ARBITRAL HEARING

May 13-17, 2013
Louisville, Kentucky

ARBITRAL OPINION

In the matter of

CAROL WHITE, AS EXECUTRIX OF THE ESTATE OF JAMES WHITE, DECEASED; AND ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES OF JAMES WHITE, PLAINTIFF,

v.

KINDRED HOSPITAL LIMITED PARTNERSHIP d/b/a KINDRED HOSPITAL-LOUISVILLE;
KINDRED HOSPITALS WEST, LLC;
KINDRED NURSING CENTERS LIMITED PARTNERSHIP;
KINDRED HEALTHCARE, INC., and
KINDRED HEALTHCARE OPERATING, INC., DEFENDANTS

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ARBITRAL OPINION AND AWARD

I.
Introduction

The parties convened for arbitration on Monday, May 13, 2013, in Louisville, Kentucky. The mediation continued from day to day concluding on Friday, May 17, 2013. Following the conclusion of the formal arbitral hearing, the parties at the arbitrator's request submitted additional materials. Those materials, along with the arguments, testimony and evidence admitted during the arbitral hearing have been given due consideration and carefully evaluated by the arbitrator. Some evidence has been given greater weight than other evidence, however, all evidence was considered.

The arbitrator would be remiss not to mention the very high quality of representation afforded to the litigants by their attorneys. Both plaintiff and defendants were zealously and effectively represented by their respective counsel. While the evidence ultimately guides the arbitrator to the decision, the advocacy of the attorneys to vigorously put the evidence in the light most favorable to their client was considerable.

The arbitrator is mindful of the tremendous emotional aspects of this case--the loss of a human life, and the toll that loss takes on the survivors and the caregivers who intervened in an attempt to save James White's life on April 4, 2011. It is significant to note that all attorneys in the arbitration were mindful of that as well and treated the decedent's memory with respect and dignity. The arbitrator, in rendering this opinion and award, is mindful of his role as an impartial decider of the facts having applied the appropriate law to the facts as understood by the arbitrator.

II.

The Defendants

Counsel for the parties have engaged in a heated debate and motion practice as to whom the appropriate defendant(s) should be in this case. The testimony of the defendants' corporate representatives in this regard was interesting to say the least. While Mike Moody and Jeremy Ballard testified as corporate executives, their knowledge and understandings of how their companies worked and functioned was devoid of any meaningful content. No one on behalf of the defendants seemed to know how the corporate entities functioned except the lawyers who were defending them in this arbitration. What is clear to the arbitrator is that the three defendant entities enjoy a symbiotic relationship that is intentional by design. There is no meaningful distinction between the entities. They are simply components of a singularly intended profitable enterprise. This is not in the least sinister, but it is the way the business model actually functions; hence, Moody and Ballard's inability to explain true functional distinctions.

Accordingly, the Arbitral Opinion and Award will apply to all defendants.

III.

The Experts

Each party put forth experts who testified as to the appropriate standard of care and any deviations from their perception of the standard.

David Larkin, R.T. and Dr. Loren Lipson, M.D. testified for the plaintiffs while Janet Vogt, R.T. and Dr. Phillip Buescher, M.D. testified for the defense.

It should be noted that Ms. Vogt had virtually no understanding of the standard of care concept and Dr. Buescher's concept was similarly vague.

IV.

Finding

The arbitrator has considered the opinions of each expert and has given them the weight each one is due and finds, based upon the facts and applicable law, that defendants departed from the standard of care and were negligent in their care and treatment of James White.

V.

The Critical Events of April 4, 2011

Ultimately this case comes down to those critical thirty-five minutes from 6:20 p.m. to 6:55 p.m. on April 4, 2011, in the hospital room of James White. James White had no alternative but to be in that room. Everything that occurs within that critical window of treatment is dependent upon the actions of others. At no time was James White able to intervene to positively affect his outcome. He was a dependent patient in every sense of the word. He needed assistance to perform even the most basic, personal routines, such as transference to a commode. He would be doing this under the care of the defendants' employees working under guidelines and protocols established by the defendants. These were protocols to never be shared with the patients nor their families, including whether the facility was short-staffed.

The key moment occurs at 6:20 p.m. when James White was moved from his bed to a bedside chair commode by one aide, Bobbi Shannon, with no one present to assist her. There is no proof that another aide ever entered the room to assist Aide Shannon. The inference to be drawn then is that it was the business practice and custom of the defendants to use a one-person

assist on patients like James White. Indeed, the testimony of their experts opines exactly that.

From the moment Aide Shannon goes behind the curtain alone to assist James White in transferring from the commode to the bed, then every standard at which the defendants profess to excel is put to the test and with devastating consequences.

The arbitrator finds the weight of the evidence establishes the decanullation occurred when Aide Shannon dropped James White onto his bed. This is the only event no one else observed. Other than that one moment behind the curtain there were always multiple witnesses working with or near James White. It is at this point that James White's airway is compromised and, as would be expected, he is quickly in trouble.

By 6:35 p.m., some 15 minutes after he is dropped and the trach dislodged, James White is still being treated by individuals who are not qualified to re-insert a trach. The pulse oximeter then sounds.

Another five minutes pass before attempts are made to bag James White. His airway remains compromised.

Somewhere around 6:45 p.m., some 25 minutes after the trach was dislodged, a CODE BLUE is called. There is no physician on the floor to respond to the code. Dr. Baker comes from another floor around 6:50 p.m. Whether he comes by stairs or an elevator no one knows, but what is known is that James White has lost valuable time. By now some 30 minutes have passed since the trach has been lost.

James White is pronounced dead at 6:55 p.m., although the reality of the situation is he was likely dead when the code was called at 6:45 p.m. This means his critical time of pain and suffering was approximately 25 minutes.

It is true, and should be noted here, that James White had significant co-morbidities: COPD, unrepentant smoker, abstaining alcoholic, and obesity. In short, he was precisely the kind of patient the defendants' could reasonably expect would come to their facility on a regular and routine basis. These co-morbidities are certainly relevant in assessing damages, but they are also relevant in establishing the greater degree of care and patient planning needed for such fragile and vulnerable individuals. The defendants could have elected not to accept James White as a patient, but once having accepted him it was their duty to provide him appropriate care. The defendants failed to provide the appropriate and recommended care.

Ultimately the most crucial witnesses--those who provided the most pertinent and insightful testimony--were those who were eyewitnesses and present with James White at some point within the 6:20 p.m. to 6:55 p.m. window. Considering the testimony of those witnesses as a whole, the arbitrator finds more than sufficient evidentiary basis to find for the plaintiff and conclude the defendants' departed from the standard of care.

It should be noted the arbitrator does not accept Heather Brashear's late-remembered addendums to her deposition. Her first testimony rang true and her post-deposition errata amendments are simply not credible.

Similarly Charlotte Smith's memory, some two-plus years post event, was much too clear and detailed when compared to her chartings made at the time of this incident. They were simply too many to be believable.

The testimony of Terri Yates, R.N. provides further evidence of her confusion as a caregiver of James White. At one point she testified James White was a "one-person assist," then at another point she testified she did not know James White was assessed by an occupational

therapist as a "total assist for transfer from bedside commode to bed." She admitted she did not know James White had been declared a high risk and admitted this is something she needed to know. Finally, Nurse Yates' testimony as to James White's condition when she first walked into his room April 4 was contradicted by the investigative email from Janna Grace to Juanita Clay.

V.

Punitive Damages Are Warranted

The arbitrator concludes punitive damages are warranted in this case. The defendants are in the business of taking care of patients who suffer from severe respiratory complications. The defendants profess to excel in high-risk patient care and that is why James White was transferred to the defendants' facility. The defendants have treated many patients very similar to James White and continue to accept patients in his condition. James White's needs were foreseeable. Because of the defendants' self-professed expertise in this area, better planning, training, and staffing were required. It was foreseeable that harm to James White would result in attempting a one-person assist transfer from the bedside chair commode. Indeed, the defendants were aware of the likelihood as evidenced by Heather Brashear's late attempts to put the horse back in the barn with self-serving corrections to her deposition. It is elementary that it is profitable to attempt a one-person assist when a total assist is recommended. To elect for a one-person assist resulted in devastating consequences to James White and his family. No one testified for the defendants that staffing levels was anything but appropriate. What the defendants' testimony infers is that the levels were where they chose them to be; thus, the duration of this conduct is pervasive and of more than episodic nature. Finally, no evidence was given of any effort to remedy the conduct because the defendant never conceded it did anything that should have been changed. The level

of care provided by defendants to James White demonstrates that defendants violated their duty to him with reckless disregard for the safety, health, and well-being of James White.

AWARD

Based upon all the foregoing, the arbitrator finds in favor of the plaintiff Carol White, as Executrix of the Estate of James White, deceased; and on behalf of the wrongful death beneficiary of James White, deceased; to wit, Carol White, as follows:

Funeral Expenses	$ 13,570.60
Physical pain and suffering, mental anguish, including the loss of enjoyment of life suffered by James White	75,000.00
Carol White's loss of spousal consortium due to the death of James White	150,000.00
Punitive damages	225,000.00
TOTAL	$463,570.60

ENTERED this 7th day of June, 2013.

Brian C. House, Arbitrator