The Governor's Council for Judicial Appointments

State of Tennessee

Application for Nomination to Judicial Office

Name: Dail Robert Cantrell

Office Address: 362 S Charles G Seviers Blvd
(including county) Clinton, TN 37716
Anderson County

Office Phone: (865) 457-9100 Facsimile: (865) 463-7881

Email Address: [redacted]

Home Address: [redacted]
(including county) Norris, TN 37828
Anderson County

Home Phone: [redacted] Cellular Phone: [redacted]

INTRODUCTION

The State of Tennessee Executive Order No. 54 hereby charges the Governor's Council for Judicial Appointments with assisting the Governor and the people of Tennessee in finding and appointing the best and most qualified candidates for judicial offices in this State. Please consider the Council's responsibility in answering the questions in this application. For example, when a question asks you to "describe" certain things, please provide a description that contains relevant information about the subject of the question, and, especially, that contains detailed information that demonstrates that you are qualified for the judicial office you seek. In order to properly evaluate your application, the Council needs information about the range of your experience, the depth and breadth of your legal knowledge, and your personal traits such as integrity, fairness, and work habits.

This document is available in word processing format from the Administrative Office of the Courts (telephone 800.448.7970 or 615.741.2687; website www.tncourts.gov). The Council requests that applicants obtain the word processing form and respond directly on the form. Please respond in the box provided below each question. (The box will expand as you type in the document.) Please read the separate instruction sheet prior to completing this document. Please submit your original, hard copy (unbound), completed application (*with ink signature*) and any attachments to the Administrative Office of the Courts. In addition, submit a digital copy with your electronic or scanned signature. The digital copy may be submitted on a storage device such as flash drive or CD that is included with your hard-copy application, or the digital copy may be submitted via email to ceesha.lofton@tncourts.gov..

THIS APPLICATION IS OPEN TO PUBLIC INSPECTION AFTER YOU SUBMIT IT.

PROFESSIONAL BACKGROUND AND WORK EXPERIENCE

1. State your present employment.

The Cantrell Law Firm

2. State the year you were licensed to practice law in Tennessee and give your Tennessee Board of Professional Responsibility number.

1991 014780

3. List all states in which you have been licensed to practice law and include your bar number or identifying number for each state of admission. Indicate the date of licensure and whether the license is currently active. If not active, explain.

Tennessee Nov-1991 BPR 014780 Active

4. Have you ever been denied admission to, suspended or placed on inactive status by the Bar of any state? If so, explain. (This applies even if the denial was temporary).

No

5. List your professional or business employment/experience since the completion of your legal education. Also include here a description of any occupation, business, or profession other than the practice of law in which you have ever been engaged (excluding military service, which is covered by a separate question).

Ridenour and Ridenour	Associate Attorney
Cantrell, Pratt & Varsalona	Managing Partner
Dail R. Cantrell and Associates	Managing Partner
Cantrell, Cantrell & Fischer	Managing Partner
Cantrell, Cantrell and Associates	Managing Partner
Cantrell, Goodge & Associates	Managing Partner

The Cantrell Law Firm	Managing Partner
The University of Tennessee	Adjunct Professor of Law
The State of Tennessee	Administrative Law Judge
Raybo, Inc.	Own 1/3 of a Pallet Company
Parkway Title, Inc.	Owned 1/3 of a Title Company
Buyers Choice Title, Inc.	Own 1/3 of a Title Company
Scrap Metal Solution, Inc.	Own ¼ of a Scrap Metal Company
Anderson County BOE	High School Coach

6. If you have not been employed continuously since completion of your legal education, describe what you did during periods of unemployment in excess of six months.

I have worked continuously since completing my legal education.

7. Describe the nature of your present law practice, listing the major areas of law in which you practice and the percentage each constitutes of your total practice.

I am a civil litigator. I have been lead counsel in over 100 cases that have gone to a jury verdict, and lead counsel in over 10,000 civil cases. I work almost exclusively in State Court but I do a small amount of Federal work and I am admitted to the 6th Circuit Court of Appeal and the United States Supreme Court. I have a full range of civil litigation experience including: Torts, Healthcare Liability, Breach of Contract, Domestic, Insurance Bad Faith, Education, Real Estate, Probate, Will and Conservatorship Contests, and Construction law. I primarily represent Plaintiffs, but I also do a substantial amount of defense work. My practice is almost entirely Civil Litigation, but over the approximate 30 years of practice I have argued between 50-100 cases at the Appellate level and have had several Opinions published.

8. Describe generally your experience (over your entire time as a licensed attorney) in trial courts, appellate courts, administrative bodies, legislative or regulatory bodies, other forums, and/or transactional matters. In making your description, include information about the types of matters in which you have represented clients (e.g., information about whether you have handled criminal matters, civil matters, transactional matters, regulatory matters, etc.) and your own personal involvement and activities in the matters where you have been involved. In responding to this question, please be guided by the fact that in order to properly evaluate your application, the Council needs information about your range of experience, your own personal work and work habits, and your work background, as your legal experience is a very important component of the evaluation required of the Council. Please provide detailed information that will allow the Council

to evaluate your qualification for the judicial office for which you have applied. The failure to provide detailed information, especially in this question, will hamper the evaluation of your application.

I am a trial attorney. I have tried well over 100 jury trials and have handled over 10,000 cases in my career. I would say that over 50% of my practice is tort and medical malpractice for Plaintiffs. I have obtained multiple jury verdicts in excess of one million dollars, and practice almost exclusively in Circuit and Chancery Court. I have handled cases from Mountain City to Memphis and have a wide range of litigation experience. I have handled over 1000 contested domestic relation cases, and virtually all types of civil litigation. I have tried breach of contract cases, consumer protection act cases, Bad Faith Insurance claims, cases involving real estate disputes, will contests, probate and conservatorship disputes, construction litigation and am comfortable with all civil procedural and evidentiary issues. I have argued before the Court of Appeals and Supreme Court between 50 and 100 times on several issues of first impression. I do no criminal work, no bankruptcies and only limited transactional work. I have never handled an adoption and do little work that does not involve civil litigation. I have served as General Counsel for several large corporations and have represented, and litigated against, several County and Municipal governments and agencies.

9. Also separately describe any matters of special note in trial courts, appellate courts, and administrative bodies.

My legal experience often involves complex evidentiary, procedural and jurisdictional issues. Over my career I have always done my own legal research and written my own briefs as opposed to assigning this work to an associate. I would describe myself as a legal nerd, and read every opinion that comes out every morning. I was a Professor at the University of Tennessee College of Law for ten years teaching Evidence, Legal Process and Trial Practice and at one time considered teaching full time but. I look at each case as a puzzle. I work backwards after I "See" the result to make the pieces of evidence fit within the procedural boundaries in order to convince the finder of fact of the correctness of my client's position. By doing my own research I am able to build the facts of each case on the foundation of the law so as to withstand the scrutiny of an appeal. My success rate is in the high 90's.

10. If you have served as a mediator, an arbitrator or a judicial officer, describe your experience (including dates and details of the position, the courts or agencies involved, whether elected or appointed, and a description of your duties). Include here detailed description(s) of any noteworthy cases over which you presided or which you heard as a judge, mediator or arbitrator. Please state, as to each case: (1) the date or period of the proceedings; (2) the name of the court or agency; (3) a summary of the substance of each case; and (4) a statement of the significance of the case.

I am a Rule 31 mediator. Also, I was appointed as an Administrative Law Judge in the mid 90's to hear Special Education Cases. I resigned in 1999 when our son was born prematurely and

developed Cerebral Palsy. I felt that I could no longer be impartial. I was also appointed as Referee in Anderson County and heard Juvenile and Trial Justice Court cases 4-5 days a month for about 5 years in the mid 90's. As my litigation practice grew it became impossible to manage the time. I do not recall presiding over any significant legal issues. I currently serve on the Advisory Council on Workers' Compensation for the State of Tennessee as a voting member.

11. Describe generally any experience you have serving in a fiduciary capacity, such as guardian ad litem, conservator, or trustee other than as a lawyer representing clients.

I am the POA of my uncle who is in a nursing home and manage his medical and legal needs. I have served in this capacity for other family members in the past. Additionally, I have been appointed as a guardian ad litem approximately one hundred times in cases involving children with disabilities.

12. Describe any other legal experience, not stated above, that you would like to bring to the attention of the Council.

As a professor of law I was recognized nationally as it related to my thesis of teaching Trial Practice concurrently with Evidence. When I first proposed this Evidence was required to be taken prior to Trial Practice. I opined that the student would learn better if these subjects were taught together. I was also the first proponent of "sponsorship theory" in the southern law schools, and lectured about this extensively, and worked with Don Paine to have it brought into the mainstream. I have written multiple papers and three books including a textbook used to teach healthcare professionals how to handle litigation issues that affect their practice. I have lectured extensively throughout the United States on issues related to civil litigation before other attorneys, judges, students and individuals in the health care industry.

13. List all prior occasions on which you have submitted an application for judgeship to the Governor's Council for Judicial Appointments or any predecessor or similar commission or body. Include the specific position applied for, the date of the meeting at which the body considered your application, and whether or not the body submitted your name to the Governor as a nominee.

This is my first application.

EDUCATION

14. List each college, law school, and other graduate school that you have attended, including dates of attendance, degree awarded, major, any form of recognition or other aspects of your education you believe are relevant, and your reason for leaving each school if no

degree was awarded.

University of Tennessee 1983-1988. I received a Bachelor of Arts Degree with Majors in English, American Studies and Political Science, and Minors in Chemistry and Physical Education. I began taking graduate school classes in Creative Writing and was accepted into the Masters program at Warren Wilson College, but started Law School at the University of Tennessee before receiving a Masters in Fine Arts. I graduated law school with a Doctorate of Jurisprudence in 1991. I was awarded the McClung Medal for excellence, was named the Ray H. Jenkins recipient as top moot court participant, and I was the first and only National Champion in Trial Advocacy in the history of the University of Tennessee College of Law. Subsequently I attended Lincoln Memorial University working towards a Masters of Science in Education. I have the credit hours, but never presented a thesis because I chose not to pursue a career in education.

PERSONAL INFORMATION

15. State your age and date of birth.

54 [redacted]1965

16. How long have you lived continuously in the State of Tennessee?

My entire life.

17. How long have you lived continuously in the county where you are now living?

I have lived in Anderson County my entire life.

18. State the county in which you are registered to vote.

Anderson

19. Describe your military service, if applicable, including branch of service, dates of active duty, rank at separation, and decorations, honors, or achievements. Please also state whether you received an honorable discharge and, if not, describe why not.

I have no military service.

20. Have you ever pled guilty or been convicted or placed on diversion for violation of any

law, regulation or ordinance other than minor traffic offenses? If so, state the approximate date, charge and disposition of the case.

No

21. To your knowledge, are you now under federal, state or local investigation for possible violation of a criminal statute or disciplinary rule? If so, give details.

None, other than recently a complaint was made to the Board of Professional Responsibility after a similar complaint was filed against another attorney. The Board has taken no action against me, and has not opened a file.

22. Please identify the number of formal complaints you have responded to that were filed against you with any supervisory authority, including but not limited to a court, a board of professional responsibility, or a board of judicial conduct, alleging any breach of ethics or unprofessional conduct by you. Please provide any relevant details on any such complaint if the complaint was not dismissed by the court or board receiving the complaint.

I have self-reported possible ethical infractions on several occasions but no file has ever been opened against me. Likewise, I have been reported to the Board of Professional Responsibility for possible violations but all have been dismissed without opening a file.

23. Has a tax lien or other collection procedure been instituted against you by federal, state, or local authorities or creditors within the last five (5) years? If so, give details.

No

24. Have you ever filed bankruptcy (including personally or as part of any partnership, LLC, corporation, or other business organization)?

No

25. Have you ever been a party in any legal proceedings (including divorces, domestic proceedings, and other types of proceedings)? If so, give details including the date, court and docket number and disposition. Provide a brief description of the case. This question does not seek, and you may exclude from your response, any matter where you were involved only as a nominal party, such as if you were the trustee under a deed of trust in a foreclosure proceeding.

Other than some small debt collection cases or breach of contract actions that I have filed the only litigation in which I have been involved, that I recall, were some small tort claims where I was involved in an auto accident, all settled out of court. A Declaratory Judgment Action involving the dissolution of a former partnership was resolved in arbitration, and a similar action was filed and immediately dismissed, and I filed a fraud action against an individual that stole a credit card. It is possible that there are other cases, but none of any substance, and none that were not resolved shortly after being initiated.

26. List all organizations other than professional associations to which you have belonged within the last five (5) years, including civic, charitable, religious, educational, social and fraternal organizations. Give the titles and dates of any offices that you have held in such organizations.

I am a member of the Second Baptist Church in Clinton, I serve on the Anderson County Board of Education, an elected position, and I have served as a member of the Museum of Appalachia Board of Directors.

27. Have you ever belonged to any organization, association, club or society that limits its membership to those of any particular race, religion, or gender? Do not include in your answer those organizations specifically formed for a religious purpose, such as churches or synagogues.

    a. If so, list such organizations and describe the basis of the membership limitation.

    b. If it is not your intention to resign from such organization(s) and withdraw from any participation in their activities should you be nominated and selected for the position for which you are applying, state your reasons.

No

ACHIEVEMENTS

28. List all bar associations and professional societies of which you have been a member within the last ten years, including dates. Give the titles and dates of any offices that you have held in such groups. List memberships and responsibilities on any committee of professional associations that you consider significant.

Anderson, Knox, Tennessee and American Bar associations

29. List honors, prizes, awards or other forms of recognition which you have received since your graduation from law school that are directly related to professional accomplishments.

I am a member of the Million Dollar Advocates Forum and was recognized for obtaining multiple jury verdicts in excess of one million dollars. Also, I was selected to the American Inns of Court. I was the first high school coach from Anderson County to be named to the Boys and Girls Club Hall of Fame. I was also recognized as the Prep Extra Coach of the Year. I have coached high school volleyball, track and basketball since 1983, and I am the longest tenured volleyball coach in the state, and have coached nine state championships teams.

30. List the citations of any legal articles or books you have published.

I have had two books published, Equal to the Task, about premature births, and Building and Improving your Personal Injury Practice, a textbook for healthcare providers. I have had too many literary articles, poems, and other writings published to list. The most relevant was "The Law of Opening Statements" published by the American College of Trial Lawyers.

31. List law school courses, CLE seminars, or other law related courses for which credit is given that you have taught within the last five (5) years.

None in the last 5 years, but I taught at the University of Tennessee Law School for ten years and taught a summer session at American University.

32. List any public office you have held or for which you have been candidate or applicant. Include the date, the position, and whether the position was elective or appointive.

I have been elected to the Anderson to the Anderson County Board of Education four times since 2004.

33. Have you ever been a registered lobbyist? If yes, please describe your service fully.

No

34. Attach to this application at least two examples of legal articles, books, briefs, or other

legal writings that reflect your personal work. Indicate the degree to which each example reflects your own personal effort.

I am attaching an appellate brief to the Tennessee Court of Appeals in a medical malpractice case which was dismissed by the trial court and subsequently overturned by the Court of Appeals, and a trial brief which involved an issue of first impression in a complicated post divorce parental relocation case, both of which were researched and written by myself with no assistance from anyone other than my secretary who typed both documents.

ESSAYS/PERSONAL STATEMENTS

35. What are your reasons for seeking this position? ***(150 words or less)***

I am a trial attorney. After law school I turned down offers from large law firms from all across the country for two reasons. First, I wanted to practice in the rural part of the state where I was raised, and second, I wanted to get into the courtroom immediately. I tried my first jury trial by myself the second day on the job, and won!

Two years later I opened my own firm, with older lawyers, so that I could try every type of case there was, in every court I could get into. The law school wanted me on the faculty so I began teaching trial theory less than two years after graduating with the understanding that I could stay in the courtroom. I was the youngest professor on staff.

I have loved what I have done for the last thirty years, but the days of trying forty jury trials a year are over. I have been asked to run for Circuit and Chancery positions but I would be an awful trial court judge. What fascinates me now are legal arguments, built upon an ever changing set of rules and laws, balanced against the cases that have already been decided.

I am seeking this position because it allows me to continue growing within a profession that I love.

36. State any achievements or activities in which you have been involved that demonstrate your commitment to equal justice under the law; include here a discussion of your pro bono service throughout your time as a licensed attorney. ***(150 words or less)***

Half of all the legal work that I have done over my career has been pro bono, or just for expenses. The big plaintiff's verdicts pay the bills, but my passion has always been in helping the ones who cannot help themselves.

I represented a small church and five elderly neighbors in a twenty-year fight against a billion dollar corporation that wanted to open a rock quarry and asphalt batch plant in their back yard. I never took a dime in a case I know my opponents billed for over a million dollars.

An 87 year-old widow living off of her husband's social security in a small HUD apartment got tricked into buying a vacuum cleaner that cost over five thousand dollars. She was lonely, and the salesman gave her someone to talk to. I got the contract rescinded and gave her the

attorney's fees that were awarded to me.

A young single mom, working her way thru nursing school, became involved in a brutal custody battle with the children's father. They were never married, and he came from money. She drove two hours to see one of my associates because we don't charge for consultations and she found us on Google. I over heard her crying and stepped into the office to see if I could help. I took the case for free.

Finally, just today, I accepted a case from a girl who turned eighteen last Friday. Her father was murdered two weeks ago by his next-door neighbor. This child has nothing, so I agreed to open a probate estate for free so she can get what little her dad had, and to sue the man that killed her father with the understanding that everything I recover goes to her.

37. Describe the judgeship you seek (i.e. geographic area, types of cases, number of judges, etc. and explain how your selection would impact the court. ***(150 words or less)***

The Court of Appeals in the Eastern District covers a wide and diverse area. I would join several excellent justices, with prominent legal backgrounds. My experience is different. I come from, and have worked in, the rural part of our state. Anderson, Campbell, Union, Scott, Fentress, Roane and all of the rural counties north of Knoxville.

It is important, I believe, to have Appellate Court judges from a wide geographic area and not just the larger cities. It is also essential that we have judges from small firms, even solo practitioners, not just ones from the large defense firms, to hear appeals with a different world-view.

I bring a unique perspective. Real world experience balanced by an academic's curiosity. The compassion that comes from being poor, and the toughness that comes from working your way up from nothing on your own, cannot be achieved by any method other than living it.

38. Describe your participation in community services or organizations, and what community involvement you intend to have if you are appointed judge? ***(250 words or less)***

I intend to keep coaching. I love working with young athletes. It intend to serve on as many charitable boards as will have me, and hopefully become active again with the University of Tennessee as a guest lecturer and resource. I also plan on staying active with my church and its mission projects.

Also, out legal community is struggling. Tennessee has the highest percentage of unemployed attorneys of every state in the country except Alaska, and we still are building more law schools, with little to no entrance requirements. We nee to find a way to match young lawyers, graduating with no job prospects, with attorneys preparing for retirement, with no one to take over their practice.

The rural counties where I work can't attract young lawyers, and there is no one coming into replace the ones who retire. Access to Justice starts here. I would work with these communities to find a way to get the older layers to mentor the younger lawyers with the goal of transitioning his or her practice to the next generation.

39. Describe life experiences, personal involvements, or talents that you have that you feel will be of assistance to the Council in evaluating and understanding your candidacy for this judicial position. ***(250 words or less)***

I have never practiced law for money. In 1999 I was at the top of my profession. I was the youngest professor at the University of Tennessee College of Law, I had already won over a hundred jury trials, and I married the only girl that I ever dated.

Then, on February 25, 1999, my son Benjamin was born prematurely. A brain bleed left him afflicted with Cerebral Palsy, and my world changed, forever. My family is everything to me. We struggled, but it taught me humility, compassion, if knocked me down, and then he lifted me up. Benjamin has taught me how to accept life, live it, love it. He has overcome so much, he inspires me every day to be better.

If I am chosen, I will do my best to be better than I am.

40. Will you uphold the law even if you disagree with the substance of the law (e.g., statute or rule) at issue? Give an example from your experience as a licensed attorney that supports your response to this question. ***(250 words or less)***

Yes I will. I have a special needs child, and my wife and I are advocates in the special needs community. I have also represented multiple Boards of Education.

Over the years, cases have come up involving students with disabilities. My heart tells me to give these children everything, anything, that they want. Sadly in rural school systems, with limited resources, I have to write Individual Education Plans that follow the strict federal guidelines even though I don't believe enough is being done for these students.

It's hard to tell a young mother and father that there are limits to what the school is required to provide. But that is the law. My duty as a Judge, if I am selected, is to enforce the law, not create new ones.

REFERENCES

41. List five (5) persons, and their current positions and contact information, who would recommend you for the judicial position for which you are applying. Please list at least two persons who are not lawyers. Please note that the Council or someone on its behalf may contact these persons regarding your application.

A. Dr. Chris Whaley, President of Roane State Community College,

[redacted]
B. Dr. Tim Parrott, Anderson County Director of Schools, [redacted]
C. Marcia Wade, [redacted]
D. The Honorable Brandon Fisher (ret), [redacted]
E. Daniel Goodge, [redacted]

AFFIRMATION CONCERNING APPLICATION

Read, and if you agree to the provisions, sign the following:

I have read the foregoing questions and have answered them in good faith and as completely as my records and recollections permit. I hereby agree to be considered for nomination to the Governor for the office of Judge of the [Court] Court of Appeals, Eastern District of Tennessee, and if appointed by the Governor and confirmed, if applicable, under Article VI, Section 3 of the Tennessee Constitution, agree to serve that office. In the event any changes occur between the time this application is filed and the public hearing, I hereby agree to file an amended application with the Administrative Office of the Courts for distribution to the Council members.

I understand that the information provided in this application shall be open to public inspection upon filing with the Administrative Office of the Courts and that the Council may publicize the names of persons who apply for nomination and the names of those persons the Council nominates to the Governor for the judicial vacancy in question.

Dated: 1-30, 2020.

Signature

When completed, return this application to Ceesha Lofton, Administrative Office of the Courts, 511 Union Street, Suite 600, Nashville, TN 37219.

THE GOVERNOR'S COUNCIL FOR JUDICIAL APPOINTMENTS
ADMINISTRATIVE OFFICE OF THE COURTS

511 UNION STREET, SUITE 600
NASHVILLE CITY CENTER
NASHVILLE, TN 37219

TENNESSEE BOARD OF PROFESSIONAL RESPONSIBILITY
TENNESSEE BOARD OF JUDICIAL CONDUCT
AND OTHER LICENSING BOARDS

WAIVER OF CONFIDENTIALITY

I hereby waive the privilege of confidentiality with respect to any information that concerns me, including public discipline, private discipline, deferred discipline agreements, diversions, dismissed complaints and any complaints erased by law, and is known to, recorded with, on file with the Board of Professional Responsibility of the Supreme Court of Tennessee, the Tennessee Board of Judicial Conduct (previously known as the Court of the Judiciary) and any other licensing board, whether within or outside the State of Tennessee, from which I have been issued a license that is currently active, inactive or other status. I hereby authorize a representative of the Governor's Council for Judicial Appointments to request and receive any such information and distribute it to the membership of the Governor's Council for Judicial Appointments and to the Office of the Governor.

Dail R. Cantrell
Name

Dail R Cantrell
Signature

1-30-20
Date

014780
BPR #

Please identify other licensing boards that have issued you a license, including the state issuing the license and the license number.

IN THE SIXTH JUDICIAL DISTRICT FOR THE STATE OF TENNESSEE
FOURTH CIRCUIT DIVISION

CHERRIDAN RAMBALLY, M. D., a citizen and resident of Knox County, Tennessee, residing at 1213 Bentley Park Lane, Knoxville, TN 37922,	]	
Plaintiff/Respondent,	]	
v.	]	**No.: 121902**
JOHN FRANKLIN MORRISON, III, D. O., and wife, CASEY LYN MORRISON, both citizens and residents of Knox County, Tennessee, residing at 1309 Cooper Lane, Knoxville, TN 37932,	]	
Defendant/Petitioners.	]	

PRE-TRIAL MEMORANDUM IN SUPPORT OF FATHER'S PETITION TO MODIFY AN EXISTING PERMANENT PARENTING PLAN

OF COUNSEL:

DAIL R. CANTRELL
CANTRELL, GOODGE & ASSOCIATES
Post Office Box 299
Clinton, Tennessee 37717
(865) 457-9100

IN THE SIXTH JUDICIAL DISTRICT FOR THE STATE OF TENNESSEE
FOURTH CIRCUIT DIVISION

CHERRIDAN RAMBALLY, M. D., a citizen and resident of Knox County, Tennessee, residing at 1213 Bentley Park Lane, Knoxville, TN 37922,	]	
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v.	]	**No.: 121902**
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Defendant/Petitioners.	]	

PRE-TRIAL MEMORANDUM IN SUPPORT OF FATHER'S PETITION TO MODIFY AN EXISTING PERMANENT PARENTING PLAN

Comes now the Petitioner, Dr. John Franklin Morrison, III, D.O. and wife, Casey Lyn Morrison, by and through counsel, and do hereby submit unto this Honorable Court a Pre-Trial Memorandum of Points and Authorities designed to assist the trier of fact in the adjudication of all issues currently before this Honorable Court.

I. PROCEDURAL HISTORY

The parties were divorced pursuant to a Final Decree of divorce on or about the 16th day of November, 2012. Prior to the entering into of the Final Decree of Divorce the parties submitted an Agreed Permanent Parenting Plan Order which was signed by both parties on or about October 29, 2012, and ultimately incorporated into the Final Decree of Divorce.

The above-referenced Permanent Parenting Plan is currently in effect, and has not been modified, nor has an attempt at modification been made, prior to the filing by the Father and

Stepmother of the pending Petition for Modification. A copy of the current Permanent Parenting Plan is attached as Exhibit "A."

On or about March 2, 2017, the Petitioners filed their Petition to Modify the existing Permanent Parenting Plan which included the Petitioners' proposed Amended Permanent Parenting Plan whereby the Petitioner, John Franklin Morrison, III, D.O., would be named as the primary residential parent, and each parent would receive equal co-parenting time. A copy of the Petition to Modify an Existing Permanent Parenting Plan Order filed by the Petitioners, which includes the attached Proposed Permanent Parenting Plan, is attached as Exhibit "B."

Various procedural Motions have been filed during this litigation, but all have been resolved with the exception that this Honorable Court has taken under advisement as to whether or not to allow the Stepmother/Petitioner, Casey Lyn Morrison, to remain as a party to the litigation.

II. STANDARD OF REVIEW

After a Permanent Parenting Plan has been incorporated into a Final Order or Decree, the parties are required to comply with the Order unless or until it is modified as permitted by law, Armbrister v. Armbrister, 414 S.W.3d 685 at 697 (Tenn. 2013); *See* T. C. A. 36-6-405. "In assessing a Petition to Modify a Permanent Parenting Plan, the court must first determine if a material change in circumstances has occurred and then apply the "best interest" factors of section 36-6-106 (a)." *Id.* See T. C. A. § 36-6-101(a)(2)(B)-(C); C.W.H. v. L.A.S., No. E2015-01498-SC-R11-JV (Tenn. filed 12/19/2017).

The Court of Appeals recently clarified the analysis to be used by Trial Courts in determining whether to change the primary residential parent in two (2) decisions that were issued on concurrent days this past November. Dalrymple v. Dalrymple, No. M2016-01905-

COA-R3-CV (Tenn. Ct. App. 11/14/2017); and Wilson v. Phillips, No. M2017-00097-COA-R3-CV (Tenn. Ct. App. 11/15/2017).

> "Determining whether to change the primary residential parent requires a two-day step analysis. *See* T. C. A. 36-6-101(a). The first step is to determine whether a material change of circumstance has occurred since the Court's previous custody Order. T. C. A. 36-6-101(a)(2)(B); Boyer v. Heimermann, 238 S.W.3d 249, 259 (Tenn. Ct. App. 2007). If the Trial Court finds that there has been a material change in circumstances, the Court must determine whether it is in the best interest to modify the Parenting Plan as requested. Armbrister, 414 S.W.3d at 705; Boyer, 238 S.W.3d at 259.
>
> A material change in circumstance for purposes of modifying the residential parent is a ""distinct concept"" from a material change in circumstances for purposes of modifying the residential parenting schedule. Burnett v. Burnett, No. M2014-00833-COA-R3-CV, 2015 WL 5157489, at *6 (Tenn. Ct. App. Aug. 31, 2015)(quoting Massey-Holt v. Holt, 255 S.W.3d 603, 607 (Tenn. Ct. App. 2007)). A different statutory provision applies to each circumstance. *See* T. C. A. 36-6-101(a)(2)(B), -101(a)(2) (C)." *See* Wilson at page 25.

In the case that is presently before this Honorable Court the Petitioners filed their Petition to Modify an Existing Permanent Parenting Plan pursuant to T. C. A. § 36-6-101 (a)(2)(B) *See* (Petition to Modify an Existing Permanent Parenting Plan Order, paragraph 3) as required by Tennessee Law. The Court of Appeals recently clarified the standard to be used by Trial Courts in determining whether to modify who is the residential parent in Dalrymple v. Dalrymple by stating as follows:

> "Even though the current litigation was precipitated by Father's relocation to Huntsville, Alabama, he initiated the proceeding by filing a Petition governed by T. C. A. 36-6- 101(a)(2)(C) seeking to modify the residential parenting schedule; this statute requires that he prove by a preponderance of the evidence that a material change of circumstance affecting the children's best interest has occurred. When a change in designation of the primary residential parent is sought pursuant to section 36-6-101(a) (2)(B), as pursued by the Mother, this Court has interpreted the statute to additionally

> require that the Petitioner prove that the change in circumstance be ""significant"" before it will be considered material. In Re T. C. D., 261 S.W.3d 734, 744 (Tenn. Ct. App. 2007). Under either procedure, once the Petitioner has proven a material change in circumstance, the court is to make a determination as to whether a modification is warranted based on the best interest of the children, applying the factors at T. C. A. 36- 6-106 (a)." *See* Dalrymple at page 3.

Simply, once a material change of circumstance has occurred, warranting a modification of the parenting plan, the issues before the court concern what is in the "best interest" of the minor child, and no presumption of correctness is given to the terms and provisions of the previous plan.

Pursuant to T. C. A. § 36-6-106(a), in any proceeding requiring the court to make a custody determination regarding a minor child, the determination shall be made **SOLELY** on the basis of what is in the "best interest" of the child. In taking into account the child's "best interest," the court shall order a custody arrangement that permits both parents to enjoy the maximum participation possible in the life of the child consistent with the factors set out in T. C. A. § 36-6-106(a); the location of the residences of the parents; the child's need for "**STABILITY;**" and all other relevant factors. Trial Courts shall consider all relevant factors, including the following, where applicable:

1. The strength, nature, and stability of the child's relationship with each parent, including whether one (1) parent has performed the majority of parenting responsibilities relating to the daily needs of the child;

2. Each parents or caregivers past and potential for future performance of parenting responsibilities, including the willingness and ability of each of the parents and caregivers to facilitate and encourage a close and continuing parent-child relationship between the child and **BOTH** of the child's parents, consistent with the best interest of the child. In determining the **WILLINGNESS** of each of the parents and caregivers to **FACILITATE** and **ENCOURAGE** a close and continuing parent-child relationship between the child and both of the child's parents, the court shall consider the likelihood of each parent and caregiver to honor and

facilitate court-ordered parenting arrangements and rights, and the court shall further consider any history of either parent or any caregiver denying parenting time to either parent in violation of a court order;

3. Refusal to attend a court ordered parent education seminar may be considered by the court as a lack of good faith effort in these proceedings;

4. The disposition of each parent to provide the child with food, clothing, **MEDICAL CARE**, education and other necessary care;

5. The degree to which a parent has been the primary caregiver, defined as the parent who has taken the greater responsibility for performing parental responsibility;

6. The love, affection, and emotional ties existing between each parent and the child;

7. **THE EMOTIONAL NEEDS AND DEVELOPMENT LEVEL OF THE CHILD;**

8. The moral, physical, mental and emotional fitness of each parent as it relates to their ability to parent the child. The court may order an examination of a party under Rule 35 of the Tennessee Rules of Civil Procedure and, if necessary for the conduct of the proceedings, order the disclosure of confidential mental health information of a party under T. C. A. 33-3-105(3). The court order required by T. C. A. 33-3-105(3) must contain a qualified protective order that limits the dissemination of confidential protected mental health information to the purpose of the litigation pending before the court and provides for the return or destruction of the confidential protected mental health information at the conclusion of the proceeding;

9. **THE CHILD'S INTERACTION AND INTERRALATIONSHIPS WITH SIBLINGS, OTHER RELATIVES AND STEP-RELATIVES, AND MENTORS, AS WELL AS THE CHILD'S INVOLVEMENT WITH THE CHILD'S PHYSICAL SURROUNDINGS, SCHOOL, OR OTHER SIGNIFICANT ACTIVITY;**

10. The importance of **CONTINUITY** in the child's life and the length of time the child has lived in a stable, satisfactory environment;

11. Evidence of physical or emotional abuse to the child, to the other parent or to any other person. The court shall, where appropriate, refer any issues of abuse to Juvenile Court for further proceedings;

12. The character and behavior of any other person who resides in or frequents the home of a parent and such person's interactions with the child;

13. A reasonable preference of the child if twelve (12) years of age or over. The court may hear the **PREFERENCE OF A YOUNGER CHILD** upon request. The preference of older children should normally be given greater weight than those of younger children;

14. Each parent's employment schedule, and the court may make accommodations consistent with those schedules; and

15. Any other factors deemed relevant by the Court."

It has long been the law in the State of Tennessee that in all custody cases, the paramount interest of the court is the welfare of the child. Koch v. Koch, 874 S.W.2d 571, 575 (Tenn. Ct. App. 1993) *citing* Mollish v. Mollish, 494 S.W.2d, 145, 151 (Tenn. Ct. App. 1972). Additionally, Tennessee Courts have consistently held that the **INTERESTS OF THE PARENTS ARE SECONDARY** to those of the children. Burden v. Burden, 250 S.W.3d 899, 909 (Tenn. Ct. App. 2007). Although the trial judge has a great deal of discretion in making a custody determination, this discretion is limited to some degree by T. C. A. § 36-6-106 which states that custody decisions must be made based upon the best interest of the child. In determining the "comparative fitness" of each of the parties, T. C. A. § 36-6- 101(b) was amended in 1997 to prevent the court from considering gender as a factor in awarding custody.

The Respondent has filed a Motion to Dismiss the child's Stepmother, Co-Petitioner, Casey Lyn Morrison, as a party to this action. The Petitioners were married on June 24, 2014. The Stepmother has a daughter, who is the Stepdaughter of the Petitioner, John Franklin Morrison, III, D.O., who is approximately the same age as the minor child that is the subject matter of this litigation. Both the Stepmother and the Stepdaughter have developed a close and loving relationship with the minor child that is the subject matter of this litigation, and the Stepmother provides significant support to the minor child.

Tennessee Courts have recently recognized the changing nature of families by considering the role of Stepparents, Stepsiblings, and grandparents in the life of a minor child. In 2012 the Tennessee General Assembly enacted T. C. A. § 36-6-303 which permits trial courts to allow visitation to a Stepparent when one spouse files a suit for divorce, annulment or separate maintenance upon a finding that (1) such visitation rights would be in the best interest of the minor child; and (2) that such Stepparent is actually providing or contributing towards the support of such child.

A simple and plain reading of the statute allows for a Stepparent to participate in change of custody proceedings upon a finding that the Stepparent has provided for the child and has developed a close and loving relationship with the child, and that such visitation rights would be in the best interest of the minor child.

III. APPELLATE DECISIONS CHANGING THE DESIGNATION OF THE PRIMARY RESIDENTIAL PARENT

A. Bell v. Bell, No. E2016-01180-C0A-R3-CV (Tenn. Ct. App. May 18, 2017)

Mother and Father divorced in 2012. The Permanent Parenting Plan designated Mother and Father as "co-primary residential parents" of their two (2) minor children. Subsequent to the divorce both parents remarried, and the Husband had a new wife who had a daughter.

The Court of Appeals, sitting in Knoxville, found that there had been a "significant and material change in circumstances" to justify a modification of the Permanent Parenting Plan of the primary residential parent designation. The Court of Appeals held that based upon the proof presented at trial it was clear from the testimony that the current Parenting Plan was not working in the "best interest" of the children.

The Trial Court found, and the Court of Appeals upheld, the fact that the parents were constantly arguing over parenting time, activities of the child, and the other party's failure to

communicate with or consult the other parent in regard to decisions on educational, medical or extracurricular activities.

There was no evidence of abuse or neglect of the children while in the care of either parent. The Court of Appeals held that there was no dispute that both parents loved the minor children, and that both parents were in a position where they could provide support for the minor children. However, as is in the situation it is currently before this Honorable Court, the Father was more involved with the educational needs of the children.

In the case that is currently before this Honorable Court, it is undisputed that the Father has been the parent who has taken the lead in working with the school system to determine the minor child's eligibility to receive special education services. This assertion is bolstered by the fact that it was the Father, and not the Mother, who initially met with the teachers to begin the RTI process; it was the father, and not the Mother, who met with the teachers in the fall of the coming school year to begin the eligibility determination and assessment protocol to determine whether the minor child met the criteria to receive special education services, and if so, what services the child was eligible to receive; it was the Father, and not the Mother, who had the minor child taken to Dr. Deborah Christiansen who ultimately diagnosed the minor child with ADHD; it was the Father, and not the Mother, who primarily worked with the IEP Team in trying to develop an Individual Education Plan for the minor child (NOTE: The Mother did not even stay until the conclusion of the first meeting; rather, she simply gave her consent for further testing); and the Father filed, on two (2) occasions, Emergency Petitions for Temporary Modification in an effort to block the Mother's attempts to remove the child from the Knox County School System prior to an IEP being established.

In Bell the Court of Appeals noted that T. C. A. § 36-6-402(4) defines the primary residential parent as "the parent with whom the child resides more than fifty percent (50%) of the time." However, if the child is dividing the time equally between the parents, neither parent meets the statutory definition of a primary residential parent. However, T. C. A. § 36-6-410 declares that the designation of a primary custodian is necessary for all State and Federal statutes, and applicable policies of insurance, which require a residential determination of custody. Thus, "...even though there may be no primary residential parent in fact, the law requires the designation of one parent as the primary residential parent, regardless of the statutory differences definition." Cummings v. Cummings, M2003-00086-COA-R3-CV, 2004 WL2346000 (Tenn. Ct. App. October 15, 2004). *See also* Hopkins v. Hopkins, 152 S.W.3d 447, 450 (Tenn. 2004).

B. Austin v. Gray, M2013-00708-COA-R3-CV (Tenn. Ct. App. December 18, 2013).

The above-referenced Appeal arose from the modification of a Permanent Parenting Plan in a post-divorce action. In the initial Permanent Parenting Plan the Mother was designated the primary residential parent of the son. Four (4) years later the Father filed a Petition to Modify the Permanent Parenting Plan alleging that multiple material changes in circumstances had occurred and that it was in the child's best interest for the Father to be the primary residential parent. The Trial Court found that it was in the son's best interest for the Father to serve as the primary residential parent with sole decision-making authority. The Mother Appealed, and the Appellate Court affirmed the Decision changing the residential parenting to the Father.

In the above-referenced Decision the Divorce Decree incorporated an Agreed Permanent Parenting Plan in 2007 making the Mother the primary residential parent. Thereafter, the Mother and Father's interaction with one another and attempts to co-parent their son became

increasingly acrimonious. "This was due in part to Mother's overt-bitterness against the Father… and that their child, who has ADHD, was acting out in an ever-increasing fashion."

According to the Trial Court the child started visiting a local psychiatrist in 2008, the year after the divorce became final, when he was twelve (12). The child psychiatrist who was providing treatment to the minor child observed, over time, that the child's healthy growth and developments were triangulated to his detriment by his parents' ongoing conflicts.

In 2011 the Father filed a Petition to Modify the existing Permanent Parenting Plan to be named as the primary residential parent and to have sole decision-making authority.

Ultimately, the Trial Court found that both parents were loving and affectionate, and able to support the child financially, but that all of the relevant statutory factors either favored the Father, or were equal, and modified the Permanent Parenting Plan to name the Father as the primary residential parent. The Court of Appeals affirmed the Trial Court's Decision.

The Court of Appeals held that the Trial Court's Decision was well reasoned and detailed, finding that the Father had proved a host of significant and material changes of circumstances which included the fact that the co-parenting eroded after the divorce with respect to scheduling of parenting time, overall cooperation, and joint decision-making on their son's behalf. Additionally, the Court of Appeals found that the discovery that the child was afflicted with ADHD was a material and significant change in circumstance and the Father was in a better position to provide for the child's educational needs.

The Court of Appeals also found that the Mother had essentially alienated their son's affection to the Father to a significant degree and that the Mother genuinely believed that the Father was not parenting well. The Court of Appeals also found that the Mother was concerned

with what was in **HER BEST INTEREST**, as **OPPOSED** to what was in the **BEST INTEREST OF THE CHILD.**

C. In Re: Ashton V. No. M2016-00842-COA-COA-R3-JV (Tenn. Ct. App. March 22, 2017).

This Appeal arose from a Juvenile Court's modification of a primary residential parent designation. The Mother appealed the Juvenile Court's findings that a material change in circumstances had occurred and that a change in the primary residential parent was in the child's best interest. The Court of Appeals affirmed the Juvenile Court's Decision.

The minor child was born in July, 2010, to an unmarried couple. In the absence of a Custody Order, custody of a child born out of wedlock is with the Mother pursuant to T. C. A. § 36-2-303(2014). In January, 2015, in response to the Father's request for specific parenting time, the Juvenile Court for Sumner County, Tennessee, entered an Order naming Mother as the primary residential parent and granting Father parenting time.

In September, 2015, Father filed a Petition seeking a change in the primary residential parent designation. He alleged a material change in circumstances had occurred in that the Mother was uncooperative and confrontational, and unwilling to foster his relationship with the minor child, and attempted to alienate the minor child from him. The Juvenile Court found that the Mother had made derogatory comments about the Father in the presence of the minor child, and had exhibited signs of a combative and hostile way of co-parenting.

Just as in the situation that is before this Honorable Court, not only did the Father not miss any of the co-parenting time that he was granted in the original Court Order, he exercised additional co-parenting time above and beyond what he had been given. Additionally, as in the

case that is presently before this Honorable Court, the Father was constantly being excluded from joint decision making, and was often the parent who took the lead in educational decisions.

D. In Re: Austin S. M2005-01839-COA-R3-JV (Tenn. Ct. App. March 24, 2006).

The above-referenced Appeal involved the custody of an eight (8) year old child born out of wedlock. The Rutherford County Juvenile Court initially granted the parents equal custody. However, after the entry of the Permanent Parenting Plan, the minor child was diagnosed with ADHD, and the Mother filed a Petition asserting that a material change of circumstances existed and that she should be designated as the child's primary residential parent. The child's Father agreed that circumstances had changed as a result of the ADHD diagnosis, and also sought to be designated as the child's residential parent. Following the Bench trial, the Juvenile Court found that the **DIAGNOSIS OF ADHD** was in fact a "material" and "significant" change of circumstance, and that the best interest of the minor child would be served with the Father as being the primary residential parent. The Mother appealed, and the Court of Appeals affirmed the Trial Court's Decision naming the Father as the primary residential parent.

This case is factually similar to the case that is presently before this Honorable Court in that the primary issue that gave rise to a "significant" and "material" change in circumstance was the diagnosis of the minor child with attention deficit hyperactivity disorder (ADHD). The minor child had begun to experience, just as in this case, difficulties in school. The Father asserted that the minor child would benefit from a "more stable environment" and that he was comparatively better suited to be the primary residential parent. To support his claim the Father asserted that the **MOTHER DID NOT HAVE STABLE HOUSING** and **SHE WAS NOT WORKING WITH THE SCHOOL** to develop an appropriate educational plan.

In the situation presently before this Honorable Court, not only is the Mother not working with the school system, she is actively working against the school system by trying to prevent the child from receiving any special education services, or from being "labeled" as a special education student.

The facts in this case are not in dispute. The Mother has left a stable job as a neurologist in Oak Ridge, Tennessee, and has left her home in Knoxville, Tennessee, where not only she resides, but the Father, Stepmother, and Stepsister reside, along with all but one of the grandparents, and the majority of the aunts and uncles.

When the Father and Stepmother began to notice that the minor child was struggling in school, the Father took the lead in working with the school to try and ascertain whether or not the child had a developmental delay.

At the beginning of the fall semester of this current school year, the Father was approached by the minor child's teachers and told that they believed that the RTI intervention services were not working, and that the minor child needed to be evaluated to determine whether or not he was eligible for special education services, and that a referral needed to be made to a medical provider to determine the status of his developmental delay.

Not only did the Mother excuse herself from the initial meeting with the teachers, she attempted to immediately remove the child from the Knox County School System in an effort to stop the evaluation process. In fact, but for the Father's actions in filing an Emergency Petition for Temporary Modification, the Mother would have been successful in her efforts.

Unfortunately, the minor child was ultimately diagnosed with ADHD. Prior to the IEP Team making an eligibility determination, and prior to it beginning the formulation of an IEP plan, on December 30th, without prior consultation with the Father or with other members of the

IEP Team, and in direct violation of the intent of this Honorable Court's previous Order, the Mother unilaterally removed the minor child from the Knox County School System and enrolled the child in a school system in the State of California where she is renting a place for herself, the minor child, her mother, and her two (2) brothers, on a month-to-month basis, denying the child's special education services which he desperately needs.

IV. ISSUES FOR THIS COURT TO CONSIDER IN DETERMINING WHETHER OR NOT TO GRANT THE PETITION TO MODIFY AN EXISTING PERMANENT PARENTING PLAN

A. Whether the Petitioners have proven, by a mere preponderance of the evidence, that a "significant" and "material" change in circumstance exists which would warrant the modification of the Permanent Parenting Plan that is currently in effect;

B. If this Honorable Court finds that the Petitioners have met their burden of proving that a "significant" and "material" change in circumstance exists which warrants the modification of an existing Permanent Parenting Plan, pursuant to the provisions of the "comparative fitness test" codified at T. C. A. § 36-6-106(a) as interpreted by the Tennessee Supreme Court in Armbrister v. Armbrister, 414 S.W.3d 685 (Tenn. 2013), which of the parties should be named the primary residential parent; and

C. If the Petitioners have proven, by a mere preponderance of the evidence, that pursuant to the "comparative fitness test" as set forth above, it is in the best interest of the minor child that the Father be named the primary residential parent, should the proposed Parenting Plan submitted by the Petitioners be made an Order of this Court.

V. FACTUAL HISTORY

The parties were divorced on November 16, 2012. At that time the parties were able to enter into an agreed Permanent Parenting Plan. Prior to the filing of a Petition to Modify an

Existing Permanent Parenting Plan Order by the Petitioners on March 2, 2017, no action had been taken by either party to modify the existing Permanent Parenting Plan that was entered contemporaneous to the filing of the Final Decree of Divorce.

The existing current Permanent Parenting Plan has the Mother named as the primary residential parent, and the existing parenting schedule has the Mother receiving 203.5 days per year with the minor child while the Father receives 161.5 days with the minor child.

At the time the Divorce Decree was entered the minor child had just turned five (5) years old. Currently, the minor child is ten (10) years of age, and is a fourth grade student. The minor child had continually been a student of the Knox County School System through the conclusion of the fall semester of the 2017/2018 school year, at which time the Mother made a unilateral decision to remove the child from the Knox County School System and relocate to the State of California, in violation of the existing Permanent Parenting Plan, which requires that all educational decisions; non- emergency healthcare decisions; religious upbringing and extracurricular activities be jointly made by the parties.

On or about June 24, 2014, the Petitioner, John Franklin Morrison, III, D.O., married the Petitioner, Casey Lyn Morrison, and the Petitioners have resided as man and wife continually since that time. The Petitioner, Casey Lyn Morrison has a minor daughter, who is the stepdaughter of the Petitioner, John Franklin Morrison, III, D.O, and the stepsister of the minor child who is the subject matter of this litigation, who is close in age to the child who is the subject matter of this custody litigation.

Since the entering of the Permanent Parenting Plan that is currently in effect, the Father has exercised all co-parenting time that has been made available to him (Respondent's response to Petitioner's Request to Admit No. 4). Additionally, the Father has exercised additional co-

parenting time beyond what was made available unto him in the current Permanent Parenting Plan.

The Mother concedes that both the Father and the Stepmother, and the minor child who is the subject matter of this litigation, have a close and loving relationship (Respondent's response to Petitioner's Request to Admit No. 22). In the summer of 2016, prior to the minor child's third grade school year, the medical practice with whom the Father was employed made a decision that it was going to split off from the larger corporate medical conglomerate with which it was associated. This change would go into effect as of January 1, 2017. The practical effect of the change would mean that the Father would become a partner in the newly formed medical group; would have significantly more flexibility over his work schedule; and would be able to exercise 50-50 co-parenting time.

The Father notified the Mother in the summer of 2016 that the change in his work schedule would go into effect as of January 1st, and that it was his desire to enter into a Rule 31 Mediation in the spring of 2017 in order to craft a new Permanent Parenting Plan which would allow for equal co-parenting time between the parties, and which would allow the minor child to attend either Hardin Valley Middle School or Farragut Middle School.

At the beginning of the 2016/2017 school year, which was the minor's child third grade year, the Petitioners noticed that the minor child was experiencing problems at school as it related to his academic performance in the area of reading comprehension. (Respondent's Response to Petitioner's Request to Admit No. 8).

The Father began addressing his concerns with the minor child's educational performance in September, 2016 by meeting with the minor child's teachers, and requested that the minor child be evaluated for having a potential learning disability (Respondent's Response to

Petitioner's Request to Admit No. 9). Throughout the fall semester of the third grade year the minor child continued to struggle with his grades and schoolwork. The Father suggested additional testing, but the Mother was hesitant to have the minor child "labeled" or "singled out" as being different from the other students.

It is undisputed that the parties agreed to allow the Knox County School System to implement the RTI (Response to Intervention) process in the spring semester of the child's third grade year. RTI is a process used by educators to help students who are struggling with a skill, and not just for children with special needs or who have learning disabilities. The RTI process was introduced within the parameters of the 2004 Reauthorization of the Individuals with Disabilities Act (IDEA).

On September 26, 2017, a meeting occurred at the minor child's school to address concerns that were being raised by the child's teachers related to his transition into the fourth grade. The SLS and the classroom teachers were concerned that the RTI was not successful, and that there needed to be a formal referral to determine whether or not the child was eligible to receive special education services in order to address what the Father and the teachers noted were now growing concerns of an obvious developmental delay.

The Mother initially attended, but ultimately excused herself from the September 26, 2017 meeting. However, prior to leaving the Mother did give verbal permission for testing needed to determine the nature and extent, if any, of the minor child's developmental delays.

It is important to note that prior to the testing being completed, the Mother attempted to relocate with the minor child to California in order to stop or prevent an IEP from being put into place. As a result, on or about October 20, 2017, the Father filed a Motion for an Emergency Ex Parte Temporary Modification of an Existing Permanent Parenting Plan in order to allow for the

testing to be completed. This Honorable Court granted an Ex Parte Order to require the minor child to remain in the State of Tennessee until December 23rd, which would allow time for the testing to be completed; for the IEP Team to be reconvened; for the minor child to be evaluated by a medical provider to see if he in fact was afflicted with ADHD; and to create an IEP to address the minor child's special education needs.

The Father was able to get an expedited appointment with Dr. Deborah Christiansen, a local pediatrician who specializes in the diagnosis of ADHD, which unfortunately revealed that the minor child is in fact afflicted with ADHD, which confirmed the suspicion of the Father and the minor child's teachers. ADHD is a neurobiologically-based developmental disability estimated to affect between 3% to 5% of the school age population. Unfortunately, there is no cure for ADHD, but treatment can help the minor child to adapt in order to lessen the effects of the condition.

ADHD is chronic in nature, and requires a significant amount of testing and **OBSERVATION** in order to develop an appropriate treatment protocol. It is important to do a complete and accurate evaluation made up of a combination of testing and classroom observation in order to develop an appropriate IEP which will allow the school system to create a special education program that is individually tailored to meet the minor child's specific needs.

The parties were set to reconvene the IEP Team during the last week of the fall semester, at which time the parties were notified by a member of the Knox County School System that an illness of a member of the IEP Team would prevent the meeting from taking place. Immediately upon receiving notification that the meeting would not take place, and without having any prior discussion with the Father as required by the existing Permanent Parenting Plan, the Mother made the unilateral decision to withdraw the minor child from the Knox County School System

and to enroll him in a school in the State of California, which is in direct violation of the existing Permanent Parenting Plan that is currently in effect.

As a result of the Mother's unilateral decision to remove the child from the Knox County School System prior to an IEP being completed, and then to enroll the child in a California school system, the child is not eligible to receive any special education services in the State of California.

The Father filed a Second Emergency Petition for a Temporary Modification requiring the child to be re-enrolled in the Knox County School System in order to allow the IEP Team to reconvene; to have the results of the psychological testing shared with the IEP Team; to allow Dr. Christiansen to review the results of the school testing in order to offer a medical recommendation to the IEP Team; and ultimately to have an IEP for the minor child created.

This Honorable Court entered a Second Ex Parte Order requiring the Mother to re-enroll the child in the Knox County School System for the purposes of completing an IEP for the child. This Court further ruled that it was the intention of the Court in the first Emergency Motion for a Temporary Modification that the IEP be completed prior to the child being removed from the Knox County School System.

After this Honorable Court ruled in favor of the Father, the Mother once again objected to allowing the IEP process to be completed. This Honorable Court then asked counsel for both parties to provide an Affidavit from school personnel concerning the effect of the Mother's unilateral decision to remove the child from the Knox County School System prior to the completion of an IEP.

In response to this Honorable Court's request, the Father provided an Affidavit from Sue Voskamp, a recently retired Director of Special Education; a leader in the field of Special

Education for the State of Tennessee; and an expert in Special Education Law, who opined to this Honorable Court that once a child is removed from a school system, that school system no longer has the authority to complete an IEP for the child. This was confirmed by IEP Team member, Carl Whipple, the Assistant Principal who testified at the first hearing.

Director Voskamp further opined that while the IEP Team could in fact reconvene, and allow the Mother to participate via teleconference from the State of California, the IEP Team could **NOT** formulate or complete an IEP for the minor child, nor could it take any action to determine the eligibility for the minor child to receive special education services. Director Voskamp further opined that the only action that the IEP Team could take after the removal of the child from the Knox County School System would be to provide the completed testing information to both parents.

Director Voskamp further opined that the most important component of an IEP is the classroom evaluation of the child's teachers. Director Voskamp set forth that the IEP Team is made up of medical and healthcare personnel; classroom teachers; psychologists; parents; and a local administrator. The IEP Team works in conjunction to create an IEP which would follow the child from school system to school system.

Director Voskamp further opined that the actions of the Mother in removing the child from the Knox County School System prevented the minor child from receiving any special education services, or from having an eligibility determination made showing that the child is eligible to receive said services. A copy of Director Voskamp's Affidavit is attached as Exhibit "C."

On or about Wednesday, January 18th, the Knox County School Psychologist, Julia Houston, Ed. S., released unto both parents the Psycho-Educational Evaluation which was made

an Addendum to the evaluations completed on November 9, 2017. A copy of Dr. Houston's report is attached as Exhibit "D." Dr. Houston indicated that the reason for the referral to her department was as follows:

> "Language assessments, and behavioral rating scales were completed earlier in this school year due to John's difficulties processing information (oral and written). The evaluation did not identify a Language Impairment but information was gained that suggested further evaluation should be completed to better assess potential characteristics of an Autism Spectrum Disorder. This evaluation addresses those traits as well as potential educational impact that could be related to his diagnosis of an **ATTENTION DEFICIT HYPERACTIVITY DISORDER.**"

The Father and the Stepmother, both of whom are medical personnel, had begun to suspect that the minor child was suffering from autism after the RTI was unsuccessful in the spring of 2017. These concerns were raised by counsel for the Father during the August, 2017 hearing, but both the Mother and her attorney vehemently denied that the child had any issues related to any developmental delays.

Dr. Houston noted that based upon classroom observations, the minor child began having problems with focus and reading comprehension in the first grade. Dr. Houston noted that while the minor child had maintained grade level expectations, he had difficulty using information for extrapolation, and as his grade level material required more independent production, his functioning became more concerning.

At the end of the minor child's third grade year, Dr. Houston completed an achievement test with the minor child to better understand his academic skills. The Woodcock-Johnson test revealed that the minor child performed at the low average level on reading passage comprehension; broad reading passage comprehension; and basic reading comprehension in all areas tested.

During the August, 2017 hearing before this Honorable Court, counsel for the Mother represented to this Honorable Court that the minor child was experiencing no special education concerns. In fact, the Mother has a great deal of difficulty dealing with the fact that her child suffers from ADHD and that he is autistic. In her deposition she conceded that it was in fact the Father who took the lead in having the minor child evaluated to determine whether he was eligible to receive special education services:

> "Q. Was that the first conversation that either you or Dr. Morrison had with a member of the Knox County School System as it related to potential special-education services?
>
> A. I am sorry. Can you please repeat that again?
>
> Q. Sure. Was that conversation that Dr. Morrison had in the early part of Johnny's third grade year the first conversation that either you or he had with an employee of the Knox County School System about the providing special education services services?
>
> A. Yes." (Rambally Deposition, December 13, 2017, page 47, lines 2 - 12)
>
> . . .
>
> Q. Dr. Rambally, my question is, do you feel that there is a negative--the possibility of a negative connotation that will follow your son if he is labeled as a special-education school student? Is that a concern of years?
>
> A. Things happen in life, and I just want my son to have the healthiest perspective, and I want the people surrounding him to foster a healthy perspective. As long as he's given the tools to learn, then I--
>
> Q. Give me a yes or a no instead of an explanation....
>
> Mr. Garland: I am going to object.
>
> Q. Are you concerned--
>
> Mr. Garland: It's not a yes or a no question.

Mr. Cantrell: Yes, it is.

Mr. Garland: She can answer the question how she chooses. You can't direct how she answers it.

Q. Do you have any concerns about there being a negative connotation associated with Johnny being labeled as a special-education student?

A. My concern is that of how Johnny perceives himself academically. I want him to have a healthy academic perception of himself, because that's what matters. The schools will provide the tools." (Rambally Deposition, page 55, lines 1-25).

Dr. Houston further opined in her report that classroom observations were reported that led to a potential autism spectrum disorder. At that point Dr. Houston and the classroom teachers recommended that further testing should be conducted. It was during this meeting that the Mother left, but did allow for further testing to be completed.

A reading of Dr. Houston's report, which included assessments by both the Mother and the Father, show that the Mother and Father give diametrically opposed assessments of how their son is performing both scholastically, socially and at home. It is important to note that the classroom observations lineup directly with the Father's observations, which indicate that the Mother is having significant difficulty coming to terms with the fact that her son suffers from ADHD and autism.

Dr. Houston, as is set forth in her report, did a full scale Wechsler Intelligence Scale for Children (WISC-5), which showed that the minor child has a full scale IQ of 89, which puts him in the low average category. Mrs. Smelser, the minor child's fourth grade teacher before the Mother removed him from the Knox County School System, reported that the minor child was unorganized and often seemed to struggle to focus. Mrs. Smelser further indicated that when called upon in class, the minor child seemed to "panic" and has a hard time providing important

information. Mrs. Smelser further indicated that the minor child's written expression is reported to be marked by his inability to copy materials correctly; use correct spacing for letters and words; write fluently; use a variety of sentence structure; use correct grammar in work; use writing to communicate information; use content skills appropriately; and that he struggles to apply new concepts to higher level tasks especially with multi-step mathematical problems.

Even more concerning is that Mrs. Smelser's classroom observations totally contradict the observations of the Mother, and supports the observations of the Father. Particularly, Dr. Houston makes this finding in her report:

> "Socially, Mrs. Smelser reports that John does not form bonds with other students and does not appear to have a preferred friend. He has a student that he appears to interact with that teacher report suggests that the interaction may not be reciprocal. He struggles with interaction with peers and seems to have a hard time understanding others. For example, when they offer help to John, he interprets their help as being ""bossy."" He tends to be defensive when offered help by his teacher as well. John was also observed to work independently while others were working in pairs/groups. Mrs. Smelser also reported that John may not understand an activity but appears to not understand that he is confused and will not ask specific questions. When he does ask for help, he typically says, ""I don't understand."" His teachers must provide step-by-step support on tasks that other students seem to comprehend the more global direction. For example, within a history activity the students were asked to put feathers in chronological order based on the event. After explaining the assignment again one-on-one, John's teachers had to complete the task step-by-step. In addition, on an occasion when the class schedule was modified John had a hard time understanding the new schedule while other students appeared to follow without concerns. Mrs. Smelser reported that John asked several times, ""What are we we going to do next?""

Even more concerning was the fact that Mrs. Houston asked Mrs. Smelser and both of the parents to independently complete the Behavior Assessment System for Children (BASC), a test that yielded several significant variances. For example, under hyperactivity both Mrs. Smelser

and the Father scored Johnny at between 70 and 73, while the Mother scored Johnny at a 45. As it relates to the internalizing problems, the teacher and the Father scored Johnny between 70 and 80, while the Mother scored Johnny at approximately 50. Under behavioral symptoms index, the teacher and the Father scored Johnny between 65 and 75, while the Mother scored Johnny at slightly above 50. Under social skills both the teacher and the Father scored Johnny at approximately 25, while the Mother scored Johnny at approximately 60. Under leadership skills both the teacher and the Father scored Johnny between 25 and 30, while the Mother scored Johnny at 60. Under functional communications both the teacher and the Father scored Johnny in the mid-20's, while the Mother scored Johnny at almost 50. Finally, under adaptive skills, both the teacher and the Father scored Johnny between 25 and 27, while the Mother scored Johnny close to 60.

Even more concerning is that on the teacher scale, Mrs. Smelser indicated that the minor child was experiencing clinically significant developmental social disorders; executive functioning; ADHD probability; autism probability; and a significant functional impairment.

In her conclusions, Dr. Houston stated as follows:

> "Ms. Rambally's report does not evidence any problem with John's behavior. Teacher and Father rating concur that John does not tend to act aggressively or demonstrate rule breaking behavior more than others his age. However, Mr. Morrison and Mrs. Smelser agree that he engages in a high number of behaviors that are considered disruptive, impulsive, and/or uncontrolled behaviors. Within the classroom he demonstrates a high number of behaviors that are considered restless and overactive and are likely adversely affecting other children."

Dr. Houston further found:

> "Teacher and Father Agree that he displays a high number of health-related concerns."

The Father and the Stepmother have reported that the Mother does not encourage the minor child to play outside; is constantly taking him to the pediatrician for no reason, when both parents are physicians and the Stepmother is a Nurse Practitioner, and that the Mother has conditioned the minor child to believe that he can develop Caribbean foot rot by being outside barefoot, or that he can contract multiple diseases such as West Nile virus from mosquito bites.

As it relates to adaptive skills, Dr. Houston makes the "following assessment:

> "Ratings by John's Mother were found to be within the average range in all areas of adaptive skills measured. The ratings by Mr. Morrison and John's teachers similarly evidenced a number of concerns regarding his adaptive functioning. They report that John has extreme difficulty adapting to changing situations and that John takes much longer to recover from difficult situations than most others his age. He has difficulty complementing others and making suggestions for improvement in a tactful and socially acceptable manner. In addition, he has difficulty making decisions, lacks creativity, and has difficulty getting others to work together effectively. His functional communication is considered by Father and teacher as unusually poor within expressed and receptive skills. He has significant difficulty seeking out and finding information on his own. Mr. Morrison and Ms. Rambally also disagree in regards to John's daily living skills. John's Father reports that John has difficulty performing simple daily tasks in a safe and efficient manner, while John's Mother reports that he is able to perform daily tasks safely and efficiently."

As it relates to school problems, Dr. Houston indicated that Mrs. Smelser's report evidenced clinically significant concerns with learning such that John has significant difficulty comprehending and completing school work in a variety of academic areas. Dr. Houston further indicated that Mr. Morrison also reported clinically significant difficulties associated with focused attention while Ms. Rambally's report suggested that he maintains an appropriate level of attention.

Finally, pursuant to the BASC, Dr. Houston makes the following conclusion:

> "Ms. Rambally did not endorse any other concerns. Mr. Morrison's report suggests that John occasionally engages in behaviors that are considered strange or odd and at times seemed disconnected from his surroundings. Mrs. Smelser, a teacher, identified these behaviors as occurring very frequently. Mrs. Smelser's report also indicated that John is generally alone, has difficulty making friends, and/or is unwilling to join group activities. Parents agree that he does not avoid social situation and appears capable of developing and maintaining friendships with others."

EXECUTIVE FUNCTIONING INDEX:

Index	Teacher	Mother	Father
Problem Solving	Extremely Elevated - 27	Not Elevated - 11	Extremely Elevated - 23
Attentional Control	Extremely Elevated -21	Not Elevated - 9	Extremely Elevated - 18
Behavioral Control	Elevated - 11	Not Elevated - 6	Not Elevated - 6
Emotional Control	Elevated - 10	Not Elevated - 2	Not Elevated - 0
OVERALL Executive Functioning	Extremely Elevated - 69	Not Elevated - 28	Elevated - 47

Dr. Houston additionally tested Johnny pursuant to the Childhood Autism Rating Scale, 2nd Edition (Hi-Functioning Version)(CARS 2), which is an observation system used to identify the characteristics of autism, which are obtained from observations, parent interviews, teacher interviews, and from standardized assessments. Ratings range from 1-4 and are totaled for an overall symptom level:

1 - age-appropriate skills

2 - mildly abnormal

3 - moderately abnormal

4 - severely abnormal

The minor child's score placed him in the category of severe symptoms of Autism Spectrum Disorder.

Under the Summary/Recommendation section of Dr. Houston's report, she makes the following findings:

> "These findings are consistent with the identification of an Autism Spectrum Disorder, as well as an Other Health Impairment. However, evaluation information was inconsistent across all environments as John's Mother did not endorse the concern/observations that were indicated during the assessment sessions, by the classroom teacher, as well as his Father. This inconsistency could be related to a difference of child behavior within various environments or could be due to a difference of observer partiality. For this reason, caution is provided to readers of this evaluation report."

Currently, the minor child is enrolled in a California school system, and is not receiving any special education services at the direction of the Mother.

VI. CONCLUSION

It is the position of the Petitioners that a "significant" and "material" change circumstance as defined by T. C. A. § 36-6-101(a)(2)(B) exists which would require this Honorable Court to modify the existing Permanent Parenting Plan to name the Father as the primary residential parent. The factors include, but are not limited to, the discovery and diagnosis that the minor child is suffering from ADHD, and from an Autism Spectrum Disorder, and that it is in the best interest of the minor child that he stay in a stable and consistent living environment in order for the educators, working in conjunction with the parents, medical staff, and psychologists to develop an individual education program which would provide a free and appropriate public education (FAPE) which would accomplish three (3) things:

(1) Allow the minor child the best opportunity to complete and continue his education;

(2) To allow the minor child to develop independent living skills; and

(3) To allow the minor child to develop skills which would allow him to pursue a vocation.

Additionally, the Petitioners would argue that since their marriage, the Stepmother and Stepsister have developed a close and loving relationship with the minor child, which would justify a modification of the Permanent Parenting Plan to allow for more co-parenting time with the Petitioners. Also, the Father's work schedule changed as of January 1, 2017, where he now has significantly greater flexibility over his work schedule, which will allow for him to exercise additional co-parenting time.

Further, the Petitioners would argue that pursuant to the statutory provisions of the comparative fitness test set forth above, the Father is in a superior position to be the primary custodial parent. The Mother has shown, by her actions and conduct, that she is unwilling to foster a loving relationship between the minor child and his Father and Stepmother; that she is putting her personal needs before the best interest of the minor child as it relates to his educational needs; and that she is in an inferior position to the Father to be the primary custodial parent.

WHEREFORE, PREMISES CONSIDERED, the Petitioners respectfully request this Honorable Court to grant their Petition to Modify and that the Father be named the primary residential parent for the minor child; that the proposed Permanent Parenting Plan submitted contemporaneous to the filing of the Petition to Modify be adopted as the current Permanent Parenting Plan; and that this Honorable Court determine what other relief should be awarded to the Petitioners, including, but not limited to, the awarding of attorney's fees and expenses; and that the Petitioners have such other, further and general relief to which they may be allowed.

Respectfully submitted this the ____ day of January, 2018.

DAIL R. CANTRELL (014780)
Attorney for Petitioners

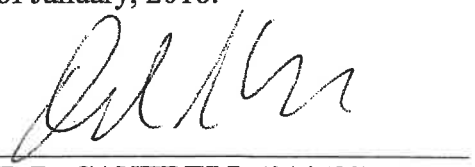
OF COUNSEL:

CANTRELL, GOODGE & ASSOCIATES
Post Office Box 299
Clinton, Tennessee 37717
(865) 457-9100

CERTIFICATE OF SERVICE

Comes now the undersigned below and does make oath that a true and exact copy of this pleading has been served upon Danny C. Garland, II, 103 Suburban Road, Suite 201-B, Knoxville, TN 37923, by placing same in the United States mail, postage pre-paid.

Respectfully submitted this the ____ day of January, 2018.



DAIL R. CANTRELL (014780)
Attorney for Petitioners

IN THE COURT OF APPEALS FOR TENNESSEE
EASTERN DIVISION
AT KNOXVILLE

ERIC JOHNSON, individually and as next of kin for decedent, JANA LANELLE JOHNSON, and the ESTATE OF JANA LANELLE JOHNSON,	]	
Plaintiff/Appellant,	]	
v.	]	**No. E2013-01228-COA-R3-CV**
PARKWEST MEDICAL CENTER,	]	
Defendant/Appellee.	]	

BRIEF OF THE APPELLANT

ON APPEAL FROM THE JUDGMENT OF
THE KNOX COUNTY CIRCUIT COURT

The Honorable Deborah C. Stevens Presiding

Dail R. Cantrell (BRP #014780)
CANTRELL, CANTRELL & ASSOCIATES
P. O. Box 299
Clinton, Tennessee 37717-0299
(865) 457-9100
Counsel for Plaintiff/Appellant

ORAL ARGUMENT REQUESTED

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TENN. R. CIV. P.

JURISDICTION STATEMENT

This action was heard in the Sixth Judicial District for the State of Tennessee, Knox County, Circuit Division, and is before this Honorable Court pursuant to a direct appeal.

NOTE REGARDING CITATION OF THE RECORD

For citing purposes, the Technical Record will be designated as "T. R." with references to the appropriate page number(s). The Transcript of the Proceedings will be designated as "T. P." with references to the appropriate page number(s). The Appellant, Eric Johnson, will be referred to as either the "Appellant," "Eric Johnson," or the "Plaintiff." The Appellee will be referred to as either the "Appellee," the "Defendant," or "Parkwest Medical Center."

STATEMENT OF THE ISSUES

I. Whether the trial court erred in dismissing the Appellant's Complaint pursuant to a Rule 12.02(6) Motion to Dismiss on the grounds that the Appellant failed to comply with T. C. A. 29-26-121(b) and T. C. A. 29-26-122(d)(4), and whether the trial court erred in determining that the Appellant failed to demonstrate extraordinary cause for said non-compliance;

II. Whether the trial court erred in denying Appellant's Motion to Set Aside a Portion of the February 9, 2012, Order Granting Partial Summary Judgment to the Appellee;

III. Whether the trial court abused its discretion in refusing to address the Appellant's Rule 34A.02 Motion for Sanctions prior to dismissing the Appellant's Complaint, and prior to denying the Appellant's Motion to Set Aside a portion of the February 9, 2012 Order Granting Partial Summary Judgment; and

IV. Whether the trial court erred in denying the Appellant's Rule 15 Motion to Amend the Complaint and Appellant's Motion to Amend the Certificate of Good Faith.

STATEMENT OF THE CASE

On or about June 26, 2008, the Appellant, Eric Johnson, individually and as next of kin for the decedent, Jana Lanelle Johnson, and on behalf of the Estate of Jana Lanelle Johnson, instigated a lawsuit in the Knox County Circuit Court (Docket No. 1-296-08) against the Appellee (Parkwest Hospital); two (2) of the Appellee's agents and employees (Charge Nurse David May and Primary Care Nurse Christina Wolfe); and an independent contractor working in the emergency room operated by the Appellee (Dr. Rodd Daigle) for failing to provide timely medical treatment which ultimately resulted in the death of the decedent on the 4th day of April, 2008 (T. R. Vol. V., p. 581).

In that action the trial court signed an Agreed Order, prepared by the counsel for the Appellee, submitted on August 5, 2008, which allowed the Appellee to obtain all of the decedent's medical records (T. R. Vol. V., p. 632). Written discovery was exchanged between the parties, and the depositions of the Appellant; the decedent's two (2) sisters; Defendant Daigle; Defendant Wolfe; and Defendant May, were completed by the fall of 2009 (T. R. Vol. V., p. 581).

Throughout the original litigation the Appellant, and his counsel, were relying upon forty-three (43) pages of medical records that had been provided: (1) by the Appellee directly to the Appellant prior to the instigation of the litigation; (2) to Appellant's counsel pursuant to the August 5th, 2008 Agreed Order for the obtaining of the medical records referenced above; and (3) during the exchange of written discovery.

These medical records were ultimately stipulated into evidence as being the complete medical file of the decedent, Jana L. Johnson. A copy of these medical records were Bates-stamped by the law firm representing the Appellee and were relied upon during all pretrial

discovery depositions as being a complete copy of all of the medical records related to the care of the decedent rendered at the Appellee's hospital. A complete copy of the forty-three (43) pages of medical records is attached as **Appendix "A"** to this Brief (T. R. Vol. V, p. 581).

Prior to trial a decision was made to Nonsuit the original lawsuit in November, 2009 (T. R. Vol. V, p. 582). Shortly thereafter, on or about November 30, 2009, pursuant to the then recently amended medical malpractice statute, T. C. A. 29-26-121(a), the attorney for the Appellant sent the anticipated notice of intent to refile the lawsuit to: (1) the agents and representatives of the Appellee designated to receive such information concerning prospective medical malpractice litigation; (2) Nurse Wolfe; and (3) Dr. Rodd Daigle. A copy of those letters is attached as collective **Appendix "B"** (T. R. Vol. V, p. 582).

On or about April 27, 2010, the Appellant refiled the previously Nonsuited lawsuit with the only difference being the deletion of Charge Nurse David May as a named Defendant. Contemporaneous to the refiling of the Complaint the Appellant filed a Certificate of Good Faith, attached as **Appendix "C,"** verifying that prior to the refiling of the lawsuit the Appellant's counsel had consulted with one (1) or more experts who had provided a signed written statement confirming that said expert is competent, pursuant to T. C. A. 29-26-115, to express opinions in the above-styled cause, and that said experts believed, based upon the information available from the medical records concerning the care and treatment of the decedent, Jana L. Johnson, for the incident at issue, that there was a good faith basis to maintain this cause of action consistent with the requirements of T. C. A. 29-26-115 (T. R. Vol. I, pp. 1-13).

The Appellee filed an Answer to the Complaint on May 20, 2010 (T. R. Vol. I., pp 17-25). Dr. Daigle filed an Answer to the Complaint on June 4, 2010 (T. R. Vol. I., pp. 26-36). On

or about September 30, 2010, Dr. Daigle filed a Motion for Summary Judgment on the theory that the care that he rendered to the decedent did not did not deviate from the accepted standard of care required of emergency room physicians in the Knox County medical community (T. R. Vol. I., pp. 37-44).

On or about October 27, 2010, the Appellee filed a Motion for Summary Judgment alleging that the conduct of its agents and employees did not constitute a deviation from the accepted standard of care for emergency room nurses and personnel operating within the Knox County medical community, and that all negligence claims should be dismissed because the Appellant's cause of action was covered exclusively by the medical malpractice statute. In support of its Motion for Summary Judgment the Appellee relied on the Affidavit testimony of Janice McKinley, the Vice President/Chief Nursing Officer for the Appellee, who averred that the forty-three (43) pages of medical records attached as **Appendix "A"** represented the decedent's "entire medical chart" (T. R. Vol. V, pp. 116-28; McKinley Affidavit, T. R. Vol. I, pp. 58-60 attached as **Appendix "D"**).

Dr. Daigle subsequently filed a Motion to Dismiss, pursuant to Rule 12 of Tennessee Rules of Civil Procedure, prior to the hearing of his previously filed Motion for Summary Judgment, also alleging that the nonmedical malpractice tort claims raised by the Appellant should be dismissed. In his Motion to Dismiss, Dr. Daigle adopted the Appellee's argument that the gravamen of the Appellant's complaints sounded in malpractice (T. R. Vol. I, pp. 129-36).

The Appellant filed a response to the Appellee's Motion for Summary Judgment on March 4, 2011, relying upon the forty-three (43) pages of medical records attached as **Appendix "A"** to this Brief, which the Appellee represented as being all of the medical records that existed

for the decedent's care (T. R. Vol. I, pp. 179-85). The Appellant responded to Dr. Daigle's Motion for Summary Judgment on March 4, 2011 (T. R. Vol. II, pp. 195-211).

On or about February 6, 2012, the parties entered into an Agreed Order granting Dr. Daigle's Motion for Summary Judgment and his Motion to Dismiss, effectively dismissing Dr. Daigle from the litigation (T. R. Vol. II, pp. 281-82). Subsequently, on February 9, 2012, the Appellant and the Appellee entered into an Agreed Order Granting Partial Summary Judgment to the Appellee on the Appellant's non-medical malpractice tort claims which was predicated on the multiple representations made by the agents and employees of the Appellee that the only medical records that existed for the decedent's care at Parkwest Hospital were the forty-three (43) pages of medical records which had been relied upon by the Appellee's expert, Janice McKinley (T. R. Vol. II, pp. 283-84).

On or about May 31, 2012, the Appellant and the Appellee submitted an Agreed Order setting the case for trial to commence on December 17, 2012 (T. R. Vol. II, p. 287). As the parties began to prepare for the December trial date, the Honorable Wheeler Rosenbaum announced his retirement effective December 31, 2012. A mutual decision was made by counsel to move the case to the spring term in order to allow Judge Rosenbaum's replacement to try the case. As a result, on or about September 27, 2012, an Agreed Order was entered resetting the trial date to April 8, 2013 (T. R. Vol. II, p. 288).

In preparation of the trial the parties entered into a Stipulation on March 11, 2013, entering the forty-three (43) pages of medical records that had been continuously represented by the agents and employees of the Appellee as being the decedent's entire medical file into evidence as Trial Exhibit No. "1" (T. R. Vol. III, p. 290).

On or about March 21, 2013, the parties participated in a pre-trial conference before the recently appointed trial judge, the Honorable Judge Deborah Stevens, who inquired as to whether there were any matters that needed be taken up prior to trial. The Appellee's counsel indicated that there would possibly be a Motion in Limine filed, but other than that the case was ready for trial. During the pre-trial conference the Appellant's counsel advised the court, and counsel for the Appellee, that he and his family were traveling early the next morning to the State of Virginia for a family reunion with his wife's family (T. R. Vol. III, pp. 424-25).

Inexplicably, late the next afternoon, at approximately 3:52 p.m. on Friday, March 22, 2013, the Appellee filed a Motion to Dismiss pursuant to Rule 12 of the Tennessee Rules of Civil Procedure alleging, for the first time, that the Appellant had failed to comply with the requirements of T. C. A. 29-26-101, *et seq.* (T. R. Vol. III, pp. 351-55).

On or about April 3, 2013, Appellant filed a response to the Appellee's Motion to Dismiss (T. R. Vol. III, pp. 369-85). That same day, and prior to the hearing of the Appellee's recently filed Tenn. R. Civ. P. 12 Motion to Dismiss, Appellant's counsel took the deposition of the manager of the Digital Imaging Department for Parkwest Medical Center, Jamie Nance. During that deposition Ms. Nance testified that the Appellant had not been given all of the decedent's medical records. It was during this deposition that the Appellant first discovered that there were additional medical records related to his wife's care which had been withheld by the Appellee (T. R. Vol. V., pp. 592-95).

Upon returning to his office that afternoon Appellant's counsel had a conversation with counsel for the Appellee whereby he inquired as to the existence of these previously undisclosed medical records. The Appellee's counsel assured the Appellant's counsel that Ms. Nance was mistaken, and that the forty-three (43) pages of medical records that had been used throughout

the course of this litigation represented the entirety of the decedent's medical file. Unexpectedly, at approximately 1:00 p.m. on April 4th, ten (10) additional pages of medical records, attached as **Appendix "E,"** were provided to the Appellant by the counsel for the Appellee. These additional medical records contained previously concealed evidence critical to the Appellant's theory of the case. As a result the Appellant immediately filed a supplement to his April 3rd, 2013, Response to the Appellee's Motion to Dismiss bringing to the trial court's attention the existence of ten (10) additional pages of relevant medical information. As a result of the newly released medical records the April 8, 2013 trial date was continued (T. R. Vol. IV, pp. 429-44).

After Appellant's counsel received the previously concealed medical records, counsel went back through the entirety of the decedent's medical file and discovered that the previously concealed medical records completely altered the theory of Appellant's case. As a result, the Appellant immediately filed a Motion to Amend the Complaint, pursuant to Tenn. R. Civ. P. 15.01, and a Tenn. R. Civ. P. 60 Motion to Set Aside a Portion of the Order Granting Partial Summary Judgment to the Appellee (T. R. Vol. IV, pp. 445-51).

On or about April 18, 2013, the Appellant filed a supplement to the previously filed Motion to Amend; a supplement to the previously filed Motion to Set Aside a Portion of the Order Granting Partial Summary Judgment to the Appellee; and a Tenn. R. Civ. P. 34A.02 Motion for Sanctions necessary to address the Appellee's spoliation of evidence. On the same date the Appellant filed a Motion to Amend the previously filed Certificate of Good Faith pursuant to T. C. A. 29-26-122(c) (T. R. Vol. V, pp. 575-647).

On or about April 26, 2013, the Appellee filed a response in opposition to the Appellant's Motion to Amend the Complaint (T. R. Vol. V., pp. 648-91). The Appellant then filed a

Supplemental Response to the Appellee's Motion to Dismiss on April 25, 2013 (T. R. Vol. V, pp. 692-715).

On the 10th day of May, 2013, the Trial Court heard all pending Motions, except for the Appellant's Rule 34A.02 Motion for Sanctions, and dismissed the Appellant's lawsuit in its entirety (T. R. Vol. VI, pp. 794-96). On or about May 22, 2013, the Appellant filed a timely Notice of Appeal (T. R. Vol. VI, pp. 806-07).

STATEMENT OF THE FACTS

The Appellant, Eric Johnson, is the surviving spouse of the decedent, Jana L. Johnson, who was an otherwise healthy forty-six (46) year old female who died on April 4, 2008, while a patient at the emergency room operated by the Appellee, Parkwest Medical Center. Mrs. Johnson was in bed with her husband when she began experiencing severe knee pain, left groin pain and chest pain at approximately 4:00 a.m. on the morning of April 4th. As her symptoms worsened, a decision was made to seek emergency medical treatment (T. R. Vol. I, pp. 1-13).

At approximately 5:27 a.m. the Knoxville Rural Metro Ambulance Service arrived at the Johnson's residence and transported Mrs. Johnson to the Parkwest Medical Center. In route, the emergency medical personnel started Mrs. Johnson on oxygen and established an intravenous line in her left forearm in order to begin an infusion of normal saline (T. R. Vol. I, p. 2).

Mrs. Johnson arrived at the emergency room at approximately 6:03 a.m. and was immediately placed under the care of Charge Nurse David May and Primary Care Nurse Annette McDonald. Both Nurse May and Nurse McDonald were agents and employees of the Appellee (T. R. Vol. I, p. 3).

During the initial nursing assessment Nurse May determined that the IV site started by the emergency medical personnel prior to Mrs. Johnson's arrival at the emergency room was not suitable for an anticipated CT scan with IV contrast. As a result Nurse May made a decision to start a second IV site in Mrs. Johnson's left AC vein (T. R. Vol. V, p. 577).

In his deposition Nurse May set forth the specific reason why he decided to start a second IV site in Mrs. Johnson's left AC vein:

> "It (the IV site) was questionable. And also if she--
> left forearm. Our CAT scan department's policy is
> if they have to get IV contrast, it has to be in the left
> AC, or in an AC vein, and that would have been a

second reason why we were--if we were trying to get a second IV site to get something in the AC" (T. R. Vol. V, p. 589).

Nurse May testified that he began attempting to establish the second IV site sometime between 6:03 a.m. and 6:15 a.m. He and Nurse McDonald both worked to start the second IV site but were not successful. Efforts to create a second working IV in Mrs. Johnson's AC vein were temporarily abandoned when Dr. Rodd Daigle, the emergency room physician assigned to Mrs. Johnson's care, arrived at her room at approximately 6:15 a.m. (T. R. Vol. V, pp. 25-26).

Dr. Rodd Daigle performed his initial physical examination on Mrs. Johnson at approximately 6:15 a.m. As a result of that examination Dr. Daigle ordered blood work and a chest x-ray (T. R. Vol. V, pp. 584-85).

The Hospital-Unit-Clerk (HUC) assigned to the emergency department inputted Dr. Daigle's order for a chest x-ray into the hospital computer system at 6:28 a.m., approximately two (2) minutes after having been handed the order by Dr. Daigle. At 6:30 a.m. the chest x-ray was completed, and the results were digitally transmitted to Dr. Daigle for his review (T. R. Vol. V, p. 585).

Somewhere between 6:30 a.m. and 6:40 a.m., Dr. Daigle reviewed the chest x-ray and examined Mrs. Johnson for a second time. It is at this point that Dr. Daigle formed a differential diagnosis which included a suspected pulmonary embolism.

NOTE: **The autopsy confirmed Dr. Daigle's differential diagnosis of a pulmonary embolism which ultimately resulted in Mrs. Johnson's death later that morning** (T. R. Vol. V, 585).

Once Dr. Daigle formed a working differential diagnosis in which he strongly suspected that Mrs. Johnson was suffering from a pulmonary emobolus, he made a decision to order a STAT CT scan with IV contrast of Mrs. Johnson's chest. The CT scan would serve two (2)

purposes: (1) it would confirm Dr. Daigle's differential diagnosis of a suspected pulmonary embolism and reveal its location; and (2) it would rule out the possibility of an aortic dissection (T. R. Vol. V, p. 613).

NOTE: **The cause of death in this case is undisputed. Additionally, experts for both the Appellee and the Appellant agree that the proper treatment protocol for a pulmonary embolism was to begin administering anti-coagulation drugs (Levonox or Heparin) to Mrs. Johnson intravenously. Dr. Daigle testified that prior to beginning the anti-coagulation therapy he felt it necessary to rule out an aortic dissection.**

Sometime between 6:40 a.m. and 6:45 a.m. Dr. Daigle handed his written order for a STAT CT scan with IV contrast to the Hospital-Unit-Clerk assigned to the emergency room. This clerk/secretary is the individual who was responsible for inputting Mrs. Johnson's name, her hospital ID number, and Dr. Daigle's handwritten order into the hospital computer system (T. R. Vol. V, p. 585).

Jamie Nance, an agent and employee of the Appellee who is in charge of the Medical Imaging Department, describes the Hospital-Unit-Clerk position as being a "secretary" assigned to the emergency room. In her deposition, Ms. Nance described the actual procedure that is followed by the secretary when she receives an order from a physician. Specifically, Ms. Nance testified as follows:

> "Q. In April, 2008, if an emergency room physician makes an order for a CT scan for a patient, how do you, or how does the Imaging Services Department, become aware that the order has been made? Is there like a written order? Was it done electronically?
>
> A. The written order was written down in the chart by the physician, and that chart is taken by the HUC.
>
> Q. Tell me what the HUC is?

A. The HUC is a **UNIT SECRETARY,** basically.

Q. Okay.

A. Hospital-Unit-Clerk.

Q. ---

A. A H-U-C, which is a unit secretary, enters the information into their computer system from the chart, and it is transmitted to the radiology department.

Q. Electronically?

A. Electronically, yes, sir. The CT department receives a printed requisition, and then that is--that basically is when we are aware of that procedure.

Q. When you get the print out from--

A. We get the printout, yes sir.

Q. Let's back up to this H-U-C. So the physician makes a written order either on a chart or something and then does what with it? Who does he give it to?

A. He gives it to the unit secretary.

...

Q. The H-U-C then types in the order into the computer, correct?

A. Correct.

Q. And that then prints out the order that says what type of scan is being ordered?

A. Correct.

Q. OK. What do you do with it, or what does the employee that then gets it from the imaging services do with it, when they get a printed order?

A. They look at the order to see what the procedure is, and then, based on the procedure, they would send

for the patient. They would page the transport system; the transporter would go down and pick up the patient. The patient would be brought up to the CT department and placed on the table" (T. R. Vol. V., pp. 592-94).

Ms. Nance further testified that she was responsible for both medical and non-medical personnel in her position as the manager of the Medical Imaging Department, and that the Hospital-Unit-Clerk/secretary who received Dr. Daigle's written order for a CT scan with IV contrast was performing a purely secretarial function in entering Mrs. Johnson's name, patient identification number, and the test being ordered by Dr. Daigle into the hospital computer system. According to Ms. Nance, the secretary would then transmit that information to the Medical Imaging Department, which would receive a computer printout of Dr. Daigle's written order (T. R. Vol., V, pp. 594-95).

Dr. Daigle has a clear recollection of handing the STAT order for a CT scan with IV contrast to the secretary responsible for entering Mrs. Johnson's information into the computer at approximately 6:40 a.m. to 6:45 a.m.:

"Q. And down at the last item that was checked where it says "CT of the chest" and then is that IV for PE or just IV, PE?

A. It's IV. It's PE protocol. It just tells the technicians how to time the injections.

Q. Okay. As to kinda what you are looking for?

A. Correct.

Q. And it's your recollection that this would have been ordered at approximately 6:30 a.m. that morning?

A. It would have been right after that that I wrote the order and then handed it to the clerk" (T. R. Vol. V., p. 20).

At this point in the recitation of the facts all of the witness' testimony is consistent with each other, and consistent with the medical records that were at one (1) time being represented as the entire medical file for Jana Johnson **(Appendix "A")**. Specifically, there is no dispute concerning the time of arrival, the treatment rendered to Mrs. Johnson, and the timing of the doctor's orders up through 6:45 a.m.

Counsel for the Appellant relied upon the forty-three (43) pages of medical records attached as **Appendix "A"** to establish a timeline relative to the treatment that Mrs. Johnson received from the agents and employees of the Appellee and from Dr. Daigle. This timeline was then used to take the deposition of Dr. Daigle, Nurse May, Nurse Wolfe, and the various experts. The medical records and the testimony of the lay witnesses who were with Mrs. Johnson, and of the medical personnel employed by the Appellee to care for Mrs. Johnson is consistent through 6:40 a.m. - 6:45 a.m., the time when Dr. Daigle handed the secretary his handwritten order of a CT scan with IV contrast (T. R. Vol. V, p. 20).

At that time, according to the Appellee's Director of the Medical Imaging Department, Jamie Nance, the secretary should have typed Mrs. Johnson's name, hospital identification number, and Dr. Daigle's handwritten order of a chest CT scan with IV contrast into the hospital computer system which would then generate a document called a STAR Requisition Order which would be received in the Medical Imaging Department. The STAR Requisition Order would have alerted the Medical Imaging Department to send down transport personnel to take Mrs. Johnson up to the Medical Imaging Department so that the CT scan with IV contrast could be performed (T. R. Vol. V., pp. 592-94).

The Appellant, and the Appellant's counsel, were operating under the assumption (based upon the testimony of the agents and employees of the Appellee) that the secretary charged with

the responsibility for entering Dr. Daigle's STAT order of a CT scan with IV contrast into the hospital computer system would have done so immediately after having been handed said handwritten order by Dr. Daigle. This assumption was predicated on the representation by the Appellee, and its agents and employees, that the forty-three (43) pages of medical records provided to the Appellant, both prior to the instigation of litigation and during discovery, were all of the medical records related to the treatment that Mrs. Johnson received in the emergency room on April 4, 2008.

The non-medical negligence which ultimately resulted in Mrs. Johnson's untimely death began at 6:45 a.m., which is the same time as shift change. At this point the secretary who was handed Dr. Daigle's order for a STAT CT scan left to be replaced by her counterpart from the next shift. Additionally, Nurse McDonald, the Primary Care Nurse responsible for Mrs. Johnson, was replaced by Nurse Christina Wolfe. It is from this point forward that the Appellant now alleges that the medical and non-medical negligence occurred, and it is from this point forward that a decision was made by the agents and employees of the Appellee to alter and/or conceal medical records.

The first notation that occurs after shift change is a 6:50 a.m. entry by Nurse McDonald which records that she was drawing additional blood from Mrs. Johnson and that Mrs. Johnson was taken to x-ray (presumably for the CT scan)**(Appendix "A" at 17)**. The Appellant would aver that it could not have been for the chest x-ray because it was completed at 6:30 a.m., and interpreted by Dr. Daigle between 6:30 a.m. and 6:40 a.m. No other procedures were ordered which would have required Mrs. Johnson to be taken from her room other than the STAT chest CT scan with IV contrast (**Appendix "A"**).

At 6:55 a.m. Nurse McDonald charts that Mrs. Johnson returns to her room from radiology (**Appendix "A" at 17**). At 7:00 a.m. primary care of Mrs. Johnson was transferred from Nurse McDonald to Nurse Wolfe (T. R. Vol. V, p. 27). At this point the Appellant alleges that one (1) of the reasons why ten (10) pages of Mrs. Johnson's medical records were concealed from the Appellant was to cover up this false entry of Nurse McDonald indicating that Mrs. Johnson was taken from her room and transported to radiology (T. R. Vol. V, p. 802).

In her deposition Nurse Wolfe testified that at approximately 7:00 a.m. Dr. Daigle questioned her about the status of the CT scan. Specifically, Nurse Wolfe testified as follows:

> "Q. Have you already spoken with Dr. Daigle concerning the status of the CT scan at the time you physically wrote the number 7:05 a.m. on this chart?
>
> A. Yes.
>
> Q. So that conversation with Daigle had to occur sometime…
>
> A. Between 7:00 a.m.--it was around 7:00 a.m. I can't give you the exact time. I don't recall" (T. R. Vol. V., p. 31).

Dr. Daigle testified that he handed a copy of his STAT order for the CT scan with IV contrast (**Appendix "A" at 14**) to the secretary responsible for inputting the order into the computer system at approximately 6:40 a.m. to 6:45 a.m., and that he anticipated receiving the results of the CT scan between 7:15 a.m. and 7:30 a.m. (T. R. Vol. V, p. 590).

It is important to note that at this time the Appellant and his counsel believed, based upon the deposition testimony of the fact witnesses, and the forty-three (43) pages of medical records attached as **Appendix "A,"** that in fact Mrs. Johnson could have been taken to radiology at 6:50

a.m. as charted by Nurse McDonald, and returned as quickly as 6:55 a.m. Specifically, Nurse McDonald's Supervisor, Charge Nurse David May, testified as follows:

> "Q. Do you have an estimate of time that it typically takes to get a STAT CT scan in the emergency room?
>
> A. If the CAT scan table is clear, it takes no more than five (5) minutes.
>
> Q. From the time the physician orders it to get it?
>
> A. It has the potential of being that fast. It can at times, yes" (T. R. Vol. V., p. 12).

The Appellant would assert that the reason Dr. Daigle inquired about the status of the STAT CT scan between 7:00 a.m. and 7:05 a.m. was because he would have a reasonable belief that it could in fact be completed that quickly (T. R. Vol. V, p. 602).

During cross-examination Nurse Wolfe attempted to explain the delay in getting Mrs. Johnson's STAT CT scan completed by fabricating a story that the emergency room was busy. Specifically, Nurse Wolfe testified as follows:

> "It was a busy morning when I had come on at 6:45 a.m. We had a lot of critical patients coming in that morning. A lot of patients were signing in out front. I remember it was just--it was busy. I can't say that it was chaos, but it was a busy morning" (Wolfe Depo., p. 15, lines 14-18)(T. R. Vol. V, p. 801).

To rebut that testimony, Appellant's counsel obtained a copy of the Emergency Room Daily Census Log for the twenty-four (24) hour period during which Mrs. Johnson was in the emergency room. As is reflected in this document, when Mrs. Johnson was logged in as a patient at 6:07 a.m., there were only four (4) other patients in the entire emergency room department, all of whom were in the process of being discharged. Three (3) of those patients

were discharged by 6:45 a.m., leaving the emergency room department empty with the exception of Mrs. Johnson and a non-emergent patient suffering from renal colic who was ultimately discharged at 7:45 a.m. The next patient to arrive did not get to the emergency room department until 7:27 a.m., and this was a non-emergent patient with abdominal pain (T. R. Vol. V, pp. 801-02).

Nurse Wolfe makes what Appellant now alleges to be two (2) more fraudulent entries into Mrs. Johnson's medical record. First, Nurse Wolfe recorded that at 7:05 a.m. Mrs. Johnson was taken from her room to the Medical Imaging Department for the CT scan that had been ordered between 6:40 a.m. and 6:45 a.m. (Wolfe Depo., p. 26, lines 1-5)(T. R. Vol. V, p. 587). Then Nurse Wolfe makes the most damning fraudulent entry into Mrs. Johnson's medical chart by recording that at 7:15 a.m. Mrs. Johnson's IV was discontinued by the CT tech (**Appendix "A" at 17**)(T. R. Vol. V, p. 588). Specifically, Nurse Wolfe was asked about this 7:15 a.m. notation, and she testified as follows:

> "Q. Who made that notation?
>
> A. I did. I was notified that CT had taken her IV out upstairs while she was in CAT scan, that the IV that they tried to use to inject the dye had infiltrated, and that was the IV that was in her **LEFT FOREARM** when I went in to assess her that morning.
>
> Q. I want to stay on that for just a minute. So someone from CT scan contacted you?
>
> A. Yes.
>
> Q. Do you recall who that was?
>
> A. I don't remember their name, honestly, no I don't.
>
> Q. When did that occur?

A. It was around 7:15 a.m. Actually it was at 7:15 a.m. because after I got off the phone they told me they had taken her IV out because it had infiltrated up there, and I documented that they had done that" (Wolfe Depo., p. 27, lines 11-25; page 28, lines 1-12)(T. R. Vol. V, pp. 14-15).

Nurse Wolfe would have gotten away with this lie, and she and Nurse McDonald would have gotten away with the altering of medical records, had Ms. Nance not alerted the Appellant to the existence of the additional medical records. Specifically, the previously concealed medical records **(Appendix "E")** reveal that Dr. Daigle's STAT order of the CT scan with IV contrast that he handed to the unit secretary between 6:40 a.m. to 6:45 a.m. was not even entered into the hospital computer system until 7:16 a.m., a minute after Nurse Wolfe enters the fraudulent notation that at 7:15 a.m. she received a call from the CT department telling her that there were problems with Mrs. Johnson's IV **(Appendix "E")**.

Further, proving that the above-referenced statement from Nurse Wolfe is a lie, is information contained within the previously concealed medical records from the Medical Imaging Department. According to these records Mrs. Johnson did not even arrive at the Medical Imaging Department until 7:20 a.m. (**Appendix "E"**).

When Nurse Wolfe made the fraudulent notation that she had received a call from the CT department at 7:15 a.m. (a full five (5) minutes before Mrs. Johnson even arrived at the Medical Imaging Department), and that an unidentified CT tech informed her that an IV in the left forearm had infiltrated necessitating Mrs. Johnson to be returned to the room, Dr. Daigle's order for the CT scan had not even been entered into the hospital computer system (T. R. Vol. V, p. 805).

Specifically, counsel would direct this Honorable Court to **Appendix "F1 and F2,"** which show that the check-in time when Mrs. Johnson arrived at the Medical Imaging

Department was 7:20 a.m., and that the requested-for time (the time that the secretary entered Dr. Daigle's order into the hospital's requisition system) was not until 7:16 a.m. According to these records Mrs. Johnson did not even arrive at the Medical Imaging Department until 7:20 a.m., at which time Dr. Daigle's medical order was inexplicably cancelled while Mrs. Johnson was in the waiting area. Dr. Daigle's order for a STAT CT scan with IV contrast was never again inputted into the hospital computer system **(Appendices "A" and "E")**.

Based upon the testimony of the agent and employee of the Appellee, Jamie Nance, the Director of the Imaging Service Department, the specific procedure that would be involved in obtaining a STAT CT scan with IV contrast would be as follows:

> -physician prepares a handwritten order requesting a STAT CT scan with IV contrast **(Appendix "A" at 14);**
>
> -physician hands said order to the Hospital-Unit-Clerk, an administrative/secretary staff person assigned to the emergency room (Dr. Daigle has a clear recollection of handing the STAT order for a CT scan with IV contrast to the Hospital-Unit-Clerk at approximately 6:40 a.m. to 6:45 a.m. (T. R. Vol. V, p. 594);
>
> -the above-referenced secretary enters the patient's name, patient's identification number, and the physician's order into the hospital computer system;
>
> -the Medical Imaging Services Department receives a computer printout of the physician's order that indicates what type of scan is being requested **(Appendix "E")**;
>
> -the administrative clerk located in the Medical Imaging Services Department instructs the transportation team to go to the emergency room to bring the patient up for the scan (T. R. Vol. V, p. 597).

The previously concealed medical records reveal that Dr. Daigle's order for a CT scan with IV contrast was not entered into the STAR requisition system until 7:16 a.m., more than thirty (30) minutes after Dr. Daigle handed the order to the secretary, and Mrs. Johnson did not

arrive at the Medical Imaging Department until 7:20 a.m. This is in direct contradiction to Nurse Wolfe's testimony, and her entry into Mrs. Johnson's medical records, that at 7:15 a.m. she had a conversation with an "unidentified CT tech" who allegedly informed her that the IV in Mrs. Johnson's left forearm had infiltrated necessitating that Mrs. Johnson be returned to her room (T. R. Vol. V, p. 805).

Dr. Daigle handed his order for a STAT CT scan with IV contrast to the secretary responsible for entering this information into the computer moments before a shift change. Given that Mrs. Johnson was one (1) of only two (2) patients in the entire emergency department, it is unknown as to why Dr. Daigle's order was not entered into the hospital computer system until 7:16 a.m. **(Appendix "E").**

Nurse Wolfe and Nurse McDonald were simultaneously recording vital statistics and rendering assistance to Mrs. Johnson at 7:00 a.m. Therefore, it is apparent that Nurse Wolfe and Nurse McDonald became simultaneously aware of Dr. Daigle's 7:00 a.m. inquiry as to why the CT scan had not yet been ordered (T. R. Vol. V, p. 806).

At this point in the factual recitation counsel for the Appellant would set forth that but for the honesty of Jamie Nance in providing the previously concealed medical records, neither the Appellant, nor Appellant's counsel, would have been able to determine that Nurse Wolfe was giving false testimony in her deposition, and that Nurse Wolfe and Nurse McDonald were making false entries into Mrs. Johnson's medical records. The only conceivable explanation that exists to explain how Nurse Wolfe can have a phantom conversation with an unknown member of the Medical Imaging Department concerning an allegedly blown IV at 7:15 a.m., when the unit secretary did not even enter Dr. Daigle's request for a STAT CT scan until 7:16 a.m., and when Mrs. Johnson was not even taken to the Medical Imaging Department until 7:20 a.m., is

that Nurse McDonald and Nurse Wolfe were attempting to cover up their actions, and the actions of the secretary, in not having Mrs. Johnson ready to go to the Medical Imaging Department to obtain the CT scan.

Somewhere between 7:20 a.m. and 7:25 am., according to the testimony of Nurse Wolfe and Dr. Daigle, Dr. Daigle makes a second inquiry of Nurse Wolfe as to the status of the STAT CT scan that he had ordered between 6:40 a.m. and 6:45 a.m. Nurse Wolfe, in a further attempt to cover her negligence, and her fellow employees' negligence, informs Dr. Daigle that the IV had blown, and that Mrs. Johnson was insisting that a nurse named Sandy Irons be brought in to restart the IV in order to complete the CT scan (T. R. Vol. V, p. 607).

From that time forward Mrs. Johnson received essentially no medical treatment. According to Nurse Wolfe she allegedly paged Sandy Irons at 7:56 a.m., but she concedes that no further care was given to Mrs. Johnson until 8:28 a.m. when Mrs. Johnson fell into severe physical distress before ultimately coding at 8:44 a.m. (T. R. Vol. V, pp. 33-34).

After Mrs. Johnson died her surviving spouse, Eric Johnson, met with agents and representatives of the corporate Defendant and requested a copy of her entire medical record. A copy of the two (2) paged Authorization to Release Health Information provided unto Mr. Johnson by the agents and representatives of the corporate Defendant is attached as **Appendix "G"** to this Brief. During the litigation Mr. Johnson provided testimony that in response to this request he received the same forty-three (43) pages of records that are attached to this Brief as **Appendix "A"** (T. R. Vol. V, p. 6).

Mr. Johnson initiated a lawsuit against the Appellee; two (2) of the Appellee's agents and employees (Charge Nurse David May and Primary Care Nurse Christina Wolfe), and Dr. Rodd Daigle n June 26, 2008. Written discovery was exchanged between the parties, and the

discovery deposition of the Appellant; the decedent's two (2) sisters; Dr. Rodd Daigle; Nurse Christina Wolfe; and Nurse David May were taken and completed (T. R. Vol. V, p. 581).

Prior to the taking of any of the depositions, counsel for the Appellee assembled the forty-three (43) pages of medical records attached as **Appendix "A,"** and provided a Bates-stamped copy to both the Appellant's law firm, and the law firm representing Dr. Daigle. These medical records were used throughout all discovery depositions, including the depositions of the various expert witnesses for both the Appellant and the Appellee (T. R. Vol. V, p. 581).

It was represented by counsel for Dr. Daigle, and by counsel representing the Appellee, that Dr. Daigle had no independent medical records. The Appellee represented these forty-three (43) pages of records as being the complete and entire medical file related to the treatment of Jana L. Johnson (T. R. Vol. V, p. 581).

Counsel for the Appellee further represented to the Appellant's counsel, and to the counsel for Dr. Daigle, that neither Nurse Wolfe nor Nurse May possessed or created any independent medical records, and that any medical records in which they had a part of creating were done solely in their capacity as agents and employees of the Appellee, and were included in the forty-three (43) pages of medical records attached as **Appendix "A"** (T. R. Vol. V, p. 582).

The Appellant ultimately Nonsuited the original lawsuit in November, 2009. On or about November 30, 2009, the attorney for the Appellant sent the anticipated Notice of his intent to refile the lawsuit to the agent and representative of the Appellee designated to receive information about the anticipated filing of medical malpractice litigation; to Nurse Christina Wolfe; and to Dr. Rodd Daigle, along with a HIPAA Compliant Medical Authorization form (T. R. Vol. V, p. 582)(**Appendix "B"**).

The letters were dated November 30, 2009, and it is undisputed that John T. L. Geppi received one (1) of the letters as the designated agent of the Appellee. Prior to mailing the Notice of Intent letter, as anticipated by T. C. A. 29-26-121, the parties had already engaged in extensive written discovery; taken the deposition of the parties to the litigation including Dr. Daigle; the Appellee's agents and employees, Nurse Christina Wolfe and Nurse David May; taken the depositions of expert witnesses; and had entered into an Agreed Medical Order which allowed for the parties to exchange medical records.

Specifically, on August 5, 2008, the trial court entered an Order, upon Motion of the Appellee, in the original cause of action that allowed the Appellee to obtain a copy of any and all "reports, records, notes, bills, x-rays, or other medical records related to the treatment of Mrs. Johnson." Pursuant to this Order the Appellee provided unto the Appellant the forty-three (43) pages of medical records attached as **Appendix "A."**

Clearly, prior to the refiling of the previously non-suited Complaint on April 27, 2010, the Appellee had been provided both Notice and a HIPAA Compliant Release to obtain Mrs. Johnson's medical records, and an Order which was actually used to obtain Mrs. Johnson's medical records, in compliance with T. C. A. 29-26-121. The Appellant would assert that this becomes important at a later stage in this discussion because a Probate Estate had not been opened and the August 5, 2008 Order, which was provided to the Appellee at the Appellee's request, allowed the Appellant to provide the Appellee complete access to Mrs. Johnsons' medical records while a HIPAA Compliant Release would not.

It is undisputed that the Appellee, in compliance with the August 5, 2008 Order, assembled and Bates-stamped the forty-three (43) pages of medical records which were stipulated by the Appellee as being the entire medical record for Mrs. Johnson. All of these

medical records were entered as Exhibits to the deposition of Defendant Daigle, Defendant Wolfe, and Defendant May prior to the refiling of the lawsuit (T. R. Vol. V, pp. 8-9).

The lawsuit was refiled on April 27, 2010. Prior to that day it is undisputed that the Appellee, the agent and employee of the Appellee, Christina Wolfe, and Defendant Rodd Daigle already had received Notice of the Intent of the Plaintiff to refile the lawsuit through the November 30, 2009 letter; had notice of the prospective Defendants; had notice of the addresses of the prospective Defendants; and had what was then represented as being all of the medical records at issue in this litigation, which the Appellee obtained through the Order dated August 5, 2008.

Prior to the lawsuit being refiled on April 27, 2010, and during the pendency of the first lawsuit, the Appellant also obtained an Order dated May 27, 2009, which required the Appellee to provide a copy of any and all:

-hospital records

-doctor's reports

-physician's notes

-x-rays

-x-ray reports

-nurses' notes and records

-any and all other medical records and bills.

The Appellant used this May 27, 2009, Order when he made a written request of the Appellee to provide:

> "Mrs. Johnson's "**ENTIRE MEDICAL RECORD**"(attached as **Appendix "H"**).

In response to the letter the Appellant received the same forty-three (43) pages of medical records contained in **Appendix "A."**

After the lawsuit was refiled significant additional discovery took place between the parties. Expert witnesses were deposed, additional fact witnesses were deposed, and during each deposition the parties relied upon the same forty-three (43) pages of medical records that had been compiled by the Appellee as being the complete medical record of Jana L. Johnson.

The Appellant's counsel prepared the following timeline based upon those medical records, and the deposition testimony of the various parties and witnesses:

6:03 a.m.
Charge Nurse David May and Primary Care Nurse Annette McDonald begin triage and an emergency nursing assessment for Jana L. Johnson (**Appendix "A" at 16**);

6:11 a.m.
First EKG printout is received showing that Mrs. Johnson is not suffering from a heart attack;

6:15 a.m.
Dr. Rodd Daigle begins his physical examination of Jana Johnson (**Appendix "A" at 8-9**);

6:25 a.m.
Dr. Daigle issues a series of orders for basic metabolic panel; a troponin 1 level; a CK with CKMB; and a CBC (**Appendix "A" at 22-23**);

6:26 a.m.
Dr. Daigle orders a chest x-ray;

6:28 a.m.
The secretary employed by the Appellee to enter information into a computer, enters Dr. Daigle's order for a chest x-ray into the STAR requisition system (**Appendix "A" at 27**);

6:30 a.m.
Chest x-ray is completed (**Appendix "A" at 27**);

6:30 a.m.
Nurse McDonald charts that Mrs. Johnson has increased pain in the left buttocks which is now radiating to the left leg causing the left foot to go numb (**Appendix "A" at 17**);

6:30 a.m.- 6:40 a.m.
Dr. Daigle reviews chest x-ray; examines patient for a second time; and forms a differential diagnosis which includes a suspected pulmonary embolism (Daigle Depo. pp. 70-73);

6:40 a.m.
Nurse McDonald draws labs necessary to complete the four (4) orders issued by Dr. Daigle at approximately 6:25 a.m. (**Appendix "A" at 17, 25-26**);

6:40 a.m.- 6:45 a.m.
Dr. Daigle completes written order for a STAT CT scan of Mrs. Johnson's chest with IV contrast, and hands said Order to the secretary responsible for entering his orders into the computer (Daigle Depo., p. 71, lines 12-23; **Appendix "A" at 14**).

6:43 a.m.
Results of CBC reported to medical staff (**Appendix "A" at 22-23**);

6:45 a.m.
Nurse McDonald draws blood for the ABG test (**Appendix "A" at 17**);

6:45 a.m.
Shift change;

6:50 a.m.
Nurse McDonald draws additional blood for additional medical tests (**Appendix "A" at 17**);

6:50 a.m.
Nurse McDonald charts that Mrs. Johnson is taken to x-ray (**Appendix "A" at 17**);

6:52 a.m.
ABG analysis received (**Appendix "A" at 24**);

6:55 a.m.
Nurse McDonald charts that Mrs. Johnson is returned from x-ray (**Appendix "A" at 17**);

NOTE 1: It is important to note that at this time the Appellant, and Appellant's counsel, are both acting under the assumption that the purpose of the decedent being taken to radiology at 6:50 a.m. was to obtain the STAT CT scan with IV contrast of the decedent's chest that was ordered by Dr. Daigle at approximately 6:40 a.m. to 6:45 a.m. This assumption was based upon Dr. Daigle's testimony that other than the CT scan he did not order any other tests that would have required the decedent to be taken from her room to radiology (Daigle Depo. p. 75, lines 11-24).

NOTE 2: Nurse David May, the Charge Nurse responsible for the emergency room at the time, testified that if the CAT scan bed was open, the test could be completed in five (5) minutes:

> "Q. Do you have an estimate of time that it typically takes to get a STAT CT scan in the emergency room?
>
> A. If the CAT scan table is clear, it takes no more than five (5) minutes.
>
> Q. From the time the physician orders it to get it?
>
> A. It has the potential of being that fast. It can at times, yes." (May Depo., p. 50, line 25, and p. 51, lines 1-8).

NOTE 3: All witnesses, including the Defendant's experts, indicate that the actual time involved in completing the CT scan is extremely short, and therefore it is logical to assume that the 6:50 to 6:55 a.m. time recorded by Primary Care Nurse Annette McDonald on page 17 of **Appendix "A"** indicating that the decedent was taken to radiology, would have been for the taking of the decedent to get the STAT CT scan that had previously been ordered by Dr. Daigle.

7:00 a.m.
Vital signs were recorded by Nurse McDonald and an illegible scribbling of the time believed to be approximately 7:00 a.m. is recorded by Nurse McDonald with a notation report to Christine Wolfe (**Appendix "A" at 17**);

7:00 a.m.
Nurse Wolfe takes over as Primary Care Nurse for the decedent (**Appendix "A" at 17**);

7:05 a.m.
Nurse Wolfe records that the patient was taken from the room to the CT lab (**Appendix "A" at 17**);

NOTE 4: In her deposition Nurse Wolfe, under oath, ultimately conceded that she did not see anyone take the decedent from the room. Specifically, she stated as follows:

> "A. I didn't physically see her leave the room, but when I walked back into the room she was not there, and I assumed she had went to CT. I came in and looked at the transport log, and that's the time that the transport tech had filled out, that he had taken her at 7:05 a.m." (Wolfe Depo., p. 26, lines 1-5).

7:15 a.m.
Nurse Wolfe documents that the IV was discontinued by the CT Tech (**Appendix "A" at 17**);

NOTE 5: In her deposition Nurse Wolfe was questioned about the above notation and responded as follows:

> "Q. Who made that notation?
>
> A. I did. I was notified that CT had taken her IV out upstairs while she was in CAT scan, that the IV that they tried the use to inject the die had infiltrated, and that was the IV that was in her **LEFT FOREARM** when I went in to assess her that morning.
>
> Q. I want to stay on that for a minute. So someone from CT scan contacted you?
>
> A. Yes.
>
> Q. Do you recall who that was?
>
> A. I don't recall their name, honestly, no I don't
>
> Q. When did that occur?
>
> A. It was about 7:15 a.m. Actually it was at 7:15 a.m. because after I got off the phone they told me they had taken her IV out because it had infiltrated up there, and I documented that they had done that" (Wolfe Depo., p. 27, lines 11-25; page 28, lines 1-12).

7:20 a.m.
Nurse Wolfe charts that Mrs. Johnson was returned to the room (**Appendix "A" at 17**);

7:56 a.m.
Nurse Wolfe charts that she paged nurse Sandy Irons to start the IV;

8:44 a.m.
Mrs. Johnson codes (T. R. Vol. V, pp. 584-89).

During discovery the Appellee offered Jennifer Taylor, R. N., as a standard of care expert. Nurse Taylor testified that it was her opinion that from the point that the order for the STAT CT scan with IV contrast was given by Dr. Daigle, that the average time to get the results

back to him would be within one (1) hour. Nurse Taylor conceded that if no one was ahead of Mrs. Johnson for a CT scan it could have been completed as quickly as thirty (30) minutes. This thirty (30) minute completion time was consistent with the above-quoted testimony of Charge Nurse David May who had indicated that he had seen patients go and return from getting a CT scan in as quickly as five (5) minutes. As a result of the above, the Appellant's theory of the case, and all pretrial discovery, was predicated upon the corporate Defendant's assertion that the forty-three (43) pages of medical records attached as **Appendix "A"** to this Motion were in fact the complete set of medical records for Mrs. Johnson (T. R. Vol. V, pp. 590-91).

Specifically, since Dr. Daigle ordered the STAT CT scan at 6:40 a.m. to 6:45 a.m., it would have been possible, and within the standard of care as voiced by the Appellee's own expert, for Dr. Daigle to have the results of a completed CT scan and begin anticoagulation therapy at any time from as early as 7:10 a.m.

It is important to consider at this point in the factual recitation that counsel for Appellant and counsel for Dr. Daigle were both operating under the belief that the Appellee had been truthful in its multiple assertions that the forty-three (43) pages of Bates-stamped medical records was the **ENTIRE** medical record of the decedent. Based upon that representation Dr. Daigle was ultimately able to obtain a dismissal from the lawsuit, and the Appellant's counsel agreed to dismiss all of the non-medical negligence causes of action that had been raised against the Appellee under the belief that the Appellant had been provided the medical records.

For purposes of review, the forty-three (43) pages of medical records attached as **Appendix "A"** were provided to the Plaintiff pursuant to his request of April 9, 2008 (prior to the beginning of the litigation); the same medical records were obtained by Appellant's counsel through written discovery in the first lawsuit which was ultimately Nonsuited; the same medical

records were Bates-stamped by defense counsel for the Appellee, and were stipulated into evidence as Trial Exhibit No. "1" in this cause of action; the same medical records were entered as an Exhibit and used in each and every deposition of all of the Appellee's fact witnesses, as well as all medical experts for both Appellant and Appellee in this litigation; and the same medical records were provided as an Exhibit to the Affidavit testimony of Vice President McKinley, which was used by the Appellee in its Motion for Partial Summary Judgment relating to the Appellant's non-medical malpractice causes of action.

The Appellant discovered on April 3, 2013, that the Appellee had concealed ten (10) pages of Mrs. Johnson's medical record from the Appellant. On that day Jamie Nance, the Director of the Medical Imaging Department, testified under oath that additional medical records existed which had not been provided to the Appellant. Specifically, Ms. Nance testified that the secretary who receives the handwritten order from doctor ordering the CT scan enters it into the hospital computer system that generates the document that the imaging department works from to perform the specific test. The actual order comes out as a hard copy piece of paper called a STAR requisition, which is ultimately shredded. The pertinent information is kept electronically in the patient's electronic medical record. According to Ms. Nance, there is no difference between the electronic record of the patient and the hard copy record of the patient (T. R. Vol. V, pp. 594-95).

Ms. Nance testified that if a request was made of the hospital for the hard copy record, there would being nothing in the electronic record that is different from the hard copy print out. Appellant's counsel asked Ms. Nance why he had not been provided a document that would have showed the specific time that the secretary entered Dr. Daigle's request for a STAT CT scan with IV contrast in the computer. Ms. Nance testified, honestly, that said information was readily

available in the computer system, and that she did not know why it had not been previously provided (T. R. Vol. V, p. 595).

Later that afternoon Plaintiff's counsel, along with one (1) of his Associates, contacted defense counsel and inquired as to why they had not previously been given the medical records that would have shown the time that the secretary entered Dr. Daigle's request for the STAT CT scan with IV contrast into the computer. Defense counsel indicated that she had the same question during the deposition, but that she believed that Ms. Nance had simply misspoken, and verified that there were no additional medical records for Mrs. Johnson other than the forty-three (43) pages of medical records that previously been provided (T. R. Vol. V, p. 598).

Inexplicably, the next afternoon, Plaintiff's counsel received ten (10) pages of additional medical records, **Appendix "E,"** that had been concealed from the Plaintiff despite numerous requests for the entire medical record file. The newly released medical records indicate that Dr. Daigle's STAT order for a CT scan of Mrs. Johnson's chest with IV contrast was not even entered into the computer system by the secretary until 7:16 a.m. (T. R. Vol. V, p. 598).

Based upon the information that was contained in the previously concealed ten (10) pages of medical records it became apparent to Appellant's counsel that the reason for the delay in getting the STAT CT scan, which was necessary for Dr. Daigle to begin the anti-coagulation therapy that ultimately would have saved Mrs. Johnson's life, was caused by an inordinate delay in the secretary's inputting of Mrs. Johnson's name, patient identification number, and test ordered by Dr. Daigle into the computer system so that the medical imaging department would know that they needed to come and transport Mrs. Johnson to the medical imaging department (T. R. Vol. V, p. 597).

The Appellant immediately informed the trial court that the Appellee concealed this information from the Appellant to hide the fact that the Appellee was liable for Mrs. Johnson's death pursuant to the simple negligence of administrative personnel, as opposed to the medical negligence of the nursing staff. Further, the Appellant alleged that the agents and employees of the Appellee concealed and falsified medical records in a further attempt to hide the administrative negligence of the agents and employees of the Appellee. Had this information been available to the Appellant's counsel at the time of the Appellee's Motion for Partial Summary Judgment on the issue of simple negligence, the Appellant's counsel would not have signed an Agreed Order dismissing those portions of the case (T. R. Vol. V, p. 598).

The exact timing of events in this case is important to understand the Appellant's arguments that the trial court erred in granting the Appellee's Motion to Dismiss. Specifically, the case was set for trial to begin in April 8, 2013. In final preparation of the trial the parties entered into a Stipulation that was signed by the trial court on March 11, 2013, whereby the forty-three (43) pages of medical records that had been assembled and provided by the Appellee as being the entire medical record were stipulated into evidence as Trial Exhibit No. "1" (T. R. Vol. III, pp. 288-90).

On March 22, 2013, after having announced to the trial court that there was nothing left to be argued prior to trial with the possible exception of a Motion in Limine, the Appellee filed a Motion to Dismiss pursuant to Rule 12.02 (6) for failure to state a claim upon which relief can be granted. Specifically, the Appellee asserted, for the first time, that the Appellant had failed to comply with T. C. A. 29-26-121 and T. C. A. 29-26-122 (T. R. Vol. III, p. 351). As it related to T. C. A. 29-26-121, the Appellee argued that the Appellant had failed to do the following:

> A. Attach a HIPAA compliant authorization to the notification letter;

B. State in the Complaint "whether each party has complied with Section (a);

C. Provide the documentation specified in Subdivision (a)(2) of T. C. A. 29-26-121; and

D. List the addresses and providers that received notice (T. R. Vol. III, p. 352).

Additionally, the Appellee argued that with regard to T. C. A. 29-26-122 that the Complaint should be dismissed because the Appellant did not disclose, in the Certificate of Good Faith, "the number of prior violations of this section by the executing party" (T. R. Vol. III, p. 353).

NOTE: It is undisputed that counsel for the Appellant has never violated T. C. A. 29-26-122, and that the Appellee was seeking dismissal alleging that the Appellant had an affirmative duty to include in the Certificate of Good Faith that the Appellant's counsel had received "zero" violations (T. R. Vol. III, p. 353).

The Appellee did not file any Affidavits to support its claim that it did not receive the HIPAA Release, but did attach a copy of the November 30, 2009 certified mailing that was received by its designated agent on November 30, 2009 (T. R. Vol. III, pp. 356-58).

Given that the trial date was quickly approaching, the parties continued preparations for trial, and the previously scheduled discovery deposition of Jamie Nance, the Manager of the Medical Imaging Department for the Appellee, took place on April 3, 2013. As is more fully set forth above, Ms. Nance came forward and provided information that there were additional medical records that had not previously been provided to the Appellant. Counsel for the Appellee at first disavowed this statement by Ms. Nance, however, the next day counsel for the Appellee delivered unto the counsel for the Appellant the medical records attached as **Appendix "E."** As a result, the Appellant immediately filed a Supplement to his response to the Appellee's

Motion to Dismiss and notified the trial court of the existence of the additional medical records for Mrs. Johnson (T. R. Vol. IV, pp. 429-31).

The Appellant also filed a Motion to Amend the Complaint, or in the alternative, a Motion to Set Aside the portion of Appellee's Motion for Summary Judgment that addressed the claims of simple negligence (T. R. Vol. IV, pp. 444-51).

The trial court continued the trial, and entered a Scheduling Order on April 9, 2013. The Scheduling Order dictated that the Appellee's Motion to Dismiss would be heard on May 10, 2013, and that the Appellee would have until April 26, 2013, to file a response. The Appellant's Motion to Amend the Complaint and Motion to Set Aside a Portion of the Order Granting Partial Summary Judgment would be heard on the same date (T. R. Vol. IV, pp. 573-74).

After reviewing the previously concealed medical records, and having this information reviewed by his experts, counsel for the Appellant realized the magnitude and purpose of the Appellee's deception. As a result, counsel for the Appellant filed a Supplement to his Motion to Amend the Complaint; a Supplement to the Motion to Set Aside a Portion of the Order Granting Partial Summary Judgment; and a Motion for Sanctions necessary to remedy the Appellee's spoliation of evidence in direct violation of Rule 34A .02 of the Tennessee Rules of Civil Procedure (T. R. Vol. V, pp. 576-642).

Additionally, the Appellant filed a Motion to Amend the Certificate of Good Faith to address the Appellee's concern that counsel for the Appellant had not included the word "zero" as it relates to any previous violations of T. C. A. 29-26-122 (T. R. Vol. V, p. 643).

Ultimately, on May 10, 2013, the trial court heard all pending Motions. Specifically, the trial court addressed the Appellee's Motion to Dismiss first. In rendering her Opinion, the Honorable Deborah Stevens stated as follows:

> "While the Defendant has asserted a number of different reasons why the Complaint is technically deficient, this court's focusing on three (3) of those.
>
> One (1) is that, under 121(b), if a Complaint is filed in the court, the pleading shall state whether each party has complied with section (a), which is the provision of the Notice Statute. That language, under 121(b), is required to be in the Complaint, and the parties agree that language is not in the complaint.
>
> The second is under 29-26-122(b). 121(b) requires that the Plaintiff shall provide the documentation that is required under the Notice Statute and in (a)(2), and that documentation was not attached.
>
> And then the third one is that under 29-26-122, while a Certificate of Good Faith was attached to the Complaint, it did not contain a statement that there were not--that there had been no disclosures, and the Plaintiff's position is since there had not been any, there wasn't any reason to have that paragraph two (2) in the Certificate of Good Faith (T. R. Vol. VII, pp. 36-37)."

Judge Stevens stated that the Myers case, and the Tennessee Supreme Court, have both held that 121(b) and 122(a) are only subject to being excused when there is extraordinary cause. Judge Stevens also held that:

> "The Myers court very clearly says those provisions are mandatory, that I can't look at the issue of whether or not prejudice has or has not occurred, and that I don't have any discretion to waive the requirements of 121 and 122. While I think Mr. Cantrell has done a very, very good job giving a lot of reasons why this court should not take form over substance, I am unfortunately in the position that I think that the courts above me have put me in the position of doing exactly that and giving adequate meaning to 121 and 122 and those "shall" provisions."
>
> ...so it will be my ruling that the Motions to Dismiss filed by Parkwest Hospital will be granted. I do so, Mr. Cantrell, with a heavy heart and a lot of butterflies in my stomach, but I feel that's what I'm required to do."

And with that, the trial court granted the Appellee's Motion to Dismiss, and denied the Appellant's Motion to Amend the Complaint and Motion to Amend the Certificate of Good Faith (T. R. Vol. VII, pp. 37-39).

Counsel for the Appellant then asked if he would be allowed to argue the Appellant's Motion to Set Aside the court's previous Order Granting Summary Judgment on the negligence allegations that had been raised in the original Complaint given that the previously concealed information revealed that the delay in ordering the CT scan was actually caused by the negligence of the secretary in not timely entering Dr. Daigle's order into the computer system (T. R. Vol. VII, p. 39).

The trial court denied the Motion to Set Aside the Agreed Order Granting Partial Summary Judgment relief on the grounds that it was filed more than one (1) year from the date of the Order, and that the Appellant's Rule 60 Motion was filed pursuant to Rule 60.02(1) and 60.02(2) and not pursuant to Rule 60.02(5) (T. R. Vol. VII, p. 73).

The trial court refused to address the Plaintiff's' Motion for Sanctions related to spoliation, but preserved these issues for the Court of Appeals (T. R. Vol. VII, pp. 40-01).

After the hearing the trial court issued its written Order, and the Plaintiff timely filed the Notice of Appeal (T. R. Vol. VI, pp. 799-800).

STANDARD OF REVIEW

On appeal, the standard of review in analyzing a trial court's decision to grant a Motion to to Dismiss filed pursuant to Rule 12 of the Tennessee Rules of Civil Procedure is reviewed *de novo*, with no presumption of correctness Trau-Med of Am., Inc. v. Allstate Ins. Co., 71 S.W. 3d, 691, 697 (Tenn. 2002).

ARGUMENT

I. *The trial court erred in dismissing the Appellant's Complaint Pursuant to a Rule 12.02(b) Motion to Dismiss, and in its determination that extraordinary cause for the alleged non-compliance existed.*

On or about May 20, 2013, the trial court entered an Order Granting the Appellee's Motion to Dismiss on the basis that the Appellant failed to comply with the mandatory provisions of T.C.A. 29-26-121(b) and T. C. A. 29-26-121(d)(4) and that the Plaintiff had failed to demonstrate extraordinary cause for said noncompliance (T. R. Vol. VI, pp. 794-795).

T.C.A. 29-26-121 (b) reads as follows:

> (b) If a Complaint is filed in any court alleging a claim for health care liability, the pleading shall state whether each party has complied with subsection (a) and shall provide the documentation specified in subdivision (a)(2). The court may require additional evidence of compliance to determine if the provisions of the section have been met. The court has discretion to excuse compliance with this section only for extraordinary cause shown.

T.C.A. 29-26-122 (b)(4) reads as follows:

> (b)(4) A Certificate of Good Faith shall disclose the number of prior violations of this section by the executing party.

The information that the court was referring to, set forth in 29-26-121(a)(2), includes the full name and date of birth of the patient whose treatment is at issue; the name and address of the claimant authorizing the Notice and the relationship to the patient, if the Notice is not sent by the patient; the name and address of the attorney sending the Notice; a list of the names and addresses of all providers being sent the Notice; and a HIPAA compliant medical authorization permitting the provider receiving the Notice to obtain medical records from each other provider being sent a Notice.

The letter that was received by the Appellee on November 30, 2009, which was sent by counsel for the Appellant in satisfaction of the Notice provision of T.C.A. 29-26-121, clearly sets forth the full name and date of birth of the patient; the name and address of the claimant authorizing the Notice and the relationship to the patient; the name and address of the attorney sending the Notice; and a list of the names of all providers being sent a Notice. It is conceded by the Appellant that while a list of the three (3) providers that were being sent a Notice was included, i.e. Dr. Rodd Daigle; Parkwest Medical Center; and Christina C. Wolfe, R. N., the Appellant did not provide the specific address of Christina C. Wolfe, R. N., or Dr. Rodd Daigle.

Nurse Wolfe was an agent and employee of Parkwest Medical Center, and her notification was sent to the same address as Parkwest Medical Center. Both Parkwest Medical Center and Nurse Wolfe signed for the notification at Parkwest Medical Center, 1410 Centerpointe Boulevard., Suite 401, Knoxville, Tennessee 37923-0993. Therefore, while Nurse Wolfe's address was not specifically referenced in the letter that was sent to Parkwest, it is undisputed that she was an agent and employee of Parkwest Medical Center, and had designated that the notification be sent to the same address. Additionally, prior to the original lawsuit being nonsuited, Nurse Wolfe was deposed, and her address was stated at the beginning of her deposition.

As it relates to Dr. Rodd Daigle, his letter was also sent to Parkwest Medical Center, but it is conceded that it was sent to a different address. However, it is undisputed that Dr. Rodd Daigle was an independent contractor working at Parkwest Medical Center at the time that he received his notification, and it is undisputed that his deposition had been taken prior to the sending of the statutory notification letters.

The issue of whether or not the HIPAA Compliant Release was contained with the letter is in dispute. Clearly, in the letter that the Appellee received, the following language is contained:

> "Please find enclosed a HIPAA Medical Authorization form permitting you to obtain complete medical records from each of the above-named providers being sent a Notice."

Additionally, in that letter there was a Notice at the bottom of the page stating that the HIPAA Compliant Medical Release was in fact enclosed.

There is no dispute that John T. Geppi, the agent and representative of Parkwest Medical Center designated to receive the above-referenced statutory notifications, actually received the above-referenced notification on or about November 30, 2009. There is also no dispute that what was then being represented as being a complete copy of Mrs. Johnson's medical file had been exchanged between the parties pursuant to a court Order dated August 5, 2008, **PRIOR** to the filing of the lawsuit. It is also important to note, at the outset, that there is absolutely no dispute that the only medical records at issue were those that were in possession of the Appellee. Its agent and employee, Nurse Christina Wolfe, created no independent medical records, and neither did the independent contractor, Dr. Rodd Daigle.

The first time that it was ever alleged that the Appellee did not receive the HIPAA Compliant Release Form that was sent with the November 30, 2009, letter was on March 22, 2013, approximately two (2) weeks prior to trial, when the Appellee filed a Motion to Dismiss alleging, for the first time, that the November 30, 2009, letter did not contain a HIPAA Complaint Medical Release. The Appellee provided no sworn testimony or Affidavit proof to substantiate the totally unsupported claim that the November 20, 2009, letter received by Mr. Geppi did not include the referenced HIPAA Compliant Medical Release.

The Motion to Dismiss had the effect of putting Appellant's counsel in a practically untenable position of having to prove that the HIPAA Compliant Release was in fact included in the letter. The Appellant's counsel, and his Administrative Assistant, both provided Affidavit proof that it was their practice to send a HIPAA Compliant Release with the statutory notification letters, and that there would be no reason why the HIPAA Compliant Release, which was specifically referenced and noted to be enclosed in the letter, would not have been enclosed. None of the Defendants raised this issue during the four and one-half (4 ½) years of often contentious litigation until the eve of trial, and at that point it was only raised as an unsworn general averment.

Additionally, counsel for the Appellee, prior to the filing of the Complaint on April 27, 2010, obtained an Order on August 5, 2008, so as to obtain a complete copy of Mrs. Johnson's medical records. This Order allowed the Appellee access to all of Mrs. Johnson's complete medical records.

Given that Rule 12 requires all inferences to be found in favor of the non-moving party, the unsubstantiated averment of the Appellee that it did not receive a HIPAA Release would have to fail, and therefore the Appellant would assert that the only item being referenced by the trial court in finding that the Appellant failed to meet the requirements of T.C.A. 29-26-121(d)(4) would be the fact that the addresses of Nurse Wolfe and Dr. Rodd Daigle were not included in the pre-suit notification letter.

As it relates to T.C.A. 29-26-122(d)(4) it is undisputed that contemporaneous to the filing of the Complaint the Appellant filed a Certificate of Good Faith evidencing that he had in fact obtained experts who had provided written opinions substantiating the Appellant's claim of malpractice against the Appellee. It is further undisputed that the Appellee was also provided

with pre-trial discovery depositions which set forth the opinions of said experts. Further, it is undisputed that the Appellant's counsel did not write in the word "zero" in satisfaction of T.C.A. 29-26-122(d)(4) which indicates that a Certificate of Good Faith shall disclose the number of prior violations of this section by the executing party. It is further undisputed that neither the Appellant's counsel, nor the law firm in which the Appellant counsel practices, has ever received a sanction for violating this section.

During the hearing on the Appellee's Motion to Dismiss the Appellant brought to the trial court's attention language set forth in T.C.A. 29-26-122(c):

> The court may, upon Motion, grant an extension within which to file a Certificate of Good Faith if the court determines that a health care provider who has medical records relevant to the issues in the case has failed to timely produce medical records upon timely request, or for other good cause shown.

The only legal support relied upon by the Appellee concerning this portion of its Motion to Dismiss was Vaughn v. Mountain States Health Alliance, No. E2012-01042-COA-R3-CV, 2013 WL 817032, (Tenn. Ct. App. March 5, 2013) which was issued by this Honorable Court on March 5, 2013, approximately two (2) weeks prior to the filing of the Motion to Dismiss, attached as **Appendix "I."**

The Vaughn decision involved a medical malpractice cause of action arising out of the treatment and subsequent death of a forty-three (43) year old individual, and involved multiple Defendants. The surviving spouse of the decedent had filed a wrongful death action pursuant to the Medical Malpractice Act. The Defendants filed a Motion for Summary Judgment for the husband's failure to comply with several requirements of the Act, specifically T.C.A. 29-26-121 (a)(2), (3), (4) and (b). It was further asserted by the Defendants that the Certificate of Good Faith did not comply with the requirements of T.C.A. 29-26-122.

After a lengthy discourse as to the defects related to the failure to follow the Notice provision, this Honorable Court briefly addressed the requirement that the Certificate of Good Faith contain the number of prior violations of this section by the executing party in one (1) paragraph:

> "It is undisputed that husband failed to comply with Tennessee Code Annotated 29-26-122, and that he failed to include the number of prior violations of the section by the executing party, which is mandatory pursuant to said subsection (d)(4) of the Tennessee Code Annotated 29-26-122. Nowhere in the body of the Certificate does it disclose the number of prior violations, if any, of the party executing the Certificate. If there have not been any prior violations, husband's counsel should have disclosed the number "zero" on the Certificate."

The trial court, in the case presently before this Honorable Court, relied on the dicta set forth in Vaughn, and misapplied the case law interpreting T. C. A. 29-26-121 and 122.

In its opinion the trial court focused on what it felt were the Appellee's three (3) arguments asserting that the Complaint was technically deficient:

> "1. That under T.C.A. 29-26-121 (b) if a Complaint is filed in the court, the pleadings shall state whether each party has complied with subsection (a) which is the provision of the Notice Statute;
>
> 2. Pursuant to T.C.A. 29-26-121(b) the Plaintiff is required to provide documentation set forth in section (a)(2); and
>
> 3. The Plaintiff was required to state the word "zero" in the Certificate of Good Faith" (T. P. pp. 36-37).

The trial court interpreted Myers v. AMISUB (SFH), Inc., 382 S.W3d 300 (Tenn. 2012) as holding that T.C.A. 29-26-121(b) and T.C.A. 29-26-122 (d)(4) are only subject to being excused when there is extraordinary cause, and that the Myers court clearly stated that those provisions are **MANDATORY** and that the trial court **LACKED ANY DISCRETION** to waive

the requirements of either T.C.A. 29-26-121 or T.C.A. 29-26-122 (T. P. p. 37). The trial court makes the following statement pursuant to its issued Opinion:

> "The Myers court very clearly says those provisions are mandatory, but I can't look at the issue of whether or not prejudice has or has not occurred, in that I don't have any discretion to waive the requirements of 121 and 122. While I think Mr. Cantrell has done a very, very good job giving at a lot of reasons why this court should not take form over substance, I am unfortunately in a position that I think the courts above me have put me in a position of doing exactly that in giving adequate meaning to 121 and 122 and those "shall" provisions
>
> ....
>
> I think, ultimately, when we get to the Thurman case, which clearly is part of our ever-evolving case law, having come out in the last few days, it makes it pretty clear that 122--both 121 and 122 are mandatory and that failing to attach those documents as required is a fatal flaw and is not subject to amendment. So it will be my ruling that the Motions to Dismiss filed by Parkwest Hospital will be granted. I do so, Mr. Cantrell, with a heavy heart and a lot of butterflies in my stomach, but I feel like that's what I am required to do. I also believed that the language in the statutes that--the language in the statutes as well as the recent case law does not permit me to allow an amendment to cure the defects that we have been discussing" (T. P. pp. 37-39).

The Appellant will begin his discussion of the legal issues by agreeing with the trial court's statement that the Appellate decisions regarding T.C.A. 29-26-121 and 122 are ever evolving. In fact, on October 24, 2013, the Court of Appeals of Tennessee at Nashville issued an Opinion in the case of Aubrey E. Givens et al. v. Vanderbilt University, et al., No. M2011-00186-COA-R3-CV, 2011 WL 5145741 (Tenn. Ct. App. Oct. 28, 2011)(**attached as Appendix "J"**). This was a medical malpractice case arising from the death of the decedent in a situation where the Defendants moved the trial court to dismiss the action for failure to comply with the Notice requirements set out in T.C.A. 29-126-121. The Court of Appeals subsequently held that

T. C. A. 29-26-121 does not mandate dismissal for noncompliance with its terms, and that the failure to comply with the Notice Requirements does not make dismissal automatic.

Specifically, in Givens cited above, an original lawsuit was filed on September 11, 2007, prior to the General Assembly enacting the statutory changes to the Tennessee Medical Malpractice Act setting forth the requirements for medical malpractice actions filed on or after October 1, 2008. The Plaintiff subsequently dismissed the lawsuit on June 5, 2009. Shortly thereafter the General Assembly amended the Tennessee Medical Malpractice Act on July 1, 2009, with said changes in effect when the Plaintiff refiled her medical malpractice Complaint (Complaint #2) on June 3, 2010.

The Plaintiff attached a Certificate of Good Faith to the Complaint, but failed to provide the statutorily required sixty (60) day pre-suit Notice. The Plaintiffs did however provide the Defendant with written notice on the day of the refiling of the lawsuit.

On September 24, 2010, the Plaintiff filed the third Complaint with an attached Certificate of Good Faith and a statement exhibiting compliance with the Statutory Notice requirements, and then attempted to consolidate the three (3) lawsuits. The trial court refused to consolidate and dismissed lawsuit three (3). The Plaintiff appealed, and the Court of Appeals affirmed the dismissal because the third lawsuit was not filed within the statute of limitations. Upon remand the Defendants sought the dismissal of lawsuit two (2) alleging that the Plaintiff had failed to comply with the Notice requirements set forth in T.C.A. 29-26-121. The trial court agreed and dismissed the Plaintiff's lawsuit.

Two (2) issues were raised on appeal: (1) whether the Plaintiff's failure to comply with the Notice requirements set forth in T.C.A. 29-26-121 mandate a dismissal of the action and (2)

whether the trial court abused its discretion by failing to excuse compliance with the Notice requirements set forth in T.C.A. 29-26-121.

In Givens, as in this case, the Defendant filed a Motion to Dismiss as anticipated in Myers alleging that the Plaintiff has failed to comply with the statutory requirements set forth in T.C.A. 29-26-121. The Court of Appeals correctly held that the trial court's granting of the Motion to Dismiss is subject to a *de novo* review with no presumption of correctness because it is reviewing the trial court's legal conclusions.

The Court of Appeals then asserted that the question of whether the Plaintiff has demonstrated extraordinary cause that would excuse compliance with the statute is a mixed question of law and fact, and the Appellate review of the determination is *de novo* with the presumption of correctness applying only to the trial court's findings of fact and not to the legal effect of those findings. The Court of Appeals is required to review a trial court's decision as to whether or not to excuse compliance under an abuse of discretion standard.

The Court of Appeals addressed Myers as follows:

> "In Myers, a case similarly involving a re-filed Complaint, the Tennessee Supreme Court ruled that the statutory requirements that a Plaintiff give sixty (60) days pre-suit Notice and file a Certificate of Good Faith with the Complaint are mandatory and not subject to substantial compliance 382 S.W. 3d at 310. The Court held that the re-filed action commenced pursuant to the Saving Statute was a new action governed by the statutory provisions in sections 29-26-121 and 122. However, the Court also held that "the Legislature did not expressly provide for the consequence of dismissal with prejudice as it did in section 29-26-121." Id. at 312. Indeed, the Court referring to address the "appropriate sanction" for failure to comply with section 29-26-121 because the Plaintiff has also failed to comply with the certification requirements, which mandate a dismissal."

In Givens the Court of Appeals spent a significant amount of time discussing the recent case of Foster v. Chiles, No. E2012-01780-COA-R3- CV, 2013 WL 3306594 (Tenn. Ct. App.

June 27, 2013)(attached as **Appendix "K"**) in which a panel of the Court of Appeals considered the issue of sanctions in a case involving slightly different circumstances. In Foster, the Plaintiffs filed the proper pre-suit Notices before filing their initial Complaint. The Plaintiffs voluntarily dismissed their initial suit and then filed a second Complaint without filing the proper pre-suit Notices or attaching copies of the prior Notices to the second Complaint. The Court of Appeals declined to affirm the dismissal of the second Complaint for failure to comply with section 29-26-121 by stating as follows:

> "Although Myers found it unnecessary to explicitly address the consequences of noncompliance with section 121, the import of the Supreme Court's analysis seems clear. If the Legislature intended to require the draconian remedy of dismissal with prejudice for noncompliance with section 121, then it would have said so, just as it did with respect to section 122, which was enacted at the same time and which addresses the same general subject matter. We conclude that section 121 **DOES NOT REQUIRE** the court to dismiss the Complaint with prejudice for noncompliance with the Notice requirement of that section.
>
> This conclusion is keeping with the strict principle that Tennessee law strongly favors the resolution of all disputes on their merits. Henley v. Cobb, 916 S.W.2d 915, 916 (Tenn. 1996); see also Hinkle v. Kindred Hospital, et al. No. M2010-02499-COA-R3-CV, 2012 WL 3799215 (Tenn. Ct. App. 2012 (**Appendix "L"**) filed August 31, 2012)(declining to conclude that any deviation from the strict letter of T.C.A. 29-26-121 would compel the courts to dismiss any medical malpractice claims asserted, no matter how meritorious, and observing that the hospital received actual notice)."

The Court of Appeals followed the string of cases that have been recently decided holding that the language of section 121(b), providing that the trial court may require additional evidence of compliance to determine if the provisions of this section have been met, supports the conclusion that automatic dismissal with prejudice is not required when a Plaintiff neglects to attach proof of service to his or her Complaint. In such an instance the statute contemplates a

hearing so the court may consider additional evidence of compliance rather than outright dismissal.

In the case presently before this court it is clear, as set forth in its Opinion, that the trial court felt that the "shall" language in the statute, and the Myers case, did not permit the trial court to allow an amendment to cure the defects that we have been discussing. It is also clear that there is no question that Notice was in fact given.

Further, in Givens, the Court of Appeals specifically addressed the question of whether or not a trial court abuses its discretion by failing to excuse compliance. In its Brief the Plaintiffs alleged that:

> "Based upon a lack of case law during the time period wherein the [Plaintiffs were] filing [the] the Complaint pursuant to the Saving Statute and the extraordinary efforts of Plaintiffs in attempting to comply with the statute should be deemed extraordinary cause and [Plaintiffs] should be excused from failure to strictly comply with the same."

The Court of Appeals ruled, however, that the Plaintiffs' attempts to comply with pre-suit Notice requirements were anything but "extraordinary." In Givens the Court of Appeals held that the Plaintiffs made no effort to afford Defendants any pre-suit Notice prior to filing the second lawsuit, which is readily distinguishable from the Appellant's situation.

In this case there is no question that prior to the Nonsuit the case was extensively litigated. There is also no dispute that pursuant to the Statute, and more than sixty (60) days prior to the refiling of the previously nonsuited Complaint, the Appellant sent, and the Appellee received, the statutory notification letter. The only argument that the Appellee raises concerning the Notice is that in the notification letter that it received the address of Dr. Rodd Daigle, an independent contractor working through the emergency room of the Appellant, and the address of Nurse Christina Wolfe, an agent and employee of the Appellee, were not included. Clearly, as

the Tennessee Court of Appeals now acknowledges, that in and of itself is not a justification for a strict dismissal of the case.

With regard to the Plaintiff's Certificate of Good Faith, the only objection that was raised is that Appellant's counsel did not include the word "zero" in the response to the requirements of T.C.A. 29-26-122(d)(4) which states that "a Certificate of Good Faith shall disclose the number of prior violations of this section by the executing party." It is undisputed that counsel for the Appellant has never violated this particular section of the Medical Malpractice Act. On April 18, 2013, the Appellant moved to amend the Certificate of Good Faith pursuant to T.C.A. 29- 26-122(c).

The Appellant cited Truth v. Eskioglu, 781 F.Supp. 2d 630 (M. D. Tenn. 2011) which held that a doctor's failure to provide a patient with full medical records excused the patient from filing a Certificate of Good Faith required by the Tennessee Medical Malpractice Act. The Plaintiff alleged that the actions of the Appellee in concealing ten (10) pages of additional medical records were sufficient grounds to allow for an amendment.

The only legal support offered to support the Appellee's conclusion that the Certificate of Good Faith did not meet the statutory standard of T.C.A. 29-26-122 was the above-referenced dicta contained in Vaughn, which seems to suggest that the undersigned counsel should have written the word "zero" as the "number" of times that he has violated T.C.A. 29-26-122 (d).

The Appellant would begin his discussion of this section by noting that the court in Vaughn actually dismissed the Plaintiff's case therein due to the running of the Plaintiff's statute of limitations, and not due to Plaintiff's counsel's failure to cite the "number" of attorney violations pursuant to T.C.A. 29-26-122 (d). The Appellant would assert that Vaughn is an unreported case with only persuasive authority at best.

Specifically, the Appellant takes issue with the Appellees' assertion that he was required to note that his counsel had committed "zero" violations of T.C.A. 29-26-122(d). Nowhere within the medical malpractice act does the General Assembly choose to define "number." Therefore, the courts have to look outside of the statute in order for a determination of the word "number" as used by the Tennessee General Assembly when it amended the medical malpractice statute in July, 2009.

T. C. A. 29-26-122 must be construed with the well-settled principles of construction set forth by our Supreme Court in Myers as follows:

> "The leading rule governing our construction of any statute is to ascertain and give effect to the legislature's intent. To that end we start with an examination of the statute's language, presuming that the legislature intended that each word be given full effect. When the import of a statute is unambiguous, we discern legislative intent from the natural and ordinary meaning of the statutory language within the context of the entire statute without any forced or subtle construction that would exceed or limit the statute's meaning." Myers v. AMISUB (SFH), Inc., 382 S.W.3d 300, 308 (Tenn. 2012).

The Appellant would argue that this definition is not as simple as accepting the Appellee's premise that the Tennessee General Assembly intended "zero" to be included as a number. The Appellant would concede that zero is a symbol contained within a set of "real numbers" used in mathematical theory. Specifically, it can be defined as being the additive identity, the number that, when added to any other number "x," that does not change the value of "x," or similarly, the multiplicative identity, the number that, when multiplied by another number "x," does not change the value of "x." The Appellant would ask this Honorable Court to take judicial notice that the General Assembly is not made up of mathematical theorists, nor is the Tennessee Bar or its judiciary.

"Real numbers" are exclusively limited to mathematical theory. "Natural numbers" or what are often referred to as "counting numbers" are the only type of "numbers" that could realistically have been referred to by the General Assembly in enacting the statute. Specifically, Webster's dictionary defines "natural numbers" as being any positive integer: 1, 2, 3, etc. The symbol zero (0) is not a member of the set of "natural numbers" since people do not begin counting with zero (0).

The Appellee would argue that even a primitive society that is developing a counting system would not think of the concept of "nothing" when they begin to develop the ability to count. Rather, they begin counting with the number "1." Even a child understands the distinction between "real numbers" used in mathematics, and "natural members," used in counting. Children learn to count by reciting 1, 2, 3, etc. As they develop, they learn mathematics (unfortunately, most attorneys lose the ability to do anything other than divide by three (3) after they attend law school!)(**emphasis added by the author**).

For purpose of statutory interpretation you have to look at what was the purpose of the Tennessee General Assembly when it enacted the statute. The purpose was to **COUNT** the number of violations of the statute by Plaintiff's counsel, and not to **CALCULATE**. The Appellant would argue that the difference between **COUNTING** and **CALCULATING** is the difference between whether the General Assembly intended to use **REAL NUMBERS** or **ORDINARY NUMBERS.**

It is clear that the General Assembly intended to count, and not calculate, and therefore the only statutory interpretation available is that "number" to be defined as a "natural number" as opposed to a "real number," and therefore zero (0) is not a number. Therefore, the Appellant's

counsel correctly prepared the Certificate of Good Faith because he has never been in violation of the statute.

The Appellee is attempting to complicate what the Appellant believes is an easy concept to understand. Further definition of the word "number" classifies it as being either a "cardinal" or an "ordinal number." Again, the Appellant would simply refer to Webster's Dictionary which shows that a "cardinal" number is any number used in counting or in showing how many. Zero "0" is not considered a "cardinal" member. Ordinal numbers are any numbers used to indicate an order, i.e. 2^{nd}, 9^{th}, 25^{th}, etc.

Again, the Appellant would ask this Honorable Court to take judicial notice that there is no conceivable way that the Tennessee General Assembly would expect the Bar Association or the Judiciary to do anything beyond "counting" as it relates to this statute, and therefore the only reasonable assumption is that the only "natural" numbers were intended, and since zero (0) is not a natural number, the Appellee's argument must fail.

Additionally, the Appellant submits that the Tennessee Court of Appeal's specific holding in Hinkle reflects that the filing of an Affidavit by a medical doctor satisfied the statutory requirements of 29-26-122 and outweighs the dicta in Vaughn. In the present case the Appellee has been provided more medical proof than the Certificate of Good Faith provides. Further, the Appellee had more than ample time to inquire as to whether the undersigned counsel had ever violated 29-26-122(d).

As set forth above, the Tennessee General Assembly has made it more than clear that a Defendant cannot withhold medical records and still rely upon 29-26-122 in moving to dismiss a Plaintiff's case. In light of the above, the Appellant would assert that the trial court erred in

dismissing the Complaint relying solely on dicta contained in Vaughn, and further erred in not allowing for an amendment of the Certificate of Good Faith to set forth the word "zero."

Returning to the discussion concerning 29-26-121, over the last five (5) years the Tennessee Medical Malpractice Act has been one of the most litigated pieces of legislation in the State. Interestingly, soon after changes to the Act were enacted, the Tennessee Bar Journal ran an article which stated that "The language contained in T. C. A. 29-26-121 will lead to litigation regarding its interpretation and the simplicity of T. C. A. 29-26-121's Notice requirement is troubling and will no doubt be the root of several Appellate decisions as lawyers flesh out what it really means to give pre-suit Notice" Tennessee Bar Journal, 44-Sep at. 14, 15, 18 (Sep. 2008).

The Appellee argued during the hearing on its Motion to Dismiss that "every Appellate Court that has been called upon to review the application of T.C.A. 29-26-121 and/or 122 has held that, in absence of demonstrated good or extraordinary cause (depending upon the applicable versions of the statutes in effect), the Plaintiff's failure to comply with the mandatory enumerations of section 29-26-121 and 122 has warranted dismissal of the case." That assertion is simply wrong. Rather, both State and Federal Courts have "taken a stab" at interpreting the new provisions of the Tennessee Medical Malpractice Act and have come up with wildly divergent opinions.

For example, in Jenkins v. Marvel, 683 F.Supp.2d 626 (E. D. Tenn. 2010), the **ONLY** published Opinion available to the Appellant when he refiled the Complaint, the Federal Court for the Eastern District of Tennessee held that the Plaintiff therein was not obliged to submit a sixty (60) day notice, as set forth in T. C. A. 29-26-121, when the Plaintiff's case was the refiling of a cause that had previously been filed prior to the enactment of the sixty (60) day Notice

Requirement. Id. at 639 (finding that, as it was the legislative intent for Defendants to have Notice of the Plaintiff's claim in an opportunity to attempt to settle the case outside of court, the Defendant(s) therein, indeed, had Notice of the Plaintiff's claim via the previous action).

In Hinkle v. Kindred Hospital, et al. No. M2010-02499-COA-R3-CV, 2012 WL 3799215 (Tenn. Ct. App. 2012)(attached as **Appendix "L"**) the middle section of the Tennessee Court of Appeals reversed a Circuit Court's dismissal of Plaintiffs' case and remanded the matter for further proceedings. Further, in the Hinkle opinion, the Court of Appeals noted that the Defendants therein, as with the Defendant in this case, were in no way prejudiced by the Plaintiff's failure to provide a signed HIPAA release. The Court of Appeal stated:

> "The record also shows that the parties exchanged medical records months before the Complaint was filed, and the hospital does not allege that any relevant medical records were withheld. In the months of discussion, the hospital never requested a HIPAA authorization."

The Appellant acknowledges that the Supreme Court's decision in Myers was issued after the Court of Appeals decision in Hinkle. However, the Appellant submits that, in light of the fact that the Myers case did not address the sanction for Plaintiffs' failure to strictly follow section 29-26-121 in the situation where a Certificate of Good Faith was actually filed, the Hinkle Opinion should be found persuasive for this court in the present case if the court finds that the Plaintiff failed to adhere strictly to sections 29-26-121 and 122.

As this Honorable Court is well aware the Hinkle case has been appealed to the Tennessee Supreme Court and the Court has elected to hold that case in abeyance while it considers Stevens v. Hickman Community Healthcare Services, Inc., N2012-00582-SC-S09-CV (Tenn. 2012).

Based on the Briefs filed in the Stevens case, it appears that the Circuit Court for Hickman County refused to dismiss a medical malpractice case where the Plaintiff provided a timely sixty (60) day Notice with the technically non-compliant HIPAA medical release. In that case the Circuit Court found that while there was not technical compliance there was extraordinary cause to excuse the deficiency. Specifically, the Circuit Court found that because the decedent died before a suit was filed, and the Defendants had actual Notice of the suit since the Plaintiff had filed a proper Certificate of Good Faith, the Plaintiff could fulfill the intent of T.C.A. 29-26-121, and there was "extraordinary cause" for the court to excuse compliance. The Court of Appeals refused to hear the requested Interlocutory Appeal and the Defendants appealed to the Supreme Court where the case is currently pending.

The Supreme Court, while citing some examples of what might constitute "extraordinary cause" in Myers, has to this point not specifically defined "extraordinary cause" for failure to comply with the Notice and Certificate of Good Faith provisions of the Tennessee Medical Malpractice Act. It is anticipated that the Supreme Court will be addressing those issues in the Stevens case referenced above.

Specifically addressing the Notice provisions set forth in T.C. A. 29-26-121, as alluded to above, this cause of action herein arose as a re-filing of a previous action originally filed with the trial court on June 26, 2008, as documented. After the Complaint was filed the parties submitted, and the court entered on August 5, 2008, an Agreed Order for Release of Medical Records which was compliant with federal HIPAA regulations and requirements.

The above-referenced HIPAA compliant Order specifically granted the Appellee access to all of the decedent's medical records, including records wholly unrelated to her passing. As has been stipulated, the only medical records that were in existence were the medical records that

were actually retained by the Appellee itself. One (1) of the other two (2) original Defendants, Nurse Wolfe, who was an agent and employee of the Appellee at the time of the incident, produced no records that were not records of the Appellee. Additionally, Dr. Daigle, who was an independent contractor working in the emergency room of the Appellee, created no independent medical records.

Extensive written and oral discovery took place, including expert depositions, at which time the Appellee affirmatively asserted that the only medical records involved for the purposes of litigation were the forty-three (43) pages of medical records attached to this Brief.

Thereafter, on November 2, 2009, the original Complaint was nonsuited. On or about November 30, 2009, the Appellant sent the Appellee a letter providing Notice that he intended to refile his medical malpractice action against the Defendant. The Appellee currently asserts that this Notice letter did not include a HIPAA compliant medical release, but has offered no sworn testimony to that effect. In response to that bare and unsubstantiated allegation, the Appellant's counsel and Office Manager provided Affidavit testimony that it is their practice to always include that HIPAA Compliant form with the notification letter, and that in fact the letter itself makes reference to said HIPAA compliant Release. Be that as it may, the Appellant would submit that said argument is moot because there were no records to obtain other than those that were in the possession of the Appellee.

The Appellant refiled the Complaint on April 27, 2010, and shortly thereafter, on May 25, 2010, the trial court entered a second Agreed Order for the release of medical records, which additionally acted as a fully HIPAA Compliant Release. The Appellee's only other allegations related to the Notice provision were that the Complaint itself was silent to the idea that the

Notice provisions had been complied with, and the Notice letters had not been attached to the Complaint.

The Appellant would assert that Hinkle is a case much more similar to the present action than any case relied upon by the Appellee. The Appellant is not asking this Honorable Court to excuse compliance, but simply to acknowledge compliance by the Appellant as set forth in Hinkle. Further, in Hinkle, the Court of Appeals reversed the Circuit Court's dismissal of the Plaintiff's case and remanded the matter for further proceedings. In doing so the Court of Appeals noted that the Defendants therein, as with the Appellee in this case, were in no way prejudiced by the Appellant's failure to provide a signed HIPAA Release. The Court of Appeal stated:

> "The record also shows that the parties exchanged medical records months before the Complaint was filed, and the hospital does not allege that any relevant medical records were withheld. In the months of discussion, the hospital never requested a HIPAA authorization."

As with the Hinkle case, the Appellee in this case was well aware of the Plaintiff's claims of malpractice and a sixty (60) day Notice letter was sent. Moreover, as with the Hinkle case, the Appellee herein is relying upon a non-prejudicial technicality; i.e. that the Appellant allegedly failed to provide a proper HIPAA Release to seek dismissal of the case.

Since the trial court's determination to grant the extraordinary relief of an outright dismissal, the Tennessee Court of Appeals issued an Opinion in Foster, where a panel of this court considered the fact scenario where Plaintiff filed proper pre-suit Notices before filing their initial Complaint, but then voluntarily dismissed their initial suit and filed a second Complaint without filing the proper pre-suit Notices or attaching copies of the prior Notices to the second Complaint. This Honorable Court declined to affirm the dismissal of the second Complaint for

failure to comply with T. C. A. 29-26-121 and held that section 121 does **NOT** require a trial court to dismiss a Complaint with prejudice for non-compliance with the Notice requirement of that section. This conclusion was in keeping with the general principle that Tennessee law strongly favors the resolution of all disputes on their merits. Henley v. Cobb, 916 S.W.2d 915, 916 (Tenn. 1996).

This Honorable Court in Foster stated that the technical requirements of the statute are intended to provide just Notice of the claim. The language of section 121(b) providing that the court may require additional evidence of compliance to determine if the provisions of this section have been met supports the conclusion that automatic dismissal with prejudice is not required when a Plaintiff neglects to attach proof of service to his or her Complaint. There is no reason why the court should not have allowed Plaintiffs to rectify their oversight by filing the required proof late.

It is clear that Judge Stevens was operating under the erroneous assumption that Myers left her no option but to dismiss. Looking at the concerns that were addressed by the trial court, individually, it yields that case law would support the Appellant's conclusions that the Motion to Dismiss should have been denied. Specifically:

(1) The alleged failure to provide a HIPPA compliant release.

As has been set forth above, this is merely an allegation, and there was no Affidavit proof to support this general averment;

(2) The Complaint was silent in stating that the Medical Malpractice Act had been complied with by providing the statutory notification letters, and in not attaching the letters to the Complaint.

Again, as has been set forth in Hinkle, and its progeny, the remedy of an outright dismissal is not appropriate. The Plaintiff should have been allowed to Amend his Complaint

to assert compliance, or the court should have taken judicial notice of compliance in order to satisfy the extraordinary cause exception;

(3) The statutory notification letters were defective because they did not include the address of the agent and employee of the Appellee, Christina Wolfe, nor did it include the address of the independent contractor working for the Appellee, Dr. Rodd Daigle.

Again, all of this information had been exchanged and was given to the Appellee well in excess of filing the notification letters. Where is the prejudice? Additionally, as set forth in Hinkle and its progeny, the trial court should have allowed for a simple Amendment of the Complaint to cure this defect and not grant an outright dismissal; and

(4) The Certificate of Good Faith was faulty because it did not include the word "zero."

As has been set forth in this section, the Appellant would argue that this issue was only addressed in the week prior to filing the Motion to Dismiss when this Honorable Court referenced in dicta that the Certificate of Good Faith requires the word "zero" to be included in the document itself. The Appellant would assert that this Honorable Court was incorrect in issuing that statement, and that in no way did the Tennessee General Assembly intend that the word "zero" had to be set forth in the Certificate of Good Faith. It is obvious that the intent of the law itself was that the Appellant's counsel had to disclose the "number" of times that he or she had been sanctioned for failing to comply with this section. Given that Appellant's counsel had never been sanctioned, and given that zero is not a "number" as anticipated by the statute, there is no defect for the Certificate of Good Faith. Even if there was a defect, the Appellant should have been allowed to cure said defect by its Motion to Amend the Certificate of Good Faith, especially given that additional medical records had been withheld by the Appellee.

Based upon all of the above considerations, combined with the fact that Hinkle is still good law, and the Court of Appeals' recent decisions in Foster and Givens, it is clear that the trial court was acting under the mistaken belief that it had no option but for the granting of the

Appellee's Motion to Dismiss. For the above-stated reasons, the Appellant would respectfully request this Honorable Court for an Order setting aside the Motion to Dismiss and remanding this case back to the trial court for adjudication.

II. *The trial court erred in denying the Appellant's Motion to Set Aside a portion of the February 9, 2012 Order Granting Partial Summary Judgment to the Appellee.*

The original Complaint in this action was filed on or before April 27, 2010. It contained the following specific averments:

> "36. The Plaintiff would aver that the Defendants are guilty of the specific torts of negligence; battery; outrageous conduct; negligent infliction of emotional distress; fraud; deceit and misrepresentation.
>
> ...
>
> 39. The conduct of the Defendant is so reckless that it gives rise to a claim for punitive damages. Additionally, the conduct of the Defendants in fraudulently altering the medical records also gives rise to a claim for punitive damages" (T. R. Vol. I, pp. 9-10).

On or about October 27, 2010, the Appellee filed a Motion for Summary Judgment pursuant to Rules 54 and 56.02 of the Tennessee Rules of Civil Procedure. In support of its Motion the Appellee relied upon the Affidavit of Janice McKinley, the Chief Nursing Officer/Vice President of Nursing for the Appellee; Mrs. Johnson's medical records; and the deposition testimony of Primary Care Nurse Christina Wolfe

(T. R. Vol. I, pp 116-28).

As part of the Statement of Undisputed Material Facts the Appellee alleged as follows:

> "At 7:05 a.m. Mrs. Johnson was transported to the radiology department for her ordered CT (Chart, 17). While in radiology Mrs. Johnson's IV, which had been started by the emergency medical technicians prior to her arrival at Parkwest, infiltrated preventing the CT from being performed (Chart, 19). Mrs. Johnson was subsequently returned to the emergency department at 7:20 a.m. for the insertion of a new IV (Chart, 17)" (T. R. Vol. I, pp. 118-19).

In her Affidavit, Ms. McKinley made the following statement:

"4. I have reviewed the Complaint (Complaint filed April 27, 2010) in this lawsuit by Plaintiff, and I have also reviewed the **ENTIRE MEDICAL CHART** of Mrs. Jana Johnson for her hospitalization at Parkwest Medical Center in April, 2008, which is the hospitalization addressed and at issue in this Complaint. See Exhibit "1" "medical chart"" (**Appendix "D," ¶ 4**).

The medical chart referred to by Ms. McKinley is the forty-three (43) pages of Bates-stamped medical records that had been assembled and provided by the Appellee, and represented throughout the litigation as being the entire medical record for Jana Johnson. Ms. McKinley, who was being offered by the Appellee as an expert witness in the area of nursing, based her opinions solely on her review of the Complaint and of the forty-three (43) pages of medical records (**Appendix "D," ¶ 5**).

As has been more fully set forth in the other portions of this Brief, the Appellant was forced to rely upon the multiple assertions of the Appellee, through its agents and employees, that the following information was true and accurate:

A. The forty-three (43) pages of Bates-stamped medical records that had been assembled and provided by the Appellee did in fact represent the entire medical record as was testified to by Ms. McKinley; and

B. That according to the above-referenced medical records, and to the sworn testimony of Primary Care Nurse Christina Wolfe, at 7:05 a.m. Mrs. Johnson was transported to the radiology department for her ordered CT scan and that while in radiology, Mrs. Johnson's IV infiltrated which prevented the CT from being performed. As a result Mrs. Johnson was subsequently returned to the emergency department at 7:20 a.m.

Based upon the above-referenced sworn assertions, the Appellant entered into an Agreed Order Granting Partial Summary Judgment to the Appellee regarding the Appellant's claims for: ordinary negligence (separate and apart from any allegations related to the medical malpractice

claim), fraud, deceit, misrepresentation, battery, outrageous conduct, negligent infliction of emotional distress, intentional infliction of emotional distress, and punitive damages, allowing the lawsuit to proceed on the singular theory of medical malpractice (T. R. Vol. II, pp. 283-84).

Inexplicably, on April 3, 2013, the Appellee provided ten (10) pages of additional medical records which had not previously been provided to either the Appellant, nor to his counsel. These additional medical records are attached, in their entirety, as **Appendix "E."** According to information contained in these medical records, Dr. Daigle's order for a CT scan of Mrs. Johnson's chest with IV contrast was not even entered into the hospital Start Requisition Computer System until 7:16 a.m., and Mrs. Johnson was not transported to the radiology department for a completion of the CT scan until 7:20 a.m. This information is in direct contradiction with the information set forth in the Appellee's Motion for Summary Judgment which provided that Mrs. Johnson was taken to radiology at 7:05 a.m. and that at 7:16 a.m. Nurse Wolfe was allegedly advised by an unidentified technician from the radiology department that the IV had infiltrated, and that Mrs. Johnson would be sent back to her room.

Immediately upon learning that the Appellee had provided false testimony through Nurse Wolfe, and upon learning that the Appellee had withheld vital pieces of Mrs. Johnsons' medical file from its expert, Ms. McKinley, the Appellant filed a Motion to Set Aside a Portion of the above-referenced Order Granting Partial Summary Judgment to the Appellee (T. R. Vol. IV, pp. 445-51).

Rule 60.02 of the Tennessee Rules of Civil Procedure sets forth the mechanism which allows for a party to seek relief from a Final Judgment or Order. Specifically, Rule 60.02 reads as follows:

> "On Motion and upon such terms as are just, the court may relieve a party or the party's legal representative from a

Final Judgment, Order, or proceeding for the following reasons:

(1) mistake, inadvertence, surprise or excusable neglect;

(2) fraud, misrepresentation, or other misconduct of an adverse party;

(3) the Judgment is void;

(4) The Judgment has been satisfied, released, or discharged, or a prior Judgment upon which it is based has been reversed or other vacated, or it is no longer equitable that the Judgment should have prospective applications; or

(5) any other reason justifying relief from the operation of the Judgment.

Rule 60 of the Tennessee Rules of Civil Procedure is designed to afford relief in those cases wherein the Judgment or Order, either standing alone or when viewed in connection with other portions of the Record, shows facially that it contains errors arising from oversight or omission. Pennington v. Pennington, 592 S.W.2d 576 (Tenn. Ct. App. 1979). Rule 60 acts as an escape valve from possible inequity that might otherwise arise from the unrelenting imposition of the principle of finality embedded in the procedural rules. Toney v. Mueller Co., 810 S.W.2d 145 (Tenn. 1991).

The Appellant would concede that even though Rule 60.02(5) is written broadly, it has been construed narrowly by the Appellate Courts. Its purpose is to alleviate the effect of an oppressive Final Judgment, and therefore Appellate Courts have interpreted the purpose of the Rule as to strike a balance between the competing interests of justice and finality. Whitaker v. Whirlpool Corp., 32 S.W.3d 222 (Tenn. Ct. App. 2000).

The language "any other reason" as set forth in Rule 60.02(5) has been defined as either a reason of "overriding importance," one of "extraordinary circumstances," or one which creates an "extreme hardship" on a party to the litigation. Gaines v. Gaines, 599 S.W.2d 561 (Tenn. Ct. App. 1980).

The Appellant would argue that Tennessee Rule of Civil Procedure 60.02(5) was broadly written so as to allow the trial court the flexibility to grant relief from prior Orders due to unique, exceptional or extraordinary circumstances as defined by the Tennessee Supreme Court in Jerkins v. McKinney, 533 S.W. 2d 275, 280 (Tenn. 1976). This language was lifted by the Tennessee Supreme Court directly from the United States Supreme Court in Ackerman v. U. S., 340 U. S. 193 (1950).

The Tennessee Supreme Court has acknowledged that Rule 60.02 itself is open-ended and therefore leaves the task of interpretation to the trial court. Underwood v. Zurich Ins. Co., 854 S.W.2d 94 (Tenn. 1993). The Appellant would argue that while Tennessee Courts have traditionally chosen to construe Rule 60 narrowly, it is often allowed in cases of overwhelming importance, and in those involving extraordinary circumstances or extreme hardship.

In a recent Tennessee Court of Appeals' decision, Sud v. Ho, No. E2011-01555-COA-R3-CV, 2012 WL 1079896 (Tenn. Ct. App. Mar. 30, 2012)(attached as **Appendix "M"**), this Honorable Court overruled the trial court's denial of a Rule 60.02(5) Motion when it was found that one (1) of the parties withheld relevant information from another party to the lawsuit.

In its response to the Appellant's Motion to Set Aside a Portion of the above-referenced Order Granting Partial Summary Judgment the Appellee relied upon Affidavit testimony of Janice Watkin, the Director of Health Information Management for the Appellee. Ms. Watkin testified that she had received the medical records of Mrs. Johnson produced in this case, and

that the forty-three (43) pages of medical records was a true, exact, and complete copy of Mrs. Johnson's entire medical record. Ms. Watkins further testified that the ten (10) additional pages of medical records that were withheld from the Appellant would not be technically considered a "medical record" (T. R. Vol. V, pp. 683-86).

The Appellant would argue that if the Appellee's argument is sincere, and this information was not information that would be contained in the "medical record," then the reasoning set forth by this Honorable Court in Sud would be applicable whereby a Rule 60.02 (5) Motion should have been granted based upon the inadvertent concealment of information between the parties.

In Sud, cited above, the Plaintiff was the landlord of a restaurant being rented by two (2) tenants, Mr. Ho and Mr. Yong. A third party, Mr. Pang, was the personal guarantor on the Lease. Mr. Yong died unexpectedly, and Mr. Ho failed to make payments on the lease. A lawsuit was then initiated in the Knox County Circuit Court in which the landlord (Mr. Sud) sued the surviving tenant (Mr. Ho). During the litigation Mr. Ho raised the responsibility of the personal guarantor in his Answer, and subsequently the trial court granted the landlord's Motion to Amend the Complaint to add Mr. Pang, the personal guarantor, as an additional Party Defendant.

Mr. Pang spoke little English, and filed an Answer to the ligation in which he represented himself pro se. During the trial Mr. Pang appeared, unrepresented by counsel, and was questioned by the trial judge through an interpreter about whether he agreed that he was legally responsible for the debt.

Ultimately, the trial judge entered a Judgment against Mr. Pang in his capacity as personal guarantor, holding him responsible for a previous Judgment that had been entered

against Mr. Ho. Mr. Pang then sought legal representation and filed a Rule 60.02(5) Motion to Set Aside the Judgment of the trial court on the two (2) grounds that: (1) he had erroneously relied upon information provided to him by Co-Defendant Ho, who was attempting to act as an interpreter in the trial proceeding; and (2) that the Plaintiff (Sud) and the Co-Defendant (Ho) concealed information from Mr. Pang during the proceedings that was relevant to the case. Specifically, Mr. Sud had in his possession a Release that he had signed modifying the Lease after Mr. Yong's death which he failed to disclose at trial.

The Court of Appeals ultimately held that the trial judge abused his discretion in refusing to grant Mr. Pang's Rule 60.02(5) Motion to Set Aside the Judgment on the grounds that the combination of the use of a Co-Defendant as an interpreter, and the withholding of relevant evidence by the Plaintiff, was sufficient to satisfy the requirements set forth in Jerkins: a unique, exceptional, and extraordinary circumstance which created an extreme hardship, as defined in Gaines, on a party to the litigation. As a result this Honorable Court set aside the Judgment and allowed the case to proceed to trial.

The above fact scenario is closely on point with the case at hand. Clearly, the Appellee had in its possession ten (10) additional pages of medical records which for some reason were not given to the Appellant. The reason given by Ms. Watkin for the withholding of these medical records was that they were not "medical records," therefore, there was no duty to provide them to either the Appellant or to the Appellee's own expert witness, Janice McKinley. Clearly, this created an extreme hardship on the Appellant, and would satisfy the unique, exceptional and extraordinary circumstances requirements set forth in Jerkins.

Even accepting the Appellee's argument that the withholding of medical records was not concealment, the Appellant would request this Honorable Court to take notice that the

information set forth in the ten (10) pages of additional medical records is, at the least, relevant, and should have been provided to the Appellee's expert, Ms. McKinley, who based her opinion on the supposition that Nurse Wolfe was telling the truth, and that Mrs. Johnson was taken for the CT scan at 7:05 a.m. and not at 7:20 a.m. as is set forth in the new information.

The trial judge in this case posed a question to the Appellee's counsel as follows:

> "Mr. Fitzpatrick, let's presume Mr. Cantrell is correct, and he's proceeding under 60.02(5), which is not subject to the one-year limitation on the--when we can set aside an Order. He does make an argument as to whether or not the failure to produce these ten (10) pages is inadvertent or not at this point in the proceeding is not relevant to the court. The question is: He's now got ten (10) pages that he claims he didn't have before that would have changed his view of his ordinary negligence claim. Whether or not that's a good claim, I don't know that, but why shouldn't this court allow the amendment and go forward to another day to address the issue of whether negligence would be subject to a Motion for Summary Judgment?"

This trial court asked the correct question, but then failed to apply the correct legal standard. It is undisputed that there is a disagreement between the Appellee's administrative staff as to whether the additional ten (10) pages of information showing the time that Dr. Daigle's order was entered into the computer system, the time Mrs. Johnson was taken to the CT lab, and the time that someone cancelled Dr. Daigle's order for a CT scan are medical records. Ms. Nance says they are; Ms. McKinley says they are not.

There is no disagreement that neither Ms. McKinley nor the Appellant was given this information, and that this information is critical to the Appellant's case. As set forth in Gaines, the Appellant has met his burden by showing that Rule 60.02(5) applies because of the "overriding importance," "extraordinary circumstances," and "extreme hardship" created by letting this Order stand.

Clearly, this is the exact situation that was anticipated by the Tennessee Supreme Court when it defined the circumstances that require a trial court to set aside a Judgment or an Order pursuant to Rule 60.02(5). As the trial court correctly stated, there is absolutely no prejudice to the Appellee to set aside that portion of the Order Granting Appellee's Motion for Partial Summary Judgment and then allowing the Appellant to file a response, and then rule on this issue now that all of the records have been provided to the Appellant.

The trial court's sole reason for denying the Appellant's Motion was that it felt that the Rule 60.02 Motion was filed pursuant to Rule 60.02(1) or (2), and not 60.02(5), and was therefore barred by the one (1) year statute of limitations. This was an error.

The trial court abused its discretion by disregarding the Tennessee Supreme Court's holding in Jerkins which requires it to grant relief from prior Orders due to "unique," "exceptional," or "extraordinary circumstances," pursuant to Rule 60.02(5). Therefore, the Appellant asks this Honorable Court to follow the reasoning set down in Sud and to set aside the trial court's Order Granting Partial Summary Judgment.

III. *The trial court abused its discretion in refusing to address the Plaintiff's Motion for Sanctions pursuant to Rule 34A.02 of the Tennessee Rules of Civil Procedure.*

Effective July 1, 2006, the State of Tennessee adopted Rule 34A .02 of the Tennessee Rules of Civil Procedure concerning the spoliation of evidence. Specifically, Rule 34A.02 reads as follows:

> "**OTHER SPOLIATION**
> Rule 37 sanctions may be imposed upon a party or an agent of a party who discards, destroys, mutilates, alters, or conceals evidence."

The Advisory Commission comment to the 2006 Amendment concerning Rule 34A.02 states as follows:

> "The Rule has a new, broader heading. Rule 34A.02 is new. Also, Rule 37 sanctions are made available against offenders. Those sanctions include, at 37.02, refusal to allow claims or defenses; even dismissal of a Plaintiff's Complaint and entry of a Default Judgment against a Defendant are possible."

Obviously, it was the intent of the Tennessee Supreme Court, and of the General Assembly, to place severe sanctions upon parties to civil litigation who discard, destroy, mutilate, alter or **CONCEAL** evidence. The sanctions set forth in Rule 37.02 of the Tennessee Rules of Civil Procedure are broad, and include penalties as severe as rendering a Judgment by default against a disobedient party.

Tennessee courts have consistently utilized the remedies available in Rule 37.02 of the Tennessee Rules of Civil Procedure to sanction opponents for an abuse of the discovery process. Appellate courts have ruled that trial courts were appropriate in dismissing a Plaintiff's Complaint with Prejudice for failing to attend Noticed depositions (See Langlois v. Energy Automation System, Inc., 332 S.W.3d 353 (Tenn. Ct. App. 2009)); have approved dismissing of Complaints as a sanction for disregarding trial court's Orders and directives concerning the

conditions of the limited continuance of the matter (Amanns v. Grissom, 333 S.W.3d 90 (Tenn. Ct. App. 2010)). Given the relative newness of Rule 34A.02, there is a dearth of Appellate decisions that address the issue of where a litigant conceals evidence from other parties. Prior to July 1, 2006, and the enactment by the Supreme Court in establishing Rule 34A.02, it was already well established by Tennessee Appellate Courts that sanctions may be levied against a litigant for improper action during the discovery process where there is a clear record of delay or inappropriate conduct. Potts v. Mayforth, 59 S.W.3d 167, 171 (Tenn. Ct. App. 2001)(quoting Shahrdar v. Global Housing, Inc., 983 S.W.2d 230, 236 (Tenn. Ct. App. 1998)).

The Potts v. Mayforth case, cited above, dealt with a trial court's decision to enter a Default Judgment as a permissible discovery sanction. The Court of Appeals followed the holding set forth in Shahrdar, which explained the propriety of granting a Default Judgment as a sanction against a party who fails to conduct himself properly during the discovery process. The logic behind providing trial courts with the remedies provided in Tennessee Rule of Civil Procedure 37.02 was first set forth by the United States Supreme Court in 1976, in the case of National Hockey League v. Metropolitan Hockey Club, Inc., 427 U. S. 639 (1976), which held as follows:

> "There is a natural tendency on the part of reviewing courts, properly employing the benefit of hindsight, to be heavily influenced by the severity of outright dismissal as a sanction for failure to comply with a discovery Order. It is quite reasonable to conclude that a party who has been subjected to such an Order will feel duly chastened so that even though he succeeds in having the order reversed on appeal, he will nonetheless comply promptly with future discovery Orders of the District Court.
>
> But here, as in other areas of the law, the most severe in the spectrum of sanctions provided by Statute or Rule, must be available to the District Court in appropriate cases, not merely to penalize those whose conduct may be deemed to warrant such a

> sanction, but deter those who might be tempted to such conduct in the absence of such a deterrent.
>
> If the decision of the Court of Appeals remained undisturbed in this case it might well be that these Respondents would faithfully comply with all future discovery Orders entered by the District Court in this case. But other parties to other lawsuits would feel freer than we think Rule 37 contemplates they should feel to flout other discovery Orders of other District Courts" Id. At 642-43.

The above-referenced holding of the United States Supreme Court was adopted by the State of Tennessee in Holt v. Webster, 638 S.W. 2d 391 (Tenn. Ct. App. 1982), when it held that the above-stated reasoning of the Supreme Court is applicable to the courts of Tennessee:

> "The trial courts of Tennessee **MUST** and do have the discretion to impose sanctions such as dismissal in order to penalize those who fail to comply with the Rules and further, to deter others from flouting or disregarding discovery Orders."

Clearly, as the Advisory Comment states, the same Rule 37.02 sanctions that have long been used by Tennessee courts to assess penalties against parties who abuse the discovery process are to be equally enforced against litigants who conceal evidence in violation of the recently enacted spoliation Rules. Litigants now operate in a digital age. In fact, Jamie Nance, the current Director of the Medical Imaging Department at Parkwest Medical Center, was brought to Parkwest Medical Center to install a digital imaging system which stores all of the patient's records electronically, and allows doctors to instantaneously receive diagnostic information. The dangers of going to a paperless system is that it allows for unscrupulous litigants to hide, alter, conceal or otherwise disregard computer-generated information that is only available electronically.

In 2012 a Tennessee District Court held that a trial court has the inherent power to control the judicial process and impose sanctions for spoliation of evidence, including sanctions which

would include the entering of a Default Judgment. Boyd v. Nashville Limo Bus, LLC, No. 3:11-CV-0841, 2012 WL 4754659 (M. D. Tenn. Oct. 4, 2012)(attached as **Appendix "N"**).

The only Tennessee case that cites Rule 34A.02 is Cincinnati Insurance Company v. Mid-South Drillers Supply, Inc., et al. No. M2007-00024-COA-R3-CV, 2008 WL 220287 (Tenn. Ct. App. Jan. 25, 2008)(attached as **Appendix "O"**). In this unreported case the issue presented was whether a trial court could exercise its discretion granted under Rules 34 and 37 of the Tennessee Rules of Civil Procedure to dismiss a party's case for spoliation of evidence where the spoliation may have been inadvertent rather than intentional. The Court of Appeals held that the trial court has the discretion to sanction a party by dismissal of its case where the parties' destruction of evidence severely prejudices an adverse party's defense irrespective of whether the destruction was inadvertent or intentional.

The Honorable Chief Justice E. Riley Anderson was brought in as special judge in the Cincinnati Insurance case cited above. The trial court had ruled, *sua sponte*, that sanctions were in order because of the destruction of a key piece of evidence by the Plaintiff. The trial court accordingly dismissed all actions against the Defendant as a sanction. The Plaintiff appealed, contending that dismissal of an action was a drastic sanction which should be imposed only if the court concluded that a party's failure to cooperate in discovery is due to willfulness, bad faith, or fault. The Defendant responded that Rule 34A.02 of the Tennessee Rules of Civil Procedure **DOES NOT** require that a party's concealment of evidence be intentional prior to the assessment of sanctions.

In writing the Opinion of the Court, Honorable Chief Justice Anderson states as follows:

> "We agree that that sanctioning a party by completely dismissing its action is a severe remedy, which can only be justified in the most serious cases. Such cases include a situation where a party has intentionally concealed or destroyed important evidence in

> order to suppress the truth. However, nowhere in Rule 34A does it state that a finding of intentional destruction of evidence is required before a trial court can order sanctions under Rule 37."

Chief Justice Anderson went on to further state as follows:

> "Furthermore, there are other situations were spoliation of evidence would justify a complete dismissal of an action. For example, such a sanction would be appropriate in circumstances where any less severe remedy would not be sufficient to redress the prejudice caused to a Defendant by a Plaintiff's spoliation of evidence."

The Tennessee Supreme Court has long held that a trial court's determination of the appropriate sanction to be imposed pursuant to Rule 37 will not be disturbed on appeal unless the court commits an abuse of discretion. Lyle v. Exxon Corp., 746 S.W.2d 694, 699 (Tenn. 1988). Appellate Courts have set forth the standard for when an abuse of discretion occurs as being when "the trial court has misconstrued or misapplied the controlling legal principles or has acted inconsistently with the substantial weight of the evidence." White v. Vanderbilt Univ., 21 S.W.3d 215, 223 (Tenn. Ct. App. 1999)(citing Overstreet v. Shoney's, Inc., 4 S.W.3d 694, 709 (Tenn. Ct. App. 1999)).

Chief Justice Riley Anderson, in writing for the Court in the Cincinnati Insurance case, followed the reasoning of the Michigan Court of Appeals in Citizens Ins. Co. v. Juno Lighting, Inc., 635 N.W.2d 379 (Mich. App. 2001), which held that in cases involving the loss or destruction of evidence, a court must be able to make rulings as necessary to promote **FAIRNESS AND JUSTICE.**

Justice Anderson ended the Opinion by making the following statements:

> "We agree with and find persuasive the reasoning of the Michigan Appeals Court in Citizens Ins. Co., supra, and we believe the same reasoning applies to the present case. Cincinnati's (Plaintiff's) failure to notify Mid-South (Defendant) of the results of its investigation and its agent's subsequent destruction of the blue

> hose, whether advertent or inadvertent, made it **EXTREMELY DIFFICULT**, if not impossible, for the defendants to present an effective defense to counter the Plaintiff's theory of the case."

The Plaintiff would argue that the facts presented in this case are one of first impression for the Appellate Courts in this State. Specifically, whether a trial court abuses its discretion in refusing to even consider the awarding of sanctions in a medical malpractice action where a Defendant hospital conceals medical information in order to cover up the administrative negligence of its staff.

In beginning its discussion as to how this law should be applied, the Appellant wants to briefly review testimony from two (2) of the Appellee's employees. Specifically, Jamie Nance was offered by the Appellee as a non-medical fact witness to discuss the policies and procedures of the Medical Imaging Department relating to the obtaining of a CT scan with IV contrast. It is undisputed that Ms. Nance served in an administrative capacity at the hospital, and was offered by the Appellee to discuss policies and procedures related to the obtaining of diagnostic tests.

A copy of Ms. Nance's deposition was made part of the Court Record, and attached to the Appellant's Motion for Sanctions. Ms. Nance testified that she had been the manager of the Imaging Services Department for Parkwest Hospital for approximately five (5) years and prior to that she was the PACS Administrator, which is the picture archiving communications system that stores digital medical records (T. R. Vol. V, p. 516).

During her deposition Ms. Nance was questioned about the retention of medical records relating to the ordering of diagnostic tests. She testified that the physician ordering the test would handwrite the order which would ultimately be handed to the Hospital Unit Clerk (a secretarial position) who works for that particular department. The secretary would then be responsible for entering the patient's name, hospital identification number, and the specific test

that had been ordered by the physician into the hospital computer system. This would result in a hard copy printout of a document called a Star Requisition (T. R. Vol. V., pp. 549-550).

Ms. Nance was then asked what happened to the hard copy printout that would show the actual CT scan order. She testified that it was shredded, but that the information was stored electronically. At this point Ms. Nance offered testimony that was inconsistent with all of the information contained in the medical records that had been previously provided to the Appellant. Specifically, the following questions and answers occurred:

"Q. Does anybody keep a hard copy piece of that paper that would show the actual CT scan order?

A. The printed out Star Requisition, no.

Q. And is that called a Star Requisition?

A. That is called a Star Requisition.

Q. Okay.

A. And that paper is not kept.

Q. So it's just discarded? Shredded? What do you do with them?

A. It's put in a security document, the shredder.

Q. The shredder?

A. Yes.

Q. It doesn't go into the patient's chart?

A. No, sir, because information is electronic.

Q. Okay. Do you keep a copy of the electronic information that would show what time the order actually came in?

A. That is in the Star radiology system.

Q. So that would still be in this same--that would still be in the same computer generated document or software?

A. Correct.

Q. I don't know the terminology that—

A. It would still be in the patient medical record.

Q. The hard copy record or the electronic record?

A. The electronic record.

Q. **IS THERE A DIFFERENCE BETWEEN THE ELECTRONIC RECORD OF THE PATIENT AND A HARD COPY RECORD OF THE PATIENT?**

A. **NO.**

Q. **SO EVERYTHING--IF WE'VE MADE A REQUEST OF THE HOSPITAL FOR THE HARD COPY RECORD AND HAVE GOTTEN PRINTED OUT PAGES, THERE SHOULDN'T BE ANYTHING IN THE STAR SYSTEM DIFFERENT THAN WHAT'S IN THE PRINTOUT, TO YOUR UNDERSTANDING.**

A. **TO MY UNDERSTANDING, NO, SIR"** (T. R. Vol. IV., pp. 550-51).

It is clear from Ms. Nance's testimony that everything that would be contained in the patient's electronic record would also be kept in the hard copy record of the patient. In an effort to rebut the testimony of Jamie Nance, on April 26, 2013, the Appellee filed the Affidavit of Janice A. Watkin, the Director of Health Information Management at Parkwest Medical Center.

Ms. Watkin testified that approximately three (3) to five (5) days after discharge, the paper copy of a patient's emergency department medical chart is converted to an electronic format and stored and retained by Parkwest Medical Center. The electronic version of the

patient's medical chart becomes the official, permanent, medical record of a patient for all purposes (T. R. Vol. V, p. 654).

Ms. Watkin then takes the extraordinary position that the original forty-three (43) pages of medical records that had been offered is the true, exact, and complete copy of Mrs. Johnson's medical record. Further, Ms. Watkin testified that the ten (10) additional pages of medical records were not part of the patient's medical records because "a patient's medical record does not include test request data input into the Star radiology electronic computer system relating to an order for an imaging test if the test was not ultimately performed for whatever reason." Specifically, Ms. Watkin testified as follows:

> "If a CT test was ordered, the test request was subsequently entered into the Star radiology electronic computer system by a CT Tech, but the test was not performed, the information input into the Star system by the CT Tech would not become part of the patient's medical record because the information entered, up until the point when the tests are received, is clerical/administrative information and such clerical/administrative information is not included in the patient's medical records" (T. R. Vol. V, p. 685).

This statement is directly contradictory to the statement of Ms. Nance, the employee of the Appellee who is actually over the Medical Imaging Department, who testified that if a patient makes a request of the hospital for the hard copy record, there would not be anything in the Star system different than what is in the printout, and that there is no difference between the electronic record of the patient and the hard copy record of the patient.

In justifying its action in concealing relevant medical records, the Appellee asserts that "medical records" are defined by the Appellee as being all medical histories, records, reports and summaries, diagnosis, prognosis, records of treatment, and medication ordered and given, x-ray and radiology interpretations, physical therapy charts, and lab reports, in justifying its concealment of the additional ten (10) pages of records (T. R. Vol. V, p. 649).

The Appellee's argument is that the ten (10) pages of additional medical records that were previously concealed from the Appellant were not "medical records" and therefore it had no duty to provide them. This argument fails because the Appellee's own witness, Ms. Nance, testified that if a patient makes a request for his or her hard copy record, these ten (10) pages of medical records should have been included.

T.C.A. 29-26-121(d)(1) clearly states that all parties, including the Plaintiff, shall be entitled to obtain complete copies of the claimant's medical records from any other party. The Appellee's sole argument in justifying why ten (10) pages of medical records were not provided is that they were not medical records, and therefore the Appellant was not required to provide them.

It is clear from looking at these ten (10) pages of medical records that they include information relating to what specific medical tests were ordered for Mrs. Johnson, the name of the physician submitting the order, the time that the order was entered into the hospital computer system, and the fact that a physician ultimately canceled the order. To now take the extraordinary position that these are purely administrative records is not a credible statement. Specifically, this is a sampling of the information contained within the ten (10) pages of concealed records:

- name of ordering physician;
- diagnosis of patient which includes chest pressure;
- name of physician submitting the order;
- working diagnosis;
- time that ordering physician's order was entered into the Star Requisition System;
- time that patient arrived for diagnostic procedure;

- description of diagnostic procedure that had been ordered (PCT thorax with contrast);
- comments from the physician concerning a suspected pulmonary embolism;
- designation of a STAT priority; and
- designation of the time that said procedure was canceled.

The fact that the CT scan with IV contrast that was ordered by Dr. Daigle was canceled is contained nowhere else in the medical records. Surely the decision to cancel a diagnostic procedure is a "medical record." Additionally, these documents contain a diagnosis; they contain Dr. Daigle's comments that he suspected the patient was suffering from a pulmonary embolism; and they give a specific description of the diagnostic test ordered by the physician. Therefore, these cannot be considered purely administrative records in that they contain information related to patient care.

It is impossible for the Appellee to dispute that it did in fact conceal this information from the Appellant for several years. It is also impossible for the Appellee to dispute the fact that this information not only clearly reveals the negligence of the secretarial staff who was charged with the responsibility of entering this information into the computer system, but also exposes the fact that Nurse Wolfe and Nurse McDonald entered false information into the computer system.

On or about April 18, 2013, the Appellant filed a formal Motion for Sanctions to remedy the Appellee's spoliation of evidence. The Appellee filed the following in its response in opposition to the appellant's Motion to Amend the Complaint as follows:

> "This is a response solely to the Plaintiff's Motion to Amend Complaint and not a response to Plaintiff's Supplement to the Motion for Sanctions to Remedy Defendant's Spoliation of Evidence in Violation of T. R. C. P. 34A.02. During the parties' last hearing on this matter, April 4, 2013, the court informed the parties that only Parkwest's Motion to Dismiss and Plaintiff's

> Motion to Amend Complaint would be heard during the May 10th hearing. In response to the statement by the court, counsel for Plaintiff stated that he had filed a "Spoliation Motion" but that it would be "appropriate to wait on" hearing that Motion (T. R. Vol. V, p. 648).

The context of that statement, which was contained on Page 21 of the transcript of that hearing and attached as an Exhibit to the Appellee's response, references a previously filed Request for a Special Jury Instruction related to the spoliation of evidence prior to the Appellant being aware of the scope of the concealment. As this Honorable Court will recall when looking at the procedural history, everything happened at a relatively quick pace in preparation for the April trial date. Once the Appellant had the opportunity to consult with his expert witnesses concerning this matter, he immediately filed a formal Motion for Sanctions to remedy the spoliation of evidence on April 18, 2013, eight (8) days after the Scheduling Conference.

Judge Stevens acknowledged the subsequent filing of the spoliation Motion, and stated "all issues, Mr. Cantrell, that you have raised will be clearly preserved, and I presume we'll see something on this at some later point in time" (T. P. pp. 73-74).

The issue that is being raised on appeal is whether or not Judge Stevens abused her discretion by not addressing the spoliation Motion prior to the dismissal of the lawsuit. The Appellant would aver that it is incumbent upon this Honorable Court to review the totality of the circumstances. The purpose of Rule 34A.02 was to prevent a party from benefiting when it conceals evidence. The Court of Appeals in the State of Tennessee has already ruled that the concealment of evidence need not be intentional in order to subject the parties to sanctions. In this particular case Judge Stevens refused to address the issue related to spoliation prior to ruling upon the Appellee's Dispositive Motion to Dismiss.

Tennessee Appellate Courts have reasoned that in situations where spoliation of evidence occurs, there has to be a remedy to redress the prejudice caused by the actions of a party. Further, the Appellant would assert that in this situation he has suffered catastrophic repercussions by the concealment of this evidence. It was an error for the trial court to refuse to look at the remedies available for redress under Rule 34A.02 and Rule 37.02 of the Tennessee Rules of Civil Procedure.

One (1) remedy would simply have been to allow the Appellant to Amend the Complaint to allege the non-medical malpractice negligence of the administrative employee who failed to timely enter Dr. Daigle's order for CT scan with IV contrast. Another remedy would have been to simply grant Appellant's Rule 60.02(5) Motion to Set Aside the Portion of the Order Granting Summary Judgment on the non-medical malpractice grounds. Judge Stevens' refusal to address the Appellant's Motion was an abuse of her discretion, and therefore this case should be remanded back to the trial court to allow Judge Stevens to determine what, if any, sanctions are appropriate, including the refusal to allow the Appellee to assert certain defenses (i.e. the request that this matter be dismissed on procedural grounds) or to prevent the Appellee from objecting to the amendment of the Complaint, or a revision of the Order Granting Partial Summary Judgment.

IV. *Whether the trial court erred in denying the Appellant's Motion to Amend the Complaint and the Motion to Amend the Certificate of Good Faith*

As has been set forth previously in this Brief, immediately upon being provided ten (10) additional pages of previously concealed medical records which altered the Appellant's theory of his case, the Appellant immediately filed a Motion to Amend the original Complaint and a Motion to Amend the Certificate of Good Faith.

Rule 15.01of the Tennessee Rules of Civil Procedure states that a party may amend the party's pleadings either by written consent of the adverse party, or by leave of the court, and further instructs the trial court that leave should be **FREELY GIVEN WHEN JUSTICE SO REQUIRES**. The purpose of amending pleadings is to enable the pleader to state his cause of action or defenses so that the action can be determined by the merits. Amendments are proper to bring before the court issues which, if found in favor of the pleader, would be conclusive of the case. Branch v. Warren, 527 S.W.2d 89, 91 (Tenn. 1975); Liberty Mutual Ins., Co. v. Taylor, 590 S.W.2d 920 (Tenn.1979).

It is well settled that a trial court does not abuse its discretion by granting leave to Amend a Complaint when the amendment is "necessary to bring before the court an issue which, if found in favor of the pleader, would be conclusive of the case." Freeman Industries, LLC v. Eastman Chemical Co., 227 S.W.3d 561, 566 (Tenn. Ct. App. 2006). Additionally, the Tennessee Supreme Court has held that it is reversible error when a trial court fails to rule on a Plaintiff's Motion to Amend a Complaint prior to granting a Defendant's Dispositive Motion. Cumulus Broadcasting, Inc., v. Shim, 226 S.W.3d 366 (Tenn. 2007).

As set forth by the Tennessee Court of Appeals in Newcomb v. Kohler Co., 222 S.W.3d 368, 384-385 (Tenn. Ct. App. 2006), Tennessee courts have long followed the idea that

Tennessee law and policy have always favored permitting litigants to amend their pleadings to enable disputes to be resolved on the merits, rather than to be dismissed on legal technicalities. The Appellant would aver that the primary reason for the Appellant's Motion to Amend was due to the concealment by the Appellee of vital and extremely relevant medical information which had concealed for over four and one-half (4 ½) years.

The Appellee argued at trial that Rule 15 of the Tennessee Rules of Civil Procedure does not allow for a Plaintiff to Amend his Complaint to revive an already dismissed claim. Clearly, that would not apply in this fact scenario in that the Complaint was being amended to allege the additional negligence of a specific administrative employee whose conduct had been fraudulently concealed by the agents and employees of the Appellee in intentionally creating false entries into the decedent's medical records, and then intentionally withholding relevant information which would have revealed this negligence.

The Appellant's entire theory of the lawsuit changed once the fraud of the agents and employees of the Appellee was revealed. Specifically, it was ultimately discovered that contrary to the information set forth in the decedent's medical records, and the sworn testimony of the agents and employees of the Appellee, the decedent was **NOT** taken to the radiology department for a STAT CT scan with IV contrast as was testified to by Nurse Wolfe and as was recorded in the decedent's medical records.

Based upon the testimony of the agents and employees that was given throughout the pretrial discovery, and what we now know to be as fraudulent entries into the decedent's medical records, Mrs. Johnson was not taken from her room until more than one-half hour after the STAT order for a CT scan with IV contrast had been given by Dr. Daigle because of a secretary's failure to enter this information into the hospital requisition system. In an attempt to cover-up

the administrative negligence of the secretary, Nurse Wolfe and Nurse McDonald gave false sworn testimony and entered false information into the decedent's medical records.

The trial court abused its discretion in refusing to allow for an amendment of the Complaint to address the administrative negligence of the secretary whose conduct was concealed by agents and employees of the Appellee. Additionally, the Appellant would assert that the trial court abused its discretion in not allowing for an amendment to the Certificate of Good Faith pursuant to T.C.A. 29-26-122(c) which allows an extension of time to file a Certificate of Good Faith if a healthcare provider fails to timely produce medical records, or for other good cause shown.

The Appellant respectfully requests this Honorable Court to set aside the trial court's Order denying the Appellant's Motion to Amend the original Complaint and the Motion to Amend the Certificate of Good Faith and to place this matter back onto the court's docket.

CONCLUSION

The Appellant would assert that the facts and issues in this case are extraordinary. It is undisputed that for four and one-half (4 ½) years the Appellee kept ten (10) pages of vital medical records from the Appellant, and only produced these medical records when an administrative supervisor employed by the Appellee brought to the Appellant's attention that there were ten (10) pages of medical records that had not been provided.

Even more egregious is the fact that the Appellee produced multiple fact witnesses whose sworn testimony was predicated upon the idea that the only medical records in existence related to the decedent were the forty-three (43) pages of medical records that had been provided by the decedent to the Appellant prior to litigation beginning.

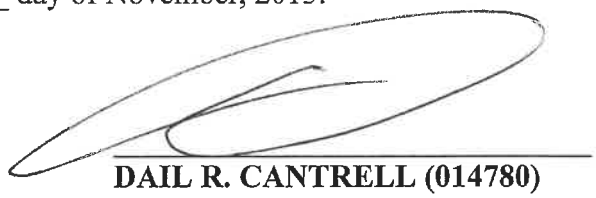
The individual who brought this matter to the court's attention is an agent and employee of the Appellee charged with significant administrative responsibility, and who is over the entire Medical Imaging Department. This employee has intimate knowledge of the record keeping system, and was brought to the hospital to help install the digital record keeping service that is currently in effect. The Appellee has attempted to rebut the testimony of its own witness by bringing in another employee of the hospital whose **ONLY** justification for not providing these records is a statement that these are not medical records as defined by the State of Tennessee. That statement is simply too incredible to be believed.

Additionally, the Appellant would assert that the ever evolving law concerning the Notice and Certificate of Good Faith provisions of the Medical Malpractice Act has been in a constant state of flux since its inception.

Based upon the extraordinary set of factual circumstances brought forth by this appeal, and by recent Tennessee Appellate Decisions which clearly indicate that the trial court abused its

discretion and was unfamiliar with the proper legal standards to be applied in this case, the case should be remanded back to the trial court for a hearing of the Appellant's Motions for Sanctions pursuant to the spoliation of evidence by the Appellee; the case should be placed back on the court's docket for a trial on the merits; and the Appellant should be allowed to amend both his original Complaint and his original Certificate of Good Faith based upon the newly acquired information that had been previously concealed from the Appellant by the agents and employees of the Appellee.

Respectfully submitted this the 6th day of November, 2013.



DAIL R. CANTRELL (014780)
Attorney for Appellant

OF COUNSEL:

CANTRELL, CANTRELL & ASSOCIATES
Post Office Box 299
Clinton, Tennessee 37717
(865) 457-9100

CERTIFICATE OF SERVICE

Comes now the undersigned below and does make oath that a true and exact copy of this pleading has been served upon F. Michael Fitzpatrick, 2300 First Tennessee Plaza, P.O. Box 300 Knoxville, TN 37901-2300 by placing same in the United States mail, postage pre-paid.

Respectfully submitted this the 6th day of November, 2013.

~~DAIL R.~~ CANTRELL (014780)
Attorney for Appellant