at 334.

[108] *Sears, Roebuck & Co.*, 893 A.2d at 549.

[109] 2 McCormack on Evidence, § 265, 6th Ed.; *see also Alvariza v. Home Depot*, supra, at 590; *Vick v. Tex. Employment Comm'n*, 514 F.2d 734 (5th Cir. 1975); *Baldridge, supra*; *Henning v. Union Pac. R.R.*, 530 F.3d 1206 (10th Cir. 2008); *Bashir v. Amtrak*, 119 F.3d 929 (11th Cir. 1997).

harm as "substantial prejudice" and harm that "substantially affected the outcome of this case."[110] Other courts have defined the harm that must exist as "[t]he evidence was crucial to the movant being able to prove its *prima facie* case or defense," "significant impairment in the ability to prove the lawsuit," "prejudice."[111] Clearly, a "sanction for spoliation is not appropriate where, as here, the missing evidence does not cause any prejudice."[112]

A missing evidence instruction is a powerful weapon.[113] It imposes an unfair sanction on a party if there is not a genuine factual issue that evidence was intentionally destroyed, in bad faith, causing substantial prejudice.[114] The very purpose of a missing evidence instruction is to "nudge" or "tilt" the jury and therefore the "likelihood of harm from [an] erroneous instruction is substantial."[115] As a result, a missing evidence instruction must be prudently and sparingly given, otherwise it will "impose unfair sanctions."[116]

It is by these long-held standards that the trial court's decision to give a missing evidence instruction must be judged. Here, it is undisputed that there was no evidence that the Hospital "intentionally and in bad faith lost or destroyed the incident report." There also was no evidence of substantial prejudice to Beglin due to the missing report. Thus, the trial court's decision to give the missing evidence instruction, and the Court of Appeals' decision affirming, are clearly erroneous and resulted in substantial prejudice to

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110 *Tinsley*, 771 S.W.2d at 332; *Roark v. Commonwealth*, 90 S.W.3d 24 (Ky. 2002).
111 *St. Cyr v. Flying J, Inc.*, 2007 WL 1716365 (M.D. Fla. 2007); *Swofford*, 671 F.Supp.2d at 1280; *Foss v. Kincade*, 766 N.W.2d 317 (Minn. 2009).
112 *Salvatore v. Pingel*, 2009 WL 943713 (D.Colo. 2009); *Henning*, 530 F.3d at 1220; *Costello v. Chief Alternative, LLC*, 140 P.3d 234, 236 (Colo.App. 2006).
113 *Morris v. Union Pac. R.R.*, 373 F.2d 896, 901 (8th Cir. 2004).
114 *Phillips*, 625 N.W.2d at 721; *Sears Roebuck & Co.*, 893 A.2d at 550; *Henning*, 530 F.3d at 1219.
115 *Wal-Mart Stores, Inc.*, 106 S.W.3d at 724.
116 *Phillips*, 625 N.W.2d at 721.

the Hospital. Giving the instruction violated the principles set down by this Court, as well as the Hospital's right to a fundamentally fair trial consistent with due process principles. The Hospital is entitled to a new trial because of the trial court's erroneous missing evidence instruction.

2. The trial court improperly gave the jury a missing evidence instruction when no factual basis existed on which the jury could find that the incident report had been "intentionally and in bad faith lost or destroyed" or that its absence substantially prejudiced Beglin.

A trial court's proper performance of its "gatekeeper" responsibilities is critical to a fundamentally fair trial consistent with the dictates of due process. These gatekeeper duties include not only ruling upon the admissibility of evidence, but also determining if sufficient evidence exists warranting a particular instruction.[117] The opinions of this and other courts firmly recognize that a trial judge has an obligation not to submit an instruction for which there is no factual support.[118]

In this case, the trial court abdicated its gatekeeper responsibility to make that determination and the Court of Appeals erroneously concluded that under Kentucky law the only evidence needed to justify a missing evidence instruction is that a document is missing. According to the Court of Appeals, bad faith, intentional misconduct and substantial prejudice are irrelevant because a jury "was not required to weigh the evidence at all."[119]

The trial court also erroneously believed that Kentucky law does not require evidence of intentional, bad faith conduct or substantial prejudice in order to give a

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[117] *W. Va. Tractor & Equip. Co. v. Cain*, 487 W.S.2d 910 (Ky. 1972); *Young v. Vista Homes, Inc.*, 243 S.W.3d 352 (Ky.App. 2007).
[118] *Sears Roebuck & Co.*, 839 A.2d at 552; *RFC Capital Corp. v. EarthLink, Inc.*, 2004 WL 2980402 (Ohio App. 2004); *Alvariza, supra; Roark, supra.*
[119] Exhibit 2, p. 8.

spoliation or missing evidence instruction. Throughout the in-chambers discussions regarding a potential spoliation instruction, the court made no finding that any of these prerequisites existed.

The Court of Appeals' Opinion gave lip service to the bad faith requirement set forth in *Estep* but then never mentioned the other critical components of intentional misconduct and substantial prejudice.[120] Nor did the Court of Appeals give any hint that there was evidence which satisfied the required elements for a spoliation instruction that the Hospital "intentionally and in bad faith lost or destroyed the incident report,"[121] much less that Beglin was actually prejudiced. The Court of Appeals concluded:

> [s]imply put, the [trial court] left the decision as to whether the Hospital acted in bad faith up to the jury.... Thus, the jury was not required to weigh the evidence at all, much less in favor of Appellees.[122]

Thus, the Court of Appeals endorsed the new procedure used by the trial court, which permits the jury to receive a spoliation instruction without the trial court performing its traditional gatekeeper role. The Court of Appeals affirmed the use of a spoliation instruction without the trial court or appellate court determining as a matter of law that evidence exists which supports a conclusion of intentional misconduct and substantial prejudice.

3. <u>There was no evidence to justify a jury finding that the Hospital "intentionally and in bad faith lost or destroyed" the incident report.</u>

The instruction given by the trial court specifically required the jury to find that: (1) the Hospital "intentionally" lost or destroyed the incident report; <u>and</u> (2) the Hospital

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[120] Exhibit 2, pp. 6-8.

[121] T.R., Vol. 22, pp. 3251-3270.

[122] Exhibit 2, pp. 7-8.

"in bad faith lost or destroyed the incident report."[123] There is not a scintilla of evidence from which a jury could infer these matters, much less that Beglin was substantially prejudiced by the absence of the incident report.

The only evidence presented to the jury was that the incident report was lost. Beglin himself never contended that the Hospital intentionally misplaced or lost the report. Beglin never contended that the Hospital acted in bad faith in losing or misplacing the report. Be glin never contended that Beglin's case was substantially prejudiced by the absence of the report. Beglin did not make these contentions because there was no evidence to support any of these claims. Instead, Beglin's position was:

> [t]hat if it should be in there and it isn't and it's not, you're allowed to draw an inference in your deliberations that what would have been in here is bad.[124]

In other words, no proof of intentional bad faith destruction or prejudice is required - speculation is sufficient.

Beglin falsely believed, and the Court of Appeals erroneously held, that a lost document by itself establishes a factual predicate for a jury to infer both bad faith and intentional misconduct and is sufficient justification for a large punitive damage award. According to Beglin, a jury can infer substantial prejudice by simply looking at the incident report form and inferring the worst possible contents of what Cantrall may or may not have recorded in it.[125] Simply stated, Beglin argued to the Court of Appeals that because the Hospital's policy regarding the preparation of an incident report "is so detailed it is unimaginable one could accidentally lose the incident report."[126]

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[123] T.R., Vol. 22, pp. 3251-3270.
[124] VR No. B18: 7/28/06; 17:15:00.
[125] Brief of Appellees/Cross-Appellant, Michael G. Beglin, pp. 20-22.
[126] *Id.* at 23.

A missing incident report, however, is not evidence that the document was "intentionally and in bad faith lost or destroyed" or that its absence has caused substantial prejudice. The fact that a report is lost or missing is equally consistent with a finding of no bad faith and no intentional misconduct, but simply that the report is "lost" or "missing," or might never have existed. That is why courts that have confronted this issue have held that the fact a report is lost or missing does not give rise to an inference that it was intentionally destroyed in bad faith.[127]

An inference is a "conclusion reasonably drawn from facts established by evidence."[128] This Court has held that an inference must be based upon evidence that indicates "the probable, as distinguished from a possible cause."[129] Evidence of a lesser quality is simply "speculation, supposition or surmise."[130] That is why in *NCAA v. Hornung*,[131] for example, this Court held that a jury was improperly permitted to infer that the NCAA acted in bad faith when it disapproved Hornung as a color analyst based on evidence that two of the seventeen committee members discussed using another committee member as the color analyst.[132] What two members discussed does not justify an inference that a majority of the committee discussed the same thing, any more than it can be inferred from a missing document that it was intentionally destroyed in order to prevent an adverse party from seeing it.

Beglin never attempted to show that the Hospital had a practice of losing, misplacing or destroying incident reports. Nor did he attempt to introduce other evidence

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[127] *Brewer*, 862 S.W.2d at 160; *Alvariza*, 240 F.R.D. at 590; *Sears Roebuck & Co.*, 893 A.2d at 549.
[128] *Hurt's Adm.'r v. Louisville & Nashville R.R. Co.*, 298 Ky. 617, 183 S.W.2d 628, 629 (1944).
[129] *Briner v. Gen. Motors Corp.*, 461 S.W.2d 99, 101 (Ky. 1970).
[130] *Briner, supra, Hurt's Adm'r, supra.*
[131] 754 S.W.2d 855 (Ky. 1988).
[132] *Id.* at 859.

from which a jury could reasonably infer that it was probable the report had been "intentionally and in bad faith lost or destroyed."

The Court of Appeals' Opinion likewise fails to even mention any evidence from which a jury could reasonably infer the intentional, bad faith destruction of the incident report. Contrary to the Court of Appeals, it is not the function of the trial court to simply leave "the decision as to whether the Hospital acted in bad faith up to the jury," especially where there is no evidence to support such a decision.[133]

The Court of Appeals' statement that "the jury was not required to weigh the evidence at all with regard to whether the Hospital intentionally and in bad faith destroyed or lost the incident report" is an egregious misstatement of the law. The principal function of a jury is to "weigh the evidence" and to impartially arrive at a verdict based on fact, not speculation. Judge Wine in his dissent correctly observed that "no one accuses the Hospital or any agent of intentionally destroying the report or exercising bad faith in making the report unavailable."[134]

In addition to the absence of any evidence that the Hospital "intentionally and in bad faith lost or destroyed the incident report," there was not a scintilla of evidence of "substantial prejudice." It was Beglin's burden to introduce proof that whatever box in the incident report Cantrall may have marked, if any, or whatever statement she may have made in the incident report, if any, supported Beglin's position that any delay in blood getting to the OR was Cantrall's fault. There is no such evidence. It is rank speculation to suggest that Cantrall recorded during surgery that she received the blood sample at

[133] Exhibit 2, p. 7.
[134] *Id.* at 20.

8:05 p.m. but, shortly after surgery, recorded in an occurrence report that she actually received the blood 20 minutes earlier.

Substantial prejudice does not and cannot exist simply because a potential piece of evidence is missing. Substantial prejudice arises only where the "evidence was crucial" to proving a claim or defense.[135] It must be demonstrated by "concrete evidence" rather than a fertile imagination.[136]

Beglin introduced the anesthesia log and the testimony of Galandiuk, Lerner, Okca and Cheng to show that Jennifer's blood sample was taken and given to Cantrall at 7:45 p.m. There was no evidence that whatever may have been in the incident report, if it existed, was favorable to Beglin, that the missing report was the least bit necessary for Beglin to attempt to prove that the blood sample was taken at 7:45 p.m., or that anything in the missing occurrence report bore on any misunderstanding of the doctors as to when blood would arrive in the OR.

Absent evidence of substantial prejudice, the trial court's gatekeeper duty required it to refuse to give a missing evidence instruction. It was reversible error under these circumstances for the trial court to permit the jury to speculate about the lost report and it was equally improper for the Court of Appeals to affirm the trial court's missing evidence instruction when there was a total absence of evidence of substantial prejudice. The change in procedure implemented by the trial court and approved by the Court of Appeals permitted the jury to find liability and award punitive damages based only upon speculation.

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[135] *St. Cyr,* 2007 WL 1716365 at * 3; *see also, Swofford,* 671 F.Supp.2d at 1280.
[136] *Alvariza,* 240 F.R.D. at 590.

4. <u>The trial court's spoliation instruction tainted the verdict and the punitive damage award.</u>

An erroneous jury instruction is presumed prejudicial:[137]

> It is only in a case which is clear and free of all doubt on the point that an instruction which is erroneous can be said by the court to have been without prejudicial effect on the minds of some of the jurors.[138]

The purpose of a spoliation instruction is to "nudge" or "tilt" the jury in order to counteract the effect of the spoliation.[139] That is why an erroneously given spoliation instruction is particularly invidious and the likelihood of causing harm substantial.[140] Traditionally, the court's gatekeeper role ensured that the jury did not consider spoliation absent intentional bad faith destruction and prejudice, but that protection was not in place in this case.

Not only is it impossible to conclude that the erroneous missing evidence instruction did not affect the jury's verdict on liability and compensatory damages, it also clearly infected the jury's punitive damage award. Because the report was prepared after surgery, it clearly did not fall within the parameters of the court's punitive damage instruction which limited the jury's consideration to events between the "time blood was ordered until it was delivered" to the OR.[141] Beglin's counsel ignored that restriction and argued that the jury should punish the Hospital because of the missing report anyway:

> I told you about the spoliation instruction. I want to tell you a little bit about the punitive damages instruction.... And it's your opportunity, if you so choose, to be the

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137 *McKinney v. Heisel*, 947 S.W.2d 32, 35 (Ky. 1997); *Hamilton v. CSX Transp., Inc.*, 208 S.W.3d 272, 276 (Ky.App. 2006); *Prichard v. Kitchen*, 242 S.W.2d 988, 992 (Ky.App. 1951).

138 *Hamilton*, 208 S.W.3d at 276.

139 *Wal-Mart Stores, Inc.*, 106 S.W3d at 724.

140 *Wal-Mart Stores, Inc., supra; Henning*, 530 F.3d at 1219, 1220; *Sears Roebuck & Co.*, 893 A.2d at 550.

141 T.R., Vol. 22, pp. 3251-3270.

> conscience of the community.... It's your opportunity, if you so choose [to] say not in my community are you going to fail to preserve an incident report.... That instruction is your opportunity to do that. And if you want to deter future conduct at this institution and others and if you want to send a message, this is your opportunity.[142]

Based upon the record, it certainly cannot be said that it is "free and clear of all doubt" that the erroneously given missing evidence/spoliation instruction did not affect the jury's liability, compensation damages and punitive damage verdict.[143] The Hospital is entitled to a new trial.

B. It Was Reversible Error For The Trial Court To Give A Punitive Damage Instruction Based On *Respondeat Superior* Because There Was No Evidence From Which A Jury Could Reasonably Conclude That The Hospital "Ratified Or Should Have Anticipated The Conduct In Question" As Required By KRS 411.184(3).

This issue was preserved for appellate review by the Hospital's objection to the punitive damage instruction and its motion for directed verdict and post-trial motion for JNOV, to alter, amend or vacate the judgment and for new trial.[144]

1. Beglin's "ratification" argument and the Court of Appeals' Opinion affirming the award of punitive damages.

At the conclusion of Beglin's case in chief the trial court acknowledged that it had "not heard what I think is gross negligence," but denied the Hospital's motion for a directed verdict anyway.[145] The trial court overruled the Hospital's renewed motion for a directed verdict at the close of all proof.[146] The court then gave the following punitive damage instruction:

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[142] VR No. B18: 7/28/06; 17:36:10.
[143] *Hamilton*, 208 S.W.3d at 276.
[144] T.R., Vol. 23, pp. 3365-3421.
[145] VR No. BB: 7/21/06; 17:26:24.
[146] VR No. BB17: 7/27/06; 16:04:12; VR No. B18: 7/28/06; 09:51:57.

> [i]f you are further satisfied from clear and convincing evidence that University Medical Center, Inc. d/b/a University of Louisville Hospital, acted in reckless disregard for the lives, safety or property of others, including Jennifer Beglin, during the operation from the time blood was ordered until it was delivered, you may, in your discretion, award punitive damages...
>
> * * *
>
> To award punitive damages against University Medical Center, Inc. d/b/a University of Louisville Hospital, you also must find by clear and convincing evidence that University Medical Center (1) should have anticipated the conduct in question, or (2) that it authorized the conduct in question, or (3) that it ratified the conduct in question.

Beglin's closing argument to the jury consists of nearly 45 transcribed pages.[147] Only six transcribed lines of his closing argument were devoted to KRS 411.184(3)'s ratification requirement. Beglin's counsel did not argue that the Hospital authorized or should have anticipated the events that occurred between the time "blood was ordered until it was delivered." Beglin's "ratification" argument was that the jury should award punitive damages against the Hospital because "its whole defense here ratifies the conduct" and because the Hospital should have performed a more thorough investigation of Jennifer's surgery:[148]

> Now let me say this. There's language in there about ratifying the conduct. You only need to look at the investigation of where's Marty Brewer [sic] that supposedly was conducted, the testimony that they didn't know about all these phone calls, decide whether or not their whole defense here ratifies the conduct.[149]

The Court of Appeals approved the trial court's decision to give the punitive damage instruction and the jury's $3.75 million punitive award. According to the Court

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[147] VR No. B18: 7/28/06; 16:24:56.

[148] VR No. B18: 7/28/06; 17:38:32.

[149] *Id.*

of Appeals, even though there was no evidence of prior misconduct by Cantrall or of blood not being delivered to the OR timely, the jury "could have believed that the Hospital should have anticipated a mishap in light of evidence that there was some irregularity in the execution of the Hospital's blood policies."[150] In other words, KRS 411.184(3) requirements become irrelevant whenever there is "some" evidence of irregularity in following procedures.

2. The court's instruction and the jury's award of punitive damages were improper because there was no factual basis on which the Hospital "should have anticipated the conduct in question" when there was no evidence that the same or similar conduct had ever occurred in the past.

KRS 411.184(3) states:

> In no case shall punitive damages be assessed against a principal or employer for the act of an agent or employee unless such principal or employer authorized or ratified or should have anticipated the conduct in question.

The purpose of KRS 411.184(3) is to broadly limit an employer's vicarious liability for punitive damages to only those situations in which the employer has actively condoned an employee's gross negligence.[151]

The General Assembly did not define the phrase "should have anticipated the conduct in question" in KRS 411.184(3), perhaps because its meaning is commonly understood. "Anticipate" means to "foresee," to "realize beforehand."[152] Blacks Law Dictionary defines "anticipation" as "probability, not possibility, as applied to a duty to anticipate consequences of conduct attacked as negligence."[153]

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150 Exhibit 2, p. 12 (emphasis added).
151 *Berrier v Vizer*, 57 S.W.3d 271, 283 (Ky. 2001).
152 The American Heritage Dictionary of the English Language, 5th Ed.
153 Blacks Law Dictionary, 6th Ed.

In order that the Hospital "should have anticipated the conduct in question," it was essential that the same or similar conduct had previously occurred.[154] In *Patterson v. Tommy Blair, Inc.*, for example, Patterson claimed that he was entitled to a punitive damage instruction imposing vicarious liability on Tommy Blair, Inc., for the acts of its employee in repossessing a vehicle. Specifically, while repossessing Patterson's vehicle Tommy Blair, Jr., shot out the tires on Patterson's car with a gun he typically carried.

Patterson contended that Blair's previous experience in repossessing vehicles and the fact that he "usually carried a handgun" were enough to satisfy the test of "should have anticipated the conduct in question" and warranted a punitive damage instruction. The Court of Appeals disagreed and held that Tommy Blair, Inc., could not have "anticipated" the conduct, "since there is no evidence that Blair, Jr. previously repossessed any vehicles in an impermissible manner" and because "there is no evidence that Blair, Jr. had ever previously used any gun in an inappropriate manner."[155] Clearly, "should have anticipated the conduct in question" requires more than "some irregularity." It requires that the same or similar conduct occurred in the past that placed a defendant on notice that the conduct might reoccur.

There was no such evidence against the Hospital that anything remotely similar had ever occurred. To the contrary, there was affirmative evidence that a similar event had never occurred. Dr. Deveaux, who began Jennifer's surgery, described the Hospital as "a great hospital ... it's got all the resources you need to take care of critically ill patients."[156] Dr. Learner, the chief anesthesiologist handling Beglin's surgery, testified that delivery of blood from the blood bank to the operating room "had never been an

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[154] *Patterson v. Tommy Blair, Inc.*, 265 S.W.3d 241, 245 (Ky. App. 2007).

[155] *Id.* at 245 (emphasis added).

[156] VR No. BB: 17:7/27/06; 12:12:35.

issue before."[157] Dr. Okca testified that "this was unusual."[158] Even Beglin's counsel characterized what had happened to Jennifer in his questioning as an "unforeseen incident."[159]

In addition to this affirmative evidence, Beglin made no attempt to present any evidence that the Hospital "should have anticipated the conduct in question." For example, there was:

1. no evidence that Cantrall had ever delayed in sending a blood sample from an OR to the blood bank before, failed to properly keep doctors accurately apprised of when blood was expected from the blood bank, had violated in the slightest degree any of the Hospital's rules, policies and established procedures, or had ever been disciplined for anything;

2. no evidence that there had ever been an occasion when a nurse had delayed sending a blood sample from an OR to the blood bank or had failed to correct any misunderstanding of the surgical team as to when blood could be reasonably expected from the blood bank;

3. no evidence prior to suit being filed that of the thousands of surgical procedures performed by Galandiuk, Okca, Lerner, and Cheng, there had ever been an instance where type and cross-matched blood or emergency blood had not been timely delivered to the OR; and

4. no evidence that Galandiuk, Okca, Lerner, and Cheng told anyone at the Hospital that there was any delay in getting blood to the OR on the evening of Jennifer's surgery until after suit was filed.

The Hospital's blood bank handles more than 17,000 specimens a year.[160] There was no evidence of a pattern of conduct that this Court in *Ky. Farm Bureau Mut. Ins. Co. v. Troxell*[161] characterized as "central to satisfying the criteria contained in KRS 411.184(3)." Beglin never contended, much less attempted to prove, that the Hospital

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[157] VR No. B9: 7/17/06; 12:40:54.
[158] VR No. B14: 7/24/06; 16:04:28.
[159] VR No. B16: 7/26/06; 11:32:30.
[160] VR No. B16: 7/26/06; 10:36:00.
[161] 959 S.W.2d 82 (Ky. 1997).

had prior knowledge of similar problems which put it on notice that it "should have anticipated the conduct in question."

In its Opinion, the Court of Appeals found the "should have anticipated" test satisfied because "[s]imply put, the jury could have believed that the hospital should have anticipated a mishap in light of evidence that there were some irregularities in the execution of the hospital's blood policies."[162] But, evidence of "some irregularities" does not satisfy the "should have anticipated" requirement of KRS 411.184(3) unless those same irregularities or ones similar to them had previously occurred and thus put the Hospital on notice that the irregularities might reoccur. There was no such evidence in this case.

The Court of Appeals' Opinion does not identify any such evidence. Beglin's counsel never contended there was any such evidence, and the trial record is absolutely silent on the existence of any irregularity of any type from which the Hospital "should have anticipated" the conduct that occurred "during the operation from the time blood was ordered until it was delivered." The Hospital was entitled to a directed verdict on Beglin's punitive damage claim, or, at bare minimum, is entitled to a new trial.

3. Punitive damages may not be vicariously awarded against a hospital or employer for conducting what a plaintiff contends is something less than a perfect post-event investigation. There must be ratification, which requires that the employer acted with full knowledge of all material facts.

Beglin argued to the trial court that he was entitled to a punitive damage instruction imposing vicarious liability on the Hospital because it had "ratified" the events that occurred during Jennifer's surgery in one of two ways. First, Beglin contended that the Hospital was guilty of ratification because it had denied that it was

[162] Exhibit 2, p. 12.

negligent and defended itself against Beglin's Complaint. Second, Beglin contended that the Hospital was guilty of ratification because its post-surgery investigation was not thorough enough.

This Court's predecessor in *Gillihan v. Morgulon*, defined "ratify" as:

> Ratification is the affirmance by a person of a prior act which did not bind him but which was done or professively done on his account, whereby the act, as the sum of all persons is given effect as if originally authorized by him.[163]

Ratification requires that a principal or employer "have full knowledge, at the time of the ratification, of all the material facts of the transaction."[164]

The fundamental fallacy with Beglin's contention that the Hospital ratified the conduct in question by merely denying the allegations of negligence and defending this action is that it would entitle every plaintiff to a punitive damage instruction in every case. Section 14 of Kentucky's Constitution guarantees its citizens the right of access to court. That right of access would be worthless if Beglin's view of ratification is adopted and the cost of defending a suit is an automatic award of punitive damages. The same argument was rejected by the Idaho Supreme Court in *Manning*:

> Similarly, we are satisfied that the hospital's failure to apologize, and the hospital's defense at trial that the nurses did nothing wrong does not constitute sufficient evidence to support a finding of ratification. In addition to the lack of evidence indicating an intent to ratify, the plaintiff's position, if adopted, would effectively require a principal to admit its agent's negligence or wrongdoing in every case to avoid a finding of ratification. Such a double-edged position is not sound policy.[165]

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[163] 186 S.W.2d 807 (Ky. 1945).

[164] *Short v. Metz Co.*, 165 Ky. 319, 176 S.W. 1144 (Ky. 1915); *Manning v. Twin Falls Clinic & Hosp., Inc.*, 122 Idaho 47, 830 P.2d 1185 (Idaho 1992); *Broudy-Cantor Co. v. Levin*, 135 Va. 283, 116 S.E. 677 (Va. 1923).

[165] *Manning*, 830 P.2d at 1194.

The second prong of Beglin's ratification argument, and the one accepted by the Court of Appeals, is that the Hospital failed to conduct a thorough enough investigation into the cause of either blood not timely arriving in the OR or Cantrall not clarifying the surgeon's misunderstanding as to when blood would arrive in the OR. According to the Court of Appeals:

> [t]he jury could have believed that the hospital ratified the conduct by failing to perform an adequate investigation following Beglin's surgery, as evidenced by the fact that the hospital did not uncover in its investigation that there was a delay in getting blood to the operating room.[166]

The "adequacy" of an investigation is nowhere near the equivalent of "full knowledge, at the time of the ratification, of all the material facts of the transaction."[167] The record is undisputed that Cantrall's performance in the OR was never questioned until after Beglin filed suit. Neither Cheng, Lerner, Okca or Galandiuk filed an occurrence report or reported to the Hospital that blood was delayed in getting to the OR.[168] Sally Long and Jill Leonard both testified without contradiction that the issue of delayed blood never arose until after litigation was filed.[169]

Long also reviewed Jennifer's patient records, including the five-page perioperative report, the anesthesia record prepared by the anesthesiologist, and the report prepared by Lerner and signed by Okca immediately following surgery.[170] None of these records, two of which were prepared by members of the surgical team, made any mention of blood being delayed in getting to the OR.[171] As a result, there was nothing further for

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166 Exhibit 2, p.12 (emphasis added).

167 *Short*, 176 S.W. at 1148.

168 VR No. B12: 7/20/06; 11:16:29; VR No. B16: 7/26/06; 13:42:21; VR No. B12: 7/20/06; 13:50:20.

169 VR No. B12: 7/20/06; 11:14:18; VR No. B16: 7/26/06; 13:39:53.

170 VR No. B16: 7/26/06; 13:34:08; 13:38:59.

171 VR No. B16: 7/26/06; 13:41:53.

the Hospital to investigate. Certainly, the Hospital did not have "full knowledge" of what the doctors claimed until pre-trial discovery was underway, when the doctors for the first time claimed that blood was delayed.

This case is nearly identical in many respects with *Manning*. In that case, Darryl Manning suffered from numerous maladies, including end stage chronic obstructive pulmonary disease. When Manning entered the hospital his death was imminent and he was classified as a "no code" patient.[172] While in the hospital, the decision was made to transfer Manning to another room for his comfort. In the process, the supplemental oxygen which he was using was disconnected for the short move. Almost immediately Manning experienced extreme respiratory disease and stopped breathing.

The evidence was that the hospital was unaware that the nurses typically temporarily suspended a person's supplemental oxygen when moving a patient from room to room. Manning's estate contended that the hospital's failure to prevent this practice constituted "ratification" because the nurses were not reprimanded for their conduct.

The Supreme Court of Idaho rejected that argument. In ruling that the hospital's motion for a directed verdict on punitive damages should have been granted, the court held that "the hospital's failure to reprimand or punish the nurses, standing alone, was insufficient to support a finding of ratification on the basis of the record before us."[173]

The failure to reprimand or fire an employee does not constitute ratification.[174] Nor does the failure to conduct the best investigation satisfy the requirement of KRS 411.814(3). It is contrary to everything in the trial record to conclude, as did the Court of

[172] *Manning,* 830 P. 2d at 1187.
[173] *Id.* at 1194.
[174] *Manning, supra.; Turner v. Werner Enter., Inc.,* 442 Fed. Sup. 2d 384 (E.D. Ky. 2006).

Appeals, that an inadequate investigation is the equivalent of the hospital ratifying "the conduct in question."[175] The Hospital was entitled to a directed verdict on Beglin's punitive damage claim or, at bare minimum, is entitled to a new trial.

C. The Punitive Damage Award And The "Missing Evidence" And Punitive Damage Instructions Violated The Hospital's Due Process Rights.

The Due Process Clause prohibits imposing grossly excessive or arbitrary punishments on a tortfeasor.[176] The Constitution limits both the procedures for awarding punitive damages and amounts forbidden as grossly excessive.[177] The "missing evidence" and punitive damages instructions, as well as the $3,750,000 award suffer from both deficiencies: arbitrariness and excessiveness.

1. Procedural Due Process Violations

The novel spoliation procedure used by the trial court and adopted for the first time by the appellate court in this case, and the impact of the "missing evidence" instruction violated the Hospital's due process rights. A spoliation instruction is designed and intended to "nudge" or "tilt" the jury. Thus, as discussed above, if a spoliation instruction is given erroneously, the jury necessarily is tilted, and a fundamentally unfair trial results. Accordingly, care must be taken to ensure that spoliation instructions are not given unless warranted.

In this case, the new "missing evidence" instruction and the new procedure which permitted the jury to determine whether intentional bad faith document destruction warranted an adverse inference, tainted both the punitive instruction and award. As

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[175] KRS 411.184(3).

[176] *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 416-17 (U.S. 2003)(citations omitted*), see also, BMW of North America, Inc. v. Gore,* 517 U.S. 559, 562 (U.S. 1996)(quotations and citations omitted.

[177] *Philip Morris USA v. Williams,* 127 S.Ct. 1057, 1062 (U.S. 2007)(quotations and citations omitted).

discussed above, Beglin's counsel told the jury that the Hospital may have intentionally destroyed a document and then told the jury to award punitive damages to send a message that documents cannot be destroyed. Thus, the jury was encouraged to punish the Hospital based on speculation that the document was destroyed intentionally in bad faith. This prejudiced Beglin, since no evidence was presented to support any such conclusion. The link between the two instructions violated the due process mandates of clear instructions and that punitive damages may be awarded only to punish conduct that caused a plaintiff's injury.[178] After-the-fact conduct alleging destruction of a document that may never have existed did not cause Jennifer's injury.

Prior to this case, Kentucky law and practice required special care before a spoliation instruction was given, as a spoliation instruction was not permitted absent a judicial determination of intentional bad faith destruction and prejudice. The new process adopted by the appellate court in this case does not include any substitute procedure for ensuring that a spoliation instruction is not given erroneously. Instead, the new process permitted the jury to consider spoliation in the utter absence of even a scintilla of evidence of intentional bad faith destruction or prejudice. Accordingly, the new procedure adopted by the appellate court is a substantial departure from prior Kentucky law and practice, as it does not include any procedural protection to ensure that spoliation issues do not reach a jury absent a judicial determination that a spoliation instruction which tilts the jury is warranted.

Adopting the new procedure in this case, which fails to take any step to ensure that a spoliation instruction is not given erroneously, violates the Hospital's procedural

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[178] *Campbell,* 538 U.S. at 422-24.

due process rights and should be reversed. Particularly when punitive damages are at issue, new procedures require careful consideration to ensure due process. For example, in evaluating a new procedure adopted in Oregon, the United States Supreme Court unanimously held that the new procedure was unconstitutional in violation of the defendant's due process rights.[179] In reaching this holding, the Court stated that:

> Punitive damages pose an acute danger of arbitrary deprivation of property. . . Judicial review of the amount awarded was one of the few procedural safeguards which the common law provided against that danger. Oregon has removed that safeguard without providing any substitute procedure and without any indication that the danger of arbitrary awards has in any way subsided over time.

Thus, Oregon's changed procedure was held to violate due process because it removed a traditional procedural protection without providing a substitute procedure to provide protection from arbitrary awards assessed under imprecise standards.[180]

Similarly, the new procedure adopted by the appellate court in this case violates due process because it:

1. removed the traditional Kentucky safeguard of a judicial finding of intentional bad faith destruction of a document and prejudice as a predicate to a spoliation instruction;

2. contrary to traditional Kentucky procedure and practice, permitted the jury to speculate that a document that may never have existed and could not have caused plaintiff's injury contained evidence that was "bad" for the Hospital, and that the speculative "bad" evidence was sufficient to support the jury's award of punitive damages; and

3. contrary to traditional Kentucky procedure and practice, permitted the jury to assess punitive damages despite the trial court's determination that she had not heard evidence of gross negligence but an undisclosed "personal issue" precluded a grant of the Hospital's motion for directed verdict on punitive damages.

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[179] *Honda Motor Co., Ltd. v. Oberg*, 512 U.S. 415,432 (1994).
[180] *Id.*

The new Kentucky procedure adopted by the appellate court violates due process because it removed traditional protections without providing any substitute procedure to protect the Hospital from an arbitrary verdict and punitive damage award.[181]

Accordingly, on due process grounds and based on the precedents noted above, the new procedure adopted by the appellate court should be rejected and this case should be remanded for a new trial under Kentucky's traditional procedures.

2. Excessiveness Violates Due Process

Finally, if the case is not reversed based on the due process violations articulated above, the punitive damages verdict is unconstitutionally excessive. The constitutional excessiveness inquiry begins with an identification of the state interests that the punitive award is supposed to serve.[182] Prior law advised the Hospital that Kentucky had no interest in punishing ordinary negligence and good faith mistakes - the State's only

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[181] *Honda Motor Co., Ltd., supra; see also Philip Morris USA*, at 354 127 S.Ct. 1057, 1065 (prohibiting punitive damages based on injury to non-parties and prohibiting a process that permitted juror speculation stating that: "The jury will be left to speculate. And the fundamental due process concerns to which our punitive damages cases refer -- risks of arbitrariness, uncertainty and lack of notice -- will be magnified."); *Id.* ("[a]lthough the States have some flexibility to determine what *kind* of procedures they will implement, federal constitutional law obligates them to provide *some* form of protection in appropriate cases."); *Roberts v. United States Jaycees*, 468 U.S. 609, 629, 104 S.Ct. 3244, 3256, 82 L.Ed.2d 462 (1984)("The requirement that government articulate its aims with a reasonable degree of clarity ensures that state power will be exercised only on behalf of policies reflecting an authoritative choice among competing social values, reduces the danger of caprice and discrimination in the administration of the laws, enables individuals to conform their conduct to the requirements of law, and permits meaningful judicial review.")(citations omitted); *Giaccio v. State of Pennsylvania*, 382 U.S. 399, 402-03, 86 S.Ct. 518, 520-21, 15 L.Ed.2d 447 (1966)("[A] law fails to meet the requirements of the Due Process Clause if it is so vague and standardless that it leaves the public uncertain as to the conduct it prohibits or leaves judges and jurors free to decide, without any legally fixed standards, what is prohibited and what is not in each particular case.")(citations omitted); *Grayned v. City of Rockford*, 408 U.S. 104, 108-09, 92 S.Ct. 2294, 2298-99, 33 L.Ed.2d 222 (1972)("A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application.")[footnote omitted].

[182] *Gore*, 517 U.S. at 568.

interest is in punishing and deterring outrageous misconduct. Due process required prior notice to the Hospital that the "unforeseen incident" that occurred over a 20 minute time span in the OR would be considered outrageous enough to subject it to punitive damages, not to mention notice of "the severity of the penalty that [Kentucky] may impose" for the conduct.[183] In this case, it was arbitrary to give the basic punitive charge.

Second, the $3,750,000 award is grossly excessive. It is clear from *Campbell, BMW* and *Chicago Title Insurance Corporation v. Magnuson* that "punitive damages should only be awarded if the defendant's culpability, after having paid compensatory damages, is so reprehensible as to warrant the imposition of further sanctions and achieve punishment or deterrence."[184] Jennifer's death was tragic. But there was no evidence of the reprehensible conduct that due process requires for punitive damages.

Jennifer's harm was physical, but the Hospital and its employees (1) were not indifferent to her health and safety and did not recklessly disregard them, (2) the Hospital did not prey on her "financial vulnerability," (3) the surgery was "an isolated incident" (the Hospital has never experienced such an event before or after this case), and (4) the harm resulted from "mere accident."[185] Only one "reprehensibility factor" weighed in Beglin's favor, so the punitive damages award cannot be sustained.[186] Finally, the Legislature seems not to have established a civil penalty bearing on the allegations in this case[187] which also counsels against the award.

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183 *Campbell,* 538 U.S. at 147.

184 *Chicago Title Ins. Corp. v. Magnuson,* 487 F.3d 985, ,2007 WL 1461396 (6th Cir. 2007)(quashing award of punitive damages because of insufficient reprehensibility).

185 *Campbell,* 538 U.S. at 419.

186 *Id.*

187 *Gore,* 517 U.S. at 583.

As a matter of law, any award of punitive damages in this case is inimical to the due process required by the Constitution.

VI. CONCLUSION

The legitimate purpose of a missing evidence or spoliation instruction is to guard a party's judicial right to a fair trial from intentional, bad faith destruction of evidence that substantially prejudices an opponent by placing him at an evidentiary disadvantage. Properly applied, the instruction serves to maintain a level playing field for all. Improperly applied, as occurred in this case, the instruction told the jury that the Hospital was a "bad actor, guilty of destroying evidence."[188]

The Court of Appeals' Opinion effectively creates a new rule of law governing any "missing evidence" that applies regardless of whether the evidence was destroyed intentionally, in bad faith and caused substantial prejudice. Under this new standard, the search for missing evidence is but a contest whose only purpose is to unearth a single missing document among hundreds or perhaps thousands that may exist. The prize ultimately sought is a missing evidence instruction that tells the jury it may infer intentional, bad faith conduct and substantial prejudice based on nothing more than the defendant cannot find a document. Given this instruction, the jury is then asked to impartially determine if the defendant is liable for the plaintiff's injuries and how much should be awarded in compensatory and punitive damages.

The trial court failed in its gatekeeper duty by giving the missing evidence instruction because there was no factual support for it. Based on the absence of any evidence to support the instruction and counsel's argument to the jury, the instruction prejudiced the Hospital's right to a fundamentally fair trial. The new procedure removed

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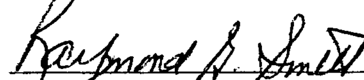
[188] *Morris v. Union Pac. R.R.*, 373 F.3d 896 (8th Cir. 2004).

important protections that traditionally were in place in Kentucky to protect a defendant from arbitrary and unfair spoliation instructions and punitive damage awards. No new similar protection was put in place, in violation of the Hospital's due process rights. The Hospital is entitled to a new trial.

Moreover, there was also no evidence to justify the trial court's punitive damage instruction. KRS 411.184(3) was not intended to impose vicarious liability upon a defendant because it defended itself in a lawsuit. Nor does it impose vicarious liability upon an employer by holding that the employer ratifies an employee's act through the use of a jury's 20/20 hindsight on how "adequate" the employer's investigation was. Ratification requires full knowledge of the facts, not how adequate an investigation was. The Hospital was entitled to a directed verdict on Beglin's punitive damage claim, and is entitled to a new trial due to the unconstitutional effects of the spoliation instruction and the speculation that unfairly was permitted to support the punitive damage award.

Submitted by:
BOEHL STOPHER & GRAVES, LLP



Edward H. Stopher
Raymond G. Smith
AEGON Center, Suite 2300
400 West Market Street
Louisville, KY 40202
Phone: (502) 589-5980 / Fax: (502) 561-9400
COUNSEL FOR APPELLANT/CROSS-APPELLEE