SUPREME COURT OF KENTUCKY
2009-SC-000289 AND 2009-SC-000839

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

v.

MICHAEL G. BEGLIN, EXECUTOR OF THE
ESTATE OF JENNIFER W. BEGLIN, AND
AND MICHAEL G. BEGLIN, INDIVIDUALLY,
AND MICHAEL G. BEGLIN, PARENT AND
NEXT FRIEND OF THE MINORS, WIILIAM
PATRICK BEGLIN AND KELLY ANN
BEGLIN — APPELLEE/CROSS-APPELLANT

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

COMBINED BRIEF OF APPELLEE/CROSS APPELLANT
MICHAEL G. BEGLIN

F. THOMAS CONWAY
1800 Kentucky Home Life Building
239 South Fifth Street
Louisville, Kentucky 40202
(502) 583-4433

CHADWICK N. GARDNER
1916 Kentucky Home Life Building
239 South Fifth Street
Louisville, Kentucky 40202
(502) 583-2423

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing was mailed, first class, postage prepaid, to Edward H. Stopher, Raymond G. Smith, Matthew B. Gay, Aegon Center, Suite 2300, Louisville, KY 40202, Counsel for Appellant/Cross Appellee, and Hon. Charles L. Cunningham, Jr., Judge, Jefferson Circuit Court, Division Four, 700 West Jefferson Street, Louisville, KY 40202; Samuel P. Givens, Jr., Clerk, Court of Appeals, 360 Democrat Drive, Frankfort, KY 40601; Hon. Jack Conway, Attorney General, The Capitol, Room 118, Frankfort, KY 40601; Wesley R. Butler, 489 E. Main St., Suite 300, Lexington, KY 40507; Josh M. Kantrow, Lori S. Nugent, 120 N. LaSalle St., Chicago, IL 60602-2412, Counsel for Amicus Kentucky Hospital Association; Virginia Hamilton Snell, 500 W. Jefferson St., Suite 2800 Louisville, KY 40202, Counsel for Amicus Kentucky Chamber of Commerce, this 12th day of July, 2010. It is further certified that the record on appeal was not withdrawn by the Appellant.

Counsel for Beglin

STATEMENT CONCERNING ORAL ARGUMENT

Appellee/Cross-Appellant Beglin requests oral argument because of the complexity of the issues, the number of issues, the length of the trial, the magnitude of the loss, and the magnitude of the verdict.

COUNTERSTATEMENT OF POINTS AND AUTHORITIES

COUNTERSTATEMENT OF FACTS

Jennifer Beglin, age 40, presented to University of Louisville Hospital (hereinafter UMC) on July 14, 2003, for a routine, scheduled surgery and bled into a comatose, vegetative state because it took UMC employees over one hour to get blood to her in the operating room from the hospital blood bank just one floor away. It sounds oversimplified and unbelievable, but that is what occurred to Jennifer Beglin. Patients presenting to a Level One Trauma Center across the street from the Red Cross should not die from lack of blood.

Jennifer died on October 9, 2003, after three months in a vegetative state, when her family discontinued life support. She left a husband, Michael, a son, Patrick, age 15, and a daughter, Kelly, age 13. Michael, on behalf of Jennifer's Estate and his two children, sued UMC, Dr. Susan Galandiuk, the surgeon, and Dr. Guy Lerner, the anesthesiologist. Trial began July 5, 2006 and ended August 1, 2006. The jury exonerated both physicians and unanimously held UMC 100% responsible for Jennifer's death and grossly negligent. It awarded the following damages to the Estate of Jennifer Beglin: Destruction of power to labor and earn money $1,922,102.00; pain and suffering $0; medical expenses $367,358.09; and, funeral expenses $7,543.00. It awarded Patrick and Kelly $1,500,000.00 each for loss of parental consortium. It awarded punitive damages against UMC of $ 3,750,000.00.[1]

This appeal concerns evidentiary sufficiency and nothing more. It concerns UMC's conduct and the evidence to support it. Jennifer Beglin died because she did not receive blood. The only issue at trial was who bore responsibility for that negligent failure, and in the case of UMC, whether its actions were reckless, or grossly negligent. UMC's appellate

---

[1] R.A. 3251-3270.

briefs never deny negligence. They deny gross negligence and bad faith in the spoliation of evidence. The differences are matters of degree left to the jury. The physicians' exoneration is final because UMC failed to name them partner to the appeal. Beglin cannot overemphasize, however, the dynamic conflict between the physicians and the hospital at trial. What began as a unified defense devolved throughout the month long trial to a series of fierce attacks on the doctors by UMC and upon UMC by the doctors. UMC blamed the doctors for not ordering blood, and the doctors blamed UMC for the delay in delivery.

UMC's Court of Appeals Brief virtually admitted negligence, and stated: "The Hospital...does not 'approve' of what may have taken place in this case," and "Good faith *mistakes* do not justify an award of punitive damages."[2]

Beglin directs the Court to evidence the jury could sift from controversy to support the verdict. All agreed that: (1) Jennifer Beglin died of anoxic encephalopathy, a lack of oxygen (blood) to the brain.[3] (2) What happened should not have happened. (3) Jennifer Beglin had Crohn's Disease that necessitated her surgery, but Crohn's disease had nothing to do with the failure to deliver blood or her cause of death. Nor does it affect life expectancy.[4] (4) Michael, Patrick and Kelly Beglin made empathetic plaintiffs.

The Pre-op and Surgery

Jennifer Beglin's surgery was scheduled and elective, but if a person in the Louisville region needs blood, needs a lot of it, and needs it fast, University Hospital is the place to go. UMC bragged in the Court of Appeals Brief that "U of L Hospital is a Level One Trauma

---

[2] UMC Brief 26, 21 (Emphasis added); pages attached as Exhibit U.

[3] Galandiuk, B5, 16:39:04.

[4] Stephen McClave, M.D. deposition at 37 (counter on video record begins deposition play at 15:52:07).

Center. It is designed to handle incidents involving massive, life-threatening events such as the shooting at Standard Gravure," and that they can have emergency release blood to a patient in ten minutes or less.[5]

Jennifer Beglin checked in early on July 14, 2003, for an 8:00 a.m. colo-rectal surgery that began at 5:00 p.m.[6] She alerted hospital nurses in person and on the history form that she had a bleeding history.[7] She had suffered severe blood loss during a 1998 surgery Dr. Galandiuk performed.[8] UMC nurses overlooked this important fact. They never discussed it with the anesthesia team or the resident unfamiliar with her history who began the surgery. Other UMC nurses said they would have. The anesthesia pre-operative forms contained multiple errors.[9] The primary circulating nurse on the case was surprised no blood had been set up for Beglin, but said nothing. This surprised Beglin's family, for she had been to UMC the week before surgery for blood work.[10]

The Surgery

Beglin and her physicians expected the surgery to last about two hours, no more than four. This surgery took over four hours. Jennifer's normal blood volume was 4000-4500 cc's.[11] Average blood loss for the surgery is 300 to 400 cc's. Jennifer lost over 2000 cc's, about half her blood volume, and bled into a coma,[12] a Level IV hemorrhage.

---

[5] UMC Court of Appeals Brief of Appellant 3.

[6] Galandiuk, VR, B5, 14:02:00.

[7] Plaintiff's Exhibit 23; Pollock VR, B8, 10:54:30.

[8] Galandiuk, VR, B5, 11:59:59.

[9] Plaintiff's Exhibit 45 (falsely state no bleeding disorder, no prior surgery complications).

[10] M. Beglin, VR, B4, 12:21:40.

[11] Galandiuk, VR, B5, 12:09:03.

[12] Id at 14:35:54.

Dr. Galandiuk's fellow, Dr. Peter Deveaux, began the surgery.[13] Within ninety minutes Beglin had lost about 500 cc's of blood, more than the loss expected for the entire procedure. The anesthesia and surgical teams continued to fill Beglin with fluids, and by 8:00, she had received about 11,000 cc's. Meanwhile, I-stat tests showed her hematocrit and hemoglobin levels dropping.[14] Anesthesiologists measure blood quality with hematocrit and hemoglobin readings monitored together on an I-stat test. Results are available in minutes. Hematocrit, the larger number expressed as a percentage, represents the percentage of total blood comprised of red blood cells. Hemoglobin, about one-third of a hematocrit reading, is the oxygen carrying compound of the blood that makes it red. Normal hematocrit range is 36-44; normal hemoglobin is 12-15. Oxygen carrying hemoglobin was the critical reading in this case. Beglin presented to UMC with a hematocrit of 43.7 and hemoglobin of 14.5.[15]

Around 7:04, Beglin's hematocrit was 27.9, hemoglobin 9.1.[16] Dr. Lerner ordered blood around 7:40. Dr. Galandiuk agreed and wanted it in the room.[17] Dr. Lerner received another I-stat test at 8:08 that arrived around 8:12 or 8:15 with a plummeted, dangerously low hematocrit of less than 15, and a hemoglobin of less than 5.[18] The I-stat does not measure any lower. Beglin needed blood, and she needed it badly. It had been 32 to 35 minutes since Dr. Lerner ordered it. It took *another* 40 minutes to get it.

---

[13] Id. at 14:02:31.

[14] Plaintiff's Exhibit 27, attached Exhibit C.

[15] Galandiuk, VR, B5 14:29:55; Plaintiff's Exhibit 45.

[16] Plaintiff's Exhibit 27; attached Exhibit C.

[17] Lerner, VR, B9, 15:28:46.

[18] Id. at 15:35:35.

Begging for Blood

The blood Jennifer desperately needed was one staircase away.[19] The team had two options for blood: type and cross match, or emergency release universal donor blood. Type and cross match takes about 45 minutes to process. Universal donor blood, typically used in emergent trauma situations, takes about one minute per unit to get to the OR, and should be there in 10 minutes max.[20] Anesthesiologist Guy Lerner had been asking for blood. Surgeon Susan Galandiuk had been asking for it. Circulating Nurse Barbara Cantrall made at least 12 to 18 calls to the blood bank.

The operating team ordered blood around 7:40 p.m.[21] Because no one prescheduled blood, the blood bank needed a blood sample first. Based on twenty years' experience, Dr. Lerner expected Jennifer Beglin's blood type in the operating room 45 minutes from then, or 8:25. When the I-stat labs returned around 8:12 or 8:15 showing Beglin's hematocrit less than 15 percent and her hemoglobin less than 5,[22] Nurse Cantrall told Lerner the patient's blood type or universal emergency release blood both were ten minutes away. The delay being equal, Dr. Lerner preferred Jennifer's type, so they continued to wait based upon Cantrall's information. What Cantrall failed to tell anyone in the OR was that she had not sent the necessary specimen to the blood bank to start the 45 minute clock running until 8:05. She denied it, but evidence suggested she let it lie in the OR for 20 minutes before sending

---

[19] Looney, VR, B12, 14:14:05.

[20] Looney, VR, B12, 14:12:14.

[21] Lerner, VR, B9, 14:53:27.

[22] Lerner, VR, B9 12:02:47; 11:41:16, 11:48:55.

it out. Her failure to communicate this critical point placed the physicians on a completely different time line for expectation of blood.

The blood expected by 8:25 had not arrived. They needed it badly. By then, it had been 45 minutes from the time the blood was ordered, and Dr. Lerner testified: "We should have had this blood. We were told ten minutes and it didn't show up and now we needed it, so we decided to go ahead and give this patient O negative."[23] He was not alone in that feeling: "At 8:25 it was our feeling, that's Akca's and myself and Dr. Galandiuk's feeling that sufficient time had gone on, we should have seen the blood."[24] It was chaos at that point, but it was "controlled chaos."[25] He ordered emergency release blood STAT at 8:25.[26] Emergency release blood should take about one (1) minute per unit to get out of the blood bank.[27] Even at this late hour, had the emergency release blood arrived timely, Jennifer would be alive today.[28] They waited – and still waited.

In the blood bank, tech Cynthia Williams had taken the first of several calls for blood and considered them urgent.[29] Djuna Looney, another tech, received at least one call before the specimen arrived and then calls every two to five minutes for forty-five minutes until the cross match was ready.[30] She kept telling the caller, Nurse Cantrall, that emergency release blood was available, but Cantrall ignored her and just hung up the phone with no reply

---

[23] Id. at 12:40:28.

[24] Id. at 12:45:18.

[25] Id. at 12:45:48.

[26] Id. at 16:25:54.

[27] Looney, VR, B12, 14:12:14.

[28] Frost, VR, B7, 10:56:03; Mecca (Lerner's expert), VR, B14, 12:09:27.

[29] Williams, VR, B12, 11:21:53.

[30] Looney, VR, B12, 14:21:14.

whatsoever.[31] UMC held both ends of the phone! Looney was answering the phone so much, she began to carry the cordless phone around with her.[32] She recalled the OR as being very concerned,[33] and that night as "one of the more urgent cases that we've had to deal with."[34]

Finally, the blood Dr. Lerner originally ordered around 7:40 showed up between 8:50 and 8:55 while Beglin was coding.[35] It had been an hour and 15 minute wait for the typed and cross-matched blood ordered originally, "well exceeding our expectation,"[36] but it had been 25 to 30 minutes since the physicians ordered emergency release blood at 8:25, which should have arrived in 10 minutes max. When it finally arrived between 8:50 and 8:55, the physicians literally had to squeeze it into Jennifer.[37]

The operating team begged for blood for over an hour. The ambivalent delay was reprehensible. The jury heard damaging testimony from physicians who serve and love this hospital. Dr. Lerner stated the following:

> But I've been doing it for fifteen, twenty years now, right? I've never ever had a time where I had to wait for blood. OK? When I wanted it, I needed it. OK?[38]
>
> This was the I-stat where the hemoglobin was read as less than five. We asked for the blood. And we were waiting for the blood.[39]
>
> It's never been an issue. When we needed blood products, we could get blood products. Including the most difficult blood products would be things like platelets.

---

[31] Id at 14:25:36.

[32] Id at 14:26:16.

[33] Id at 14:27:31.

[34] Looney, VR, B12, 14:09:27.

[35] Lerner, VR, B9, 16:25:54.

[36] Lerner, VR, B9, 12:42:18.

[37] Acka, VR, B14, 15:35:01.

[38] Lerner, VR, B9, 16:20:24.

[39] Id. at 11:49:06.

> I mean the Red Cross is right across the street. But when we needed blood product, we could get blood products.[40]

Dr. Galandiuk testified:

> We're working at a Level One trauma center . . . we can rapidly deliver blood at ten minutes notice; if we need blood, we can have it there very easily . . . In addition, the Red Cross is across – a block across the street.[41]
>
> I believe people kept calling the blood bank for blood. I told them to go send somebody to get it. But at the end of that I'm not sure how they arrived.[42]
>
> We're at a Level One trauma center where blood is readily available if we need it. We're across the street from the Red Cross.[43]

When the 8:08 I-stat came back, about 45 minutes ***before*** the code, Dr. Cheng, a resident anesthesiologist, lamented at that early time:

> That's the time I wish I could give my own blood to the patient.[44]

When asked if blood products were inordinately delayed, Dr. Acka testified:

> That's what I recall. I mean, it was–it was taking much more than expected. And I'm repeating, again, this is–I'm working at University of Louisville Hospital. I'm still in my hospital. And I'm happy and proud of my hospital. And this hospital is used to delivering care for level one trauma cases. . . But this was–whichever we calculate, it's–if we take the time as 8:50, it's like, one hour and 20 minutes or one hour and 10 minutes after I drew and handed the blood sample. This is way more than what it takes usually.[45]

Gross Neglect

Gross neglect by UMC employees and the administration itself caused these failures.

1) UMC Nurse Barbara Cantrall never oriented the anesthesia and surgical team to the

---

[40] Id. at 12:47:00.

[41] Galandiuk, VR, B5, 14:17:40.

[42] Id at 15:12:07.

[43] Galandiuk, VR, B8, 14:46:06.

[44] Cheng, VR, B10, 15:42:00 to end.

[45] Acka, VR, B14, 15:59:34.

blood's expected arrival time. 2) There was a total communication failure between the operating room and the blood bank. 3) No blood was prescheduled for Beglin because UMC nurses ignored her clearly marked history of a bleeding disorder.[46] 4) UMC did not follow its policies that insure the actors involved know when and where blood is needed. 5) UMC's administration continuously allowed departures from these policies and procedures.

UMC claimed Beglin's blood specimen left the OR at 8:05. The parties hotly contested whether the specimen left at 7:45 or 8:05, but UMC dropped the ball in either case. If the specimen left around 7:45, as the physicians said, then Nurse Cantrall let it lie in the operating room for twenty minutes, which is unacceptable.[47] She acknowledged it is poor nursing care to let a sample lie in the operating room for ten to twenty minutes. UMC's nursing expert agreed.[48] If Cantrall was correct that the sample did not leave until 8:05, she should have reoriented the team to the blood's expected arrival time because Dr. Lerner clearly expected it at 8:25.

According to Cantrall, Dr. Lerner first asked for blood around 7:45.[49] She knew then that Beglin's hematocrit and hemoglobin levels had dropped precipitously from 43.7/14.5 to 27/9, and that Beglin had no specimen in the bank or prescheduled blood.[50] She knew if a blood specimen leaves at 8:05 for a type and cross match, not to expect it until 8:50.[51] She need not call the blood bank to answer that question.[52] By 8:08 or 8:09, just minutes after

---

[46] Plaintiff's Exhibit 23.

[47] Lerner, VR, B9, 16:21:49; Cantrall, VR, B11, 13:49:20.

[48] Timmons, VR, B10, 11:22:20.

[49] Cantrall, VR, B11, 11:21:55.

[50] Id at 11:22:33.

[51] Id at 13:52:27.

[52] Id at 13:52:48.

Cantrall claims she sent the blood specimen, she said Dr. Lerner was "panicking."[53] He was panicked because he had just received I-stat labs showing the hematocrit and hemoglobin, 15/5, had fallen off the chart.[54] On her timeline, she knew blood would not arrive until 8:50. Nevertheless, she never told the physicians, "The blood will not be back until 8:50."[55] Instead, she kept calling the blood bank.[56]

Cantrall never asked the anesthesia team what time they expected the blood.[57] She could not recall one single word the blood bank told her during these multiple phone calls, but claimed she told anesthesia whatever the blood bank told her.[58] She and UMC's nursing expert admitted that if she gave the runner the sample and told him to "run," and ten minutes later an anesthesiologist asked her where the blood was, she had an obligation to explain blood just had left the room and would not be there for 45 minutes.[59]

UMC Policies and Guidelines[60]

A. Blood Transfusion Policies and Standards/Missing Blood Triplicate Form.

UMC Policies and Procedures provide "proper identification and labeling of all specimens...is mandatory."[61] Their Transfusion Policies and Procedures provide: "The nursing staff initiates orders for red blood cells by entering an order for a cross match in the

---

[53] Id at 11:23:23.

[54] Id at 11:22:15.

[55] Id at 13:56:53.

[56] Id at 13:56:00.

[57] Id at 13:59:33.

[58] Id at 13:55:14.

[59] Id. at 13:55:14; Timmons, VR, B10, 14:00:07.

[60] All policies discussed are directly adopted by UMC, which bears importance to the issue regarding punitive damages ratification.

[61] Plaintiff's Exhibit 52.

hospital computer system.[62] The type of component, the amount requested, and ***time needed*** are noted on the order." (Emphasis added).

UMC claimed to meet this standard with "blood triplicate forms" and by logging information in their computer system. The forms have a place to show who drew the blood, the time it was drawn, when it is needed, where it is needed, and who ordered it.[63] They serve as a checklist to insure the blood products ordered match what is delivered, particularly when the OR is extremely busy and the blood may not return for 45 minutes.[64] Cantrall prepared a triplicate form for Beglin.[65] The top copy should have been in her chart,[66] but the hospital did not have it. UMC's compliance officer admitted forms should be kept for a year.[67] UMC claimed not to keep them because it transferred their information into its computer system. The only document available at trial was the information transferred into the computer system, and the information on it was inaccurate.[68]

According to the computer form at the blood bank, Beglin's blood was needed in ***endoscopy,*** not the OR.[69] UMC claimed "endoscopy" appeared on the form by computer default from a previous admission. If Cantrall put "endoscopy" on the blood triplicate form, and it properly was transferred to the computer system as UMC claims it is, it was a reckless

---

[62] Plaintiff's Exhibit 53.

[63] Defendant Lerner Exhibit 7; Blank triplicate form attached as Exhibit E; Cantrall, VR, B11, 11:38:28.

[64] Cantrall, VR, B11, 11:43:46.

[65] Cantrall, VR, B11, 13:45:45.

[66] Strong, VR, B11, 16:23:10.

[67] Adams, VR, B12, 15:44:33.

[68] Defendant UMC Exhibit 14, attached Exhibit E.

[69] Id.; Cantrall, VR, B11, 11:43:46.

error. If she did not, UMC blood bank employees either paid no attention to the blood triplicate form when logging the information or never used it all.

The "time needed" on the computer form stated 20:20, or 8:20.[70] This makes no sense given Cantrall's testimony that it takes 45 minutes for type and cross matched blood to return if she sent it out at 8:05. It coincides with Dr. Lerner's testimony that he ordered the blood at 7:40. Cantrall said she noted STAT on the triplicate form, but UMC had no record of that. We will never know what the form said because UMC shredded it.[71] The trial court allowed UMC to explain away this "missing evidence" without including it on the missing evidence instruction.

Shredding the form violated policy. The American Association of Blood Banks' "Standards for Blood Banks and Transfusion Services,"[72] adopted by UMC[73] and like a "bible" to blood bank techs,[74] forbids the destruction of originals unless all information on an original form has been transferred completely and correctly.[75] Compliance was impossible because the original blood triplicate form has a place to note when the blood is needed, e.g., STAT or ASAP, but the computer does not. UMC employees violated their policy, but the administration failed to provide proper means to follow it.

---

[70] Id. 11:44:00.

[71] Leonard, VR, B12, 15:35:33.

[72] Plaintiff's Exhibit 55, attached Exhibit G.

[73] Plaintiff's Exhibit 53, page 2; attached Exhibit D.

[74] Cynthia Williams, VR, B12, 13:53:30.

[75] Standard 6.2.1.1 provides: Prior to the destruction of the original records, the blood bank or transfusion service shall have a process to insure that copies of records are identified as such. Copies of records shall be verified as containing the original content and shall be legible, complete, and accessible.

UMC faced an insurmountable problem. It had to either (a) admit that the "8:20 p.m." in the blood bank computer record is how it complies with its "time needed" policy, and therefore, the blood bank staff knew the OR needed blood by 8:20 p.m., which would have saved Jennifer Beglin's life, or, (b) it had to claim that this "8:20" was something else, in which case, the hospital could not show anywhere in the blood ordering records where it complied with its own policy to advise the blood bank of the "time needed."

UMC unsuccessfully opposed evidence about the blood triplicate form. Nurses Cantrall and Supervisor Strong clearly testified that triplicate forms are used in the OR.[76] Dr. Lockwood, Chair of UMC's Blood Transfusion and Utilization Committee, said they were not.[77] To skirt the fact that the computer form lacked a field to comply with the "when needed" mandate of the policy, Cantrall claimed the "when needed" part of the policy did not apply in the OR. It only applied to floor nurses.[78] Conversely, Dr. Lockwood, the blood committee chair, said there is no such exception.[79] Blood Bank Supervisor Jill Leonard agreed.[80] Testimony on this issue was all over the map, and, because it involved top-down policies, went to the heart of corporate ratification and adoption.

Dr. Lockwood confessed several policy failures. He admitted the hospital has no way to document time needed as policy requires.[81] The only way the blood bank knew who ordered blood was by knowing who made the call, and the evidence showed it receives

---

[76] Cantrall, VR, B11, 13:45:35; Strong, VR, B11, 16:31:31

[77] Lockwood, VR, B10, 13:36:35.

[78] Cantrall, VR, B11, 13:44:05.

[79] Lockwood, VR, B10, 13:36:36.

[80] Leonard, VR, B12, 15:25:48.

[81] Lockwood, VR, B10, 14:06:20.

many.[82] Dr. Lockwood had no way to explain how the requisite "where needed" was documented, and admitted "endoscopy" was incorrect in this case.[83] The blood bank has no policy to document when emergency release blood is ordered, and it is the most critical blood the hospital delivers.[84] UMC has no policy to document when regular blood is ordered; no policy to document how long it takes to get blood ready for release and ready to go to the OR;[85] no policy to document when a specimen arrives at the blood bank; no policy to keep track of what is "stat," routine, or something else; no policy to document when emergency release blood is requested; and, no information to determine whether the blood bank timely prepared the products.[86] The blood bank techs rely completely on *written* policy. There is no other routine they follow.[87] UMC's *administration* failed to enact policies and failed to insure mechanisms and forms were in place to comply with the policies it did have.

B. AORN Standards

Nurse Cantrall violated Association of Operating Room Nurses (AORN) Standards adopted by UMC.[88] Those standards provide in part that "the collection of data about the health status of the individual is systematic and continuous. The data are retrievable and communicated to appropriate persons." They further provide that "reassessment of the individual, reconsideration of nursing diagnosis, resetting of goals, and modification and implementation of the nursing care plan are a continuous process." The policies are adopted

---

[82] Id at 14:47:46.

[83] Id. at 14:46:40.

[84] Id. at 14:04:40.

[85] Id at 14:05:32.

[86] Williams, VR, B12, 11:38:08.

[87] Lockwood, VR, B10, 13:59:32.

[88] Plaintiff's Exhibit 44; attached Exhibit H.

to assure "accurate chronological documentation of peri-operative activities as related to patient care provided during the surgical procedures."

The procedures provide the nurse circulator "is responsible for the complete and accurate documentation on the peri-operative record." The record must reflect assessment and planning. It should reflect care given by members of the surgical team and its outcomes. "All care should be documented." It should reflect "a continual evaluation of the peri-operative nursing care."

In this case, documentation was horrible. Beglin's medical record provided no indication that something went wrong during her surgery.[89] It provided no indication that there was a delay getting blood. It provided no documentation of physicians' repeated orders for blood and orders to call to find out where the blood was. In the face of continuously dropping hematocrit and hemoglobin levels, it provided no assessment or reassessment of Beglin's condition with respect to her dire need for blood.

Missing Incident Report

Several sources required UMC to complete an incident report in a surprise case like this. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits UMC, requires it. UMC's policies and procedures required it report in this case.[90] The report seeks detailed information about what occurred, who was involved or responsible, what hospital systems broke down, what corrections are necessary, and how the hospital can

---

[89] The original discharge summary, dictated by Dr. Robert Shirley, came closest to admitting failures occurred, but the trial court excluded it, and allowed only the "revised" discharge summary dictated by Defendant Dr. Galandiuk, *after* the suit was filed. Beglin raises this on cross-appeal.

[90] Plaintiff's Exhibit 42.

prevent such recurrences.[91] Nurse Cantrall completed an incident report at the instruction of her supervisor and placed it in the appropriate bin. There really is no dispute about this as UMC would have the Court believe. Even Judge Wine's dissent acknowledges Cantrall prepared an incident report. Reporting requirements and a sample form are a central issue discussed in the "Argument."

UMC's expert initially was surprised there was no incident report, but tried to change her testimony at trial to claim one was not mandatory.[92] Cantrall claimed the only information she would have written on the report is that Beglin coded and CPR was performed. She would not have noted when the blood was ordered or if it was delayed; she would not include when specimens were sent or what time the blood arrived. She would not include a chronology about how things unfolded. "I would have put exactly what I knew, and that was CPR was done in the OR . . . I would state the facts."[93] UMC admits that in her deposition she said she would have noted a chronology of events. As the Court can see, the chronology was critical. The failure to preserve a critical document that recorded it prejudiced Beglin. Ironically, (or perhaps not), the ***only*** time Nurse Cantrall left the operating suite was during Beglin's code and the administration of CPR. The Court will see below there was much more for Cantrall to describe besides the event she completely missed.

Missing Code Sheet

Beglin coded. There should have been a code sheet.[94] There was none. A code sheet should document who was there, what medications or products were given, strips showing

---

[91] Plaintiff's Exhibit 41.

[92] Timmons, VR, B10, 11:32:37.

[93] Cantrall, VR, B11, 12:06:00–12:07:50.

[94] Pollock, VR, B8, 10:57:58.

the heart rate before and after the code, who was massaging the heart and other pertinent information.[95] UMC and Cantrall claimed the code sheet was part of the anesthesia record.[96] It was not. Supervisor Elaine Strong was present for the code. She brought in the crash cart. She came to the OR because Cantrall needed help and just before Beglin coded and the long awaited blood arrived, Cantrall needed a restroom break. UMC had no record of Elaine Strong ever being in the room![97] The only place anyone found out who was massaging Beglin's heart was in a deposition. There was no medical record of it. The code sheet was another piece of missing evidence the trial judge refused to let the jury consider.

Sham Investigation

Many were talking the next day at UMC about what happened to Jennifer Beglin the night before.[98] Barbara Cantrall told circulating nurse Tambra Guinn that Beglin suffered major blood loss and there was difficulty getting blood to her.[99] Dr. Galandiuk told UMC Risk Management the next day what had happened during Beglin's surgery and told them not to bill Beglin for it.[100] (UMC billed Beglin $16,280.63 for blood administration anyway).[101] She suggested the hospital preserve and maintain any appropriate records.[102] Dr. Acka went to the blood bank the next morning to learn why it took so long to get blood.[103]

---

[95] Id.

[96] Cantrall, VR, B11, 11:56:55.

[97] Pollock, VR, B8, 11:03:20.

[98] Strong, VR, B11, 16:27:27.

[99] Guinn, VR, B12, 10:13:46.

[100] Galandiuk, VR, B5, 15:53:50.

[101] M. Beglin, VR, B4, 12:37:31; (Plaintiff's Exhibit 7)

[102] Shorr, VR, B7, 7-13-06, 194.

[103] Acka, VR, B14, 15:59:34.

UMC Vice President Marty Brewer began an "investigation," at the request of UMC Risk Manager Sally Long,[104] but failed to interview the important actors. No one ever asked Dr. Galandiuk, Dr. Lerner, Dr. Acka, Dr. Cheng, Elaine Strong, the runner who "ran" the blood, or anyone at the blood bank their version of what occurred. They never even asked *Barbara Cantrall*. Marty Brewer, spearhead of this critical investigation, never testified at trial, and the risk manager did not know who she interviewed about this incident.[105] Beglin's file contained no records to enable a hospital administrator to reconstruct what occurred.[106]

ARGUMENT

The trial court properly submitted the spoliation instruction, and UMC never contested whether Cantrall's actions were authorized, ratified, or should have been anticipated. Evidence supported all three. Beglin asks this Court to affirm the trial court's judgment. If this Court reverses, Beglin cross-appeals discovery and evidentiary rulings and the trial court's failure to include lost enjoyment of life in the jury instructions.

I. SYNOPSIS OF BEGLIN'S BRIEF

The language of the missing evidence and punitive damages instructions is not an issue because UMC wrote both of them, and the trial court submitted them verbatim. The only issue is evidentiary sufficiency to submit them, which this Court reviews under an abuse of discretion standard. Johnson v. Commonwealth, 134 S.W.3d 563, 569-70 (Ky. 2004); Ratliff v. Commonwealth, 194 S.W.3d 258, 274 (Ky. 2006). Bad faith and intent are state of mind factual issues for a jury to determine. Jefferson Co. Fiscal Court v. Peerce, 132

---

[104] Long, VR, B16, 14:16:02.

[105] Id. at 14:09.

[106] Shorr, VR, B7, 16:48:29.

S.W.3d 824, 831 (Ky. 2004); Hamilton Mut. Ins. Co. of Cincinnati v. Buttery, 220 S.W.3d 287, 293 (Ky. App. 2007). Reasonable inferences support such a finding, Perry v. Motorist Mut. Ins. Co., 860 S.W.2d 762, 764-66 (Ky. 1993).

To the extent Kentucky missing evidence law requires bad faith, intent, and prejudice the instructions included those elements as prerequisites to drawing any adverse inference. The law presumes the jury followed those instructions. Conner v. Akins, 441 S.W.2d 784, 786 (Ky. 1969); Fisher Equip. Co. v West, 365 S.W.2d 319, 322 (Ky. 1963); Fields v. Wilkins, 277 S.W.2d 467, 468 (Ky. 1955). The jury system's survival rests upon this presumptive belief.

As a permissive instruction that stated the jury, "may, but [was] not required to" draw an adverse inference, it is complete speculation to assume the jury utilized the instruction against UMC, and UMC requested no specific finding. Without requesting an instruction that would eliminate speculation, UMC failed to preserve the error. Sand Hill Energy, Inc. v. Smith, 142 S.W.3d 153, 162-65 (Ky. 2004). UMC alleges the missing evidence instructions poisoned the punitive verdict, but there is no reason to disturb the compensatory award, and UMC does not make that argument.

UMC's request for a preliminary judicial determination that bad faith and intent exist is completely novel and unpreserved because UMC never raised the issue until it sought discretionary review. Kennedy v. Commonwealth, 544 S.W.2d 219, 222 (Ky. 1979); Skaggs v. Assad, 712 S.W.2d 947, 950 (Ky. 1986). It also is contrary to law.

The punitive damages instruction was separate from the missing evidence instruction. The Court must presume the jury followed those instructions separately. Whether UMC "authorized, ratified, or should have anticipated" was uncontested by UMC, and at worst,

a factual issue. KRS 411.184(3). All of Nurse Cantrall's actions were authorized and within the scope of her employment. Non-existent or flawed policies and procedures directly authorized by management caused or contributed to the operating room chaos and failure to deliver blood one staircase away for over an hour despite 12 to 18 phone calls.

The $3,750,000 punitive damages award that was a .7 multiplier of compensatory damages does not violate due process. See Steel Technologies, Inc. v. Congleton, 234 S.W.3d 920, 931-32 (Ky. 2007). The lower courts did not employ any "new" procedures.

There is no indication this jury was "mad." It deliberated thoughtfully and followed the instructions. A " mad"jury does not award "zero" for pain and suffering after a patient bleeds to death and later suffers episodes of awareness.

II. THE TRIAL COURT PROPERLY SUBMITTED A SPOLIATION INSTRUCTION.

UMC's argument paraphrased is "we deny we intentionally or in bad faith lost the report so Beglin cannot prove those required elements; the report is gone and without knowing its contents Beglin cannot prove prejudice; therefore, the instruction is improper." The absurd result is UMC's claim of "loss" assures its innocence, eliminates inferences, and eliminates the consequences of destroying evidence. UMC had incentive to conceal the report when, at worst, the court *may* give an appealable instruction. Reversal would strengthen the incentive to destroy or "lose" evidence for future litigants.

A. The Law of "Missing Evidence" Seeks to Remedy and Deter What Occurred Here.

"Losing" vital evidence without explanation has consequences. Missing evidence remedies range from doing nothing to an independent tort. This Court chose missing evidence instructions as a middle ground remedy in civil cases in Monsanto Co. v. Reed,

950 S.W.2d 811(Ky. 1997), which also involved missing documents, and declined to create a spoliation tort. "Where the issue of destroyed or missing evidence has arisen, we have chosen to remedy the matter through evidentiary rules and 'missing evidence' instructions." Id. at 815. Monsanto drew from Tinsley v. Jackson, 771 S.W.2d 331 (Ky. 1989) and Sanborn v. Commonwealth, 754 S.W.2d 534 (Ky. 1988). Sanborn condemned destruction of evidence and recommended an instruction.[107] Id. at 540.

"The evidentiary value of the inference is derived from the common sense observation that a party who destroys a document with knowledge that it is relevant to litigation is likely to have been threatened by the document." Phillips v. Covenant Clinic, 625 N.W.2d 714, 718 (Iowa 2001) (citing Beil v. Lakewood Eng'g & Mfg. Co., 15 F.3d 546, 552 (6th Cir. 1994)). "[A]n inference serves to deter parties from destroying relevant evidence." Id. "[A] party with notice of an item's possible relevance to litigation who proceeds nonetheless to destroy it is more likely to have been threatened by the evidence than a party in the same position who does not destroy it." Welsh v. United States, 844 F.2d 1239, 1246 (6th Cir. 1988) (civil medical negligence case). "The maxim, *Omnia praesumuntur contra spoliatem*, "all things are presumed against the spoliator," rests upon a logical proposition that one would ordinarily not destroy evidence favorable to himself." Miller v. Montgomery County, 494 A.2d 761, 768 (Md. App. 1985).

Documents "lost" or "inadvertently destroyed" can show bad faith and support an instruction. Most Kentucky missing evidence cases involve criminal defendants, and the

---

[107] In footnote 3, Sanborn quoted with approval the following instruction:

> If you find from the evidence that there existed a tape recording . . . and that the state intentionally destroyed the tape recording, you may, but are not required to, infer that the information contained on the tape recording would be, if available, adverse to the state and favorable to the defendant.

analytical framework is different. Criminal cases determine whether missing evidence deprived a defendant of criminal due process. Collins v. Commonwealth, 951 S.W.2d 569, 573 (Ky. 1997) (analysis emanates from Federal Due Process law); Estep v. Commonwealth, 64 S.W.3d 805, 810 (Ky. 2002). "The purpose of a 'missing evidence' instruction is to cure any Due Process violation attributable to the loss or destruction of *exculpatory* evidence by a less onerous remedy than dismissal or the suppression of relevant evidence." Id.

UMC latches onto Estep's phraseology about intentional and bad faith destruction, which is the law Judge Clayton followed. Closer review of Estep's context, however, further supports her decision to instruct on missing evidence. Estep's case actually involved two missing evidence instructions. It was the second time his case appeared in an appellate court. The published opinion reversed a missing evidence instruction that favored the Commonwealth during Estep's *second* trial.

Estep, a toll booth operator, stood trial for the reckless homicide of Jackson who consistently failed to stop and pay at the toll booth, had displayed a gun, and had threatened Estep. Id. at 806-07. After Estep shot Jackson, the coroner directed hospital personnel to clean Jackson's body because his family awaited viewing. Id. at 807. This prevented gunshot residue tests. Id. After trial one, the court of appeals reversed Estep's conviction and ordered the trial court to hold a suppression hearing to determine whether the Commonwealth failed to preserve exculpatory evidence by cleaning the body. Id. The court of appeals identified acquittal, suppression of evidence, or a missing evidence instruction as potential remedies. "The trial court opted for a 'missing evidence' instruction." Id. Although not the focus of the appeal, the instruction in trial one was warranted solely based upon the coroner's instruction to clean Jackson's body because his family awaited viewing.

UMC claims a party must show egregious and unspeakable bad faith to attain a missing evidence instruction. The threshold is more simple if a party destroys valuable evidence within its exclusive control. The coroner directing personnel to clean the body for the family's sake met these requirements.

After trial one, Estep discovered evidence of gunshot on his car, Id. at 807, but before trial two, his car was repossessed, which prevented examination by the Commonwealth. Id. at 809. The trial court issued a missing evidence instruction permitting the jury to draw an inference that evidence found on Estep's vehicle would have been adverse to him and favorable to the Commonwealth. Id. at 808-09. The Court concluded:

> There is no basis for an instruction permitting the jury to infer that missing evidence, if available, would be adverse to the defendant and favorable to the Commonwealth.... Second, the Due Process Clause is implicated only when the failure to preserve or collect the missing evidence was intentional and the potentially exculpatory nature of the evidence was apparent at the time it was ***lost*** or destroyed.

Id. at 810 (emphasis added). It further noted, "[m]issing evidence amounts to a Due Process violation only if the evidence was intentionally destroyed by the Commonwealth or destroyed ***inadvertently outside normal practices***." Id. at 809 (citing Tamme v. Commonwealth, 759 S.W.2d 51, 54 (Ky. 1988)) (emphasis added).

"***Lost***" and "***inadvertent***" describe circumstances when a missing evidence instruction is proper. To the extent bad faith is essential in a civil case, evidence "lost" or "inadvertently" destroyed "outside normal practices" gives rise to it. Estep did not reject the instruction for lack of bad faith, but because it gave rise to an inference in favor of the Commonwealth, which has no entitlement to due process.

UMC cites Swofford v. Eslinger, 671 F.Supp.2d 1274 (M.D. Fla. 2009), but the case strongly favors Beglin's position. In a §1983 civil action wherein sheriff's deputies shot a homeowner, the court granted the plaintiff's motion for spoliation sanctions, awarded costs and stated "the jury shall be instructed to infer that emails deleted . . . contained information detrimental to all defendants in this case." Id. at 1289. It ordered the "jury will be instructed that [the deputy's] laptop computer contained information detrimental to the [sheriff's offices] and deputy's defense of this case." Id.

UMC claims lost documents are insufficient to warrant a spoilation instruction as a matter of law. Most cases UMC relies upon contained some explanation of how or why the "accident" occurred.[108] The Swofford case UMC cites held: "While it is now impossible to determine precisely what or how many documents were destroyed, the bad faith destruction of a relevant document, by itself, 'gives rise to strong inference that production of the document would have been unfavorable to the party responsible for its destruction.'" Id. at 1282 (quoting Telectron, Inc. v. Overhead Door Corp., 116 F.R.D 107, 133 (SD. Fla. 1987)). Notably, the Swofford instruction was much stronger than Kentucky's.

"[T]he spoiliating party need not have acted with malice when spoliating the evidence in order for the court to draw an adverse inference." Id. at 1280. With a clear duty to preserve the documents, "[n]othing other than bad faith can be inferred from the facts of this case." Id. at 1280. The court blamed the sheriff's in-house counsel for failing to preserve the

---

[108] Sears Roebuck & Co. v. Midcap, 893 A.2d 542, 546-47 (Del. 2004) (Sears explained missing document regarding range sold four years ago was destroyed in accordance with appropriate document retention policies. Sears had moved its storage facility and document may have been lost in move; Brewer v. Quaker State Oil Refining Corp., 72 F.3d 326, 334 (3rd Cir. 1995) (employee files missing because lost in connection with death of in-house attorney and not intentionally destroyed); Brewer v. Dowling, 862 SW2d 156, 159 (Tex.App. 1993) (affirm trial court's discretion not to issue instruction; did not hold lost evidence forbids missing evidence instruction as a matter of law).

evidence, noting that counsel must "take affirmative steps to monitor compliance" to preserve evidence. Id. at 1281. In this case, UMC's risk management, and presumably counsel, were involved the very next day. They should have preserved the incident report per JCAHO policies and their own, and if truly lost by the very next day, directed Cantrall (and perhaps others) to complete another one.

Judge Wine cited law to indicate an instruction is proper when a party has no explanation for missing evidence:

> Accordingly, an instruction regarding spoliation of evidence is proper when a party has "*deliberately destroyed evidence or has failed to either produce relevant evidence* ***or explain*** *its nonproduction.*" 75A Am. Jur. 2d *Trial* § 1100 (2007) (emphasis added).[109]

Curiously, Judge Wine then wrote, "Clearly the Hospital should have preserved the postoperative report. For unexplained reasons it was lost or destroyed." This meets the requirement of the law he cited.

UMC has no explanation for the missing incident report, other than they "lost" it. According to Estep, that is enough. UMC's policies show losing an incident report falls "outside normal practices." While some cases refuse missing evidence instructions when there is a plausible explanation for evidence's absence, no explanation at all fails the test.

Submission of an instruction should not rise and fall based upon a party's claim that "losing" evidence "inadvertently" or without explanation extinguishes any missing evidence instruction because there is no evidence of bad faith. That is not the law and for good reason. Foxes do not guard henhouses, and parties do not adjudicate their own culpability by claiming innocent mistake.

---

[109] Court of Appeals Opinion at 23

B. The Lower Court Judges Correctly Applied the Law, and UMC's Criticisms Are Unwarranted, Disrespectful and Unpreserved.

UMC portrays (then) Trial Judge Denise Clayton as a rogue jurist who abandoned all missing evidence law. It describes Judges VanMeter and Guidugli as rubber stamp judges who paid "lip service" to the law's requirements but "egregiously" misstated and misapplied it.[110] UMC never asked any lower court to make or require a "preliminary judicial finding." There has been no dispute in the law about the remedy or how to apply it since Monsanto.

1. The trial court issued UMC's favorable instruction based upon an instruction Kentucky has used for decades.

Judge Clayton issued UMC's tendered instruction.[111] UMC objected, but when

---

[110] UMC states the following about Judge Clayton and Judges VanMeter and Guidugli:

"Instead of making a judicial determination of bad faith destruction and prejudice, the trial court shifted this responsibility to the jury. . .This instruction is at odds with Kentucky practice." (UMC Brief 15)

"The Court of Appeals apparently believed that a trial judge does not serve as the gatekeeper in determining if a spoliation instruction is warranted." (UMC Brief 18-19)

"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." This was a significant departure from prior Kentucky law, which required proof of prejudice before a spoliation instruction may be given." (UMC Brief 19; UMC's emphasis).

"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.'" (UMC Brief 24)

"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." (UMC Brief 25).

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."*** (UMC Brief 28; emphasis added).

"Improperly applied, as occurred in this case, the instruction told the jury that the Hospital was a "bad actor, guilty of destroying evidence." (UMC Brief 45).

[111] R.A. 3341, 3262; attached Exhibits M & N.

overruled, wrote the most favorable instruction it could. It prejudiced Beglin by being too watered down and omitting from consideration the missing code sheet and destroyed blood triplicate form. It was similar to the instruction this Court approved Sanborn, 754 S.W.2d at 540, that repeatedly has been used since.

UMC mischaracterizes the court of appeals' opinion as holding that the trial court never required the jury to weigh the evidence. This is false. Taken in context, the court of appeals explained that UMC's claim that the jury used the missing evidence instruction against it fell short because the instruction did not affirmatively tell the jury to infer the missing evidence was adverse to UMC. It said you "may, but are not required to." Johnson v. Commonwealth, 892 S.W.2d 558 (Ky. 1994) rejected an instruction allowing the jury to "assume" instead of infer or not infer that missing evidence would have favored the defendant. The lower courts followed the law.

Most instructions require an affirmative finding. If P (premise), then C (conclusion). If P, a party, violated a duty, then C, find against the party. The missing evidence instruction tendered here, however, is completely neutral.[112] It stated if P, and P, and P, then you may find C or you may not find C. Some instructions go further with interrogatories and ask, "Do you find P1, P2, and P3?" UMC's tendered instruction renders its use speculative.

---

[112]Instruction No. 8
If you find from the evidence that an incident report was in fact prepared by Nurse Barbara Cantrall ***recording material information*** about Mrs. Beglin's surgery, ***and if*** you further find from the evidence that University Medical Center, Inc. d/b/a University of Louisville Hospital, intentionally and 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 plaintiffs. (Emphasis added)

UMC, as author, cannot twist the context of the court of appeals' opinion to argue the statement "the jury was not required to weigh the evidence" means the court sanctioned an instruction when there was no evidence to weigh. There was. If the jury failed to weigh that evidence as the instruction allowed, it hurt Beglin, not UMC.

2. The Court must presume the jury followed the instructions.

The presumption that juries follow instructions is the foundational bedrock of the entire jury system. Courts presume juries follow instructions. Conner v. Akins, 441 S.W.2d 784, 786 (Ky. 1969); Fisher Equip. Co. v. West, 365 S.W.2d 319, 322 (Ky. 1963). "A jury must be credited with some intelligence and understanding." Fields v. Wilkins, 277 S.W.2d 467, 468 (Ky. 1955). Conner assumed an instruction *incorrect,* but held the jury could have sorted things out to arrive at the correct result, making the incorrect instruction non-prejudicial. Conner, 441 S.W.2d at 786.

The instruction contained multiple qualifiers. It required three findings before the jury could hold the absence of the incident report against UMC: 1) that Cantrall prepared a report; 2) that it contained material information, and; 3) that UMC intentionally or in bad faith lost or destroyed it. If so, "you may, but are not required to" infer the information would be adverse to UMC.

UMC cannot dispute the legal presumption that the jury adhered to these criteria. Judge Clayton properly held it was not for her to decide whether Cantrall told the truth in her deposition or at trial about preparation of the incident report. It was not for her to decide how thorough Cantrall would have been in completing the report when the jury heard and saw her, her documentation in the chart, and the reporting policies. It was not for her to decide the culpable state of mind of this hospital with extremely strict policies about the

security, protection and confidence of these reports, that heard doctors' concerns within hours, that immediately involved risk management who oversees these reports, that immediately began an investigation that failed to interview central actors, that removed a doctor's discharge summary from the patient's hospital record and substituted a more favorable one six months after suit was filed, that faced many millions in damages, that tried to blame two doctors throughout the trial, that had its own doctors blaming it, and that had no explanation for what happened to the report. It was not Judge Clayton's role to sort that out, but the Court must presume the jury abided by her instructions when it did.

3. UMC never requested the "preliminary determination" they claim as error and failed to preserve the issue.

UMC's theory that a trial judge must make a preliminary "judicial determination" of bad faith or intentional conduct is nowhere in Kentucky jurisprudence. Knowing the weakness of an evidentiary sufficiency argument under an abuse of discretion standard, UMC created the "preliminary determination" assignment of error after losing at the court of appeals to attract discretionary review.

"It goes without saying that errors to be considered for appellate preview must be ***precisely*** preserved ***and identified*** in the lower court." Skaggs v. Assad, 712 S.W.2d 947, 950 (Ky. 1986) (Emphasis added); See also Baker v. Weinberg, 266 S.W.3d 827, 835 (Ky. App. 2008). Kennedy v. Commonwealth, 544 S.W.2d 219 (Ky. 1979) rejected a claim that the trial court failed to hold a hearing because the defendant never requested one. Justice Lukowsky concluded: "The appellants will not be permitted to feed one can of worms to the trial judge and another to the appellate court." Id. at 222. Issues not raised in a prehearing statement are not preserved. Osborne v. Payne, 31 S.W.3d 911, 916 (Ky. 2000).

In the trial court and in seventy-seven (77) pages of court of appeals briefing, UMC never requested or mentioned a "preliminary" finding, determination or hearing. UMC's prehearing statement[113] objects to the missing evidence instruction, but says nothing about any "preliminary determination" that has become a refrain in this Court. It is an act of desperation. The claims of "new procedures," "departures from prior law," and "new standards" is a can of worms freshly opened with the Motion for Discretionary review.

A true procedural departure is to require trial judges to hold hearings and make special preliminary determinations *as a matter of law* beyond hearing directed verdict and jury instruction arguments, which this trial court entertained over a period of days. It is unworkable to hold hearings to make special determinations over every instruction. UMC does not claim the trial judge should make a preliminary finding of gross negligence as a matter of law before instructing on punitive damages. If the punitive award is what hurts, why not make the same argument? UMC's missing evidence argument is bait for this Court to find error.

Judge Clayton did what all trial judges do. She heard the evidence and determined it warranted a missing evidence instruction.[114] She specifically noted it was her role to determine whether sufficient evidence existed to submit an instruction.[115] She did not forsake her gatekeeper role as UMC claims. When it came to the incident report, she could not "second guess the jury. . . it's their call."[116] As "gatekeeper," she refused Beglin's request to include the missing code sheet and the missing blood triplicate form in the

---

[113] See attached Exhibit V.

[114] VR, B18, 10:28.

[115] Id.

[116] Id.

instruction, noting that UMC provided some explanation why those items were destroyed in the normal course of business, but there was no explanation why the completed incident report went missing.[117]

C. Evidence Supported Submission of the Instruction.

"We review a trial court's rulings regarding instructions for an abuse of discretion." Ratliff v. Commonwealth, 194 S.W.3d 258, 274 (Ky. 2006); Johnson v. Commonwealth, 134 S.W.3d 563, 569-70 (Ky. 2004). The trial court is "in the best position possible to know about the merits of the case" and its submission to the jury. Clark Equip. Co., Inc. v. Bowman, 762 S.W.2d 417, 421 (Ky. App. 1988).

Bad faith and intent are state of mind factual issues for a jury to determine. Jefferson Co. Fiscal Court v. Peerce, 132 S.W.3d 824, 831 (Ky. 2004); Hamilton Mut. Ins. Co. of Cincinnati v. Buttery, 220 S.W.3d 287, 293 (Ky. App. 2007). Reasonable inferences can support such a finding, Perry v. Motorist Mut. Ins. Co., 860 S.W.2d 762, 764-66 (Ky. 1993), and such evidence existed in this case. "Intent, where different inferences can be drawn from undisputed facts, is a question of fact and not of law." Id.

The Court should put to rest a few issues UMC confuses. Cantrall did prepare an incident report. Even Judge Wine noted, "Both parties agree that Cantrall prepared the report as instructed by her superiors and she placed it in the appropriate area for maintenance of hospital records. For unexplained reasons, the postoperative report could not be located."[118] Double speaking, UMC claims the report was not material evidence because Cantrall only would have recorded that CPR was performed, but also states she testified she

---

[117] VR, B17, 17:04.

[118] Court of Appeals Opinion 20.

would have included a chronology and her perception of events that occurred during surgery.[119] The entire case hinged upon chronology and perceptions during surgery.

Evidence not argued is not evidence lost. UMC complains Beglin's counsel failed to argue certain issues in closing argument. It is impossible to argue every piece of evidence from a month long trial in a limited closing. We rely upon juries to recall the evidence and to recall it accurately. Courts instruct jurors they are the fact-finders and arbiter of evidence, despite counsel's arguments.

UMC complains Beglin did not argue to include bad faith as an element of the instructions. That was UMC's job. All that matters is that the trial court gave UMC's instruction, which contained every word, qualifier, and option UMC requested.[120]

UMC's incident reporting policy[121] and form, as well as other fresh recollections of what occurred, the "investigation" and its own statements discussed below, present a question of intent, bad faith and incentive to destroy.

1. UMC's policies and procedures that highly protect and safeguard incident reports make it virtually impossible to lose one in good faith.

UMC's policies and procedures regarding incident reports provide in relevant part: "The information provided by the Occurrence Reporting and Investigation Report is essential in developing loss prevention measures and assessing the severity of the occurrence."[122] UMC has this policy to meet JCAHO reporting standards. Statements below indicate a UMC

---

[119] UMC Brief at 13-14.

[120] R.A. 3341, 3262; attached Exhibits M & N.

[121] See attached Exhibit I; Plaintiff's Exhibit 42.

[122] Plaintiff's Exhibit 42, attached hereto as Exhibit I.

policy to highly preserve, secure--and in some ways conceal--incident reports. The policy provides in part:

> Occurrence Report and Investigations shall be held in strict confidence and information/copies will not be shared with outsiders or unauthorized personnel. Failure to abide by this policy will subject the employee to severe disciplinary actions, including termination.
>
> Hospital personnel must not make any statements admitting fault, liability, or make an offer of settlement under any circumstances.
>
> Occurrence Reports are not to be filed with patient medical records. Also, no notation stating that an occurrence report was completed is to be made in medical records. (Emphasis original.)
>
> University of Louisville Hospital will challenge all attempts to subpoena Occurrence and/or Investigation Reports.

Among the purposes of the report are to:

> To help identify problems and potential lawsuits.
>
> ***To provide information necessary for defending the hospital's staff or physician in a lawsuit.*** (Emphasis added).

This tells the judge and jury three things: First, UMC should take great care of these Incident Reports. Second, the reports are kept secret to the point of being grounds for termination because the information on them could damage the hospital significantly. Third, a stated purpose is to provide information to assist the hospital in a lawsuit. Make no mistake, when this surgery concluded after an hour wait for blood, 12 to 18 phone calls to the blood bank, an unusual handwritten note by Dr. Lerner, a visit from Dr. Galandiuk to risk management saying "don't bill this patient and preserve all records," and comments from other doctors at the risk management office and blood bank, UMC knew a lawsuit was coming. Under their policy, one does not "accidentally" lose the incident report.[123]

---

[123] Long, VR, B16, 14:09.

2. The incident/occurrence report, admittedly prepared, should have contained critical information.

UMC's six (6) page incident report form[124] seeks important details about what happened, who was involved, why something went wrong, and what UMC can do to prevent it in the future. There are six pages with six additional pages of instructions on how to complete it.[125] Employees complete the reports. UMC is strict about it. Its contents prove materiality, prejudice and incentive to destroy.

The form seeks a "Brief *Objective* Statement Of Facts." (Emphasis added). If Barbara Cantrall provided objectivity it is understandable why UMC "lost" the report. Pages two (2) through five (5) involve a series of check boxes for different occurrences. There is a "BLOOD" section on page 2 with a box for "wrong time/delayed." At trial and still, UMC denied any delay. After 12-18 blood bank calls, (which shows UMC knew of a delay), Cantrall probably did check this box. That would sink UMC's defense.

There is a "POST ANESTHESIA CARE UNIT (PACU)" series of boxes, two of which are "excessive blood loss" and "life-threatening complication of anesthesia." Blood loss is an issue in this case. Blood stability is the responsibility of anesthesia.

THE SURGICAL OUTPATIENT/CLINIC section on page 3 has a check box for "excessive blood loss." The OPERATING ROOM section on page 3 has boxes for "excessive blood loss," "postoperative nerve damage or neurological deficit," "life-threatening complication of anesthesia." An early admission of excessive blood loss would

---

[124] Plaintiff's Exhibit 41, attached hereto as Exhibit J.

[125] Plaintiff's Exhibit 42, attached hereto as Exhibit I.

limit causation defenses. Whether neurological deficits existed were important because UMC and the doctors contested Jennifer Beglin's pain and suffering.

UMC's report form has a "GENERAL" section where it can check whether the patient/family was dissatisfied or whether the hospital employee has a "gut feeling" that a patient is litigious. Checking the "gut feeling" box would leave UMC in a very tought spot to explain why no one interviewed the central actors. Without it, UMC has claimed "we never knew we did anything wrong because no one ever told us there was a delay." If Cantrall's report reflected there was a delay, UMC loses this defense too.

Page 4 of the form bears greatly on the punitive damages ratification issues UMC raises. The "CONTRIBUTING CAUSE CODES" contain the following check boxes:

[ ] 01 Policy and procedure does not provide needed direction
[ ] 02 Policy and procedure not followed
[ ] 03 Policy and procedure not enforced
[ ] 04 Staff not educated/trained
[ ]07 Staff assignments-number or competence-not made according standards
[ ] 08 Documentation requirements not completed/illegible
[ ] 14 Initial history/assessment not completed
[ ] 17 Medical orders, test results, etc., not communicated
[ ] 20 Established protocol not followed
[ ] 21 Proper consent form not obtained
[ ] 22 Medical order not executed
[ ] 25 Care rendered/response time not acceptable to patient

Barbara Cantrall should have checked every box above. If policies and procedures failed to provide appropriate direction, were not followed, were not enforced, and the staff was not educated or trained on them, UMC bears a direct responsibility for punitive damages. Evidence at trial suggested all of these occurred, yet UMC continues to fight these issues. Checks in these boxes would constitute a fatal admission and deprive UMC of any opportunity to claim evidence of "authorization, ratification, or anticipation" did not exist.

Incentive to destroy or "lose" the occurrence report is apparent if Cantrall checked boxes on page 4 of UMC's occurrence report to indicate the following: staff assignments were insufficient or incompetent; documentation requirements were not completed (such as the blood bank order form); history of bleeding disorders and complications were ignored; the doctor's medical orders or the test results from the blood lab were not communicated; established protocol was not followed; medical orders, such as the orders for blood, were not executed; or that the rendered response time was not acceptable.

Page 6 of the occurrence report has a "CORRECTIVE ACTION CODES" section inquiring how UMC can prevent future problems. It provides boxes for the following:

A. POLICIES AND PROCEDURES
   01 Evaluation
   02 Recommend revision
   03 Change
   04 Develop
   05 Enforce

B. MONITOR/INSTRUCTION/COUNSELING
   11 Ql monitor
   12 Q1 study
   13 Inservice education
   14 Individual counseling
   15 Return demonstration
   16 Work improvement program
   17 Restrictions of duties/privileges
   18 Initiate disciplinary process

If Cantrall noted procedure problems under "CONTRIBUTING CAUSE CODES," and that policies and staff instruction needed improvement under the "CORRECTIVE ACTION CODES," UMC undeniably adopted, authorized, or ratified the conduct in question. Without it, UMC contested ratification and preserved an appellate issue.

Ethical considerations aside, UMC was better off to take its chances on the *possibility* of an appealable instruction instead of producing such decisive evidence. If this Court reverses, businesses and hospitals will have further incentive to destroy valuable yet honest evidence that hurts them.

D. Failure to Produce the Incident Report Did Prejudice Beglin.

Availability of evidence through other means does not eliminate prejudice or preclude a missing evidence instruction. Chumbler v. Commonwealth, 905 S.W.2d 488, 496-97 (Ky. 1995) approved a missing evidence instruction about footprints when a video of the crime scene was missing, despite that "photographs of the footprints were introduced and numerous witnesses testified regarding the placement of the footprints and who could have made the prints." Id. at 497.

Swofford v. Eslinger, 671 F.Supp.2d 1274 (M.D. Fla. 2009), cited by UMC, flatly rejected the argument that an offending party can use concealment of the evidence as a sword to prevent proof of prejudice: "Whether the spoliated evidence would have actually been detrimental to the case is irrelevant at this point, because no one, other than perhaps the defendants themselves, can know for certain." Id. at 1282 (citing Telectron, Inc. v. Overhead Door Corp., 116 F.R.D. 107, 133 (S.D. Fla. 1987). If Cantrall truthfully completed the incident report, the hospital's fate was sealed, especially on issues of policy and management breakdown, which bear directly upon the authorization and ratification of conduct.

UMC's statements in its Brief (primarily when claiming ignorance to escape punitive damages) show several ways an accurate incident report, made immediately following the event, would have proven valuable. UMC states at pages 9 and 10:

> 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.
>
> * * * *
>
> Testimony regarding events after 8:05 p.m. was equally conflicting.

The anesthesia log lacked important timing information. When Dr. Lerner was in the OR and gave orders and when Cantrall received the blood sample were central issues in the case.

Dr. Lerner prepared a hand-written summary the night of surgery. He knew there was problem. UMC refers to it in its Brief[126] and used it against him at trial. The incident report Cantrall prepared served the same purpose–to record events freshly. She, too, knew there had been a problem. If Lerner's handwritten summary, which was not an ordinary part of the medical record, was valuable evidence, so was Cantrall's incident report.

Trying to escape punishment, UMC claims Dr. Galandiuk never mentioned a delay getting blood until trial. UMC points to her fresh discussions with risk management the next day and her interrogatory answers early in the litigation.[127] Dr. Galandiuk's fresh recollections were important to UMC. So were Cantrall's to everyone else.

UMC's argument that evidence was available elsewhere relies upon the mistaken belief that witnesses never make contradictory statements. Critical witnesses like Cantrall do not always testify consistently, as UMC points out occurred in her deposition and at trial. Witnesses can become "tainted' with threats of litigation and the advice of counsel, which is why fresh, untainted recollections are important.

---

[126] UMC Brief at 11-12.

[127] UMC Brief at 12. In truth, Dr. Galandiuk's next day discussion with risk management did advise problems had occurred, advised the hospital not to bill Beglin (they did anyway) and told risk management to preserve all records. It is unimaginable that the hospital could receive a physician's request not to bill a patient for an expensive procedure and claim ignorance of any problem. VR, B5, 15:53:50.

UMC states "[n]either Cheng, Lerner, Okca or Galandiuk filed an occurrence report or reported to the Hospital that blood was delayed in getting to the OR."[128] UMC says Sally Long reviewed the perioperative report, anesthesia record, Dr. Lerner's handwritten report, and "[n]one 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."[129]

Double speaking, UMC argues the medical records contained everything Beglin needed to know to prove his case without the incident report, while simultaneously arguing these same medical records were insufficient to advise the hospital a problem occurred. UMC cannot have it both ways. Completion of an incident report, by its very definition, means a problem occurred. Hospital personnel observed a problem that, according to UMC, the medical records apparently did not reflect. An incident report should have been the first thing Long requested. She of all people knew one was required, and it was her duty to preserve it. If one truly did not exist, she should have requested it immediately. To say "we lost it" defies credibility and intent and bad faith become submissible issues.

UMC argues absence of the incident report did not cause Beglin's injury. Preservation, not causation is the issue. UMC and JCAHO standards required preservation. Although prepared after surgery, the report contained information about what occurred *during* surgery and why. It is fresh documentation without the taint of risk management's or counsel's involvement.

Even if evidence is available by other means, if concealed evidence impairs a party's ability to prove a claim, it is prejudicial. Beglin gained *some* of it through testimony, but

---

[128] UMC Brief at 38.

[129] UMC Brief at 38.

stories change and lawyers coach witnesses. Nothing takes the place of a *freshly recorded recollection* in document form, *made at or near the time of the event*, produced by the hospital itself and *pursuant to regular record-keeping practices*. The law deems the italicized factors so reliable that they form a basis for hearsay exceptions to ordinarily inadmissible evidence. Surely a party is prejudiced when deprived of freshly *reliable* documentary evidence. The incident report made very near the time of the surgery likely was the best, most accurate recounting of what occurred -*and why*- but we never will know. The law allows the jury to infer UMC did not want us to know.

E. The Missing Evidence Instruction Did Not Taint the Punitive Damages Verdict, and UMC Cannot Show the Jury Used It Against Them.

UMC describes the missing evidence instruction as a "nudge" or a "tilt." Missing evidence instructions are not fatal, and as issued here, do not compel the jury to take any action. A court should not reverse a judgment on instruction errors unless they affect the substantial rights of the complaining party. Ballback's Adm'r v. Boland-Maloney Lumber Co., 208 S.W.2d 940, 943 (Ky. 1948). "If the statements of law contained in the instructions are substantially correct, they will not be condemned as prejudicial unless they are calculated to mislead the jury." Id. at 652-53.

Generally, erroneous instructions are presumed prejudicial, but if no prejudice resulted, the presumption is overcome. McKinney v. Heisel, 947 S.W.2d 32, 35 (Ky. 1997). The issue here is not whether there was an error in the instruction, but rather, whether the evidence was sufficient to submit it. The cases that presume error typically involve erroneous language, not evidentiary sufficiency. The discretionary issue of evidentiary sufficiency is a hurdle UMC must, but cannot, clear before it evaluates prejudice.

1. The separate missing evidence instruction did not taint the punitive award.

Some spoliation instructions do more harm than others. Kentucky's is not a "powerful weapon" or "sledgehammer" as claimed. In Wal-Mart Stores, Inc. v. Johnson, 106 S.W.3d 718 (Tex. 2003), "[t]he instruction informed the jury that it ***must*** presume that the missing reindeer would have harmed Wal-Mart's case if the jury concluded that Wal-Mart disposed of the reindeer after it knew or should have known that they would be evidence in the case." Id. at 721 (emphasis added). It directed an inference. The instruction in Morris v. Union Pacific Railroad, 373 F.3d 896 (8th Cir. 2004) advised the jury the destruction of evidence was inappropriate. Id. at 900.[130] Kentucky's instruction tells the jury it may or may not make an inference and bears little comparison to the ones in these cases.

UMC falsely argues the missing evidence instruction was linked to the punitive damages instruction, and continuously attempts to link the two because it cannot show harm without that bridge. At one point, UMC tendered an instruction linking the two which Beglin opposed.[131] The trial court ultimately held the two were separate issues.[132] The punitive damages instruction specifically limited consideration of the grossly negligent

---

[130] The instruction read in relevant part:

... this court found in another hearing or a previous hearing that Union Pacific should not have recorded this tape pursuant to its policy but should have saved the tape because it was on notice that a serious injury had occurred and it knew there was a possibility that a lawsuit would follow the injury. Because Union Pacific destroyed the information on the tape when it should have kept the information, you may, you may, infer that there was information in the recorded communications that would have proved damaging to Union Pacific or helpful to John Morris.

[131] VR, B18, 10:29-10:30. Exhibit 8 to UMC's Brief, a portion of the trial transcript quotes Beglin's counsel as follows:

> It's that issue of spoliation separate and apart from the issue of punitive damages. It goes into the mix about whether or not this whole thing rises to the level of punitive damages. But the issue of spoliation, you can't just say spoliation, punitives and yank it all up. The spoliation issue [is]separate and apart.

[132] VR, B18, 10:18; 10:28

conduct to the time period of the surgery.[133] To say missing evidence infected the punitive award requires UMC to overcome the legal presumption that the jury followed them separately. UMC, critical of the lower courts' "egregious departures" from what it says is the law, cannot pick and choose what parts of the law apply to it.

Based upon UMC's allegations that Cantrall denied preparing a report, it is possible the jury believed Cantrall never prepared a report and took the instruction no further. Having requested no finding or interrogatories, UMC cannot leap to the belief that this instruction with multiple qualifiers cost it punitive damages as if nothing else could have.

A missing evidence instruction is not a punishment. It grants the right to draw an inference. UMC requested and received a limitation of conduct from the time blood was ordered until the conclusion of the procedure.[134] UMC admits "[b]ecause 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.'" UMC's only way around this is to ignore the presumption that juries follow instructions.

UMC cites a few short lines of Beglin's closing argument to support the claim of "taint." Taken in context, the statements are a microcosm of a lengthy list of grossly negligent conduct, and UMC never objected, which waives any complaint. See Steel Technologies, Inc. v. Congleton, 234 S.W.3d 920, 927-28 (Ky. 2007). UMC wants to tie counsel's hands from referring to the two issues simultaneously, which runs afoul of counsel's latitude in closing argument. Equitania Ins. Co. v. Slone & Garrett, P.S.C., 191

---

[133] R.A. 3251-70.

[134] See Exhibit N.

S.W.3d 552, 554-55 (Ky. 2006); Tamme v. Commonwealth, 973 S.W.2d 13 (Ky. 1998).

UMC refers to the trial court's musings when discussing instructions. The jury never heard these discussions, so they had no bearing on its verdict. The trial court specifically stated the basis for punitive damages was *not* the incident report.[135] Regardless of the trial court's thinking behind the instructions, what ultimately came before the jury was the instruction UMC tendered. UMC also makes reference to an in-chambers discussion not on the record, which is improper. CR 76.12(4)(c)(v).

2. By not requesting a jury finding, UMC fails to demonstrate prejudice that the jury used the instruction at all, much less against the hospital.

UMC cannot infer from an adverse verdict that the missing evidence instruction caused it, particularly given other harmful evidence against it and the criticisms by its own doctors.[136] In a case involving Rule 11 sanctions, Clark Equip. Co., Inc. v. Bowman, 762 S.W.2d 417, 421 (Ky. App. 1988) noted that "instead of evidence, Clark Equipment asked the trial court, and now this Court, to infer from the fact that it obtained a verdict in its favor, that Bowman's attorney necessarily failed to make a reasonable inquiry into her claim... Without evidence to support the Appellant's serious accusations, we could not possibly determine the trial court erred." Id.

As a permissive instruction that stated the jury, "may, but [was] not required" to draw an adverse inference, it is complete speculation to assume the jury utilized the instruction against UMC, and UMC requested no specific finding. Without such a request or tender of an instruction that would eliminate speculation, UMC failed to preserve the error. Sand Hill

---

[135] VR, B16, 10:32:52.

[136] See p. __ of this Brief.

Energy, Inc. v. Smith, 142 S.W.3d 153, 162-65 (Ky. 2004); Skaggs v. Assad, 712 S.W.2d 947, 950 (Ky. 1986). Even vote-trading or compromises on issues behind the closed door of a jury room is not an independent ground for reversal and is inadmissible. See Nolan v. Spears, 432 S.W.2d 425 (Ky. 1968). Only the jurors know how this matter played into the verdict, and there are no affidavits or record to indicate it had any effect.

UMC fails to show the jury gave any stronger consideration to this evidence than the other conflicting evidence. It defies justice to strip this widower and his two children of an award that a jury thoughtfully deliberated after a month long trial on the basis of a completely neutral instruction, the jury's use of which is completely unknown.

III. UMC AUTHORIZED, RATIFIED OR SHOULD HAVE ANTICIPATED THE CONDUCT IN QUESTION.

The principal-agent limitation of KRS 411.184(3), which Beglin submits is unconstitutional, uses the disjunctive, attaching punitive liability if the principal "authorized, ratified, or should have anticipated the conduct in question." UMC did not contest or argue that Cantrall did anything unauthorized. UMC ignores the "authorization" avenue to punitive damages, and in its focus on "should have anticipated,"states: "The record is undisputed that Cantrall's performance in the OR was never questioned until after Beglin filed suit."[137] UMC clearly authorized and ratified Cantrall's conduct. This should lay the issue to rest.

Horton v. Union Light and Power Co., 690 S.W.2d 382, 390 (Ky. 1985) held a principal liable for an agent of the electric company, based in part on failed policies, training and a series of mishaps. The court held as follows:

> Historically Kentucky has awarded punitive damages against the principal coextensive with the award of punitive damages against the agent. . .Here the

[137] UMC Brief at 38.

> acts of managerial employees in establishing policy and procedures and in failing to do so, in training their personnel to handle situations such as the present one . . . implicated the company as a whole in the charge of wanton or reckless disregard for the safety of others. Here liability for punitive damages is not based on a single, isolated unauthorized and unexpected act of negligence by an employee.

UMC's liability for punitive damages results not only from the acts of a single employee, but from a series of systemic failures that involved circulating nurses, blood bank employees, and a series of flawed policies and execution failure concerning when to pre-order blood, specimen labeling, and proper follow-up procedures after an incident. UMC adopted and ratified these flawed policies, failed to insure its staff followed them, and condoned departures from them.

When individual conduct is an issue, discretion of the actor is an important factor. Northeast Health Management, Inc v. Cotton, 53 S.W.3d 440 (Ky. App. 2001), a wrongful discharge case, held a hospital liable for firing an employee because the hospital gave firing discretion to the person who did it with little supervision. Id. at 449. Simpson Co. Steeplechase Assn., Inc. v. Roberts, 898 S.W.2d 523 (Ky. App. 1995), upheld a punitive damages verdict against an employer because the corporation gave the actor broad discretion and authority. Id. at 527. Both cases held the jury was free to believe or disbelieve whether the employer authorized or ratified the conduct. Simpson Co., 898 S.W.2d at 527; Northeast Health Management, 56 S.W.3d at 449; See also Kroger Co. v. Willgruber, 920 S.W.2d 61, 68 (Ky. 1996). Under the "authorized" provision UMC ignores, Cantrall's acts of doing her job fall so squarely within this law, the jury should not have had to decide the issue.

Barbara Cantrall was the only circulating nurse working the OR during the relevant time. UMC gave her complete discretion and "authorization" to run the OR during Beglin's

case. She had no direct supervision. Her supervisor, Elaine Strong, did come into the case when Cantrall requested a restroom break just before Beglin coded; however, Strong gave no indication that she disapproved of anything Cantrall had done.

From the moment Strong came into the operating suite, she had a sense Beglin was in trouble and the anesthesia team seemed very concerned. She heard numerous phone calls to the blood bank; she heard the anesthesiologist asking for blood numerous times; she heard the phone calls for blood. She was aware that UMC could have emergency release blood to an operating room in as little as five minutes. She saw members of the operating team literally squeeze blood into Beglin's body. They were applying manual pressure, and at that point, she was aware anesthesia had been waiting on blood for at least 30 minutes. She developed an impression the OR team was desperate for blood. She even heard people talking about the case the following days.[138]

In spite of all this, this *manager* never saw the incident report *that she requested*, and apparently was not concerned enough to inquire. She never expressed concern that a code sheet was not completed. She was aware of and observed many of these multiple, critical lapses. She took no corrective action or follow-up and made no investigation. This *manager* authorized or ratified Cantrall's conduct and the conduct of the blood bank employees.

The vice president's "investigation" omitted critical witnesses from the fact-finding. The jury was entitled to conclude UMC's failure to acknowledge that *any* complication occurred, constituted authorization and ratification. These are not trial defenses. UMC cites Manning v. Twin Falls Clinic & Hosp., Inc., 830 P.2d 1185 (Idaho 1992) which held a hospital's failure to punish an employee, "*standing alone*" was insufficient to support

---

[138] Strong, VR, B11, 16:23:45–16:27:05.

ratification. Id. at 1194. UMC's failure to punish not does stand alone. UMC displayed managerial, administrative acceptance and affirmation of prior events.

UMC claims defending lawsuits "would entitle every plaintiff to a punitive damage instruction in every case . . . . The cost of defending a suit is an automatic award of punitive damages." Patterson v. Tommy Blair, Inc., 265 S.W.3d 241 (Ky. App. 2008), cited by UMC, shows otherwise. Tommy Blair defended the claim, and it did not result in an "automatic" award of punitive damages. Tommy Blair, Jr. repossessed a car by shooting out the tires. Id. at 243. At issue was whether Blair, Sr., authorized, ratified or should have anticipated the conduct. The court noted Blair, Jr. was authorized to repossess cars, but was not authorized to do it by shooting out their tires. Id. at 244-45. The court did not hold Blair, Sr.'s failure to reprimand Blair, Jr., as a ratification, but noted that Blair, Sr. indicated some wrongdoing or deviation by Blair, Jr. from the scope of his employment.

A "pattern practice" of conduct is not required to impose liability on a principal for punitive damages. In Tommy Blair, for example, had Blair, Jr. been authorized to shoot tires during repossession, whether he had done it before would make no difference. Here, UMC never contested authority or scope of employment.

The presumed purpose behind 411.184(3) is to avoid punishment of a principal for the acts of a rogue employee that exceed the scope of employment. Cantrall was not a rogue employee who abandoned her job duties. UMC's complete silence on this disputed factual issue is not the equivalent of defending a lawsuit. The jury's belief that her actions or UMC's flawed policies reached a degree of recklessness higher than negligence does not change the fact that she was authorized to act as she did. If UMC disputed Cantrall's authority, it should have addressed that factual question in some fashion.

UMC's citation of Kentucky Farm Bur. Mut. Ins. Co. v. Troxell, 959 S.W.2d 82, 85-86 (Ky. 1998) is misleading. UMC cites it for the proposition that pattern conduct is a required element of proof "central to satisfying the criteria contained in KRS 411.184 (3)."[139] Troxell simply held evidence of the KFB adjustor's involvement in prior litigation was relevant to show KFB "had knowledge of a pattern of conduct practiced by its agent." Troxell, 959 S.W.2d at 86. The issue was relevance, not requisite proof.

BLANK PAGE

BLANK PAGE

BLANK PAGE

BLANK PAGE

V. THE PUNITIVE DAMAGES INSTRUCTION AND AWARD DO NOT VIOLATE DUE PROCESS.

The court of appeals concluded the punitive damages were not excessive, and dissenting Judge Wine agreed.[145] The applicable punitive standard is "gross negligence," meaning a willful, wanton, **or reckless** disregard for the lives and safety of others. Williams v. Wilson, 972 S.W.2d 260, 263-64 (Ky. 1998.; Thomas v. Greenview Hospital, 127 S.W.2d 663 (Ky. App. 2004).

"A reviewing court cannot substitute its judgment for that of the trial judge unless the trial judge is clearly erroneous." Bierman v. Klapheke, 967 S.W.2d 16, 18-19 (Ky. 1998). "The more judges take cases away from juries, the more the concepts of reasonable conduct, negligence and gross negligence become synonymous with the view of the judge or judges on the court. . .The conscience of the community speaks through the verdict of the jury, not the judge's view of the evidence." Horton, 690 S.W.2d at 385.

UMC does not contest whether the evidence supported a punitive damages award in this Court. (It did at the court of appeals). It only claims the award was excessive. Because the Court will evaluate the evidence to determine excessiveness, Beglin refers the Court to evidence that supports a finding of recklessness.[146]

---

[145] Court of Appeals Opinion at 15-16, 25.

[146] The following evidence supports a finding of recklessness, at a minimum:

1. Jennifer's blood sample was drawn between 7:30 and 7:40 p.m., but was not sent to the blood bank until 8:05 p.m. It was reckless to allow a vital blood sample to lay around the operating room so long when all OR blood requests are to be processed STAT.
2. UMC blood bank employees received between 12 and 18 phone calls from Nurse Cantrall during a 45-60 minute period before they released blood. The hospital held both ends of the phone during this critical time, but could not manage to get the blood one floor away.
3. *UMC expert* Linda Timmons testified that if time expectations change, Cantrall had a duty to tell the doctors about the delay and when to expect the blood.
4. Dr. Lerner and Dr. Galandiuk ordered emergency release blood (universal donor blood) at 8:25 p.m. after attempts to obtain matched blood for Jennifer Beglin failed. Emergency release blood should arrive in the OR in five or ten minutes max. It did not arrive until after 8:50 p.m., despite

State courts have wide latitude and "considerable flexibility" to allow punitive damages as a deterrent. BMW of North America, Inc. v. Gore, 517 U.S. 559, 568 (1996); TXO Production Corp. v. Alliance Resources, Corp., 509 U.S. 443, 456 (1993); Pacific Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 21 (1991). UMC claims the award is arbitrary, but before this Court can evaluate arbitrariness under due process standards, it must find the punitive award "grossly excessive." Id.

---

consistently falling hemoglobin and hematocrit readings and multiple phone calls to the UMC blood bank expressing an emergency in the OR..

5. UMC failed to follow its own policies regarding blood ordering. Blood is life-saving treatment at a Level One Trauma Center, and failure to follow the established policies is reckless by its very nature. UMC's transfusion policy requires blood orders to note the "time needed" and "where" needed. Jennifer Beglin's order form said the blood was needed in "endoscopy" at 20:20 (8:20 p.m.). The blood bank was on notice that blood was needed at 8:20 p.m. After more than a dozen urgent calls, emergency release blood finally arrived after 8:50, and the physicians futilely squeezed it by hand into Jennifer Beglin.

6. When questioned about these policies, the hospital claimed it did not use the "when" field on the forms, and that the "time needed" field only applied to routine floor orders. The blood bank supervisor, however, admitted UMC does not record the "time needed" for routine orders either because they have no control over that computer field. UMC failed to follow its own policies, properly complete its own forms, or supply the necessary forms comply with its policies.

7. The triplicate blood order forms in Jennifer Beglin's case were completed, but destroyed, despite testimony that they should have been in her chart and kept for a year. The destruction violates the American Association of Blood Banks' standards on record retention, which UMC adopted. UMC claimed its computer charting contains the information from the triplicate order form, and the triplicate order forms are destroyed because someone copies the same information into the computer. Not true. UMC employees testified they cannot type in the "when" field in the computer system; it is not accessible to them. The triplicates have a section to note "when" blood is needed. The computer logging system does not. Knowing when the OR needed the blood was a critical issue in this case. To ignore that critical fact in the computer logging system, and meanwhile throw away the forms that *should* contain the information, is reckless, wanton, willful, and directly adopted and authorized by UMC.

8. Hospital Risk Management knew about this incident the following day. Anesthesiologist Dr. Acka went to the blood bank the next morning to inquire about the time expectations for arrival of blood at UMC. Dr. Galandiuk told risk management what occurred and asked them not to bill Beglin. She told them to preserve important records and documentation. Nurse Cantrall filled out an incident report and placed it in the proper bin. UMC claimed it investigated to find out what occurred, but failed to interview the doctors, nurses, runners, blood bank employees or even Cantrall.

9. Barbara Cantrall, who made 12 to 18 *frantic* phone calls, who repeatedly was asked by Dr. Lerner about the blood, and who told the runner to "run," excused herself to the restroom while the surgical team awaited the *emergency release blood* to save Jennifer's life. She completely missed the code and arrival of the blood! One must wonder whether she indeed went to the restroom, went to recompose having realized what just occurred, or went to the next floor to get the blood herself.

10. Aside from Cantrall being authorized to do everything she did in the OR, the policy failures described above emanate directly from management and constitute total ratification. The policy lapses, they reveal problems UMC "should have anticipated."

State Farm Mut. Auto Ins. Co. v. Campbell, 538 U.S. 408 (2003) considered as excessiveness factors whether the harm caused was physical as opposed to economic; whether the conduct showed indifference or reckless disregard to health and safety; whether the target of the conduct had financial vulnerability; whether the conduct involved repeated actions or was isolated, and; whether the harm was accidental or the result of intentional malice trickery or deceit. Campbell, 538 U.S. at 419. Campbell held the "reprehensibility" factor most important. Id.

The punitive damages against UMC were a *fraction* of the compensatory damages. The Supreme Court has refused to articulate a "bright line" multiplier for excessiveness, but has held that "single digit multipliers are more likely to comport with due process." Id. at 582. Steel Technologies, Inc. v. Congleton, 234 S.W.3d 920, 927-28 (Ky. 2007) acknowledged that Constitutional punitive damage limits may fall somewhere in the range between a 4 or 9 to 1 ratio. Id. at 932. This Court noted punitive damages were 1.5 the amount of the Estate's damages and approximately 3/8 of the amount of all compensatory damages to the Estate and children. This Court stated "[b]oth these ratios are significantly lower than those found to be inappropriate by the Supreme Court." Id. at 932. "While the degree of reprehensibility in this case may not even approach the conceivable maximum, it is balanced by the fact that the ratios of punitive damages to compensatory damages and to civil fines are significantly lower than those in the Supreme Court's jurisprudence. In light of this, the punitive damages in this case were not excessive or exorbitant and therefore survive the Due Process challenge." Id.

These "multipliers" are recurrent discourse in due process arguments, but UMC fails to mention that the multiplier in this case is .7, and for good reason. Permissible multipliers

under the law above would uphold punitive damages ranging from about $21.2 million (4x) to $47.7 million (9x). Furthermore, in this case KRS 411.184 and KRS 411.186 provide due process safeguards and guide the jury.

If a court determines an award excessive, the due process analysis focuses upon three "guideposts": 1) the reprehensibility of the conduct; 2) the ratio of punitive damages to compensatory damages; and 3) a comparison of criminal or civil penalties for similar misconduct. Gore, 517 U.S. at 575-583.

Jennifer Beglin bled into a coma and died. The catalog of facts outlined in the footnote above evinces a reckless disregard for her health and safety. Her death was not the result of isolated conduct. A series of reckless mistakes occurred, one compounding another. Internal policies were aborted. Nurses and blood bank technicians failed to communicate. Blood that was minutes away failed to get to an operating room, despite repeated requests by physicians who never were told the blood would be slow to arrive. When an inexcusable death occurred, the "investigation" headed by a hospital vice president failed to ask the attending surgeon, any of the three attending anesthesiologists, its own circulating nurse who bore most responsibility for what occurred, or the runner who delivered the blood, what happened. The incident report prepared by the central nurse at issue disappeared.

UMC cites Honda Motor Company Limited v. Oberg, 512 U.S. 415, 432 (1994), arguing that Oregon adopted a new procedure and that adopting new procedures offends due process. The offensive "new procedure" was Oregon's rescission of appellate review of excessive damages. Id. at 426-27, 432. UMC's contention that Oberg stands for the proposition that "new procedures" akin to missing evidence instructions and ratification (which are not new procedures at all) violate due process is a questionable misuse of Oberg.

If the procedure of holding an instructions hearing and determining there is sufficient evidence to submit an instruction offends due process, then all instruction hearings fall short. There was nothing new under the sun here. That is what has happened in all Kentucky missing evidence cases.

VI. THE COURT SHOULD AFFIRM COMPENSATORY DAMAGES.

UMC has not questioned the compensatory damages award here or below. It complains the missing evidence instruction infected the punitive verdict because it made the jury "mad." Compensatory damages awarded were a fraction of what Beglin sought, and the jury awarded "0" for pain and suffering. Incidentally, "mad" juries do not award "0" for pain and suffering. Deliberate juries perhaps do. Beglin seeks affirmation. If the Court disagrees, punitive damages should be the only issue on any retrial see Deutsch v. Shein, 597 S.W.2d 141, 146 (Ky. 1980); Nolan v. Spears, 432 S.W.2d 425 (Ky. 1968).

VII. THE ARGUMENTS OF THE AMICI ARE IMPLAUSIBLE AND SEEK TO ABANDON LEGAL SAFEGUARDS FOR ALL LITIGANTS.

The Amici seek to abandon entrenched "middle ground" legal remedies for losing evidence. They claim the trial court abandoned Kentucky law, drastically changed the legal landscape of missing evidence, and henceforth all cases will focus on missing documents and nothing else. The claim is false and absurd.

A. Kentucky Hospital Association

KHA claims the trial court did not err in judgment, but failed to exercise any at all.[147] Not true. As stated above, Judge Clayton refused to include the missing code sheet and blood triplicate forms in the instruction because UMC explained their absence. There was

[147] KHA Brief at 1.

no explanation for the missing evidence instruction, so she properly let the jury decide.

Hospitals will not feel the consequences of the court of appeal's opinion more than others if they plausibly can explain why critical evidence and important documents disappear. UMC's problem was that it required a detailed report, mandated that personnel guard and secure it, completed one in this case, and failed to produce it or recreate one when risk management was investigating the very next day, without any explanation whatsoever.

In Kentucky, missing evidence instructions are not punitive; they are remedial. Monsanto, 950 S.W.2d at 815. This Court has rejected instructions compelling a jury to *assume* the evidence is adverse and instead stated the jury may or may not draw an adverse inference. Johnson, 892 S.W.2d at 561. With the freedom to do nothing, they arguably are not even a "nudge" or a "tilt."

KHA falsely states a missing evidence instruction "notifies the jury that a party has acted in bad faith" and "informs the jury that a party has violated the most valuable commodity in a trial–evidence."[148] One must wonder whether KHA's counsel read the instruction. The instruction does not notify the jury UMC acted in bad faith. It presents that consideration to the jury. It does not "inform" the jury that a party violated evidence, but presents the issue for the jury's consideration.

KHA seems to complain that missing evidence instructions allow the jury to weigh evidence that does not exist. While not exactly true, to some degree that is the purpose of the missing evidence instruction. The adversely affected party would prefer the evidence. Its preservation rests within the offending party's exclusive control. To abolish this valuable remedy licenses and encourages parties to destroy harmful evidence without any risk of

[148] KHA Brief at 5.

penalty. If the Court accepts KHA's plea, hospitals will rarely, if ever, produce truthful, adverse incident reports again. They will "lose" them.

KHA's worries about ratification in the court of appeals' opinion are unfounded. That court simply found sufficient evidence to support the "authorization" finding to award punitive damages. If KHA is confused about investigations, it should learn from this case that an adequate investigation at least interviews the central actors.

B. Kentucky Chamber of Commerce

KCC's argument loses credibility in its first paragraph wherein it describes this .7 ratio punitive damages verdict as a "runaway" verdict. The Chamber expresses concern that the court of appeals "has expanded Kentucky tort law in a manner that unfairly permits verdicts based on speculation rather than fact."[149] There is no "expansion" of tort law. The court of appeals' opinion in Monsanto that created a spoliation tort was an expansion of tort law. All the court of appeals did in this case is determine that the trial court did not abuse her discretion in finding sufficient evidence to submit an instruction, and that the permissive nature of the instruction failed to prove the jury used it against UMC at all.

The Chamber claims by giving an instruction on missing evidence, "the judge, wrapped in the aura of black robes, high on the bench and esteemed by everyone in the courtroom-raises doubt about a party's honesty."[150] If this is true, then the judge who instructs on punitive damages believes the jury should be punished. The judge who instructs on a breach of the medical standard of care believes the offending party breached it. Judges, and especially parties, make clear at trial that juries decide the facts.

---

[149] Chamber Brief at 2.

[150] Chamber Brief at 7.

If spoliation instructions were the targets these parties allege, more cases about them would exist. Few civil cases involve missing evidence instructions. Hospitals and businesses do keep many documents, and when they potentially become evidence most preserve and produce the documents or give some explanation why they cannot. When critical documents disappear that a party is required to preserve by regulation and its own policy, there *must* be a remedy. The jury is entitled to weigh in. To eliminate that remedy by imposing unattainable burdens will result in evils of fraud and destruction that a missing evidence instruction does not even approach.

VIII. BEGLIN'S ISSUES ON CROSS-APPEAL

Beglin's first request is for the Court to affirm the trial court's judgment. If reversed, Beglin appeals the following: 1) Denial of Beglin's Motion to Compel evidence concerning the Sentinel Event and Root Cause Analysis reports filed with the Joint Commission on Accreditation; 2) removal of the language "lost enjoyment of life" from the jury instructions pertaining to pain and suffering; 3) exclusion of evidence of UMC's committee minutes and policy changes regarding blood pre-scheduling; and, 4) exclusion of Dr. Robert Shirley's original discharge summary that UMC removed from Beglin's medical record.[151]

A. Trial Court's Ruling that the Root Cause Analysis was not Discoverable.

Beglin preserved this issue by filing discovery requests for any sentinel event report, root cause analysis, and a motion to compel production of the same.[152] The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to perform a root cause analysis whenever a sentinel event occurs. JCAHO defines a sentinel

---

[151] Beglin preserved this issue at pages 3141-3152 of the record.

[152] R.A. 191-97.

event as "an unexpected outcome causing injury or death to a patient." UMC admitted it filed a sentinel event report with JCAHO, and performed a root cause analysis, but refused to produce them, claiming privilege. The trial court agreed.[153] Later in the litigation, UMC could not produce the incident report. Beglin moved the trial court to reconsider its ruling based in part upon UMC's inability to produce an incident report.[154]

Kentucky affords discovery rules very liberal treatment. Volvo Car Corp. v. Hopkins, 860 S.W.2d 777 (Ky. 1993), and privileges are strictly construed and disfavored. Sisters of Charity Heath Systems, Inc. v. Raikes, 984 S.W.2d 464 (Ky. 1999). Courts disfavor broad claims of privilege because they contravene the principle that "the ... public has a right to every man's evidence." Meenach v. General Motors Corp., 891 S.W.2d 398, 402 (Ky. 1995); Haney v. Yates, 40 S.W.3d 352 (Ky. 2000). More particularly in medical malpractice cases, Nazereth Literary and Benev. Inst. v. Stephenson, 503 S.W. 2d 177 (Ky. 1973), stated "claims of privilege are carefully scrutinized, and impediments to the discovery of truth are afforded validity in relatively few instances. Id. at 179. Nazareth rejected protecting internal hospital reports. In fact, Beglin asked the trial court to note that in another medical malpractice case with the very same trial judge, Hon. Denise Clayton, the root cause analysis had been produced and considered.[155] McFall v. Peace, Inc., 15 S.W.3d 724 (Ky. 2000) reversed a court for trying a medical negligence case when an incident report was withheld.

To support a claim of privilege, a party must show the documents contained some mental thoughts or impressions of the attorney or party. TARC v. Vinson, 703 S.W.2d 482,

---

[153] R.A. 219, 244; attached Exhibit A.

[154] R.A. 220-27.

[155] R.A. 191-97; Artemecia Brooks v. Ten Broek Dupont, Inc., Case No 01-CI -06581 (Jefferson Circuit Court, Div. 5).

486 (Ky. App. 1985). One can overcome the privilege by showing substantial need of the material and an inability to obtain it elsewhere without undue hardship. Id. at 486. Disclosure to a third party waives the privilege. Id. at 486.

The withheld documents were not privileged because they were not prepared in anticipation of litigation. UMC prepared the sentinel event report and root cause analysis because JCAHO accreditation guidelines required them to. UMC provided the documents to JCAHO, a third party organization to whom UMC voluntarily belongs. Disclosure to this third party destroys the privilege.

Discoverability is not admissibility. Case law strongly disfavors hiding information, and when other important documents like occurrence reports, code sheets, and blood order forms do not exist or come up "missing," if there is any privilege, Beglin overcame it by showing his need for the information. UMC failed to complete or "lost" the incident report and other documents it would have had to provide Beglin, but conveniently maintained what it had to provide its accrediting organization. The Court should not approve.

B. "Lost Enjoyment of Life" Is an Element of Pain And Suffering.

Beglin preserved this issue for appeal in his proposed instructions,[156] during the argument over the instructions, and by objecting when the trial court instructed the jury to draw a line through that element of the pain and suffering instruction *while the trial judge was reading them to the jury* immediately before closing.[157]

Westfield Ins. Co. v. Hunt, 897 S.W.2d 604 (Ky. App. 1995) holds a party "may properly introduce evidence of loss of enjoyment of life for the jury's consideration as it

---

[156] R.A. 3327.

[157] VR, B18, 12:57:40–13:04:15.

relates to pain and suffering. However, there can be no separate instruction as to loss of enjoyment of life." Id. at 609. Gossage v. Roberts, 904 S.W.2d 246 (Ky. App. 1995) reversed and remanded a case because the trial court did not provide an opportunity for the jury to consider lost enjoyment of life as part of a pain and suffering claim. Id. at 250. Lost enjoyment of life is a compensable part of a pain and suffering claim.

The trial judge misinterpreted clear law on this issue. Instructing the jury to draw a line through that part of the instructions while they were in the jury's hands placed undue influence upon the erroneous ruling.

C. Exclusion of Adoption of Policy Concerning Pre-scheduling of Blood.

Beglin preserved this issue in his response to UMC's motion in limine to exclude the evidence.[158] Beglin criticized the failure of UMC nurses and staff to take note of Jennifer Beglin's history of bleeding (at its very own facility) and their failure to inquire of the anesthesiologist and surgeon whether UMC should preschedule blood and have it available for this belly surgery.[159] Before Jennifer bled into a coma, UMC did not have a policy to delineate approved circumstances for the prescheduling of blood.

In the wake of Beglin's tragic outcome and the chatter it generated throughout the medical community, UMC adopted a Maximum Surgical Blood Ordering Schedule (MSBOS), which included surgeries like Beglin's.[160] Beglin sought to introduce UMC's relatively new MSBOS policies and minutes from the UMC Transfusion/Blood Utilization Committee Meetings where there were heated discussions over the issue. The trial court

---

[158] R.A. 2791-96.

[159] Pollock, VR, B8, 10:54:30.

[160] R.A. 1965-75.

excluded both as subsequent remedial measures.[161] KRE 407 excepts from exclusion of subsequent remedial measures evidence offered to prove control, feasibility, or impeachment, which apply in this case.

When parties dispute who has control or authority to make decisions in a particular circumstance, measures taken after the fact that illustrate an ability to control are admissible exceptions. Phelps v. Louisville Water Co., 103 S.W.3d 46 (Ky. 2003). UMC blamed any failure to order prescheduled blood on the physicians. Only physicians can give orders, and it was not within UMC's control, they claimed. The MSBOS policy proves the opposite. In the wake of Jennifer's tragedy, UMC's MSBOS policy allowed prescheduled blood for surgeries like Beglin's. If prescheduling blood is something only a doctor can control, then why did UMC implement a policy concerning the issue? UMC *did* have some control over the prescheduling of blood. It does have policies that assist and guide doctors in decision-making and advise doctors it is acceptable to preschedule blood for procedures like Beglin's. As much as UMC blamed the physicians at trial, this improperly excluded evidence certainly had a bearing on what UMC could have prevented.

Equally compelling is the feasibility/impeachment exception. Davenport v. Ephraim McDowell Memorial Hosp., Inc., 769 S.W.2d 56 (Ky. App. 1988) held a hospital's changed policy to begin using heart monitor alarms was admissible because the hospital had claimed that such alarms were unnecessary, useless and unreliable. Its implementation of the alarms after the plaintiff's injury refuted that claim. Similarly, UMC claimed it had no reason to preschedule blood for Jennifer Beglin for the kind of surgery she had. The trial court should have allowed Beglin to refute UMC's claim that prescheduled blood was not warranted for

[161] R.A. 3121-24, attached Exhibit B.

Beglin with the newly adopted policy showing that it is now. The committee minutes and new policies further showed prescheduling blood for procedures like Beglins was feasible.

D. Exclusion of Original Discharge Summary that UMC replaced in Beglin's Medical Record.

Unusually, Beglin's chart contained two discharge summaries. Dr. Robert Shirley dictated the original discharge summary, which contained repeated references that Jennifer Beglin was "under-resuscitated" with blood.[162] *After* Beglin filed suit, UMC *removed* Jennifer Beglin's discharge summary from her medical record and replaced it with one dictated six months later by Dr. Susan Galandiuk. The original discharge summary belonged to Jennifer Beglin, see KRS 422.317, and was relevant. UMC altered Beglin's medical record by removing this document that plainly indicated a problem. Its removal from an official medical record was unconscionable, and the jury should have considered it. It was relevant to assess UMC's credibility and to impeach UMC's claimed ignorance of the significance of what went wrong during Beglin's surgery.

CONCLUSION

Appellee/Cross Appellant Beglin asks this Court to affirm the trial court in total, and if not, to affirm the compensatory damages verdict and to reverse the trial court's decisions on the issues he raises in his cross-appeal.

Respectfully submitted,

F. THOMAS CONWAY
1800 Kentucky Home Life Bldg.
239 South Fifth Street
Louisville, Kentucky 40202
(502) 583-4433

CHADWICK N. GARDNER
1916 Kentucky Home Life Bldg.
239 South Fifth Street
Louisville, Kentucky 40202
(502) 583-2423

[162] Deposition of Robert Shirley, M.D., Exhibit 1, attached as Exhibit S.