In The
Court of Appeals
Seventh District of Texas at Amarillo

No. 07-16-00211-CV

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER, APPELLANT

V.

BRENDA L. BONEWIT, APPELLEE

On Appeal from the 237th District Court
Lubbock County, Texas
Trial Court No. 2012-504,004; Honorable Les Hatch, Presiding

November 15, 2017

MEMORANDUM OPINION

Before QUINN, C.J., and CAMPBELL and PIRTLE, JJ.

Appellant, Texas Tech University Health Sciences Center ("TTUHSC"), brings this interlocutory appeal of the trial court's order denying its *Plea to the Jurisdiction and Motion to Dismiss* a medical malpractice action filed by Appellee, Brenda L. Bonewit.[1]

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[1] An interlocutory appeal is permissible when a court grants or denies a plea to the jurisdiction by a governmental unit. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 51.014(a)(8) (West Supp. 2017). TTUHSC is a governmental unit. *See Cox v. Klug*, 855 S.W.2d 276, 277 (Tex. App.—Amarillo 1993, no writ).

In two issues, TTUHSC asserts the trial court erred by (1) imputing actual notice to TTUHSC in the absence of any evidence that anyone at TTUHSC had any subjective awareness of fault related to Bonewit's negligence claims and (2) denying in part TTUSHC's motion to strike the affidavits of Bonewit's stepdaughter, Katherine Williams, and Bonewit's husband, Vidal Rivera, Jr., for consideration in the proceedings. We affirm the trial court's order denying TTUHSC's *Plea to the Jurisdiction and Motion to Dismiss*.

BACKGROUND

This is a medical malpractice action wherein Bonewit alleges TTUHSC's employees were negligent in connection with a surgery performed at TTUHSC to repair a hernia in 2010. When that surgery was performed, Bonewit's medical history included a prior hernia repair in 2006 wherein her doctor created an anastomosis, i.e., a procedure where an unhealthy portion of her colon was removed and the healthy ends of her colon were reconnected to restore functional continuity. Although she developed an infection several months after the 2006 surgery, that infection had healed.

Four years later, in the summer of 2010, Bonewit sought treatment in connection with polyps in her colon. She made an appointment with Dr. Shirmila Dissanaike, a TTUHSC employee. During the examination, Dr. Dissanaike noticed Bonewit's hernia was swollen and suggested that she have it repaired. Bonewit subsequently made an appointment to go forward with the hernia repair. A normal hospital stay for such a procedure is typically five to seven nights. Therefore, before she went into surgery, Bonewit's expectation was that she would return to work in approximately a week.

On October 6, 2010, Bonewit entered the hospital for the hernia repair surgery. Accompanying Dr. Dissanaike during Bonewit's surgery was Dr. LaJohn Quigley, a surgical resident and TTUHSC employee. The surgeons anticipated performing an open ventral hernia repair with repair of Bonewit's abdominal wall by creating an incision, placing mesh between the muscle layers, and closing the abdominal incision. While removing adhesions and separating her abdominal wall from her bowel, two enterotomies, or unintended cuts or perforations, of the bowel occurred. The potential risk of an enterotomy is that, if undetected, leakage can lead to intra-abdominal sepsis or infection. In his deposition, Dr. Quigley characterized these two cuts as "unintended injuries" to Bonewit's colon with the attendant risk that contents of her bowel could leak into her abdomen. The two enterotomies were repaired with sutures, but not before bowel fluids or feces had spilled into Bonewit's abdomen.

After the two enterotomies, the surgeons observed that although Bonewit's colon appeared normal on the exterior, the interior was "large" and "boggy." The surgeons then decided to remove the unhealthy colon tissue and staple the ends of the healthy colon tissue together. They removed the unhealthy colon tissue, including both repaired enterotomies, and created a second anastomosis. Due to the complications encountered, Bonewit's surgery took twice the time a ventral hernia repair would normally take.

In his deposition, Dr. Quigley described the process of creating an anastomosis as using staples to connect two ends of a pipe. He stated that the standard of care is that you make the closure so that there is no anastomotic leak because where there is such a leak, the patient is at risk of becoming septic.

On October 12, Bonewit's sixth day of post-operative treatment, she became critically ill. She was hypotensive with septic shock from gross peritonitis due to leaks attributed the anastomosis created by Drs. Dissanaike and Quigley six days earlier. Dr. Dissanaike described "sepsis" as the presence of a higher heart rate and higher breathing rate due to a known or suspected infection. She also described Bonewit's gross peritonitis as fecal contamination of her abdomen comprised of more than one abscess area due to an anastomotic breakdown. In his deposition, Dr. Quigley indicated that he could not say when the leaks developed. Although he believed the leaks developed days after the initial surgery, he also stated that it was possible the leak could have occurred the first day following the surgery.

Bonewit was transferred to the Surgical Intensive Care Unit where she was seen by Dr. John Griswold, a general/trauma surgeon employed by TTUHSC and chair of TTUHSC's department of surgery. Drs. Disssanike and Quigley reported to him, and in the event of an adverse medical event, he reported to the risk management department. Dr. Griswold was called in to repair the anastomotic leak that was causing Bonewit's infection and to explore her abdominal region. During the surgery performed by Dr. Griswold, he discovered there were multiple leaks from the anastomosis with gross contamination of Bonewit's abdominal cavity, i.e., fluids were leaking out of her intestine into her abdominal cavity, a condition Bonewit did not have when she arrived at the hospital for surgery on October 6.

In his deposition, Dr. Griswold agreed with counsel that on October 12 and 13, he had knowledge that there was an anastomotic leak in multiple areas with gross contamination of Bonewit's abdominal cavity. She had a leaking anastomosis and "[he]

took care of it." "The lady had an issue that I needed to deal with, so I dealt with it." He agreed that, on October 12, he was aware the anastomotic leak was due to her initial hernia surgery. He also agreed that "[t]he leak occurred in the anastomosis done by Dr. Dissanaike and Dr. Quigley."

Due to the gross contamination from the leak, Dr. Griswold sought to redirect Bonewit's stool away from her abdomen area in order to promote healing by performing a new procedure, an ostomy. That is, he surgically adapted Bonewit's bowels to allow for feces and fluids (bowel functions) to be collected outside her body in a colostomy bag. Dr. Dissanaike indicated this was not a common procedure in an open ventral hernia repair. On deposition, Dr. Griswold conceded that it is possible for a surgeon to make an anastomotic connection where the seal is not good, and if the doctor did a technically improper anastomosis, the surgery would be below the standard of care.

Subsequent to the surgery by Dr. Griswold, Bonewit underwent six more surgical procedures. Other procedures included attempts to close the surface incision on her abdomen because it was difficult to bring the skin tissue together due to swelling from the infection. Additionally, a number of the procedures were abdominal washouts to lessen the amount of bacteria in her abdomen. Dr. Quigley testified that when someone comes in for a ventral hernia repair, the patient should reasonably anticipate a single surgery and not six additional surgical procedures. In other depositions, TTUHSC surgeons agreed that these additional procedures were necessary because Bonewit became septic as a result of complications associated with her initial hernia surgery.

On October 29, TTUHSC surgeons were finally able to close Bonewit's abdomen. Her wound had been left open for approximately seven to ten days. When

she was finally discharged from the hospital on November 3, her total hospital stay had lasted twenty-seven days, not the typical five to seven days she had originally anticipated.

On September 28, 2012, Bonewit filed her *Original Petition* and, on November 30, 2012, filed her *First Amended Original Petition* alleging a medical malpractice claim against TTUHSC based on the actions of Drs. Dissanaike and Quigley. On May 27, 2015, TTUHSC filed its *First Amended Answer* and its *Plea to the Jurisdiction and Motion to Dismiss* contending Bonewit's cause of action was barred by the doctrine of sovereign immunity because she failed to give TTUHSC notice of her claims within six months of the alleged tortious conduct occurring on October 6, 2010. *See* TEX. GOV'T. CODE ANN. § 311.034 (West 2013); TEX. CIV. PRAC. & REM. CODE ANN. § 101.101 (West 2011).[2]

Following a hearing on April 15, 2016, the trial court entered its order denying TTUHSC's plea and motion and this interlocutory appeal followed. On appeal, TTUHSC asserts the trial court erred by (1) imputing actual notice to TTUHSC under section 101.101 because there is no evidence that anyone at TTUHSC was aware of any breach of the standard of care, mistake, or error that was committed during Bonewit's 2010 hernia repair surgery and (2) denying its motion to strike certain portions of the affidavits of Williams and Rivera.

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[2] Throughout the remainder of this *Memorandum Opinion*, references to "section _____" or "§ _____" are references to the Texas Civil Practice and Remedies Code.

ISSUE ONE—NOTICE

STANDARD OF REVIEW

We review *de novo* a trial court's ruling on a plea to the jurisdiction. *See Tex. Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 228 (Tex. 2004). If a plea to the jurisdiction challenges the existence of jurisdictional facts, as TTUHSC does here, we consider relevant evidence submitted by the parties when necessary to resolve the jurisdictional issues raised, just as the trial court was required to do. *Id.* at 227; *Bland Indep. Sch. Dist. v. Blue,* 34 S.W.3d 547, 555 (Tex. 2000) (holding that a court deciding a plea to the jurisdiction is not required to look solely to the pleadings but may consider evidence and must do so when necessary to resolve the jurisdictional issues raised). If the evidence creates a fact question on the jurisdictional issue, then the trial court cannot grant the plea to the jurisdiction, and the fact finder will resolve the question. *Miranda*, 133 S.W.3d at 227-28. However, if the relevant evidence is undisputed or fails to raise a fact question on the jurisdictional issue, the trial court rules on the plea as a matter of law. *Id.* at 228.

The standard of review for a plea to the jurisdiction based on evidence "generally mirrors that of a summary judgment under Texas Rule of Civil Procedure 166a(c)." *Id.* Under this standard, we take as true all evidence favoring the nonmovant and "we indulge every reasonable inference and resolve any doubts in the nonmovant's favor." *Id.* "[A]fter the [party asserting immunity] asserts and supports with evidence that the trial court lacks subject matter jurisdiction, we simply require the [opposing party], when

the facts underlying the merits and subject matter jurisdiction are intertwined, to show that there is a disputed material fact regarding the jurisdictional issue." *Id.*

ANALYSIS

TTUHSC is a "governmental unit" entitled to the protections of the Texas Tort Claims Act—Chapter 101 of the Texas Civil Practice and Remedies Code. *Tex. Tech Univ. Health Sci. Ctr. v. Ward*, 280 S.W.3d 345, 348 (Tex. App—2008, pet. denied). Absent a waiver, governmental entities, like TTUHSC, are generally immune from suits for damages. *Univ. of Tex. Southwestern Med. Ctr. v. Estate of Arancibia*, 324 S.W.3d 544, 546 (Tex. 2010). The Texas Tort Claims Act waives immunity from suit "to the extent of liability created by [the Act]." § 101.025(a). *See Rusk State Hosp. v. Black*, 392 S.W.3d 88, 94 (Tex. 2012). The Act provides, among other waiver provisions, that a governmental unit is liable for "personal injury and death so caused by a condition or use of tangible personal or real property if the governmental unit would, were it a private person, be liable to the claimant according to Texas law." § 101.021(2).

To take advantage of this waiver, plaintiffs must notify the governmental unit of a claim within six months. § 101.101(a). The notice must reasonably describe the injury, the time and place of the incident, and the incident itself. *Id.* However, this formality is not required "if the governmental unit has actual notice that . . . the claimant has received some injury." § 101.101(c). The purpose of the notice requirement is "to ensure prompt reporting of claims to enable governmental units to gather information necessary to guard against unfounded claims, settle claims, and prepare for trial." *Cathey v. Booth*, 900 S.W.2d 339, 341 (Tex. 1995).

Specifically, section 101.101 states as follows:

> (a) A governmental unit is entitled to receive notice of a claim against it under this chapter not later than six months after the day that the incident giving rise to the claim occurred. The notice must reasonably describe:
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> (1) the damage or injury claimed;
>
> (2) the time and place of the incident; and
>
> (3) the incident.
>
> (b) A city's charter and ordinance provisions requiring notice within a charter period permitted by law are ratified and approved.
>
> (c) The notice requirements provided or ratified and approved by Subsections (a) and (b) do not apply if the governmental unit has *actual notice* that death has occurred, *that the claimant has received some injury*, or that the claimant's property has been damaged.

(Emphasis added).

Standing alone, mere knowledge that an incident or injury has occurred does not establish actual notice. *Univ. of Tex. Health Sci. Ctr. v. McQueen*, 431 S.W.3d 750, 755 (Tex. App.—Houston [14th Dist.] 2014, no pet.) (citing *Cathey*, 900 S.W.2d at 341). To constitute actual notice, the governmental unit must have knowledge that amounts to the same notice to which it is entitled under section 101.101(a) which "includes subjective awareness of its fault, as ultimately alleged by the claimant, in producing or contributing to the claimed injury." *Arancibia*, 324 S.W.3d at 548-49 (quoting *Tex. Dep't of Criminal Justice v. Simons*, 140 S.W.3d 338, 347 (Tex. 2004), *superseded by statute on other grounds*, *Tex. Tech Univ. Health Sci. Ctr. v. Lucero*, 234 S.W.3d 158, 165-66 (Tex. App.—El Paso 2007, pet. denied)).

"[A]n unqualified confession of fault" by the governmental entity is not required; *see Arancibia*, 324 S.W.3d at 550, and "a government cannot evade the determination [of liability] by subjectively refuting fault." *Id.* Neither is the governmental unit required to know that the claimant has actually alleged fault. *Simons*, 140 S.W.3d at 347-48. Instead, "[f]ault, as it pertains to actual notice, is not synonymous with liability; rather it implies responsibility for the injury claimed." *Arancibia*, 324 S.W.3d at 550 (stating "'fault' as required under *Simons* is not fault as defined by *the defendant*, but rather 'as ultimately alleged by *the claimant*'" (emphasis supplied)); *Simons*, 140 S.W.3d at 347-48 (finding a governmental unit need only have subjective awareness that its purported fault could have produced or contributed to the death, injury, or property damage).

To have a subjective awareness of its fault, "there must exist something in the circumstances to provide a subjective signal to the governmental unit within the six-month period that there might be a claim, even if unfounded, at issue." *McQueen*, 431 S.W.3d at 761. Subjective awareness may be proven by circumstantial evidence. *Simons,* 140 S.W.3d at 348. Furthermore, medical records may create a fact issue on actual notice if they "indicate to the [governmental unit] its possible culpability in causing the injuries." *Dinh v. Harris Cty. Hosp. Dist.*, 896 S.W.2d 248, 253 (Tex. App.—Houston [1st Dist.] 1995, writ dism'd w.o.j.) (citing *Parrish v. Brooks*, 856 S.W.2d 522, 525 (Tex. App.—Texarkana 1993, writ denied)). *See also Gaskin v. Titus County Hosp. Dist.*, 978 S.W.2d 178, 181-82 (Tex. App.—Texarkana 1998, pet. denied).

Actual notice may also be imputed to the governmental unit by an agent or representative that receives notice of the required elements and who is charged with a duty to investigate the facts and report them to a person of sufficient authority. *Univ. of*

Tex. Health Sci. Ctr. at San Antonio v. Stevens, 330 S.W.3d 335, 339-40 (Tex. App.—San Antonio 2010, no pet.). Actual notice thus is not limited to only a particular government official or employee, such as a director of risk management or hospital administrator. *Id.* at 340.

Although actual notice is a fact question when the evidence is disputed, in many instances it can be determined as a matter of law. *Simons*, 140 S.W.3d at 348. It is undisputed that Bonewit did not give TTUHSC formal, written notice of her claim as provided by section 101.101(a). *See* § 101.101(a). In addition, with the exception of the admissibility of portions of the affidavits of Williams and Rivera, the parties do not dispute the evidence presented on the jurisdictional issue; they simply dispute its legal significance. Accordingly, we will review the trial court's ruling as a matter of law, without considering the contested affidavits. *See Miranda*, 133 S.W.3d at 226, 228.

From the record we know that in 2006, Bonewit underwent a hernia repair wherein her doctor created an anastomosis. Although she developed an infection from that surgery, that infection was healed within a few months. That her prior surgery was unremarkable creates an inference when compared to her second ventral hernia repair and anastomosis, that the second surgery was quite remarkable.

On October 6, 2010, Bonewit entered the hospital for a ventral hernia repair which would normally involve a single surgical procedure accompanied by a five-to-seven-night hospital stay. During her surgery, Drs. Dissanaike and Quigley made two unintended cuts in Bonewit's bowel. The two injuries required immediate repair to prevent the contents of her bowel from leaking into her abdominal cavity and causing infection. The doctors then removed the section of her bowel they had just cut and

repaired, and performed a second procedure to reconnect the two ends of her bowel creating an anastomosis. Six days after surgery, Bonewit became critically ill. She was hypotensive with septic shock from gross peritonitis. Dr. Griswold performed a second major surgical procedure and discovered there were multiple leaks around the anastomosis created by Drs. Dissanaike and Quigley, permitting gross contamination of her abdominal cavity from fluids leaking out of her bowel at the point of the anastomosis. Due to her condition, Dr. Griswold sought to redirect Bonewit's stool away from her abdomen area by undoing the anastomosis performed by Drs. Dissanaike and Quigley, and performing a new procedure, an ostomy. That is, he surgically adapted Bonewit's bowels to allow feces and fluids (bowel functions) to be collected outside her body in a colostomy bag. Bonewit later underwent six additional surgical procedures to address the infection and complications arising therefrom.

All TTUHSC's surgeons who participated in the two major surgeries on Bonewit, Drs. Dissanaike, Quigley, and Griswold, agreed on deposition that Bonewit's elongated hospital stay and additional surgical procedures were the result of her becoming septic as a result of her initial surgery for hernia repair. To this day, Bonewit continues to use a colostomy bag and is unable to return to work.

It is true, as TTUHSC asserts, that no TTUHSC surgeon came forward after Bonewit's initial surgery with an "unqualified confession of fault." However, under this record, we cannot say that there was no "subjective signal" to TTUHSC that Bonewit might be bringing a claim, even if unfounded, against TTUHSC in connection with the initial surgery performed by Drs. Dissanaike and Quigley. The evidence showed that, when Bonewit was reopened by Dr. Griswold, he discovered that the anastomosis

created by Drs. Dissanaike and Quigley had multiple leaks resulting in gross contamination of her abdomen. This contamination in turn caused Bonewit to be in a critical condition and necessitated that Dr. Griswold undo the surgery performed by Drs. Dissanaike and Quigley by performing yet another surgical procedure to stem Bonewit's infection and prevent additional infection. Because Dr. Griswold was TTUHSC's agent or representative with a duty to gather facts and report to TTUHSC, we cannot say the trial court erred in imputing actual notice to TTUHSC. *See Stevens*, 330 S.W.3d at 339.

Viewing the evidence in a light most favorable to Bonewit and resolving all doubts in her favor, this record demonstrates that TTUHSC was subjectively aware of its possible fault as ultimately alleged by Bonewit well before the expiration of the six-month notice period following her initial surgery. Her proof went beyond the injury alleged and we cannot conclude that TTUHSC was unaware of its fault in producing or contributing to Bonewit's alleged injury. *Arancibia*, 324 S.W.3d at 549-50. *See, e.g., City of Wichita Falls v. Jenkins*, 307 S.W.3d 854, 861 (Tex. App.—Fort Worth 2010, pet. denied) (finding city representative had actual notice city-owned vehicle was at fault due to report showing on-duty officer rear-ended car, vehicle was damaged, and identities of person involved in accident were known); *Lucero*, 234 S.W.3d at 168 (finding actual knowledge where physician knew of bile leak, knew the patient's identity, and knew CT scan was misread). Accordingly, TTUHSC's first issue is overruled.

ISSUE TWO—EVIDENTIARY ERROR

In response to TTUHSC's plea and motion, Bonewit submitted affidavits from Williams and Rivera. Much of the content of the affidavits was duplicative of the evidence submitted in support of TTUHSC's plea and motion. Williams's affidavit,

stated that on October 12, nurses became aware of Bonewit's infection prior to her discharge when they removed her bandage and fecal matter began to pour out of the incision. She also stated that her father subsequently told a doctor working on his wife that he did not want Drs. Dissanaike or Quigley to work on her anymore because of what they had initially done. In his affidavit, Rivera stated that he was told after his wife's surgery on October 6 that she would be returning to work in four days. He also stated that on October 12, he told the doctors in the intensive care unit that because of the injuries sustained by his wife, he did not want Dr. Dissanaike doing anything else to his wife and was advised that she would not be performing any other procedures.

TTUHSC filed objections to these affidavits. TTUHSC asserted the affidavits contained statements by interested witnesses as members of Bonewit's family, hearsay statements, improper factual assertions, and legal conclusions. In its ruling, the trial court sustained some objections by TTUHSC but overruled other objections. While TTUHSC does appeal the trial court's adverse evidentiary rulings, Bonewit does not. Therefore, because our disposition of issue one does not turn on any evidence which was alleged to have been improperly admitted, discussion of TTUHSC's second issue is unnecessary and pretermitted. *See* TEX. R. APP. P. 47.1.

CONCLUSION

The trial court's order denying TTUHSC's *Plea to the Jurisdiction and Motion to Dismiss* is affirmed.

Patrick A. Pirtle
Justice