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# Commonwealth of Kentucky

# Court of Appeals

NO. 2014-CA-000125-MR

BETTY RIGGS MITCHELL, A/K/A
BETTY RIGGS, ADMINISTRATRIX
OF THE ESTATE OF MICHAEL
DAVID RIGGS, DECEASED; CHRISTY
K. RIGGS, AS NEXT FRIEND OF
ALLISON RIGGS, KIMBERLY RIGGS,
AND APRIL RIGGS, MINORS — APPELLANTS

v.

APPEAL FROM FAYETTE CIRCUIT COURT
HONORABLE PAMELA R. GOODWINE, JUDGE
ACTION NO. 11-CI-00822

BAPTIST HEALTHCARE SYSTEM, INC.,
D/B/A CENTRAL BAPTIST HOSPITAL — APPELLEE

OPINION
AFFIRMING

** ** ** ** **

BEFORE: DIXON, KRAMER, AND J. LAMBERT, JUDGES.

J. LAMBERT, JUDGE: Betty Riggs Mitchell, Administratrix of the Estate of Michael David Riggs, Deceased and Christy K. Riggs, as Next Friend of Allison

Riggs, Kimberly Riggs, and April Riggs, Minors, appeal from the Fayette Circuit Court's judgment following a jury verdict in favor of Baptist Healthcare System, Inc. d/b/a Central Baptist Hospital (Central Baptist). After careful review, we affirm the judgment of the trial court.

In order to fully understand the facts of this case, some background information is essential. In 1994, Michael Riggs was diagnosed with diabetes after he passed out behind the wheel of his automobile in his home state of South Carolina. Riggs's physician informed him that he "would be dead by 40" if he did not stop drinking alcohol. Over the ensuing sixteen years, Riggs continued to abuse alcohol. Additionally, Riggs failed to properly take the medication prescribed to him as treatment for his diabetes. Instead, he attempted to control his condition by occasionally taking his medications when he felt like it was needed. During this time, he developed vision problems, congestive heart failure, seizures, hypertension, and kidney disease associated with his uncontrolled diabetes. The kidney disease eventually progressed into kidney failure. In December 2009, when he was 39 years old, Riggs's heart had already deteriorated to the point that he required the placement of a pacemaker.

In February 2010, Riggs's adult son, Dewayne Riggs, lived in Pineville, Kentucky, and Riggs lived in Aiken, South Carolina, with his mother, Betty Mitchell. Riggs did not own an automobile, and Dewayne drove to South Carolina to pick up Riggs for a trip to Kentucky. Before the group started to Kentucky on February 13, 2010, they stopped at a liquor store and purchased a

bottle of liquor that Riggs "drank straight" and shared with another passenger during the trip.

The next morning, on February 14th, Riggs walked into a Delta Gas Station in Pineville, Kentucky. A call was subsequently placed to 911 after Riggs began complaining while in the gas station that his pacemaker was misfiring. Upon arrival of EMS, Riggs told the EMTs that his pacemaker had shocked him four times that morning and that the pacemaker had been placed six months prior. Riggs was transferred via ambulance to the Pineville Community Hospital (Pineville Hospital). Riggs freely admitted to the nursing staff at Pineville Hospital that he had abused drugs and alcohol over the previous 20-30 years and acknowledged drinking at least half of a pint of alcohol each day with his last intake the night of February 13, 2010. He also gave a history of cardiac problems, congestive heart failure, diabetes, and renal failure. Riggs provided a list of his home medications to the triage nurse at Pineville Hospital. For purposes of this appeal, it is relevant to note that Riggs did not disclose a medication called Glimepiride, an oral medication he had previously been prescribed for treatment of his diabetes.

While in the emergency room, blood work was done which was significant, amongst other things, for a critically high blood sugar level of 934. Riggs was administered a few different medications in the emergency department at Pineville Hospital, including 20 units of Humulin R insulin via IV at 2:45 p.m. The emergency medicine physician, Dr. Cabuay, assessed Riggs and determined

that Riggs would need a higher level of care for assessment of his pacemaker, and subsequently contacted Dr. Thomas Goff, a cardiologist, to see if Dr. Goff would accept transfer of Riggs to Central Baptist in Lexington. Dr. Goff did indeed accept the transfer, and Riggs was transported via ambulance to Central Baptist in stable condition, arriving at the hospital at or around 5:00 p.m. on February 14, 2010.

Riggs was admitted by Dr. Goff to a telemetry unit for cardiac monitoring. Upon admission, Riggs informed Toni Marhefka, RN, of his home medications, noting that he took Lantus 10 units subcutaneously every night for treatment of his diabetes. Riggs again failed to inform Central Baptist nursing staff that he had also been prescribed Glimepiride in addition to his insulin to treat his diabetes. Riggs was noted to be alert, oriented, and able to provide a fairly detailed history of his various medical conditions. Riggs's initial blood glucose level at Central Baptist was 507 as of 5:00 p.m. Dr. Goff's initial diabetic management orders were for Lantus 10 units to be administered subcutaneously at bedtime, moderate sliding scale insulin, and blood sugar checks before meals and at bedtime, as well as a consult from the internal medicine service to manage Riggs's diabetes. Riggs's blood glucose levels were repeated via Accuchek finger sticks at his bedside at 5:01 p.m. with a level of 502; at 5:04 p.m. with a level of 507; and at 5:05 p.m. with a level of 501. Riggs's blood glucose level was subsequently checked by the laboratory at 5:20 p.m. and was noted to be 474, and again checked at 6:00 p.m., at which time the blood glucose level was 463. At 6:00 p.m. Nurse

Marhefka administered 10 units of Lantus to Riggs as ordered by Dr. Goff. Riggs's previously high blood glucose levels were reported by telephone to Dr. Goff, and he ordered Nurse Marhefka to administer 20 units of Novolog subcutaneously.

Sherri Mays, RN, assumed care of Riggs from Nurse Marhefka at approximately 7:00 p.m. Upon her initial assessment of Riggs at 7:30 p.m., Nurse Mays noted Riggs to be alert and oriented to person, time and place, and also noted him to be appropriate and cooperative. A bedside finger-stick at 8:34 p.m. revealed a blood glucose of 561, followed by a level of 600 obtained at 8:38 p.m. Dr. Julia Lyles, a hospitalist at Central Baptist, subsequently performed the consult ordered by Dr. Goff for management of Riggs's diabetes. In her consult note, Dr. Lyles documented her conversation with Riggs, during which he told her that he took 20 units, not 10 units, of Lantus every night and was also on Novolog sliding scale insulin for treatment of his diabetes. He reported difficulty controlling his high blood glucose level due to steroid medications he took for his renal failure. He also reported his consumption of one pint of liquor the previous evening. Dr. Lyles made note of Riggs's blood glucose levels at Central Baptist. She subsequently wrote orders at 9:00 p.m. for his Lantus to be increased to 20 units subcutaneously at bedtime, as well as 10 units of Novolog insulin to be given with meals, in addition to the moderate sliding scale insulin previously ordered by Dr. Goff upon admission. Riggs's finger-stick blood glucose level was 571 at 9:58

p.m., at which time Nurse Mays administered 12 units of Novolog insulin per sliding scale and 20 units of Lantus subcutaneously as ordered by Dr. Lyles.

Throughout the evening of February 14 and into the early morning hours of February 15, Riggs was regularly rounded upon by Nurse Mays and Tiffany Hale, a patient care technician. The two staff performed hourly rounds, with Nurse Mays assessing Riggs on the even hours and Hale rounding upon Riggs on the odd hours. Nurse Mays noted Riggs to be alert and oriented at 10:00 p.m., at which time he was resting on top of his bed and watching television, still wearing his street clothes (Riggs had previously refused to change into a hospital-issued gown). Riggs was noted to be awake and resting in bed at 11:06 p.m. and again at 12:00 a.m. During the safety round performed by Tiffany Hale, PCT, at 1:00 a.m., Riggs was still resting on top of his bed in his street clothes but was asleep with the lights on. Nurse Mays assessed Riggs at 2:00 a.m., at which time she noted him to be asleep but arousable. Hale and Nurse Mays again noted Riggs to be asleep and resting on top of his bed at 3:00 a.m. and 4:00 a.m., respectively, with Mays further noting that Riggs was arousable and responded to her voice. Hale also noted during her 3:00 a.m. assessment that Riggs had repeatedly used his bedside urinal. Nurse Mays further testified at trial that when she rounded upon Riggs throughout the night, she would check the patency of his IV line, during which she would touch his arm. Nurse Mays testified that at no time during the night was Riggs ever exhibiting symptoms consistent with hypoglycemia, and he made no complaints.

Shortly before 5:15 a.m., Hale performed her safety rounds and took vital signs of the patients for the morning set of vitals. Hale started to take vitals on Riggs, but found him to be unresponsive. She performed an Accuchek and noted his blood glucose level to be critically low at 38. Nurse Mays was called to the room and one ampoule of D50 (dextrose) was administered to Riggs to increase his blood glucose. A rapid response was also called at that time. Nurse Mays obtained a repeat blood glucose at 5:20 a.m., at which time it was 202, with another blood glucose of 223 measured at 5:23 a.m. Dr. Lyles and Dr. Goff were paged by the rapid response team at 5:30 a.m., at which time a Code 19 was also called. Riggs was transferred to radiology for a CT scan of his head at 5:50 a.m., while nurse Mays paged the neurologist on call. Following the CT scan, Riggs was taken to the intensive care unit (ICU). Riggs was noted to have an altered mental status secondary to the hypoglycemic event, acute respiratory failure, and diabetes.

Later on the morning of February 15th in the ICU, Amy Vibbert, RN, found a prescription blister-pack of Glimepiride tablets in Riggs's pants pocket. Glimepiride is an insulin-like substance used to lower blood sugar levels, and had previously been prescribed to Riggs in South Carolina. Nurse Vibbert counted the tablets and compared the number she found to the prescription label and the date the prescription had been filled. She documented her discovery of the Glimepiride tablets in the medical record at 10:20 a.m. and again at 10:25 a.m. Based upon the number of tablets she counted, Nurse Vibbert became concerned that Riggs had

continued to take Glimepiride while at Central Baptist, even though he did not disclose the prescription to any health care providers at Pineville Hospital or Central Baptist. In addition to his failure to inform health care providers of his Glimepiride prescription, Riggs also failed to inform the health care providers of his history of extreme blood glucose fluctuation and his lengthy history of non-compliance with the physicians' orders related to his diabetes management. Nurse Vibbert reported the discovery of the medication to another hospitalist, who ordered a sulfonylurea screen to be done, as Glimepiride belongs to a class of drugs called sulfonylureas. The screen was performed and was negative. However, the sulfonylurea screen performed by Medtox, the outside lab who held a contract with Central Baptist to perform these tests, did not actually test for the presence of Glimepiride in February 2010.[1] The Glimepiride tablets found by Nurse Vibbert were taken to the pharmacy per hospital policy. Thirty days later, when no person claimed that medication, it was destroyed per hospital policy.

Riggs remained in Central Baptist over the next few months. Unfortunately, his condition did not significantly improve and supportive measures were withdrawn. Riggs was pronounced dead on June 4, 2010, four days after his 40th birthday. His family elected not to pursue an autopsy.

[1] Glimepiride is not listed on the sulfonylurea screen found in the record. Mitchell makes no argument that this test was conclusive as to whether Riggs ingested Glimepiride, and this Court presumes this is because the test was either ordered incorrectly or there was an error with the result. Mitchell focuses her argument solely on the fact that because the Glimepiride was destroyed, there is no conclusive evidence as to how much of the medication Riggs took, if he took any at all.

On February 11, 2011, Betty Riggs Mitchell, as Adminsitratrix of the Estate of Michael Riggs, and Christy Riggs, as the Next of Friend of Allison, Kimberly, and April Riggs, (hereinafter collectively Mitchell) filed this lawsuit in the Fayette Circuit Court alleging that Central Baptist, Thomas Goff, MD, Julia Lyles, MD, and Sherri Mays, RN provided negligent medical treatment to Riggs, resulting in wrongful death. The lawsuit sought monetary damages for medical expenses, funeral expenses, pain and suffering, lost wages, and loss of parental consortium. The claims against Dr. Goff were voluntarily dismissed during the pendency of the litigation. The individual claims against Sherry Mays, RN, were also dismissed, because at all times relevant to this lawsuit, she was acting within the scope of her employment as a nurse at Central Baptist. Mitchell's negligence claim against Central Baptist was limited to the allegation that Riggs's injuries and subsequent death were caused by Nurse Mays's alleged deviation from the appropriate standard of care required of nurses when monitoring the glucose levels of hyperglycemic patients.

This matter proceeded to a jury trial against Central Baptist and Dr. Lyles, beginning on November 12, 2013. Following the conclusion of Mitchell's case, the claims against Dr. Lyles were adjudicated by a directed verdict entered in her favor on November 18, 2013. Subsequently, on November 19th, the trial court issued a directed verdict in favor of Central Baptist with regard to Mitchell's loss of consortium claims. On November 20, 2013, the jury returned a verdict in favor of Central Baptist on the remaining negligence claim. While the jury found that

there had been a deviation of the standard of care by the nursing staff at Central Baptist in their care of Riggs, the jury ultimately concluded that this deviation was not the proximate cause of any injury to Riggs, as claimed by Mitchell. On November 25, 2013, the Fayette Circuit Court entered a judgment dismissing the claims against Central Baptist in accordance with the jury verdict. On December 5, 2013, Mitchell moved for a new trial, which motion was heard by the trial court on December 20, 2013, and denied. This appeal now follows.

On appeal, Mitchell makes several arguments. We will address each one in turn. First, Mitchell argues that the trial court abused its discretion by not continuing the trial after the late production of policies and procedures related to insulin administration and monitoring by Central Baptist six days before the trial. Mitchell argues that the court erred by denying the continuance and allowing abusive and delinquent discovery tactics, which prejudiced Riggs and deprived him of a fair trial. Mitchell contends that the belatedly produced protocols and policies established Central Baptist's benchmark standards for its duties and specific steps that were supposed to be followed throughout the monitoring system. This information was necessary to establish Mitchell's claim against Central Baptist. According to Mitchell, the documents showed what was suspected the entire time, that Central Baptist had failed to follow its own procedures. Mitchell argues that any continuance or delay in the proceedings would not have been extensive, and no harm would have resulted because Riggs had already died, and Central Baptist had already been paid for its services.

The standard of review for a trial court's denial of a continuance is whether the court abused its discretion. *Guffey v. Guffey*, 323 S.W.3d 369 (Ky. App. 2010). The appropriateness of a continuance is based on the unique facts and circumstances of the case. *Id*. The *Guffey* court followed the factors set out in *Snodgrass v. Commonwealth*, 814 S.W.2d 579, 581 (Ky. 1991) (*overruled on other grounds*). The *Snodgrass* court said the factors to be considered for a motion to continue are: 1) length of delay; 2) previous continuances; 3) inconvenience to litigants, witnesses, counsel, and the court; 4) whether the delay is purposeful or is caused by the accused; 5) availability of other competent counsel; 6) complexity of the case; and 7) whether denying the continuance will lead to identifiable prejudice.

Central Baptist counters that the trial court acted within its discretion by denying Mitchell's eleventh hour motion for a continuance based upon the disclosure of irrelevant documents, which Mitchell had failed to seek in a timely manner. In support of this, Central Baptist argues that Kentucky has long embraced the unique, comprehensive ability of the trial court to consider the totality of the circumstances underlying litigation when ruling upon procedural matters of the court, such as the propriety of a continuance. As such, the trial court maintains vast discretion when ruling upon a movant's request for a continuance. *Stallard v. Witherspoon*, 306 S.W.2d 299, 300 (Ky. 1957). The decision to deny a continuance request may not be reversed simply because the trial court would have been justified in granting the continuance. *Riordan v. Riordan*, 252 S.W.2d 901,

902 (Ky. 1952). Instead, the decision to grant or deny a continuance may only be reversed upon proof that the trial court clearly abused its discretion. *Id*. Accordingly, the Court's review is limited to whether the trial court's decision was "arbitrary, unreasonable, unfair, or unsupported by sound legal principles." *CertainTeed Corp. v. Dexter*, 330 S.W.3d 64, 72 (Ky. 2010).

We agree with Central Baptist that the record demonstrates that the trial court's denial of Mitchell's motion for a continuance was well-founded. On the first day of trial, November 12, 2013, Mitchell requested a continuance based upon Central Baptist's allegedly belated disclosure of three Central Baptist protocols, policies, and/or procedures: the Hypoglycemia Protocol, Guidelines for an Insulin Drip, and Roche Accuchek Whole Blood Glucose Testing. This request was propounded in Mitchell's initial discovery requests to Central Baptist on September 13, 2012, over one year after the complaint was filed and litigation commenced. On November 9, 2012, Central Baptist filed its answers and responses to Mitchell's discovery requests. The requests and responses were as follows:

> INTERROGATORY NO. 7: Do the Defendants monitor the blood sugar level of known diabetic patients? If so, please describe in detail the monitoring system including the required intervals for monitoring and the blood sugar levels that indicate a problem.
>
> ANSWER: Objection. This Interrogatory is impermissibly vague and unclear as written. Furthermore, this Interrogatory is overly broad and unduly burdensome as it is not limited to any particular time frame or to any particular patient. Additionally, this

> Interrogatory seeks information that is not relevant to the issues before the Court and is not reasonably calculated to lead to the discovery of admissible evidence. Finally, this Interrogatory may seek the confidential health information of patients which is protected pursuant to HIPAA. Without waiving said objections, Central Baptist Hospital states that matters of diagnosis and treatment of any patient condition are determined by physicians. The frequency of monitoring a patient's blood sugar level is also at the discretion of the patient's physician(s).
>
> ….
>
> REQUEST NO. 5: Please attach all training materials for nurses and staff for the treatment of diabetic patients.
>
> RESPONSE: Objection. This Request seeks information that is confidential and proprietary. Furthermore, this Request is impermissibly vague, over broad and unduly burdensome as it is not limited in time or scope. Finally, this Request is not relevant to the issues before the Court and is not reasonably calculated to lead to the discovery of admissible evidence.
>
> REQUEST NO. 7: Please attach all procedural regulations and manuals for nurses for the treatment of diabetic patients used by the Defendant.
>
> RESPONSE: Objection. This Request seeks information that is confidential and proprietary. Furthermore, this Request is impermissibly vague, overly broad and unduly burdensome as it is not limited in time or scope. Finally, this Request is not relevant to the issues before the Court and not reasonably calculated to lead to the discovery of admissible evidence.

During the hearing on the continuance motion, Mitchell and the trial court acknowledged that the discovery requests were inarticulate and did not clearly

identify the requests for protocols, policies, and procedures related to Riggs's condition and treatment.

After Central Baptist tendered its answers and responses to the discovery requests, some eight months passed without Mitchell disputing the aforementioned answers or responses, and Mitchell failed to take further action to obtain protocols, policies, and procedures that they allegedly requested. Subsequently, on August 8, 2013, only three months prior to the scheduled trial date, Mitchell tendered a letter addressing Central Baptist's various objections to Mitchell's discovery requests. By this time, Nurse Mays and Dr. Lyles had already been deposed by Mitchell, expert reviews were complete, expert opinions had been disclosed, and the discovery period was coming to its conclusion. Despite their failure to seek the documents that she now asserts were fundamental to a fair trial, Mitchell waited until August 26, 2013, to file a motion to compel the sought-after documents.

Following a September 12, 2013, hearing on Mitchell's motion to compel, the trial court entered an order on October 16, 2013, requiring Central Baptist to disclose any existing policies, procedures, and protocols "in effect as of February 14, 2010, at Central Baptist Hospital which pertain to the monitoring of blood glucose levels and/or the administration of insulin to diabetic patients on the telemetry floor, pursuant to Plaintiffs' Interrogatory No. 7 and Request for Production Nos. 5 and 7," within fourteen days. Central Baptist tendered the documents on November 6, 2013.

Central Baptist notes that the court in *Guffey* did not require a strict application of the *Snodgrass* factors but determined that the use of the factors was "wholly appropriate…to analyze a civil motion for a continuance while taking into account all the relevant facts and circumstances." *Id*. at 372. The factors "merely set out a framework in which a trial court may exercise its discretion to grant a continuance." *Id*. at 372. (Quotation omitted). Central Baptist argues that the record of the November 12, 2013, hearing reflects that the relevant *Snodgrass* factors were thoroughly addressed by the parties and that the totality of the circumstances of the case-at-hand amply supports the trial court's denial of the continuance request.

We agree with Central Baptist that the trial court did not abuse its discretion in denying a continuance. In her pursuit of such, Mitchell argued to the trial court that the disclosure of documents necessitated additional discovery measures, including depositions of the diabetes coordinator and the lab coordinator at Central Baptist. They also claimed that the documents referenced additional policies that had not been disclosed. Although Mitchell criticized Central Baptist's initial objections to their discovery requests, they offered no explanation for their lengthy delay in disputing the objections and offered no explanation for their failure to seek a court order compelling the disclosure of the documents until the discovery process was ending. Mitchell waited until three months prior to trial to seek the documents at issue, despite the fact that the lawsuit had been pending for over two years. Mitchell failed to clearly request the applicable documents in discovery

requests and failed to dispute Central Baptist's objections to the discovery requests in a timely manner.

Furthermore, Mitchell had opportunities to question deponents regarding their knowledge of the protocol, policies, and procedures, and Central Baptist pointed out to the trial court that continuing the trial for an additional period of discovery would require re-deposing each factual witness and each expert witness regarding the documents. Central Baptist further contended that Mitchell was not prejudiced by the document disclosure date given that the three documents tendered on November 6, 2013, were unrelated to Mitchell's sole allegation regarding negligent blood glucose monitoring of a hypoglycemic patient in the telemetry unit. The Roche Accuchek Whole Blood Glucose Testing Procedure sets forth the method of operation for the Accuchek equipment but does not provide care guidelines for the nurses using the equipment. Central Baptist also contends that the Hypoglycemic Protocol was also irrelevant, given that Mitchell's lawsuit only criticized Central Baptist's monitoring of Riggs's hyperglycemic condition. Mitchell never claimed that any negligent care was provided after Riggs developed hyperglycemia. Similarly, the Guidelines for an Insulin Drip were also irrelevant, according to Central Baptist, because Mitchell's criticisms were solely related to the monitoring of Riggs's hyperglycemic condition and did not criticize the manner in which insulin was administered. In an abundance of caution, Central Baptist voluntarily tendered the referenced policy to the court for an *in camera* review to demonstrate that a policy that was internally referenced in one of the

produced documents was also irrelevant, because it only related to the care of hypoglycemic patients in surgical and ICU units and did not address the care of hypoglycemic patients in telemetry units.

A review of the record indicates that after hearing the extensive arguments made by the parties, the trial court determined that the trial would proceed as scheduled, and that counsel for Mitchell would be permitted to question all witnesses at trial regarding the policies and procedures produced by Central Baptist. Of the three documents produced, only one—the Accuchek Whole Blood Glucose Testing Procedure—was referenced at trial. Mitchell's counsel extensively questioned the fact and expert witnesses who testified at trial regarding this Hospital procedure. Thus, Mitchell was not prejudiced in this regard. The fact of the matter is that Mitchell waited a long period of time before challenging Central Baptist's responses to interrogatories and requests for production of documents. We find no abuse of discretion by the trial court in this regard.

The appropriate standard of care to which medical professionals are held is not determined by the hospital's protocols, policies, or procedures, but instead is determined by whether the professional deviated from his or her "duty to use that degree of care and skill which is expected of a reasonably competent practitioner acting in similar circumstances." *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970). While the protocols, policies, and procedures are obviously relevant as to the standard of care, the record indicates that Mitchell was able to adequately question witnesses at trial regarding the policies, protocol, and standard of care that was

applicable to the facts of this case. Furthermore, the jury ultimately found negligence existed in this case, but found that the deviation in the standard of care was not the proximate cause of Riggs's injuries. Thus, we find no error in this regard.

Mitchell next argues that the trial court abused its discretion by allowing testimony regarding whether Riggs took Glimepiride and argues that such testimony was based on pure speculation and that testimony indicated that evidence related to the Glimepiride was not in the records provided by the defense. Mitchell contends that the trial court erred by not giving a missing evidence instruction related to this testimony.

Central Baptist argued during discovery, depositions, and during trial that Riggs had ingested Glimepiride from a purported bottle, which was in Central Baptist's possession. Mitchell argues that the bottle was never produced, nor was any record of the bottle's disposition. Mitchell contends that, according to Kentucky Rules of Evidence (KRE) 705, testimony regarding Glimepiride ingestion should not have been admitted until evidence was produced and put into the record to support such an assumption. *See Byck v. Commonwealth Life Ins. Co*, 269 S.W.2d 214 (Ky. 1954).

Mitchell argues that the jury should have been instructed to disregard any testimony regarding Glimepiride due to the missing evidence. Mitchell points out that she requested a spoliation instruction concerning the records since Central Baptist was put on notice of potential litigation on July 26, 2010, and was told to

preserve all relevant records. Mitchell contends that this record was kept in the ordinary course of business by the hospital, and cites *Welsch v. U.S.*, 844 F.2d 1239 (6th Cir. 1988), for the proposition that an adverse inference from a defendant's destruction of evidence crucial to the plaintiff's case can be drawn. Mitchell contends that the trial court abused its discretion in not giving a missing evidence instruction to remedy Central Baptist's spoliation of the evidence and records of Glimepiride.

In response, Central Baptist argues that testimony regarding Riggs's potential ingestion of Glimepiride was supported by ample evidence and properly admitted by the trial court. Central Baptist points out that Nurse Vibbert testified that she found a blister pack containing Glimepiride tablets in Riggs's pants pocket after he was transferred to the ICU from the telemetry floor, and she believed that he may have taken the medication while in the hospital. She documented her discovery of the Glimepiride tablets in the medical record at 10:20 a.m. and again at 10:25 a.m. At trial, Central Baptist presented a pharmacology expert, Dr. Glenn Farr, who testified regarding how the amounts of insulin administered to Riggs at Pineville Community Hospital and Central Baptist would affect his blood glucose, and further opined that the extreme drop in Riggs's blood glucose level could have been caused by taking Glimepiride in addition to the insulin administered to Riggs at Central Baptist. Central Baptist argues that the testimonies of these witnesses were properly admitted despite the fact that the Glimepiride tablets found in the ICU and corresponding labs were unavailable.

Central Baptist points out the fact that the testimony regarding Riggs's potential ingestion of Glimepiride was based upon Nurse Vibbert's independent memory of finding the medication. Neither Nurse Vibbert nor Dr. Farr affirmatively told the jury that Riggs had taken the medication. Instead, Riggs's ingestion of Glimepiride was continuously presented as a potential explanation for the change in his condition based upon the facts. Central Baptist argues that Mitchell was able to cross-examine Nurse Vibbert and Dr. Farr to demonstrate that the ingestion of Glimepiride may or may not have occurred.

In her brief, Mitchell claims that the trial court erred by allowing Central Baptist to pose hypothetical questions regarding the potential ingestion of Glimepiride, and she relies on *Byck v. Com. Life. Ins. Co.*, 269 S.W.2d 214, 218 (Ky. 1954). In *Byck*, experts agreed that the decedent died from a coronary occlusion. *Id*. at 218. Counsel was improperly allowed to question a witness regarding whether the decedent could have been hit in the chest despite the absence of any good faith basis or evidentiary foundation to support the inquiry. *Id*. Central Baptist argues that the testimony provided by Nurse Vibbert and Dr. Farr regarding Riggs's potential ingestion of Glimepiride was not hypothetical, but instead was based upon the discovery of the medication and the number of pills discovered.

We agree with Central Baptist that the testimony from Nurse Vibbert and Dr. Farr about the possible ingestion of Glimepiride was proper, given the documented evidence that Nurse Vibbert found the medication on Riggs's person

while he was in the ICU. The medication is documented in two separate places by Nurse Vibbert and was taken pursuant to hospital protocol to the pharmacy. Neither witness testified that Riggs definitively ingested the medication, but both testified as to the possible outcomes based upon the suspicion that Riggs ingested the medication, given the evidence of his blood sugar levels dropping significantly. We find no abuse of discretion in this regard.

Regarding a spoliation of evidence instruction, Mitchell contends that Central Baptist was put on notice on July 26, 2010, of a potential lawsuit related to the care and treatment of Riggs and was under a duty to preserve evidence as of that date. In support of this, Mitchell alleges that the evidence was kept in the ordinary course of business by Central Baptist, who had absolute care, custody, and control over the evidence. Mitchell contends that an adverse inference should be drawn, because Central Baptist had notice that the evidence and records were relevant at the time they were destroyed or lost and cites to *University Medical Center, Inc. v. Beglin*, 375 S.W.3d 783 (Ky. 2011). Mitchell contends the jury should have been instructed to disregard the testimony because the evidence and records were missing under Kentucky Rules of Civil Procedure (CR) 37.02.

Central Baptist argues that the trial court correctly determined that the missing Glimepiride pills and corresponding report made by Nurse Vibbert did not warrant a missing evidence instruction. We agree with Central Baptist.

The trial court maintains discretion to issue a missing evidence instruction in cases where evidence is missing without explanation and the party who lost the

evidence had "absolute care, custody, and control" over it. *Beglin*, at 791. The consequences of missing evidence are thoroughly explained in the Kentucky Evidence Law Handbook:

> Destruction of evidence by a litigant (or potential litigant) is relevant in some instances and supportive of an inference that the destroyed evidence was unfavorable to the destroyer (or favorable to the opposing litigant), but not without preliminary proof that the destroyer knew of its potential relevance to a claim or defense. An inference based on the destruction (or loss) may not be drawn if the destroyer acted inadvertently (mere negligence) or if there is an adequate explanation for the destruction (loss).

Lawson, *The Kentucky Evidence Law Handbook*, § 2.65 (4th ed. 2003) (internal citations omitted). As described by the handbook, it is well-settled that a missing evidence instruction should not be utilized in cases where the evidence was lost as a result of negligence or destroyed in the normal course of business management. *Beglin*, at 791. Exceptions such as these clearly do not comport with the bad faith element in the missing evidence instruction. *Id*. In the case-at-hand, the Glimepiride tablets and the report were destroyed by the pharmacy as part of its regular course of business after the tablets were not claimed within thirty days of their discovery, as set forth in written policy. This policy was simply a means to manage unused medication. The tablets would have been destroyed, per Central Baptist policy, long before there was any indication that litigation would ensue. Bad faith cannot be inferred from the destruction of unused medication when done pursuant to hospital practices.

Furthermore, the trial court maintains discretion to admit testimony and other evidence related to the missing evidence despite the evidence's absence. *Id*. at 790. Nurse Vibbert's testimony was based upon her independent recollection of her discovery of the Glimepiride tablets in Riggs's personal possessions. She described the tablets and the circumstances surrounding their discovery. The absence of the medication had little bearing upon the veracity of her testimony or the ability of Mitchell to cross-examine Vibbert regarding her recollection and assumptions. The jury was in the best position to weigh Nurse Vibbert's testimony and make a determination as to whether it was possible that Riggs ingested Glimepiride while in the hospital without notifying hospital staff. Accordingly, the trial court properly admitted evidence related to the missing Glimepiride tablets and the corresponding report without issuing a missing evidence instruction.

Mitchell next argues that the evidence was insufficient to sustain a finding that the damages suffered by Riggs, including prolonged hypoglycemia, apnic episode, encephalopathy, acute respiratory failure, anoxic brain injury, and ultimate death, were not substantially caused by the breach of the duty of Central Baptist to monitor Riggs with finger stick blood glucose checks after administering insulin. Mitchell contends that the trial court should have set aside the jury verdict, arguing that it has discretion to do so due to a perceived insufficiency of evidence. The court has to review the record to determine if the evidence supports the result reached by the jury. *Commonwealth v. Dept. of Highways v. Stoker*, 423 S.W.2d 510 (Ky. 1968).

In support of this argument, Mitchell argues that Central Baptist did not present any evidence that the hypoglycemic event discovered at 5:15 a.m. was unavoidable with additional monitoring by Central Baptist. Mitchell argues that the finding by the jury that the medical conditions damages suffered by Riggs were not substantially due to the breach of the duty by Central Baptist to monitor Riggs with finger stick blood glucose checks after administering insulin to him was speculative, contrary to, and unsupported by the evidence.

We agree with Mitchell that a trial court has the discretion to set aside a jury verdict due to a perceived insufficiency of evidence. *See Stoker*, *supra*. *See also McVey v. Berman*, 836 S.W.2d 445 (Ky. App. 1992); *Carr v. Brownfield*, 255 S.W.2d 623 (Ky. 1953). However, the record reflects that Mitchell did not move for a directed verdict or a judgment notwithstanding the verdict. Kentucky law clearly provides that a motion for a directed verdict is required to preserve claims of insufficient evidence. *Commonwealth v. Blair*, 592 S.W.2d 132 (Ky. 1979). Therefore, this argument is not properly before this Court.

However, even if we were to consider Mitchell's argument that there was insufficient evidence to sustain the verdict, we would disagree. Throughout the trial, the jury was presented with evidence of Riggs's numerous preexisting health conditions, his continuous substance abuse, and his refusal to comply with the orders issued by his physicians regarding medication use and health management. The jury was also presented with evidence that Riggs failed to provide Pineville Community Hospital and Central Baptist with a complete list of medications he

had previously been prescribed. The jury also heard evidence suggesting that Riggs may have continued to take his prior prescription of Glimepiride while at Central Baptist, which was not known to the nurses or physicians in charge of his care. The record reflects that Riggs's blood glucose level was taken in compliance with physicians' orders and that he did not present physical symptoms of distress warranting additional glucose testing in the hours before he was found unresponsive.

The evidence supported the jury's findings. Dr. Philip Buescher, a pulmonary and critical care physician, testified at trial as an expert for Central Baptist. He testified that it was more likely than not that Riggs's abrupt hypoglycemic event did not occur as a direct result of the insulin administered to him at Central Baptist, or due to the fact that his blood sugar was not checked with finger sticks during the early morning hours of February 15, 2010. Further, pharmacologist Dr. Farr testified that the amount of insulin administered to Riggs by the nurses at Central Baptist would not be of a sufficient level to cause a precipitous drop in Riggs's blood glucose level on the morning of February 15th. Accordingly, the jury had ample evidence to conclude that the nurses' failure to more frequently check Riggs's blood glucose levels was not the proximate cause of his hypoglycemic event and his subsequent death. We find no error in this regard.

Next, Mitchell argues that, as a matter of law, the jury should have found *res ipsa loquitur* that failure by Central Baptist to properly monitor Riggs with finger stick blood glucose monitoring resulted in the medical conditions suffered by

Riggs. The elements of the doctrine of *res ipsa loquitur* require a "showing that (1) the defendant had full control of the instrumentality which caused the injury; (2) the accident could not have happened if those having control had not been negligent; and (3) the plaintiff's injury resulted from the accident." *Bowers v. Schenley Distillers, Inc.*, 469 S.W.2d 565 (Ky. 1971). This doctrine is not applicable if it is shown that the injury may have been due to some voluntary act on the plaintiff's part. *See Schmidt v. Fontaine Ferry Enterprises*, 319 S.W.2d 468 (Ky. 1959). The applicability of *res ipsa loquitur* in an action against a hospital for injury to a patient "depends mainly on whether the particular injury was of a kind that a jury could find would not usually occur in the absence of negligence." *See Jewish Hospital Ass'n of Louisville, Ky. v. Lewis*, 442 S.W.2d 299, 300 (Ky. 1969).

Central Baptist counters that Mitchell's argument regarding *res ipsa loquitur* is without merit, given that Dr. Farr's testimony created a question of fact regarding Central Baptist's liability for Riggs's injuries. Central Baptist points out that the jury concluded that it deviated from the applicable standard of care, and thus was negligent, but ultimately determined that the deviation was not the proximate cause of Riggs's injuries. Accordingly, Central Baptist argues that whether or not it was negligent is not relevant to this appeal, because the jury found that it was negligent, but ultimately did not proximately cause Riggs's death. We agree with Central Baptist in this regard and hold that Mitchell failed to demonstrate that there was insufficient evidence to support the jury's verdict.

Mitchell next argues that the trial court erred in dismissing the loss of consortium claim on directed verdict following the end of Central Baptist's case. The trial court issued a directed verdict in favor of Central Baptist on the loss of consortium claim of Riggs's minor children. The court stated that Mitchell had failed to provide sufficient information about the relationship between Riggs and his three minor daughters, Allison, Kimberly, and April, and the basis of the loss of affection that the children suffered. Mitchell concedes that she could have offered more evidence, but argues that the evidence offered was sufficient for the jury to make a determination of an award.

In their complaint, Appellants Allison, Kimberly, and April Riggs asserted claims for monetary compensation for their individual loss of parental consortium following the death of their father. Purportedly, Allison, Kimberly, and April were the children of Riggs and were minors at the time of his death. At trial, Mitchell failed to present any evidence in her case in chief regarding the names and ages of the children. Allison, Kimberly, and April Riggs did not testify at trial. The record reflects that the only proof elicited regarding the minor children was testimony by Mitchell, their grandmother, who described some of Riggs's children as young and indicated that the children missed their father. No testimony or evidence regarding the ages of the children or their dates of birth were presented by Mitchell. After Mitchell closed her proof, Central Baptist moved for a directed verdict on the loss of consortium claims, and after hearing arguments, the trial court granted the motion.

We agree with Central Baptist that Mitchell failed to put on adequate proof at trial to support her claims for loss of parental consortium, and thus a directed verdict was properly entered by the trial court on this claim. Generally, a defendant is entitled to a directed verdict where "there is an absence of proof on a material issue…." *Bierman v. Klapheke*, 967 S.W.2d 16, 18-19 (Ky. 1998). Although the jury is the trier of fact, the court must issue a directed verdict "where there is no evidence of probative value to support the opposite result and the jury may not be permitted to reach a verdict based upon speculation or conjecture." *Gibbs v. Wickersham*, 133 S.W.3d 494, 496 (Ky. App. 2004), citing *Wiser Oil Co. v. Conley*, 380 S.W.2d 217, 219 (Ky. 1964).

Mitchell argues that the directed verdict was improper because no formula exists for determination of loss of parental consortium claims. In *Guiliana v. Guiler*, 951 S.W.2d 318 (Ky. 1997), the Kentucky Supreme Court first recognized the right of a minor child to seek monetary damages for the loss of parental consortium. The Court reasoned that a loss of parental consortium was the reciprocal derivative of the loss of consortium rights granted to parents of minor children, a right created by the Kentucky General Assembly in Kentucky Revised Statutes 411.135. Subsequently, in *Clements v. Moore*, 55 S.W.3d 838 (Ky. App. 2000), the Court clearly stated that loss of parental consortium claims are available only to minor children. The Court provided:

> The scope of *Guiliani* is further underscored by the Supreme Court's reference to the need to protect "the right of a child to a parent's love, care and protection so

> as to provide for the complete development of that child." Clearly, the Court was not addressing concerns related to adult children or the need to protect the adult/child parental relationship…Unlike the situation presented in *Guiliani*, there is no "reciprocal" statute to finesse Section 241 of the Kentucky Constitution so as to avoid its clear provisions.

*Id*. at 840. (internal citations omitted). Thus, this Court held in *Clements* that parental consortium claims are not available to adult children. In the instant case, there was no affirmative proof presented at trial that the claimants were the minor children of Riggs at the time of his death. Absent such proof, the jury could not award loss of consortium damages to the claimants, and a directed verdict was warranted. We will not disturb this on appeal.

Finally, Mitchell argues that she was entitled to a new trial and that the trial court erred in not ordering one. Mitchell argues that her counsel moved the trial court to grant a new trial pursuant to CR 59.01(a) and (f), stating that an abuse of discretion prevented it from having a fair trial and the verdict was not sustained by sufficient evidence.

The trial court is vested with broad discretion in granting or refusing to grant a new trial, and the appellate courts will not interfere with that unless it appears there has been an abuse of discretion. *Savage v. Three Rivers Medical Center*, 390 S.W.3d 104 (Ky. 2012). Generally, reasons for granting a new trial must be very strong, and it must appear with reasonable certainty that injustice or wrong would result unless the motion is granted. *See Gray v. Sawyer*, 247 S.W.2d 496 (Ky. 1952).

In the instant case, we have reviewed the record, and the evidence supports the result reached by the jury, which was that Central Baptist was negligent in its care of Riggs, but that negligence was not the proximate cause of Riggs's injuries. Because sufficient proof exists in the record and was presented at trial to support this verdict, we will not disturb it on appeal. The trial court did not abuse its discretion when it declined to order a new trial.

Finding no abuse of discretion or error by the Fayette Circuit Court, we affirm the November 23, 2013, judgment.

DIXON, JUDGE, CONCURS.

KRAMER, JUDGE, CONCURS IN RESULT ONLY.

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