RENDERED: JULY 27, 2018; 10:00 A.M.
NOT TO BE PUBLISHED

Commonwealth of Kentucky

Court of Appeals

NO. 2016-CA-001557-MR

DENNIS THOMAS,
as Administrator of the Estate of
Glenda Thomas, Deceased; and
DENNIS THOMAS, Individually — APPELLANTS

v.

APPEAL FROM JEFFERSON CIRCUIT COURT
HONORABLE A.C. MCKAY CHAUVIN, JUDGE
ACTION NO. 09-CI-07333

UNIVERSITY MEDICAL CENTER,
INC., d/b/a University of Louisville
Hospital; NEUROSURGICAL
INSTITUTE OF KENTUCKY, P.S.C.;
TODD W. VITAZ, M.D.; SARAH C.
JERNIGAN, M.D.; AND AASIM
KAZMI, M.D. — APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: CLAYTON, CHIEF JUDGE; KRAMER AND NICKELL, JUDGES.

KRAMER, JUDGE: This appeal from a defense verdict in Jefferson Circuit Court involves claims of hospital negligence and medical malpractice stemming from the alleged wrongful death of Glenda Thomas. The issues we are asked to address primarily focus upon a "Root Cause Analysis" (RCA) and "Action Plan" that appellee University Medical Center, Inc., (UMC) produced in discovery detailing the results of its internal investigation of Thomas's death and the extent to which it related to the treatment she received at its facility, University of Louisville Hospital. The above-captioned appellants argue they are entitled to a new trial because, in their view, the trial court erroneously precluded them from utilizing the RCA and Action Plan as either substantive evidence of the appellees' culpability and negligence or as impeachment evidence. Because the trial court acted within its discretion when excluding this evidence, we affirm.[1]

By way of background, Glenda Thomas was admitted to the University of Louisville Hospital on August 15, 2008, for an anterior cervical discectomy and fusion, a procedure that required a surgical incision in her neck. The procedure was performed early that afternoon without incident, and later that afternoon Glenda was transferred to the post-anesthesia care unit. Over the course

[1]This case was originally assigned to a December 2017 panel of the Court. However, it was administratively delayed after a conflict by the prior presiding Judge was noted after oral arguments. Typically, conflicts are caught during the initial screening of cases. It was reassigned thereafter to this August 2018 panel. Due to the prior administrative delay, this panel has given rendering an opinion priority.

of the next few hours, Glenda's husband, Dennis Thomas, remained with Glenda in the recovery room, and several doctors and hospital staff members monitored Glenda at varying intervals. At approximately 9:40 p.m., Dennis exited the recovery room and told hospital personnel "My wife can't breathe." A code was called at that time; Glenda was taken back to the operating room for treatment; but she ultimately suffered irreversible brain damage and died five days later due to anoxic encephalopathy (lack of oxygen to the brain) resulting from respiratory arrest. An autopsy revealed Glenda's respiratory distress had been caused by swelling and a hematoma (blood clot) that had gradually developed at the site of the incision in Glenda's neck post-surgery, obstructing her airway.

As indicated, UMC conducted an internal investigation of Thomas's death and the extent to which it related to the treatment she had received at its facility. The products of its investigation were the RCA and Action Plan. In sum, the RCA determined the "root cause" of Glenda's death was not attributable to any factor within the appellees' control, and that the physicians and medical staff who had been charged with managing Glenda's care had been competent, appropriately licensed, and adequately trained. But, it also stated a "human factor . . . relevant to the outcome" was "Medical management of airway in postoperative patient." And, in response to the question, "How can orientation and inservice training be improved?" the RCA provided "Orientation is adequate as to this issue. No

improvements necessary. Will provide an additional inservice regarding airway management, however."

Further, in the "Action Plan," UMC listed the following "Risk Reduction Strategy" in relation to the RCA:

> Action Item #1: **Respiratory/Airway Assessment Skills:** Inservice education for nursing staff and surgical resident staff to recognize signs and symptoms of mechanical airway obstruction.
>
> Responsible Person(s): Nursing Education Residency Coordinator; Department of Neurosurgery and Department of Anesthesia
>
> . . .
>
> Measure: Inservice education will be provided in November 2008.
>
> . . .
>
> **100% of individuals involved in incident will have inservice education by Nursing Education by Nursing Education or Attending-level for Department of Neurosurgery residents and Anesthesia residents.**

The appellants later filed the instant wrongful death action in Jefferson Circuit Court against the above-captioned appellees,[2] alleging that a substantial factor in causing Glenda's death was, in their view, the collective

[2] Drs. Todd W. Vitaz, Sarah C. Jernigan, and Aasim Kazmi were resident physicians employed by UMC, and each participated to various degrees in Glenda's care and treatment while she was at University of Louisville Hospital. The appellants also filed suit against Neurosurgical Institute of Kentucky, P.S.C., (NIK) for negligent supervision, claiming NIK had a duty to properly supervise these resident physicians and had failed to do so.

failure of UMC's medical personnel to appropriately recognize and remedy Glenda's respiratory distress. The appellants' suit focused upon the training UMC had provided its staff with respect to monitoring airways of post-operative patients. And, when UMC eventually produced the RCA and Action Plan for the appellants through discovery, the appellants expressed their intention of using these documents as evidence at trial. They argued because UMC had indicated in these documents that its staff would be receiving *additional* education and training with respect to monitoring airways of post-operative patients due to the incident involving Glenda's death, a jury could reasonably infer that UMC had effectively admitted the education and training it had provided to its staff prior to Glenda's death had been *substandard*.

As discovery progressed, evidence also indicated UMC had never held the "inservice" discussed in the Action Plan or otherwise required any of the individuals involved in the events surrounding Glenda's death to receive additional education in recognizing signs and symptoms of mechanical airway obstruction. The appellants believed that this, too, was relevant to whether the training UMC had provided its staff satisfied the applicable standard of care.

With that said, the appellees moved to exclude these documents and any reference to them at trial on at least two bases. First, they argued the documents were inadmissible pursuant to Kentucky Rule of Evidence (KRE) 407.

Second, they argued the documents had little probative value, were unduly prejudicial, and would only create juror confusion. *See* KRE 403. The trial court agreed and prohibited the appellants from introducing the documents as substantive evidence of their claims or as impeachment evidence. As indicated, the appellants' claims were ultimately dismissed in conformity with a defense verdict. On appeal, the appellants argue the trial court erred and substantially prejudiced their case by prohibiting their use of the RCA and Action Plan, and that they are entitled to a new trial.

Our standard for reviewing a trial court's ruling admitting or excluding evidence is limited to determining whether the trial court abused its discretion. *Goodyear Tire & Rubber Co. v. Thompson*, 11 S.W.3d 575, 577 (Ky. 2000). The test for abuse of discretion is whether the trial judge's decision was arbitrary, unreasonable, unfair, or unsupported by sound legal principles. *Id*. at 581 (citing *Commonwealth v. English*, 993 S.W.2d 941, 945 (Ky. 1999)). Here, the trial court primarily excluded the RCA and Action Plan based upon KRE 407. In full, the rule provides:

> When, after an event, measures are taken which, if taken previously, would have made an injury or harm allegedly caused by the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence, culpable conduct, a defect in a product, a defect in a product's design, or a need for a warning or instruction. This rule does not require the exclusion of evidence of subsequent measures when offered for

> another purpose, such as proving ownership, control, or feasibility of precautionary measures, if controverted, or impeachment.

As a general matter, "formulating a plan to require additional training" qualifies as a "subsequent measure" within the plain meaning of this rule. To the extent that the appellants sought to infer any admission of fault from the appellees purely because the RCA and Action Plan called for additional training, KRE 407 was a proper basis for exclusion.

The appellants argue, however, that because other evidence indicated that the appellees *never followed through* with their plan to mandate additional training, this exclusionary rule cannot apply. Accordingly, they argue that they should have been permitted to cite the RCA and Action Plan as relevant evidence of the appellees' fault. We disagree.

The appellants cite no authority in support of this argument.[3] More importantly, the appellees' lack of follow through on mandating additional training

[3] The authority the appellants cite in this vein, which derives from various jurisdictions outside of Kentucky, does not support the appellants' assertion that a contemplated course of action which a defendant ultimately chooses not to take can be considered an admission of fault. Rather, the caselaw they cite favors two unrelated propositions. The first is that the Federal corollary of KRE 407 usually does not prohibit consideration of post-incident investigations and tests conducted for purposes of investigating an occurrence to discover what might have gone wrong or right because the reports *themselves* typically do not qualify as improvements to safety or remedial measures. *See, e.g., Rocky Mountain Helicopters, Inc. v. Bell Helicopters Textron*, 805 F.2d 907, 918 (10th Cir. 1986); *Bergman v. Kemp*, 97 F.R.D. 413, 418 (W.D. Mich. 1983). The second proposition is (as KRE 407 itself explicitly provides) that the rule excluding evidence of subsequent remedial measures is inapplicable when the evidence is offered to prove ownership, control, or feasibility of precautionary measures, if controverted, and to contradict a

undermines the appellants' claim that the RCA and Action Plan were probative of the appellees' fault. To explain, KRE 407 contemplates that defendants will often speak through their *actions*, and the rule limits what those actions can *say*. In other words, KRE 407 acknowledges that when a defendant takes the *action* of employing measures "which, if taken previously, would have made an injury or harm allegedly caused by the event less likely to occur," that *action* can *say* something powerful to a trier of fact – namely, that the defendant, through its *action, admits fault*. The function of KRE 407 is to prohibit exactly that inference, and for reasons of public policy. *See City of Newport v. Maytum*, 342 S.W.2d 703, 704 (Ky. 1961) ("To declare such evidence competent is to offer an inducement to omit the use of such care as new information may suggest, and to deter persons from doing what the new experience informs them may be done to prevent the possibility of future accidents." (Citation omitted)). The question, then, is whether an entity's *contemplation* of a measure that it ultimately *decides not to take* could reasonably be inferred as an *admission of fault*. Logically, the answer is no. If a defendant is deemed to speak through its actions and does *nothing*, it admits *nothing*. Indeed, the report itself identified no problem that additional training might have remediated.

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witness's affirmative statement of fact (*e.g.*, impeachment). *See, e.g., Patrick v. South Central Bell Telephone Company*, 641 F.2d 1192, 1195-96 (6th Cir. 1980).

This, in turn, largely coincides with the trial court's other basis for excluding the RCA and Action Plan. In the words of the trial court's order to that effect, "[t]he information developed/revealed in the course of the RCA is of minimal probative value in terms of the allegation that Mrs. Thomas' death was the result of negligent conduct by the Defendants." The RCA and Action Plan, which merely indicated additional training was *contemplated*, merely begged rather than answered the two ultimate questions posed in this litigation: (1) *What* education and training in monitoring airways of post-operative patients did the appellees provide to their staff prior to Glenda's death? And, (2) *Did* that education and training satisfy the standard of care applicable to the appellants' negligence claims?

The education and training provided by the appellees was the subject of an extensive eight-day trial, multiple exhibits, and the testimony of multiple witnesses. The RCA and Action Plan, which merely addressed the education and training in generalities, added nothing to that discussion. And at most, the RCA and Action Plan merely reflected the appellees' non-expert, subjective beliefs regarding the care they provided Glenda and the care they may have wished to provide for other patients in the future – points that had no proper bearing upon

whether the applicable standard of care had actually been met.[4] *See Blankenship v. Collier*, 302 S.W.3d 665, 675 (Ky. 2010) (explaining medical malpractice cases require an expert to testify as to the applicable standard of care and that the breach of the standard of care caused the alleged injury); *see also Lake Cumberland Reg'l Hosp., LLC v. Adams*, 536 S.W.3d 683, 695 (Ky. 2017) (explaining that a hospital's decision to maintain standards higher than that required by ordinary care does not "create a higher standard of care or otherwise alter its liability.") In short, the trial court committed no abuse of its discretion by excluding the RCA and Action Plan from evidence; these documents had little probative value and would have distracted the jury from the relevant issues presented.

Because of that, it is unnecessary to address an additional argument the appellants have set forth on appeal – namely, that the trial court erred in directing a verdict in favor of appellee Neurosurgical Institute of Kentucky, P.S.C. (NIK). Briefly, the appellants filed suit against NIK for negligent supervision, claiming NIK had negligently supervised three of UMC's resident physicians who had participated to various degrees in Glenda's care and treatment while she was at University of Louisville Hospital (*i.e.*, appellees Drs. Todd W. Vitaz, Sarah C.

[4] The same reasoning applies to another argument made by the appellants, namely, that the trial court erred by precluding them from utilizing the RCA and Action Plan to *impeach* testimony they chose to elicit at trial from the appellees' non-expert corporate representative, Cynthia Lucchese, to the effect that in her view and in the non-expert view of the appellees the education and training provided by the appellees had been adequate.

Jernigan, and Aasim Kazmi). The trial court ultimately dismissed the appellants' claims after determining NIK had no duty to supervise these individuals. Even if the trial court erred in this respect, any such error was necessarily harmless considering the jury's verdict exonerating each of these three resident physicians from liability. *See* Kentucky Rule of Civil Procedure 61.01; *see also Vittitow v. Carpenter*, 291 S.W.2d 34, 36 (Ky. 1956) ("[E]rrors are harmless or nonprejudicial where they were not responsible for the appealing party having lost what he contends on appeal he should have attained.")

We therefore AFFIRM.

ALL CONCUR.

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BRIEF FOR APPELLEE, UNIVERSITY MEDICAL CENTER, INC:

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