QUEENESTHER BANKS RILEY, FREDONIA BANKS PETERS, AND SYLVIA T. BANKS ROBINSON, EACH INDIVIDUALLY, AND JOINTLY ON BEHALF OF THE ESTATE OF LAWRENCE BANKS	*	**NO. 2001-CA-0498**
	*	**COURT OF APPEAL**
	*	**FOURTH CIRCUIT**
	*	**STATE OF LOUISIANA**
	*	
VERSUS		
	*	
MAISON ORLEANS II, INC. AND XYZ INSURANCE COMPANY	* * * * * * *	

BYRNES, C.J., CONCURS IN PART AND DISSENTS IN PART

I concur with the majority analysis of the issue of insurance coverage. However, as I find that there is no liability on the part of Maison Orleans II, Inc., I respectfully dissent from the balance of the majority opinion.

The Maison Orleans is not an insurer of Mr. Banks' safety. A nursing home has no duty to furnish a nurse or attendant at all times. *McCartney v. Columbia Heights Nursing Home, Inc.*, 25,710 (La.App. 2 Cir. 3/30/94), 634 So.2d 927.

The trial court found that, "the availability of the steel pipe to Harris created an unreasonable risk of harm to Banks." However, it is not as though the steel pipe had been dropped carelessly in the hall outside of Harris' door. Mr. Wilmore testified that the pipe was used to prop open the

door to a maintenance shed behind the kitchen, accessible only from the outside. Heavy door-stops are quite common. Harris could have struck Banks with any number of other objects that would have been reasonably available. Unlike a gun or a knife, the pipe was not intrinsically dangerous. It was only dangerous in the manner in which it was used. Even a bedpan, a hardbound book, a telephone or any number of other common items readily available to nursing home residents could have been used by Mr. Harris to strike Mr. Banks.

Mr. Harris was evaluated by Dr. Richard Richoux, an expert in general and forensic psychiatry, prior to admission to Maison Orleans II facility. Running Dr. Richoux's name through case law data bases reveals that he has qualified as an expert in countless cases, testifying at various times on behalf of the plaintiff, the defendant, the State, and as a court appointed expert. Dr. Richoux confirmed that Mr. Harris' history did not indicate violent behavior and he observed no violent or hostile propensities.

Dr. Richoux noted that Harris had Organic Brain Syndrome, a condition affecting 75-80% of all nursing home residents and "is pretty much synonymous" with Dementia. Organic Brain Syndrome is not indicative of violent proclivities. Dr. Richoux testified that there was no reason to anticipate violent or aggressive behavior from Mr. Harris. He had

no reason to believe that Mr. Harris did not belong in the home. The fact that Mr. Harris was known to "preach" to walls and talk to nonexistent people is not considered to be indicative of violent tendencies in the context of Mr. Harris' condition. The plaintiff produced no evidence from which the contrary can be inferred and it was error for the trial court's reasons for judgment to suggest otherwise.

Dr. Richoux testified that "wandering behavior is sometimes a problem" among those suffering from Organic Brain syndrome, but the record reflects that Mr. Harris had not been known to wander. Such individuals do not normally require someone following them around twenty-four hours a day:

> A. . . . So, probably the most common reason why somebody in a nursing home who has Organic Brain Syndrome might need to be closely observed is more along the lines of, if you have the unlocked facility with easy access to the outdoors, and nobody checks on an individual often enough. There have been incidences where people walked out of the door and gone walking down the street in a disorienting manner, but no other reason than that generally.
>
> Q. Not following them around inside the nursing home?
>
> **A.** No usually. Not unless there's some access to danger, which of course, in any well designed facility. **I'm talking about machinery that a confused individual is going to be subject to**

> **machinery that they can hurt themselves with or something of that nature.** [Emphasis added.]

Thus, any close supervision of Mr. Harris that might have been warranted would not have been intended to prevent him from picking up an object with which to strike another resident of the nursing home.

On cross-examination, Dr. Richoux explained that the only thing that he reported in written form concerning what may have been reported to him by others concerning Mr. Harris' behavior at the nursing home was his notation that: "Aid who accompanies him reports no agitated or hostile behavior and none is noted."

Dr. Richoux read from his report stating that his examination revealed that Mr. Harris, "shows typical evidence of Organic Brain Syndrome. Rambling conjectural speech, apparently delusional thought, disorientation, memory deficits, lay bow [sic] mood and affect." He went on to explain "delusional" meant, "thinking manifested by a person which is clearly in contradiction to objective reality, and which defies rational proofs to the contrary."

When asked by the trial judge whether it would be normal for someone in Mr. Harris' condition to strike someone else with a lead pipe, he responded:

> No,Your Honor. I would not consider it to be in a

> normal range. But I would consider it to be very unusual as a manifestation of what I perceive his psychiatric condition to be. It's not something that one expects of a person because they qualify for a diagnosis of Organic Brain Syndrome or Dementia. So, therefore, there's no way to put someone – if I diagnose Organic Brain Syndrome or Dementia I don't usually say either to a nursing home or to a care taker, for that matter, "Now, people with this condition frequently get violent so you better watch out."

Dr. Richoux did opine that had the nursing home had Mr. Harris under twenty-four hour supervision the incident might not have occurred. However, it is also clear from Dr. Richoux's testimony that had there been a recommendation of twenty-four hour supervision in Mr. Harris' case, it would have been for his protection and not for the purpose of protecting third parties from him, i.e., had there been a duty in the instant case to provide Mr. Harris with twenty-four hour supervision, it was a duty owed to him and not to third parties. Consequently, a violation of that duty would create no liability to third parties other than third parties who could have rights arising from injuries sustained by Mr. Harris, e.g., his survivors in case he were to sustain a fatal injury attributable to lack of supervision.

On redirect examination when asked to clarify what is meant by twenty-four hour supervision, Dr. Richoux explained that it meant that the patient should be checked frequently, not that the patient should be literally

followed around and/or kept under constant surveillance.

Eric Wilmore, the Assistant Administrator who ran the Maison Orleans II Nursing Home at the time of the incident, explained that the notation in Mr. Harris records, "Unable to care for self. Needs 24-hour supervision," refers to the basic reason that people are in a nursing home to begin with and it is meant "to ensure that they bathe, that they eat, that their medication is given . . ."

Mr. Wilmore testified that the nursing home did not have the capacity to lock people down and restrain them. In fact, LSA-R.S. 40:2010.8A(10) mandates that nursing home residents be free from physical and chemical restraints with certain very limited exceptions inapplicable to the instant case. He testified that he saw no reason why Mr. Harris was not an appropriate resident for the nursing home:

> Actually, he was pretty typical of a nursing home patient. He was elderly; he suffered from a certain degree of senility, as a lot of nursing home patients do. He had no history of being violent, being combative or hostile.

Mr. Wilmore further testified that nursing home residents are given a list of their rights in their admission packet, which rights include the right:

> To be free of mental and physical abuse and of restraints, not documented as medically necessary.

As matter of law Mr. Harris had the right to privacy in his room and

the right to retain personal possessions. LSA-R.S. 40:2010.8. In other words, Mr. Harris was entitled to have legal access to any number of objects, which could inflict bodily harm if wielded with the intention to do so. There are any number of conceivable and permissible personal possessions that could be used to strike another resident, for example, hardbound books, paper weights, mugs, clocks and telephones, just to name a few. In fact, there is an express statutory right to phone access. LSA-R.S. 40:2010.8A(2)(a). Mr. Harris' was not an inmate, he was a resident. He was not interdicted or confined. **In other words, it was Mr. Harris' decision, however poorly arrived at, to cause harm and not the lead pipe that was the legal cause of Mr. Banks' injuries, because had he not had access to the lead pipe he would have had access to any number of other items. The lead pipe was not intrinsically dangerous, e.g., it was not a gun, poison, or highly combustible.**

Mr. Wilmore testified without contradiction that Mr. Harris would have been able to get the pipe in the maintenance room and go to where he beat Mr. Banks without being seen by any of the sleeping employees even had they been awake. This corroborated Ms. Patterson's testimony to the effect that she did not see Mr. Harris pass in the hallway and that she could not see what was going on some 75 feet down the hallway from the nurses'

station where she was. She also noted that the recreation room where the nurses or nurses' aids were sleeping was directly across from the nurses' station only a few feet away in plain view of the nurses' station. Ms. Patterson also confirmed that she was the only witness to the beating. Ms. Patterson testified that when she arrived and while she was there, there was a nurse at the nurses' station "watching call buttons." The personnel were there to be available if necessary and a nurse was alert to call buttons. This was not a hospital facility with personnel making rounds of sick patients. LSA-R.S. 40:2010.8A(8) mandates that nursing homes allow residents "closed room doors, and to have facility personnel knock before entering the room." There is nothing in the record to show that any higher level of care would be industry practice in this kind of facility and the trial court specifically found that Ms. Patterson's account of the incident was "credible and persuasive."

The majority states that: "[H]ad even one aide been awake and on the floor that morning, Ms. Guillory could have sought immediate help when she observed Mr. Harris with the pipe before the attack." The record does not support this contention. The only testimony concerning Ms. Guillory was given by Mr. Wilmore. Ms. Guillory did not testify. Mr. Wilmore was allowed to testify without objection as to the contents of a report he received

on the incident from Ms. Guillory:

> Q. What did Ms. Guillory state as reported?
> A. She followed him with the pipe, followed behind him asking for him to give her the pipe. He refused. It's not in here but she told us –
>
> * * * *
>
> A. Well, in the document he refused to give it to her. And continued to **run** through the courtyard into the lobby and behind Mr. Banks at which time he hit him. [Emphasis added.]

Everything in the record indicates that the incident happened so quickly that there is no reason to believe that had the employees been awake that they could have reacted and gotten down the 75 foot hall in time to prevent Joseph Harris from striking Mr. Banks.

The majority states that: "The uncontroverted evidence indicates that Mr. Harris should have been checked every two hours." Mr. Wilmore testified that being a nursing home operator did not give him the right to restrain Mr. Harris to his room or to lock him in his room. Mr. Harris had the right to be up and walk around the nursing home before 5:00 a.m. if he wished to do so. Remember, Mr. Banks was also up and about before 5:00 a.m. that same morning and no one suggests that this called for any special supervision. Had someone noticed Mr. Harris up at that hour they would have had no duty to follow him around, and to do so without reason would

arguably be an intrusion on his rights to privacy. No one patrols the halls and **there is no evidence that the standard of care would require such patrols.** Mr. Harris was not interdicted and he was not a prisoner stripped of certain rights. **He was not in the custody of the nursing home and was free to leave whenever he wished. This is not an LSA-C.C.P. art. 2317 case. To suggest liability under that article would exceed any case in the existing jurisprudence and would almost certainly add ruinous insurance costs to nursing home care which would be very bad policy in our aging society**. He was only a resident, not an inmate of a prison or a psychiatric facility. For Mr. Harris the nursing home was merely an apartment house or rooming house with a high level of service. Mr. Wilmore testified that Mr. Harris' condition was typical. Assume for purposes of argument that the nursing home had checked on Mr. Harris every two hours as majority opinion suggests should have been done, and checked on Mr. Harris at 4:00 a.m. and again at 6:00 a.m. on the morning of the incident -- I still do not see how this would have prevented an incident that occurred in an instant around 5:00 a.m.

Mr. Wilmore further testified as follows:

> Q. When the nurse's aids aren't doing rounds; what can they do? Can they be in the rec room?
> A. Yes, they can.
> Q. Where are they supposed to be?

A. They should be available for the nurse. If someone pushes one of those call buttons, and the nurse is there to answer the call and send the nurse's assistant to the room.
Q. How available are nurse's aids in the rec room?
A. The rec room, and I imagine the reason they were in there is because it is directly across from me to you form the nurse's station.
Q. So they were available? They were available there?
A. Yes.
Q. This rec room, is this in line of sight down that hall where the beating took place?
A. Not where the incident occurred, no.
Q. So, if somebody in the rec room would not necessarily be able to see what was going on all the way at the court? [Sic.]
A. No.

[Emphasis added.]

Thus, even had the nursing home employees been awake at their stations they could not have seen and prevented the incident. I would expect a very negative initial visceral reaction from anyone reviewing this record to the fact that some of the employees were asleep. However, in the instant case the plaintiffs have not borne their burden of proof to show that the sleeping employees were a cause in fact of the injuries sustained by Mr. Banks. In other words, assuming for purposes of argument that the failure of the employees of the nursing home to stay awake constituted a breach of duty to Mr. Banks, the plaintiffs still failed to prove by a preponderance of the evidence that the breach of that duty was a cause in fact of the decedent's

injuries. **In other words, the plaintiffs proved only the mere possibility of injury prevention. Plaintiffs did not, as they are required to do, prove the probability of such prevention.**

This all goes to what I would characterize as a total misperception by the trial court as to the nature of the Maison Orleans nursing home facility as opposed to hospitals or psychiatric facilities. This misconception pervades the entire trial court opinion and is best exemplified by an unjustified and inappropriate reliance on the mental health case of *Jones v. State through Dept. of Health and Hospitals,* 95-1130 (La.App. 3 Cir. 3/27/96), 671 So.2d 1074. In *Jones* the forty-seven year old patient had a mental age of only three and four years and numerous other serious handicaps. The patient in *Jones* was required to be directly observed by his caretaker at all times, a level of supervision far beyond what Maison Orleans was expected to provide to Mr. Harris. The plaintiff in *Jones* was suing for the death of the patient for breach of the duty of care owed to the patient, not for damage caused by the patient to a third party. Moreover, the Pinecrest facility in *Jones* was obviously not a nursing home like the Maison Orleans. Mr. Wilmore testified without contradiction that Mr. Harris was not required to be under constant observation. A nursing home has no duty to furnish a nurse or attendant at all times. *McCartney v. Columbia Heights Nursing*

Home, Inc., 25,710 (La.App. 2 Cir.3/30/94), 634 So.2d 927; *Oswald v. Rapides Iberia Management Enterprises, Inc.*, 452 So.2d 1258 (La.App. 2 Cir.1984); *Capo v. Alliance Ins. Co.*, 499 So.2d 233 (La.App. 2 Cir.1986). The trial court in its reasons for judgment cited all of these cases, but in none of them was the nursing home held liable. These cases also point out that a nursing home is not an insurer of the safety of its patrons.

Mr. Wilmore explained that the Maison Orleans is not a hospital and is not required to make notations on patient charts concerning each observation and interaction with the patient. Mr. Wilmore's testimony is the only evidence in the record on this issue. Yet in spite of the only record evidence to the contrary, the trial court noted that "the nursing home had no system of record keeping to monitor whether or not this 24 hour supervision was being accomplished" implying that this was a breach of duty without any evidence to show that the standard of care in the industry required such record keeping. The record simply does not support the inference made by the trial court on this issue.

In *LeMoine v. Insurance Company of North America*, 499 So.2d 1004 (La.App. 3 Cir.1986), the court found that sexual abuse of an elderly nursing home resident by an unknown assailant was not reported to any family member when first discovered by nursing home employees and that alleged

instructions to all nursing home employees to be on the alert for any further indecent behavior were never delivered to any but a few employees. Numerous employees testified that they witnessed improprieties involving the elderly resident, but failed to report them. No investigation into the incidents was conducted until after they occurred for a third time. The failure to act in the face of repeated known acts of abuse in *LeMoine* involves facts so far removed from those of the instant case as to render *LeMoine* irrelevant as support for the trial court's decision below.

Similarly, the nursing home resident in *Sayes v. Pilgrim Manor Nursing Home, Inc.,* 536 So.2d 705 (La.App. 3 Cir.1988), was retarded and had been admitted to the hospital sixteen times "because of violent, combative, destructive and suicidal behavior," where she was diagnosed as having chronic brain syndrome **with psychotic reaction.** *Id.,* at p. 707. Her treating physician at the nursing home, Dr. Bahm, described her as emotionally labile with hostile reactions, or calm and cooperative one day and hostile and combative the next. *Id.* Dr. Bahm issued standing orders that his patient could be restrained for self-protection and the protection of others if she became violent. Dr. Bahm testified that she should not have been given the freedom to leave the nursing home at will, but she was, nevertheless, allowed to leave without even signing out. As a result she was

frequently picked up by the Pineville police for causing a disturbance in the surrounding neighborhood. Her behavior on the days leading up to the incident that provoked the *Sayes* litigation was notably volatile, but she was still allowed to leave the premises unsupervised. In view of her known and long history of obvious problems the court found that the nursing home was negligent in treating her "like any other resident who had nominal physical or mental disabilities." This eminently reasonable result based on the egregious facts of the *Sayes* case has no bearing on the instant case where Mr. Harris had no history comparable to that of the nursing home resident in *Sayes.*

Just as in *Sayes, supra,* in *Johnson v. Pendleton*, 98-2001 (La.App. 4 Cir. 12/29/99), 751 So.2d 332, the violent nursing home resident had been diagnosed with psychotic symptoms. Moreover, shortly before attacking the nursing home employee-plaintiff by throwing her into a table resulting in the injuries responsible for the litigation, the nursing home resident was known to have committed several acts of violence. The nursing home was held liable because of its knowledge of the resident's dangerous propensities. In the instant case, unlike *Sayes* and *Pendleton*, there was no diagnosis of psychosis for Mr. Harris and no even remotely similar history of violence on his part.

Mr. Wilmore testified that there was video monitoring equipment in the hallways, but that it was illegal to monitor the residents in their rooms. No one watches the monitor during the 11 p.m. – 7 a.m. shift. Mr. Wilmore testified that the cameras were intended more to supervise employees than to monitor the activities of patients. This explains why the video monitor is in the administrator's office and not at any of the nurse or employee stations. The plaintiff made no showing that the standard for the industry required video monitoring of the residents. Mr. Wilmore explained that the video flicked randomly from camera to camera "for sixty something" and that it showed nothing relevant for that night. **The trial court found that, "He testified . . . that he does not know where the tapes are at present," but this finding is contrary to the record. When asked: "Where are the tapes?", Mr. Wilmore replied: "At the home."** Not only was this finding of fact manifestly erroneous, the trial court's finding that "the content captured on the tape must have been adverse to the positions advanced by the defendant" was consequently erroneous:

> It is settled that when a litigant fails to produce available evidence and no reasonable explanation is made, there is a presumption that such evidence would be unfavorable. *Boh Brothers Construction*, 612 So.2d at 270; *Wilson v. U.S. fire and Casualty Company*, 593 So.2d 695 (La.App. 4th Cir.1991), *writ denied* 597 So.2d 1037 (La.1992). To decide whether to apply the adverse inference, one is guided toward the goal of a fair and equitable

> judicial process, by the likelihood that the verdict will be based on truth, and by the need to deter the wrongful, intentional spoliation of evidence in the future. *Kammerer v. Sewerage and Water Board of New Orleans,* 93-1232 ((La.App. 4 Cir. 3/15/94), 633 So.2d 1357, *writ denied* 94-0948 (La. 7/1/94), 639 Swo.2d 1163.

Williams v. Golden, 95-2712 (La.App. 4 Cir. 7/23/97), 699 So.2d 102, 108.

The defendant did not fail to produce the tape in the instant case when called upon to do so. The plaintiffs do not even suggest that they ever asked to see the videotape. In *Golden* it was established that a doctor has the responsibility to preserve a patient's medical records, but the defendant-doctor was unable to explain what happened to the plaintiff's medical records:

> Under these circumstances we are justified to apply an adverse inference and presume that Williams' records would have been unfavorable to Dr. Golden.

Id.

In *Boh Bros.*, 612 So.2d 270 (La.App. 4 Cir.1992), cited in *Golden,* this Court was concerned with a defective "filter assembly unit" which the defendant had discarded. This Court found that it was error to instruct the jury that the failure of the plaintiff to preserve this critical piece of evidence created an adverse presumption without also instructing the jury that the presumption could be overcome by explaining the failure to produce the

missing evidence. Consequently this Court conducted a *de novo* review without relying on any adverse presumptions, apparently finding satisfactory the defendant's explanation for why the allegedly defective part had been discarded. In *Boh Bros.* the missing evidence was the crux of the entire case, the part alleged to be defective, and the sole cause of the accident. This Court apparently accepted the explanation for its disappearance, that it was discarded in the normal course of maintenance prior to knowledge of the litigation. By comparison, in the instant case Mr. Wilmore testified without contradiction that the tape was still in existence at the home.

A survey of cases concerning this issue reveals that the presumption was intended to apply to evidence that was no longer in existence. There is usually an issue or at least an undercurrent of spoliation or the failure to produce evidence when requested to do so, none of which apply to the instant case. Even when the evidence has been disposed of, any reasonable explanation for the disposal serves to defeat the presumption. *Rapp v. City of New Orleans*, 98-1714 (La.App. 4 Cir. 12/29/99), 750 So.2d 1130; *Small v. Baloise Ins. Co. of America,* 96-2484 (La.App. 4 Cir. 3/18/98), 753 So.2d 234, 242; *Randolph v. General Motors Corp.*, 93-1983 (La.App. 1 Cir. 11/10/94), 646 So.2d 1019, 1027; *Wimberly v. B.P. Newman Investments, Inc.*, 34,905 (La.App. 2 Cir. 11/2/01), 805 So.2d 239, 246; *Smith v. Jitney*

Jungle of America, 35,100 (La.App. 2 Cir. 12/5/01), 802 So.2d 988, *writ denied* 2002-0039 (La. 3/15/02), 811 So2d 913; *All Seasons Const. v. City of Shreveport*, 32,190 (La.App. 2 Cir. 8/18/99), 742 So.2d 626, 635; *Johnson v. Department of Public Safety*, 627 So.2d 732 (La.App. 2 Cir.1993); *Edwards v. Daugherty*, 97-1542 (La.App. 3 Cir. 3/10/99), 729 So.2d 1112, 1131-1132; *Hooker v. Super Products Corp.*, 98-1107 (La.App. 5 Cir. 6/30/99), 751 So.2d 889, 910.

In *Wimberly, supra*, p. 9, 805 So.2d at 246, the court held the failure to produce a videotape that did not contain "vital real evidence" did not create an adverse presumption. As this Court explained in *Constans v. Choctaw Transport, Inc.*, 97-0863 (La.App. 4 Cir. 12/23/97), 712 So.2d 885:

> The cases cited by Allstate indicate apply [sic] the adverse presumption rule should only apply to situations in which the evidence was destroyed or discarded with no remaining photographs under conditions from which one could infer that the party disposing of the evidence was motivated by a desire to dispose of unfavorable evidence. There is nothing in the way that Choctaw dealt with this bumper from which we might infer that the disposition of the bumper was motivated by a desire to deprive other litigants of access to it. The theory of spoliation of evidence refers to an intentional destruction of the evidence for the purpose of depriving the opposing party of its use.

Id.

In the instant case there is no suggestion that Maison Orleans made

any attempt to conceal or destroy the videotape. There is no suggestion Maison Orleans resisted any request to produce the tape. Mr. Wilmore admitted without hesitation that the tape existed, but when he did so the plaintiffs made no request that it be produced. There are no cases even remotely approaching the fact situation of the instant case in which the adverse presumption was found to be applicable. Mr. Wilmore explained that because of the random nature of the tapes they showed nothing of probative value, i.e., the fact that the tapes showed nothing of the incident would either tend to prove or disprove the Maison Orleans' case because the entire incident and everything leading up to it could have easily occurred off camera. If the plaintiffs felt that the tape might have contained evidence helpful to their case, they should have requested that it be produced either through prior discovery or by asking that it be produced on the spot and/or asking that the receipt of evidence be held open pending the production of the tape. After all, there was no jury to inconvenience by holding open the evidence. Plaintiffs failed to take any steps in this regard. It was error for the trial court to apply an adverse presumption against the Maison Orleans under the facts of this case.

Mr. Wilmore testified that a resident who displayed violent tendencies would not be allowed to stay. The Maison Orleans is a residential facility,

not a psychiatric facility.

The first witness called by the plaintiffs was, Marquitta Patterson. At the time of the incident, Ms. Patterson was a Phelbotomist for Smith-Kline Beecham Clinical Laboratories. Her work required her to be at the Maison Orleans Nursing Home four or five days a week. She was the only witness to the incident, which she described as follows:

> I passed Mr. Banks through the recreation area. It's like a living room like. So, I passed him up that morning and as I proceeded to go down the hallway, I took a right down the hallway to the nurses station. I stood there for about 5 to 6 minutes, sorted out my paper work. As I started sorting out my paper work, I heard like a bump against the wall. After I heard the bump, I never paid it any attention. So, I just continued to sort my paper work. I heard the bump again like a wheelchair. You know, like something had fallen against the wall. I said, well, I still have to go back that way, so, just let me get my tray and I'll start out this end so I could see what it was. So, as I approached the hallway, it was Mr. Banks being beaten by one of the other residents. As I approached him, I seen like a hand come from the side of the wall and I screamed. Once I screamed the guy hit him maybe two or three more times after I screamed. And he walked away saying, "He should have cleaned my sheets." And that was it. But after I screamed I woke up everybody, because everybody was asleep except for myself and the nurse at the nurse's station.

The trial court did not find, and, indeed, the record does not reasonably permit one to infer that had some of the sleeping employees been

awake at the time Ms. Patterson screamed, that they could have rushed to Mr. Bank's assistance fast enough to prevent the battery which was already in progress.

The trial court enumerated four negligent acts in support of its conclusion, but the first example described by the trial court following its four-fold enumeration of negligence is clearly wrong as a basis for the result reached by the trial court:

> The Maison Orleans II, Inc.'s documents pertaining to Banks establish that they were aware of Harris abnormal behavior prior to the February 16, 1993 [sic] in their final notation with respect to Banks prior to this incident that on: "1/14/93, Banks continues his daily routine such as delivery of newspapers. He also enjoys standing in the hall communicating with others and watching what goes on."

The fact that Mr. Banks enjoyed standing in the hall and communicating with others provides no information to Maison Orleans II that would alert it to Mr. Harris' potential for inflicting harm upon Mr. Banks.

The entire trial court opinion is permeated with unsupported assumptions that Mr. Harris's dementia, organic brain syndrome and delusional thought were indicative of violent behavior when all of the evidence is to the contrary. **As there is simply no evidence that Mr.**

Harris' symptoms were indicative of violent propensities, the trial court, in effect, took upon itself the role of psychiatric expert; a role that court is not qualified to take upon itself when contrary to the evidence. Had there been conflicting evidence on this issue, normally the trial court would have the prerogative of choosing which evidence to credit. But there was no conflicting evidence. The plaintiffs produced no witness who testified as to any prior incident with Mr. Harris and there was no prior diagnosis of psychosis such as supported the findings of liability in *Sayes* and *Pendleton*, *supra*. Implicit throughout the trial court's reasons is the erroneous conclusion that Mr. Harris was a known psychotic and that the nursing home should have acted accordingly. I find no cases even remotely resembling the facts of the instant case in which a nursing home has been held liable. The plaintiffs cite no such cases and the trial court in its reasons cite none.

I would assign all of the fault to Mr. Harris who was not an interdict at the time of the incident.

For the foregoing reasons, I would reverse the opinion of the trial court and find in favor of the defendants. However, were I to agree for purposes of argument that the Maison Orleans is liable, then I would agree with the majority on the issue of insurance coverage.