RENDERED: DECEMBER 24, 2014; 10:00 A.M.
NOT TO BE PUBLISHED

Commonwealth of Kentucky

Court of Appeals

NO. 2013-CA-000877-MR

LARRY MARTIN AND CATHY MARTIN — APPELLANTS

v.

APPEAL FROM GREENUP CIRCUIT COURT
HONORABLE GEORGE DAVIS, JUDGE
ACTION NO. 12-CI-00167

OUR LADY OF BELLEFONTE
HOSPITAL, INC. — APPELLEE

OPINION
AFFIRMING

** ** ** ** **

BEFORE: JONES, STUMBO AND THOMPSON, JUDGES.

THOMPSON, JUDGE: Larry Martin and Cathy Martin (collectively Martin) appeal from the orders granting summary judgment to Our Lady of Bellefonte Hospital, Inc. (the hospital) and denying Martin's motion to alter, amend or vacate.

In September 2011, Larry was admitted to the hospital for evaluation and treatment for right hip pain. His treatment included narcotic pain medication.

While in his hospital room, Larry got out of his hospital bed, walked to the bathroom and fell while holding onto the bathroom door handle. The door closed on his finger, resulting in a severe injury necessitating a partial medical amputation of the digit.

In March 2012, Larry filed a complaint against the hospital. In August 2012, he amended the complaint to add Cathy's loss of consortium claim. Martin argued the hospital identified Larry as having a high risk of falling due to his medical condition and prescribed medications, and was negligent by failing "to meet the requisite standard of care imposed upon reasonably competent physicians, nurses, and other hospital agents and employees involved in medical care, treatment and diagnosis of [Larry]" by not raising his lower bed rails[1] and providing appropriate protections to prevent his injury.

Discovery commenced. In June 2012, Martin timely answered interrogatories and responded to requests for production. Pursuant to a scheduling order entered on August 29, 2012, Martin was obligated to identify all expert witnesses he intended to call at trial by December 21, 2012. In his answers to interrogatories, Martin identified Larry's treating doctors as potential expert witnesses as to the cause of his medical conditions. However, Martin did not supplement his answers or otherwise name any expert witnesses he intended to call to establish the requisite standard of care the hospital owed Larry.

[1] Two of Larry's treating nurses, Deanna Mabry and Veronica Hatfield, testified at their depositions that the top rails were raised on Larry's bed and on all patient beds as a matter of standard safety protocol. Hatfield testified doctor's orders were required before staff members were permitted to raise a patient's lower bed rails.

The hospital repeatedly requested Martin identify any experts he planned to call to testify as to the hospital's standard of care. Martin's counsel indicated in discussions with opposing counsel that he did not intend to identify an expert to address any standard of care issues because this was a slip and fall case, not a medical negligence case. However, in February 2012, Martin ultimately stated that if expert witness testimony were required to establish the standard of care relative to the hospital's fall prevention plan, he would call Jennifer Moore, a nurse and the hospital's administrator of the plan, to testify as an expert. The hospital vigorously contested that the identification of Moore would satisfy Martin's burden because Martin had not contacted Moore and had no reason to believe she was willing to testify for him or would provide favorable expert testimony.

On March 1, 2013, the hospital filed a motion for summary judgment arguing Martin's failure to identify any expert to testify as to the requisite medical standard of care prevented him from presenting a *prima facie* case of medical malpractice and required dismissal of the action. The hospital attached the letters opposing counsel exchanged regarding the need for an expert.

Martin's response stated he appropriately identified Larry's treating physicians to show medical causation and intended to call Moore to testify as to the contents of the fall prevention plan as the standard of care and her opinion regarding what constitutes a violation of this plan. Martin argued fact witnesses could testify as to whether the necessary preventative steps indicated by the fall

prevention plan were followed and Moore could be expected to testify failure to follow the plan violated the standard of care. Martin summarized his argument as follows: "In short, the Plaintiff has provided expert testimony with regards to medical causation, and expert testimony and disclosures with regards to standard of care, which is all that the Plaintiffs are required to do."

It is unclear what steps the fall prevention plan mandated because it is not part of the record on appeal. Additionally, Martin did not provide any fact witness evidence to establish that the hospital failed to follow its fall prevention plan.

The only evidence about the fall prevention plan was the deposition testimony of two of Larry's treating nurses, Deanna Mabry and Veronica Hatfield. Their testimony did not establish any violation of the hospital's fall prevention plan in the care Larry received. The nurses testified hospital employees followed the hospital's fall prevention plan by evaluating Larry's fall risk upon admission and designating him as a fall risk. The hospital then complied with its fall prevention plan by indicating Larry's status as a fall risk by tagging him with a yellow wrist band, tagging his room door with a yellow star and outfitting him with non-slip yellow socks with grips on the bottom. Mabry and Hatfield testified Larry's top bed rails were raised as standard hospital protocol for patient safety. They testified they complied with the hospital's fall risk protocol by reassessing Larry's fall risk at the beginning of each shift, ensuring that he continued to wear the appropriate socks, informing Larry to call for assistance in getting up and

making sure his call button was within reach. The nurses testified there were no indications Larry's fall risk had increased or that additional preventative steps were needed to prevent him from falling before the accident occurred. Nurse Hatfield testified Larry's bottom bedrails could not be raised as a precautionary measure without a physician's order because such a step was considered a restraint.

At the motion hearing, the trial court asked Martin whether this was a slip and fall case versus one that required an expert. Martin responded he believed he could establish the standard of care through Moore and he had not previously hired an expert because it was prohibitively expensive. If the court determined his proof was insufficient, he requested an unspecified, prolonged period of additional time to obtain the money to hire an expert, arguing the hospital would suffer no prejudice by the delay. The trial court took the matter under advisement and then issued a written order granting the motion for summary judgment.

Martin filed a motion to alter, amend or vacate, arguing he had identified an appropriately qualified expert to testify as to a violation of the standard of care or, alternatively, the court should grant his motion for an extension of time. The trial court denied Martin's motion to alter, amend or vacate. This appeal followed.

Martin argues: (1) this is an ordinary negligence case which does not require an expert witness; (2) the trial court erred by failing to make a determination that an expert witness was necessary; (3) Martin appropriately identified an expert who could testify as to the standard of care; (4) the trial court

erred by using summary judgment to penalize him rather than apply sanctions; (5) the trial court erred in failing to grant him an extension of time to retain an expert; and (6) the trial court erred by granting summary judgment without making any findings of fact.

Summary judgment should be granted "if the pleadings, depositions, answers to interrogatories, stipulations, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." CR 56.03. "The standard of review on appeal of a summary judgment is whether the trial court correctly found that there were no genuine issues as to any material fact and that the moving party was entitled to judgment as a matter of law." *Scifres v. Kraft*, 916 S.W.2d 779, 781 (Ky.App. 1996). A summary judgment "should only be used 'to terminate litigation when, as a matter of law, it appears that it would be impossible for the respondent to produce evidence at the trial warranting a judgment in his favor and against the movant.'" *Steelvest, Inc. v. Scansteel Serv. Ctr., Inc*., 807 S.W.2d 476, 483 (Ky. 1991) (quoting *Paintsville Hospital Co. v. Rose*, 683 S.W.2d 255, 256 (Ky. 1985)).

In Kentucky, ordinary negligence cases can be established without expert testimony. *See Caniff v. CSX Transp., Inc.*, 438 S.W.3d 368, 375 (Ky. 2014). Accordingly, if this is an ordinary negligence case, the trial court erred by granting summary judgment to the hospital on the basis that Martin failed to establish a *prima facie* case.

Conversely, if this is a medical malpractice case, the plaintiff would normally be "required to put forth expert medical testimony to establish the applicable standard of care, any breach that occurred and any resulting injury to the plaintiff." *Blankenship v. Collier*, 302 S.W.3d 665, 667 (Ky. 2010). However, expert testimony is not required in a medical negligence case where "the application of the *res ipsa loquitor* doctrine . . . permit[s] the inference of negligence[.]" *Andrew v. Begley*, 203 S.W.3d 165, 170 (Ky.App. 2006). Under *res ipsa loquitor*, expert testimony is not necessary to establish a standard of care and breach of that standard where "the medical evidence of record established that this type of injury was not an ordinary risk . . . , that the method by which it occurred was within the exclusive control of the defendant, and that the injury was not due to any voluntary action or contribution on the part of the plaintiff." *Perkins v. Hausladen*, 828 S.W.2d 652, 655 (Ky. 1992).

While it may be unclear in some cases whether a claim against a hospital or medical practitioners sounds in medical malpractice or ordinary negligence, this distinction is not important when deciding whether expert testimony is needed to establish a *prima facie* case, as the Court in *Jewish Hosp. Ass'n of Louisville, Ky. v. Lewis*, 442 S.W.2d 299, 300 (Ky. 1969), explained:

> In our opinion it is really immaterial whether this be treated as a medical malpractice case or one of lay negligence; in either case the question is whether the nature of the event and its consequences are within the scope of common knowledge and experience of laymen to such an extent as to warrant laymen's drawing an inference of negligence from the facts. If so, res ipsa

> loquitur can be applied, whether it be a medical malpractice case, *Jarboe v. Harting*, Ky., 397 S.W.2d 775, or one of negligence of a lay employee of a hospital, *Quillen v. Skaggs*, 233 Ky. 171, 25 S.W.2d 33.

The following can be gleaned from Kentucky cases and our sister courts as to whether expert testimony is required to establish a *prima facie* case in a hospital fall case. Whether expert testimony is required depends upon whether hospital personnel must exercise professional judgment to prevent a fall by determining which specialized measures tailored to a specific patient's condition need to be implemented or whether they are merely implementing standard care or specialized individual care per doctor's orders. However, if the need to take measures beyond standard care or ordered care is obvious, based on the extreme vulnerability of the patient or previous conduct of the patient, expert testimony is not needed to establish that staff members were negligent by not taking reasonable actions to protect the patient.

Expert testimony is not needed to establish the standard of nonmedical, administrative, ministerial or routine care. *McGraw v. St. Joseph's Hosp*., 200 W.V. 114, 121, 488 S.E.2d 389, 396 (1997); *Southwell v. Summit View of Farragut, LLC*, 494 F.App'x 508, 512-513 (6th Cir. 2012). We believe Kentucky subscribes to this same viewpoint based on the Court's analysis in *Ratliff v. Employers' Liability Assur. Corp., Ltd*., 515 S.W.2d 225, 228-229 (Ky. 1974), in which it reviewed and agreed with cases from other jurisdictions establishing professional judgment is not needed to determine whether hospital staff members

were negligent in administering routine care equivalent to what patients would receive from non-professionals in their own homes.

An example of failure to provide routine care which does not require expert testimony to establish negligence is provided in *Banfi v. American Hosp. for Rehabilitation*, 207 W.Va. 135, 529 S.E.2d 600 (2000). In *Banfi*, the patient's version of the events, the nurse failed to respond to patient's activation of call button and, as a result, the patient eventually got up without assistance and fell did not require expert testimony to establish the applicable standard of care. *Id.* at 142-143, 529 S.E.2d at 607-608.

If professional judgment is implicated, expert testimony will usually be required to determine the appropriate steps to be taken to prevent a fall. In *Ratliff*, 515 S.W.2d at 230, the Court determined recovery from a hospital's general insurance policy excluding professional services was unavailable because any negligence in determining the patient was capable of returning to his bed unassisted required professional nursing judgment. Similarly, in *McGraw,* 200 W.V. at 120-121, 488 S.E.2d at 395-396, the Court explained expert testimony may be required where professional judgment must be exercised to resolve complex patient management issues. Whether certain measures should be taken to prevent a fall beyond the standard measures a hospital uses for all patients is considered a matter of professional judgment that must be established by expert testimony. *Crosthwait v. Southern Health Corp. of Houston, Inc*., 94 So.3d 1070, 1074-1076 (Miss. 2012).

There is an exception, however, to the requirement of professional judgment where it is obvious that steps need to be taken to protect the patient. "Once the condition of the patient is factually established as helpless or severely disabled . . . common knowledge and experience can be used to determine whether the patient fell because she or he was insufficiently attended to by medical personnel." *Massey v. Mercy Medical Center Redding,* 180 Cal.App.4th 690, 697, 103 Cal.Rptr.3d 209, 215 (2010). For example, in *Vick v. Methodist Evangelical Hospital, Inc.*, 408 S.W.2d 428, 429-430 (Ky. 1966), the Court determined no expert testimony was needed to establish negligence where a woman who was highly medicated following delivery was left unattended, and she got up and fell. Similarly, in *Thompson v. Ashland Hosp. Corp.*, 2010-CA-000801-MR, 2011 WL 2693553, 2 (Ky.App. 2011) (unpublished), the Court determined no expert testimony was needed to establish negligence where a semi-comatose man fell off the x-ray table with no railings after the attendant stepped away. *Compare with Miners Memorial Hospital Ass'n of Ky. v. Miller.*, 341 S.W.2d 244, 246 (Ky. 1960) (no negligence where patient was capable of summoning a nurse for assistance with walking but failed to do so).

If hospital staff members have observed actions of the patient that make it obvious the patient is likely to leave her bed and be injured, expert testimony is not required to establish the hospital's negligence in failing to prevent her fall. *Jones v. Hawkes Hospital of Mt. Carmel*, 175 Ohio St. 503, 507, 196 N.E.2d 592, 595 (1964). In *Bryant v. Oakpointe Villa Nursing Centre*, 471 Mich.

411, 430-432, 684 N.W.2d 864, 875-876, (2004), the Court determined no expert testimony was needed to establish a nursing home was negligent by failing to take corrective measures after finding the patient entangled between the bedrails and the mattress and close to asphyxiation; merely correcting the patient's position without eliminating the now-known risk factors was sufficient for a jury to determine the nursing home was negligent when the patient died after become entangled again.

Whether Larry should be designated as a fall risk required professional judgment. There were indications that Larry was at a heightened risk of falling due to his medical condition and prescribed medications. Therefore, if Larry had received the same care as a standard patient and fell, a jury could determine the hospital was negligent in failing to take additional precautions in light of his known condition.

The parties agree the hospital correctly designated Larry as a fall risk. Therefore, appropriate professional judgment was applied to Larry's condition in making this designation and as a result he received additional precautionary care under the hospital's fall prevention plan. Hospital personnel equipped him with non-slip socks and instructed him to call for help with walking.

In light of these additional precautions, expert testimony would be needed to determine whether additional precautions were needed because it would not be obvious to a jury whether the steps taken were insufficient in light of his condition. While Larry was a fall risk, he was conscious and not helpless, could request assistance, had some ability to walk and had not previously fallen at the hospital.

Professional judgment is not needed to determine whether staff members were negligent in implementing a physician's orders as to the level of care needed. *See Ratliff*, 515 S.W.2d at 228-229 (favorable citing cases explaining no professional judgment is needed to follow orders to raise bedrails). Kentucky courts have determined jury issues existed as to whether nurses were negligent in allowing a patient to fall while they were walking a weak patient pursuant to doctor's orders and where a nurse failed to keep the patient's jaw raised pursuant to doctor's orders and he subsequently strangled. *Arnold v. James B. Haggin Memorial Hospital*, 415 S.W.2d 844, 844-845 (Ky. 1967); *Hicks' Adm'x v. Harlan Hosp.*, 231 Ky. 60, 21 S.W.2d 125, 126 (1929). *See Southwell v. Summit View of Farragut, LLC*, 494 F.App'x 508, 512-513 (6th Cir. 2012) (nursing home's failure to implement a plan of care constitutes ordinary negligence); *Massey*, 180 Cal.App.4th at 695-697, 103 Cal.Rptr.3d at 213-215 (2009) (jury could determine nurse violated doctor's orders that patient be given a walker and assistance in walking by leaving patient unattended at the walker for fifteen minutes); *Stewart v. Galen of Kentucky*, 2001-CA-001801-MR, 2003 WL 1232081 (Ky.App. 2003) (unpublished) (determining because expert testimony established the purpose of a physician-ordered bed check alarm, the jury could determine whether, but for the alarm being properly plugged in, the patient's fall would have been prevented). *But see Wheeler v. Baptist Healthcare System, Inc*., 14 Fed.Appx. 559, 562 (6th Cir. 2001) (unpublished) (determining where uncontested evidence establishes a doctor's orders as to the administration of an enema was left to the discretion of

nurses, failure to follow orders is insufficient to establish a breach in the standard of care).

It is undisputed that, as a result of Larry's designation as a fall risk, standard additional precautions pursuant to the hospital's fall prevention plan were applied to prevent him from falling. If the hospital had failed to follow steps mandated by its fall prevention plan in Larry's care, such failure would be sufficient to establish negligence without expert testimony. However, Martin does not allege the hospital was negligent in implementing any specific measure required by its fall prevention plan and deposition testimony from Larry's nurses indicated the hospital fully complied with its fall prevention plan in its treatment of Larry.

Instead, Martin argues the hospital erred by failing to raise Larry's lower bed rails and taking other precautions to protect him. However, there is no indication the hospital's fall prevention plan mandated such actions. We cannot review what the hospital's fall prevention plan required as it is not part of the record. Additionally, the only indication is that the fall prevention plan did not permit the hospital's staff to raise Larry's lower bed rails. Nurse Hatfield testified she could not raise Larry's lower bed rails without a physician's order to do so because this action was considered a restraint.

When a patient argues restraints should have been used to prevent a fall, the appropriateness of ordering restraints requires professional judgment. *Banfi*, 207 W.Va. at 141-142, 529 S.E.2d at 606-607; *Bryant*, 684 N.W.2d at 875, 471 Mich. at 429-430; *Treaster v. HealthSouth Corp*. 442 F.Supp.2d 1171, 1183 (D. Kansas

2006); 42 C.F.R. § 482.13(e); 902 KAR 20:016 § 4(2)(c)6. Similarly, requiring use of a particular technique to prevent a fall also requires professional judgment. *Taylor v. Fletcher Allen Health Care*, 192 Vt. 418, 422-423, 60 A.3d 646, 649-650 (2012).

Therefore, Martin could not establish the hospital was negligent in failing to raise Larry's lower bed rails without expert testimony establishing that such a restraint was necessary. Similarly, whether any other additional measures were needed to protect Larry beyond the hospital's heightened patient care standards mandated by its fall prevention plan required the exercise of professional judgment and needed to be established by expert testimony. Such determinations are outside a layperson's common knowledge because they involve weighing the potential risk to Larry's safety versus his freedom of movement and personal dignity, and an analysis of Larry's walking ability, judgment and likeliness of voluntary compliance with instructions that he call for help with walking. Accordingly, expert testimony was required for Martin to establish a *prima facie* case.

Martin argues the trial court erred by failing to determine whether testimony from an expert witness was necessary to establish the requisite standard of care before granting summary judgment. Based on our foregoing discussion, we disagree with Martin that his case could be established without an expert witness.

Additionally, Martin waived any argument the hospital's standard of care did not have to be established by an expert or that the trial court needed to

make a ruling on this issue. Therefore, the trial court did not err by failing to rule on this issue prior to granting summary judgment.

> [I]f the need for an expert is never disputed and if it would be unreasonable for the plaintiff to argue that an expert is not needed, (and most particularly if the plaintiff requests an extension for the express purpose of securing more time to identify his experts), there is no reason for a trial court first to enter a separate ruling informing the plaintiff that his case requires expert testimony before considering a defendant's summary judgment motion based on the plaintiff's failure of proof.

Blankenship, 302 S.W.3d at 673. Under these circumstances, if the plaintiff fails to identify an expert, the plaintiff has failed to create a genuine issue of material fact as to whether medical negligence occurred and the trial court may properly grant summary judgment against him. *Id.* at 674; *Andrew*, 203 S.W.3d at 170.

While Martin argued to opposing counsel that he did not need to establish the requisite standard of care through an expert, he never raised this issue before the trial court. Martin's complaint referenced a violation of a medical standard of care. His response to the motion for summary judgment acknowledged he needed an expert to establish the requisite standard of care. During the hearing on the motion, he denied he was challenging the need for an expert. In his motion to alter, amend or vacate, he did not claim he did not need an expert because this was an ordinary negligence case or that the trial court was required to make a ruling on whether an expert was required before granting summary judgment. Therefore, the trial court was not obligated to make a separate ruling on this non-issue before granting the motion for summary judgment for failure to create a

genuine issue of material fact as to negligence and did not err in failing to grant the motion to alter, amend or vacate.

Martin argues his identification of Moore as his expert witness to testify as to the standard of care the hospital owed Larry was sufficient to comply with his court ordered obligation to disclose expert witnesses. We disagree.

While Martin may have hoped Moore would establish the necessary standard of care and its violation through testimony about the hospital's fall prevention plan, he did not demonstrate Moore was willing to testify as his expert witness or that her testimony would be favorable to him and sufficient to establish the standard of care and its breach. All indications are that the hospital fully complied with its fall prevention plan in the care it provided to Larry. Therefore, simply naming Moore under these circumstances did not show Martin could establish a *prima facie* case.

We determine the trial court did not err in failing to consider sanctioning Martin for not making a timely disclosure of his expert witness prior to granting the motion for summary judgment. Where a plaintiff genuinely disputes expert testimony is needed, but the trial court ultimately decides it is, "imposing sanctions on the plaintiff for failing to comply with the scheduling order requiring disclosure of the expert's name and testimony is a more appropriate remedy than a summary judgment." *Blankenship*, 302 S.W.3d at 671. However, while it is inappropriate for a trial court to grant summary judgment to sanction parties for making untimely expert witness disclosures, "when the motion is based on an

actual failure of proof due to a complete lack of expert testimony, and not on a failure to meet a deadline due to an untimely disclosure, summary judgment can be appropriate." *Love v. Walker*, 423 S.W.3d 751, 756 (Ky. 2014). Therefore,

> there is no requirement that a party first be sanctioned under CR 37.02 before the trial court grants a properly supported and timely filed summary judgment motion. CR 56 stands independently of the discovery sanction rules and, provided the non-moving party has been given sufficient time to respond, the trial court may grant the summary judgment motion without preliminarily sanctioning the plaintiff for failing to identify and to produce an expert witness.

Blankenship, 302 S.W.3d at 675. As the trial court granted the motion for summary judgment on the merits, there was no error in not sanctioning Martin first.

Similarly, the trial court did not abuse its discretion by denying Martin's motion for an enlargement of time in which to obtain an expert witness. Pursuant to CR 6.02, it is within the trial court's discretion to grant or deny a motion for enlargement of time "if request therefor is made before the expiration of the period originally prescribed . . . or . . . upon motion made after the expiration of the specified period permit the act to be done where the failure to act was the result of excusable neglect[.]" *See* CR 92(2) (requiring good cause for granting a motion for enlargement of time).

There can be no excusable neglect where the reason for the delay was known prior to the expiration of the time period for the party to fulfill its obligation, yet the party did not request an extension of time until after the motion was filed,

which would result in the termination of the case. *Spradling v. Boone Cnty. Planning Comm'n*, 461 S.W.2d 548, 550 (Ky. 1970). A court does not abuse its discretion in limiting the time for discovery and refusing to grant an extension where failure to complete it by the deadline was due to a party's lack of due diligence. *Doe v. Lexington-Fayette Urban Cnty. Gov't*, 407 F.3d 755, 765 (6th Cir. 2005). No extension of time to identify an expert witness is warranted where the failure to identify the expert earlier was due to the party's own dilatory conduct. *Todd by Todd v. Merrell Dow Pharm., Inc.*, 942 F.2d 1173, 1178 (7th Cir. 1991).

Martin failed to demonstrate excusable neglect. He did not take steps to identify and obtain the required expert witness prior to the disclosure deadline or even prior to the hearing on the motion for summary judgment. Martin's only excuse was lack of money. This situation did not prevent Martin from requesting an enlargement of time to identify an expert prior to the disclosure deadline or excuse him from taking any steps to identify an expert. Additionally, Martin's financial situation was unlikely to change and he could not even propose a date by which he could obtain an expert witness if granted an enlargement of time. Under these circumstances, the trial court acted properly in denying the motion.

Martin's final contention is that the trial court erred when it did not make any findings of fact. Our civil rules provide that when rendering a decision on a summary judgment motion, findings of fact and conclusions of law are not required. CR 52.01. Furthermore, CR 52.04 states:

> A final judgment shall not be reversed or remanded because of the failure of the trial court to make a finding of fact on an issue essential to the judgment unless such failure is brought to the attention of the trial court by a written request for a finding on that issue or by a motion pursuant to Rule 52.02.

Martin did not make a written request for findings of fact and, therefore, cannot claim reversible error by the lack of such findings.

Accordingly, we affirm the Greenup Circuit Court's orders granting summary judgment and denying the motion to alter, amend or vacate.

ALL CONCUR.

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