This opinion is nonprecedential except as provided by
Minn. R. Civ. App. P. 136.01, subd. 1(c).

STATE OF MINNESOTA
IN COURT OF APPEALS
A22-1376

Judith Rygwall, as Trustee for the Heirs
and Next of Kin of Amy Rygwall, deceased,
Appellant,

vs.

ACR Homes, Inc. d/b/a ACR Homes,
Respondent.

Filed May 30, 2023
Affirmed
Larkin, Judge

Anoka County District Court
File No. 02-CV-20-2659

Adam W. Hansen, Apollo Law LLC, Minneapolis, Minnesota (for appellant)

Stephen O. Plunkett, Gillian L. Gilbert, Bassford Remele, P.A., Minneapolis, Minnesota (for respondent)

Considered and decided by Larkin, Presiding Judge; Reilly, Judge; and Slieter, Judge.

NONPRECEDENTIAL OPINION

LARKIN, Judge

Appellant-trustee challenges the district court's grant of summary judgment for respondent-care-provider on appellant's medical-malpractice and wrongful-death claims, which were based on the death of appellant's adult daughter. Because appellant failed to raise a genuine issue of material fact regarding causation, we affirm.

FACTS

Appellant Judith Rygwall's daughter Amy was born with a rare medical condition that caused significant physical and mental disabilities.[1] Amy was mostly non-verbal, had frequent seizures, and required constant supervision and assistance with daily activities. Amy at times had seizures while eating and was on a restricted diet that consisted primarily of soft or chopped foods because of her increased risk of choking.

Amy resided in a group home owned and operated by respondent ACR Homes, Inc. Amy received residential services at the group home, which was located in Andover. During the day she attended the Community Integration Program at Rise, Inc. in Anoka. Amy's Assessment and Support Plan at Rise directed staff to be "with Amy at all times" and required staff to call 911, Amy's guardian, and her group home if she had a seizure that "last[ed] longer than 4 minutes or [was] atypical." ACR's Seizure Plan for Amy also required staff to call 911 for atypical seizures and seizures lasting longer than four minutes, as well as for "any abnormal respiratory distress during a seizure." The seizure plan directed that if Amy had three or more seizures in a 24-hour period, her temperature should be checked every two hours until it was within normal range for 12 consecutive hours.

On December 29, 2015, ACR conducted Amy's monthly examination, and the results were "all within normal limits." Amy had a seizure on the evening of December 30 and another in the early morning of December 31, both lasting around 30 seconds. Rise

[1] This appeal stems from the district court's grant of summary judgment, and the record consists of various documents, expert affidavits, and deposition transcripts. The facts discussed are either undisputed or resolved in the light most favorable to the nonmoving party.

staff reported that Amy was "kind of slumped over a little bit" when she arrived at Rise on December 31 and that she had been more tired than normal over the past week.

Around noon, Amy had lunch at Rise. Amy finished her lunch and took a bite of pudding, indicated that she didn't want anymore, and was given a glass of water. Amy pushed away from the table where she was seated and began coughing. A Rise staff member noted that Amy's "eyes were watery," checked to make sure Amy had nothing in her mouth, and called for a Rise nurse. The Rise nurse reported that Amy's skin was "pale to flush" and she "had some white foam in her mouth," but that no food particles were visible. The nurse asked Amy to say "ball," which she did "with some difficulty." The nurse checked Amy's mouth for food and observed none. The nurse reported that Amy's lungs were "rattling some and 16 beats per minute" but that Amy's "base line lung sounds [were] raspy."

A Rise staff member contacted Rygwall and told her that Amy had eaten pudding and "choked on it" and that Amy "started foaming at the mouth." The staff-member told Rygwall that the seizure was "a little different this time," but Rygwall testified that she initially believed it was "a very, very small seizure, because [Amy] had that at home at times." The Rise nurse and Rygwall agreed that Amy should be seen by a physician.

At 12:35 p.m., A.J., a residential coordinator with ACR, received a call from Rise and determined that Amy should be taken to urgent care. A.J. "looked online to see the hours of the urgent care" and selected the clinic where Amy "would be seen the quickest, even though it was farther away." That clinic was in St. Paul. A.J. testified that while most

urgent-care locations showed wait times of a few hours, she didn't look for clinics outside of Amy's insurance network because "that was the procedure that we usually used."

Rise staff continued to monitor Amy until A.J. arrived. Staff reported that Amy took a nap and was "going back into normal behaviors." A.J. picked Amy up from Rise at 1:41 p.m. While driving Amy to the pre-selected urgent-care in St. Paul, A.J. saw an urgent-care clinic in "Anoka or Andover" that she did not recall seeing online and stopped there, but that clinic had a long wait time. A.J. testified that Amy "was still appearing to be her normal self" and that her "condition hadn't changed at all while [they] were driving."

A.J. arrived at the urgent-care clinic in St. Paul at roughly 2:56 p.m. A.J. testified that after they arrived at that clinic and checked in, Amy "looked normal" but her breathing sounded "a little bit rattled." A.J. testified that she did not mention Amy's condition to the receptionist when she checked in at the clinic. The urgent-care nurse took Amy's vitals and "they were good," but after the nurse left the room Amy's "face and her lips [be]came blue" and her "breathing was more labored," prompting A.J. to call for a nurse. The responding nurse described Amy's condition as follows: "lips are light blue, upper airway congestion, white foam noted at the creases of the mouth, is moving small amounts of air orally." Clinic staff called 911 at 3:30 p.m. and placed Amy on oxygen.

Emergency personnel arrived at the urgent-care clinic at 3:36 p.m. Emergency personnel noted that Amy was taking shallow, rapid breaths and that her lungs sounded "wet." Emergency notes indicate that A.J. "stated she thinks [Amy] aspirated earl[i]er today." Amy was treated "under the respiratory signs [and] symptoms protocol" while being transported to the emergency room by ambulance. The ambulance arrived at Regions

Hospital at 3:53 p.m., more than three hours after Rise staff suspected that Amy had choked on her pudding.

Hospital admission notes from 4:34 p.m. describe Amy's condition as "restless, obvious respiratory distress, O2 sats 65%, audible gurgling, lungs sound wet." Amy was placed on a BiPap machine, intubated for respiratory failure, and given IV antibiotics "for presumed aspiration pneumonia." The emergency department physician determined that Amy had "respiratory insufficiency and respiratory failure, which requires immediate intervention." A hospital report from later that evening noted that Amy tested positive for methicillin-resistant Staphylococcus aureus (MRSA) and that Amy had "possible sepsis."

On January 13, 2016, a Rise program coordinator logged the following note:

> [Rygwall] called this morning and told me that yesterday they met with all of the doctors that were working with Amy. The doctors told the family that her lungs were filling with fluid, her heart muscles were weakening[,] and her kidneys were shutting down. The family has decided that they would pull life support today at 10:30, because they were told that Amy would never be able to breathe on her own and would always be connected to machines/tubes. [Rygwall] also said that Amy would never be able to return to [ACR] nor to Rise. [Rygwall] also said that she and [Amy's father] knew that Amy would not like that and if they kept her alive with machines/tubes they would only be doing it for themselves and they felt that was being selfish. . . . Amy was extubated and passed away at 10:30 [p.m.].

Amy was 43 years old at the time of her death. Amy's primary cause of death was acute respiratory distress syndrome (ARDS), with underlying causes of acute kidney injury, septic shock, and aspiration pneumonia.

On December 27, 2018, Rygwall sued ACR, asserting claims of medical malpractice and wrongful death arising out of ordinary negligence, professional liability, and direct corporate negligence. As support for her claims, Rygwall submitted affidavits from two of Amy's treating physicians and two experts, including Dr. Jacob Keeperman. Dr. Keeperman opined that "ACR should have taken immediate steps to ensure that [Amy] was taken for emergency medical care" and that the "delay in obtaining emergency care" and the "failure to provide all relevant medical information" to medical personnel caused or contributed to Amy's deterioration and eventual death.

ACR moved for summary judgment, arguing that Rygwall "failed to produce legally sufficient expert opinions on causation as necessary to bring her claims before a jury." The district court ordered summary judgment for ACR, reasoning that Rygwall failed to establish that it was more probable than not that ACR's negligence caused Amy's death and that "[u]nder the facts of this case, the jury would be asked to speculate as to the type of appropriate treatment as well as if and when earlier treatment would have prevented Amy's death."

Rygwall appeals.[2]

DECISION

Rygwall challenges the district court's grant of summary judgment for ACR. The district court shall grant summary judgment when "there is no genuine issue as to any

[2] The district court also determined that Rygwall's claims for professional liability and direct corporate negligence failed as a matter of law. Rygwall does not appeal those rulings.

material fact and the movant is entitled to judgment as a matter of law." Minn. R. Civ. P. 56.01. "[S]ummary judgment is inappropriate when reasonable persons might draw different conclusions from the evidence presented." *Smits as Tr. for Short v. Park Nicollet Health Servs.*, 979 N.W.2d 436, 445 (Minn. 2022) (quotation omitted). Summary judgment is appropriate when the record lacks proof of any element of a claim. *Lubbers v. Anderson*, 539 N.W.2d 398, 401 (Minn. 1995). We review the grant of summary judgment de novo. *Zip Sort, Inc. v. Comm'r of Revenue*, 567 N.W.2d 34, 37 (Minn. 1997).

To establish a prima facie case of medical malpractice, a plaintiff must provide expert testimony establishing the applicable standard of care, that the defendant breached that standard of care, and that the breach was a direct cause of the plaintiff's injuries. *Fabio v. Bellomo*, 504 N.W.2d 758, 762 (Minn. 1993). A medical-malpractice plaintiff must prove, usually by expert testimony, that it is more probable than not that negligence was the proximate cause of the injury. *Leubner v. Sterner*, 493 N.W.2d 119, 121 (Minn. 1992); *see also Walton v. Jones*, 286 N.W.2d 710, 715 (Minn. 1979) (stating that expert testimony on causation "must be more than consistent with plaintiff's theory of causation" and must "show that it was more likely that death occurred from defendant's negligence than from anything else.").

The relevant portion of ACR's motion for summary judgment was based solely on the causation element of Rygwall's claims. Generally, causation is a fact question for the jury, but if reasonable minds could arrive at only one conclusion, causation is a question of law. *Lubbers*, 539 N.W.2d at 402. "[A] jury should not be permitted to speculate as to possible causes of a plaintiff's injury or whether different medical treatment could have

resulted in a more favorable prognosis for the plaintiff." *Leubner*, 493 N.W.2d at 121. Thus, medical testimony "which does nothing more than show a mere possibility, suspicion or conjecture that such a causal connection exists" generally does not meet the plaintiff's burden to show causation. *Bernloehr v. Cent. Livestock Ord. Buying Co.*, 208 N.W.2d 753, 755 (Minn. 1973).

Caselaw requires "a detailed chain of causation explaining how and why [defendant's] delay in treatment resulted in [plaintiff's injury]." *Maudsley v. Pederson*, 676 N.W.2d 8, 14 (Minn. App. 2004). In *Maudsley*, the plaintiff's expert opined:

> It is more likely than not that if treatment had been initiated on June 27, rather than June 28, Leslie Maudsley would not have lost the vision in her right eye. She may have suffered some impairment to that vision, but she would not have lost it totally. *When infections are present it is generally the rule that better outcomes are the result of earlier treatment; in fact every hour counts.* It is more likely than not that if treatment had been initiated on June 27, 1999 that Leslie Maudsley would have recovered from the infection and had the vision she had at the time surgery was performed on June 17, 1999.

Id. at 13-14 (emphasis added). The *Maudsley* court determined that the "conclusory statements that generally, earlier treatment results in better outcomes and that every hour counts fail to outline specific details explaining how and why [the] 15- to 17-hour delay in treatment caused Maudsley's blindness." *Id.* at 14. In this case, the district court relied on *Maudsley* and concluded that Dr. Keeperman's affidavit did not explain "'how' and 'why' the alleged malpractice caused the injury." Rygwall assigns error to that conclusion.[3]

[3] Rygwall assigns error to several other aspects of the district court's analysis. Because our review is de novo, we do not address them.

Dr. Keeperman's affidavit asserts that, based on the assessment of the Rise nurse, "any reasonable person, and especially an employee of ACR, should have recognized that Amy . . . was in severe distress and needed immediate emergency medical evaluation and treatment." His affidavit states that Amy was exhibiting signs of abnormal respiratory distress and that ACR failed to follow their seizure protocol, which directs staff to call 911 for "any abnormal respiratory distress during a seizure." Dr. Keeperman opined that the time it took to pick up Amy at Rise, the failure to select a closer clinic, and the failure to inform the first urgent-care clinic where A.J. stopped of Amy's condition, or to ask for an appointment at that clinic, resulted in delay that contributed to Amy's death.

Dr. Keeperman's affidavit states that, as required by ACR's seizure plan for Amy, any sign of respiratory distress following a seizure requires emergency care. His affidavit also cites studies indicating that "[d]elays in administration of appropriate antimicrobials in septic shock by as little as 30 minutes have been demonstrated to significantly increase mortality." Dr. Keeperman concludes: "Had Amy[']s change in clinical status been immediately acted on with rapid evaluation and treatment, there is a reasonable degree of medical certainty her condition never would have deteriorated to ARDS, septic shock, multi-system organ failure, and ultimately her death."

In sum, Dr. Keeperman's affidavit presents the following chain of causation:

- Amy's change in condition was evidence of respiratory distress;
- Such a change in condition required emergency care;
- ACR did not seek immediate emergency care for Amy;
- ACR took nearly three hours to get Amy to urgent care, at which point her condition deteriorated and 911 was called;

- Early and aggressive treatment for sepsis, septic shock, and ARDS decreases morbidity and mortality;
- 30-minute delays in antimicrobial treatment for septic shock can significantly increase mortality; and
- Amy's cause of death was ARDS, acute kidney injury, septic shock, and aspiration pneumonia.

Although Dr. Keeperman's expert report may explain how ACR departed from the standard of care, his general statement that research "support[s] the need for early and aggressive interventions" in ARDS cases is the type of nonspecific assertion that this court rejected as insufficient to prove causation in *Maudsley*. 676 N.W.2d at 14. Dr. Keeperman maintains throughout his affidavit that Amy showed signs of respiratory distress requiring immediate emergency intervention. Dr. Keeperman concludes that "[t]he delay in providing prompt treatment to the patient contributed to her eventual death" and that "[h]ad Amy Rygwall's change in clinical status been immediately acted on with rapid evaluation and treatment, there is a reasonable degree of medical certainty her condition never would have deteriorated to ARDS, septic shock, multi-system organ failure, and ultimately her death." But neither Dr. Keeperman's affidavit nor any other record evidence sets forth "specific details explaining how and why" the delay in Amy's treatment caused her death. *Maudsley*, 676 N.W.2d at 14. More specifically, Dr. Keeperman does not explain how Amy's treatment would have progressed had she been seen sooner or how immediate treatment would have prevented her condition from becoming fatal.

Demgen v. Fairview Hospital provides an example of an expert affidavit that set forth sufficient evidence of causation, that is, one that would be adequate to avoid

summary-judgment dismissal. 621 N.W.2d 259 (Minn. App. 2001), *rev. denied* (Minn. Apr. 17, 2001). The expert affidavit in that case stated:

> b. The applicable standard of care under the circumstances of this case would dictate that a fetal acoustical stimulation test or another type of fetal stimulation test or an immediate bedside ultrasound should have been performed.
>
> c. Had the ultrasound test been performed, it would have revealed abnormally low amniotic fluid levels (i.e., the presence of Oligohydramnios). In combination with the markedly abnormal fetal heart rate tracing, this finding would dictate the need for an immediate caesarean section.
>
> d. In a hospital comparable to that at issue, the applicable standard of care would dictate that such an emergency caesarean section be accomplished within 53 minutes, prior to this fetus dying. The failure to have the appropriate tests completed delayed having a caesarean section performed. Failing to have the appropriate tests completed was a direct cause of the fetus' death. The deviations from the standard of care specified above caused the demise of Mrs. Demgen's fetus.
>
> e. Had such an emergency caesarean section been timely performed, a live birth would have resulted. The applicable standard of care would dictate that the procedures specified above, including delivery by caesarean section, should have been completed prior to the cessation of the fetus's cardiac activity, as indicated on the monitoring strip.

Id. at 263.

Dr. Keeperman's affidavit does not compare with the detailed affidavit in *Demgen*, which explained how and why the alleged malpractice caused a death. Instead, Dr. Keeperman's affidavit and the other record evidence would leave a jury to impermissibly speculate regarding the causal connection, if any, between Amy's delayed medical treatment and her death. *See Leubner*, 493 N.W.2d at 121 ("[A] jury should not be

permitted to speculate as to possible causes of a plaintiff's injury or whether different medical treatment could have resulted in a more favorable prognosis for the plaintiff.").

Rygwall argues that the district court incorrectly determined that expert-witness evidence is "required to provide a specific medication name or treatment window" and that the district court erred in "insist[ing] on magic words to establish causation through expert testimony." Rygwall is correct that no particular words are necessary to establish a genuine issue of material fact regarding causation in a medical malpractice case. But there must be evidence that allows a reasonable person to conclude—without relying on speculation—that the alleged malpractice caused harm. That requirement has not been satisfied here.

This is an undeniably tragic case. Amy was clearly a special person who was deeply loved by those who knew her. But "it is well settled in Minnesota that expert testimony in a medical malpractice case must be more than consistent with plaintiff's theory of causation; the expert testimony must demonstrate a reasonable *probability* that defendant's negligence was the proximate cause of the injury." *Walton*, 286 N.W.2d at 715. We have reviewed the entire record in the light most favorable to Rygwall and have drawn all inferences in her favor, keeping in mind the requirement of expert causation evidence and this court's precedent setting the standard for such evidence. Having done so, we conclude that the record is inadequate to enable a reasonable person to conclude—without speculation—that the delay in providing Amy's medical care was a substantial factor in bringing about her untimely death. Because the record fails to establish a genuine issue of material fact regarding causation, we affirm.

Affirmed.