

**STATE OF MICHIGAN**  
**COURT OF APPEALS**

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LINDA J. HUMPERT and TRUDY A.  
WIERGOWSKI, Co-Personal Representatives of  
the Estate of ELLA M. MORGAN, Deceased,

UNPUBLISHED  
October 28, 2003

Plaintiffs-Appellees,

v

BAY MEDICAL CENTER,

No. 235969  
Bay Circuit Court  
LC No. 98-003227-NM

Defendant-Appellant.

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Before: Neff, P.J., and Fort Hood and Borrello, JJ.

PER CURIAM.

Defendant appeals as of right from a judgment of \$181,612.51 awarded to plaintiffs following a jury trial. We affirm.

In September 1995, the decedent<sup>1</sup> was treated by a neurosurgeon, who performed a shunting procedure to drain an excess backup of fluid on her brain. The symptoms that had caused the decedent to seek treatment, loss of balance and confusion, were alleviated by the surgery according to plaintiffs, the decedent's daughters. However, the decedent began to experience headaches that caused her to seek emergency medical treatment in June 1996. The decedent's neurosurgeon determined that an adjustment in the shunt was necessary, and that surgical procedure was performed without complications. After the surgery was concluded, the neurosurgeon did not order that the decedent be restrained, but rather, left the issue of restraints to the discretion of the nursing staff. The neurosurgeon was concerned about patient confusion because of the brain's exposure to air during the procedure. Additionally, plaintiffs testified to reporting to defendant's staff that the decedent suffered from "sundowners syndrome." Specifically, plaintiffs testified that the decedent became confused regarding her surroundings at the end of the day.

The use of various safety devices and patient placement are precautions taken to ensure that patients do not injure themselves during hospitalization. The nursing staff performs an

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<sup>1</sup> It is undisputed that the death is not related to the negligence claim raised against defendant.

assessment of the patient's need for various safety precautions. In the present case, the decedent was not restrained following surgery. Although an assessment of the patient was to occur every two hours, the medical records did not reflect that the decedent was evaluated accordingly during the day following the surgery. While patients presenting a high risk for injury were normally placed near the nurse's station for closer observation, the decedent was placed in a room down the hall from the station. The decedent was discovered on the floor of her room by a nurse about to begin her shift. Although a bed sensor, with a sound and light component located at the nurse's station, would signal a patient's departure from the bed, none of the employees could recall turning the bed sensor off. The bed sensor also signaled in the patient's room in addition to the nurse's station, and the nursing staff had to proceed to the patient's room to shut the sensor off. As a result of the fall, the decedent suffered a broken hip and arm. Initially, the decedent was to be discharged from the hospital the day after her brain surgery. However, corrective surgery occurred to repair her broken hip, but the broken arm presented difficulty and was placed in a sling. While it was anticipated that the decedent's condition would improve six to eight weeks after the fall, she was placed in a nursing home and did not improve as anticipated. Plaintiffs testified that they had planned to bring the decedent home from the hospital, but were unable to address her needs after the fall.

Shortly before the first day of trial, plaintiffs moved for a default judgment or other sanction based on defendant's failure to provide the name of a nurse that treated the decedent. On the first day of trial, it was argued that both parties had identified on their witness lists an "L. Sutt" based on a signature contained in the medical records. Plaintiffs asserted that they requested the names of all employees assigned to the unit where the incident occurred in interrogatories. In response, defendant did not disclose the nurse's correct name, Lowell Smith. Although nurse Jeff Wales identified an employee by the name of "Lowell" in his deposition, plaintiffs alleged that they were unable to locate such an employee. Before trial began, plaintiffs' counsel allegedly telephoned defense counsel requesting additional information regarding this nurse. In response, defense counsel left a message indicating that he did not know who Lowell was.<sup>2</sup> However, the trial court reviewed a memorandum dated September 13, 2000, from defense counsel's records. This memorandum stated:

I also met with Lowell Smith. Mr. Smith believes that he was a nursing student at the time that he saw Mrs. Morgan [the decedent] which was when she was transferred from ICU back to the floor. He was in charge of her for a short period of time. His notes are not counter-signed by a nurse. His dep has not been taken. He really adds nothing to the case.

Thus, nine months before the commencement of trial, defense counsel knew the true identify of "L. Sutt" and did not provide this updated information to plaintiffs. Consequently, the trial court

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<sup>2</sup> A transcription of this message was submitted to the trial court and on appeal. Defense counsel did not dispute the content of the transcription.

ruled that defendant was precluded from calling Smith as a witness and instructed the jury regarding non-production of a witness.<sup>3</sup>

The trial focused on the decedent's abilities and medical condition before the fall and the nursing care that she received during her hospitalization, both before and after the fall. The testimony of all of the nurses that cared for the decedent was submitted at trial. However, their recollections of the treatment were faint, and the medical charts could not provide missing details. For example, while the decedent had been placed in a posey restraint before her shunt adjustment surgery, the nurse did not document the underlying reasons for the restraint and could not recall the details that lead to the decision to use restraints.<sup>4</sup> The jury returned a verdict in favor of plaintiffs after concluding that the decedent was partially responsible for the fall.

Defendant first alleges that the trial court erred in its ruling regarding the non-production of Lowell Smith. We disagree.<sup>5</sup> The decision to grant or deny discovery sanctions is reviewed for an abuse of discretion. *Jackson County Hog Producers v Consumers Power Co*, 234 Mich App 72, 87; 592 NW2d 112 (1999). A trial court's factual findings regarding a discovery violation are reviewed for clear error. *Traxler v Ford Motor Co*, 227 Mich App 276, 282; 576 NW2d 398 (1998). A finding of fact is clearly erroneous when, although there is evidence to support it, the reviewing court is left with a definite and firm conviction that a mistake has been made. *Id.* A party has a duty to supplement discovery requests upon learning the identification and location of persons with knowledge of discoverable matters. MCR 2.302(E)(1)(a)(i). The trial court, upon a finding that a party failed to seasonably supplement responses, may enter an order for sanctions that are just. MCR 2.302(E)(2).

In this case, we cannot conclude that the trial court's imposition of sanctions was an abuse of discretion. *Jackson, supra*. The testimony elicited at trial revealed that hospital practices and procedures were contingent upon the status of the employee. That is, licensed

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<sup>3</sup> The trial court stated that it was imposing this sanction because it was believed that the failure to update the interrogatories was an oversight and not a willful hiding of the witness. Throughout trial, however, the judge made statements to indicate that he could have found a willful violation. For example, the trial court stated: "The records Mr. Wilson gave me when he was tryin' [sic] to find some excuse for . . . not listing Mr. Smith, which he did a very poor job of doing." Later, the trial court commented, "[W]ith those dirty hands that you [defense counsel] have that you were just raising, that's the reason why you can't bring in Mr. Smith." Additionally, when defense counsel implored the court to alter its decision regarding Smith, the trial court stated: "The evidence before the Court could establish a finding of the defendant's intentionally hiding a – a witness in this case. The Court gave the defendants [sic] the benefit of the doubt and only found that the defendants [sic] had unclean hands, and they should not benefit from their unclean hands."

<sup>4</sup> Defendant's expert opined that the failure to document information in the medical charts, such as the need for restraints, was a breach of the standard of care.

<sup>5</sup> Defendant characterizes this issue as a claim of instructional error that requires de novo review. On the contrary, the trial court's ruling was premised on the failure to supplement discovery and issued a sanction for the violation.

practical nurses served in conjunction with and under the guidance of a registered nurse. Nursing students were to be supervised and not independently charged with the care of a patient. Thus, certain functions had to be performed by a registered nurse and could not be delegated. The memorandum minimizing Smith's role in the care of the decedent was contrary to hospital practice. Even defendant's expert opined that the charge of a patient to a nursing student was a breach of the standard of care. The trial court expressly concluded that the failure to disclose the true identity of this witness was beneficial to defendant and prejudiced plaintiffs, and we cannot conclude that the factual finding was clearly erroneous. *Traxler, supra*.

We note that defendant alleges that the trial court's ruling resulted in prejudice to the defense because the trial court gave plaintiffs the discretion to call Smith as a witness. Defendant further alleges that plaintiffs proceeded to make Smith the focal point of the trial. The record does not substantiate those assertions. Plaintiffs' counsel apparently did contact Smith, but Smith refused to speak to him without defense counsel. Therefore, plaintiffs risked the possibility of being blindsided by calling Smith to the stand without any knowledge of what his testimony would be. Furthermore, review of the record reveals that Smith did not become the focal point of the trial. Rather, plaintiffs extensively explored the acts and omissions of all treating nurses both before and after the surgery. For example, plaintiffs extensively questioned whether an adequate assessment of the necessary safety precautions occurred in light of the decision to place a posey on the decedent before surgery, but not after. Plaintiffs also highlighted the placement of the decedent down the hall rather than near the nurse's station, a decision that varied with the placement of the decedent on different floors. Additionally, plaintiffs extensively questioned the primary caregiver at the time of the injury, Wales, regarding late charting, his use of safety precautions, his dinner break, and his contact with others regarding the decedent's care. The record does not substantiate the allegation of the deprivation of a fair trial.

Defendant next alleges that the trial court erred in denying its motion for a directed verdict regarding the reasonable and necessary nursing home expenses as a result of the decedent's fall. We disagree. The trial court's denial of a motion for directed verdict is reviewed de novo. *Tobin v Providence Hospital*, 244 Mich App 626, 642; 624 NW2d 548 (2001). Courts review the motion by considering the evidence in the light most favorable to the nonmoving party, with all reasonable inferences in the nonmoving party's favor. *Id.* at 643. Applying this standard, we cannot conclude that the trial court erred in denying the motion for a directed verdict. While it was planned that the decedent would return home after the brain surgery to be cared for by family, plaintiffs testified that they were unable to do so because of the injuries suffered in the fall. Additionally, a physical therapist testified that other forms of treatment were given to patients with mobility issues as a preventative measure, such as respiratory therapy to prevent the onset of pneumonia.

Defendant next alleges that the trial court erred in denying its motion for directed verdict of the claim for cognitive decline. We disagree. The jury verdict form submitted in this case did not request delineation of any award based on the cognitive impairment. Rather, the jury verdict form merely divided any award into economic and non-economic damages. Consequently, it is speculative whether the jury awarded any damages based on cognitive impairment, and defendant waived this issue. See *Dedes v Asch*, 233 Mich App 329, 335; 590 NW2d 605 (1998).

Lastly, defendant alleges that the trial court erred in denying its motion for a mistrial based on the plaintiff's reference to the term "incident report." We disagree. The trial court's decision to deny a motion for a mistrial is reviewed for an abuse of discretion and will not be reversed unless the abuse of discretion resulted in a miscarriage of justice. *Schutte v Celotex Corp*, 196 Mich App 135, 142; 492 NW2d 773 (1992). We cannot conclude that the trial court's denial of the motion resulted in a miscarriage of justice where the brief reference was immediately addressed by a curative instruction. Furthermore, the jury was well aware of the documentation of the fall because it was presented to them in the form of the medical records and the testimony of the witnesses.

Affirmed.

/s/ Janet T. Neff  
/s/ Karen M. Fort Hood  
/s/ Stephen L. Borrello