No. _____

In The
Supreme Court of the United States

KAYLA BUTTS, Individually and on behalf of her daughter A.F., a minor,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION OF PETITIONER FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Did the Appellate court violate Federal Rules of Civil Procedure 52(a) when it failed to consider all of the evidence before the trial court, inserted its own erroneous interpretation of the facts, and refused to recognize the errors of its ways when presented with them in its determination to reverse a well-reasoned and evidentiary based finding of fact by a knowledgeable, competent, and experienced trial court judge who had the opportunity to hear and watch the testimony at trial, to make decisions of witness credibility, and to appropriately apply the facts to the West Virginia law?

2. May an Appellate court reverse a trial court's decision in an FTCA claim case by misstating crucial facts when the trial court, experienced in medical malpractice cases, renders a judgment on behalf of a minor child and her mother, when the evidence presented admittedly complied with the West Virginia law, simply because the Appellate court disagrees with the result reached by the trial court?

3. May an Appellate court reverse without remand a trial court's finding on an evidentiary issue, namely the failure to present expert testimony, never raised by Appellee during the trial or through its own appellate briefing to afford the Petitioner an opportunity to cure the issue as a workaround to the clear standards of FRCP 52(a)?

THE PARTIES

The Petitioner is Kayla Butts, individually and on behalf of her minor child, A.F.

There are no corporations involved.

The Appellee is the United States government standing in place of Susan Hardy, M.D., who was acting within the scope of her employment at a federally funded clinic and issued a Westfall Certification.

PROCEEDINGS DIRECTLY RELATED TO THIS CASE

None.

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The opinions below were unreported but have been included in the accompanying Appendix.

JURISDICTION

The Fourth Circuit Court of Appeals entered judgment on July 11, 2019. App. 1. The court denied a timely petition for rehearing *en banc* on September 9, 2019. App. 45. This Court now has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case does not involve the interpretation of statutory or constitutional provisions except to the extent that it need interpret the Court of Appeals' interpretation of the role it functions in and undertook in this matter under Federal Rules of Civil Procedure Rule 52(a)(6), which states: "Findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court's opportunity to judge the witnesses' credibility."

STATEMENT OF THE CASE

Plaintiffs tried this medical malpractice case before an experienced judge of the District Court for the Northern District of West Virginia. Judgment was entered by the Court in favor of the plaintiff after extensive discovery, a five-day trial, and proposed Findings of Fact and Conclusions of Law were submitted. The United States Government appealed. The basis of the case was that the defendant was negligent in failing to transfer a newborn baby, the minor A.F., to another hospital capable of providing enhanced ventilation because Berkeley Medical Center ("BMC"), the hospital of birth, did not have a neonatal intensive care unit ("NICU"), which the experts testified was necessary for the standard of care to have been met, and could not provide enhanced ventilation in order to prevent a hypoxic injury, and that the failure to do so timely was a cause of the child's cerebral palsy.

The Fourth Circuit also stated " . . . there is no dispute A.F. suffered irreversible brain injury from the insufficient flow of oxygenated blood to her brain." (Op., p. 5) The testimony from the expert physicians was that while the baby was under the care of the Federal employee healthcare providers the standard of care required that the minor baby be transferred to another facility that had a NICU, which could provide the necessary care required, and that the insufficient flow of oxygen to the brain happened after the birth of A.F. and while she was under the care of the Government's employ because she did not appropriately transfer the

baby to a location that could provide enhanced ventilation.

ARGUMENT

The Fourth Circuit, in its conclusion at p. 12, stated the following:

- "After reviewing the whole record, we are firmly convinced the district court's finding that Dr. Hardy breached the standard of care was a mistake."
- "The district court's finding as to breach was not supported by substantial evidence in the record and was clearly erroneous."
- "Specifically, the district court's finding on breach was not supported by Butts's own expert testimony."

The result was that a cerebral palsy child who proved her case through a week of testimony before a federal judge with many experts, had her judgment taken away. It was taken away because the Fourth Circuit was "firmly convinced" there wasn't "substantial evidence" and it "was not supported by Butts's own expert testimony."

Each of these statements is wrong and the record before the trial court and the Fourth Circuit clearly demonstrated the clear error made by the Fourth Circuit.

It is also noted that it is all the evidence, not just that in the trial court's Opinion, that must be considered. The District Court's finding of a breach in the standard of care *did* have substantial supporting evidence in the record; its finding of a "breach" *was* supported by plaintiffs' experts and all of the experts' testimony; and its finding was not only "plausible," but was the only possible finding in light of the evidence.

A. The Law

1. An Appellate Court Cannot Relitigate An FTCA Case Merely Because It Has a Different View Of The Facts

The appellate court erred in this case when it decided to relitigate this case solely on its view of the facts concerning the standard of care. There is no disagreement about "causation"; there is no disagreement with the applicable law; and the disagreement is purely on the whether the facts and reasonable inferences from those facts supported a finding concerning what the standard of care was and how it was breached. There was never a challenge to the evidentiary sufficiency of the expert testimony raised by the Defendant at any point in time, which, had it been made, would have afforded Petitioner an opportunity to clarify the issue even more.

According to its own Opinion, an appellate court can only reverse the factual findings if they are "clearly erroneous." Just because it might have decided the case differently, as it noted on page 7 of its opinion, that

is not sufficient to reverse. The Court stated that "if the district court's account of the evidence is 'plausible' in light of the record reviewed in its entirety, the Court of Appeals may not reverse even though convinced that had it been sitting as a trier of fact it would have weighed the evidence differently." The questions then become: 1) *was* there evidence of the standard of care; 2) *was* it supported by substantial evidence in the record; and 3) did the expert testimony of the child support the trial court's finding on breach of the standard of care?

In other words, any "error" or "mistake" by the trial court was one of "fact."

This case represents the quintessential example of an Appellate Court granting a losing party a second bite of the apple. In doing so, the Appellate Court shifted the burden upon the Appellee to prove its case again to a new set of fact findings without the benefit of having a trial conducted before it as the District Court did.

The law of the State of West Virginia requires that in a medical malpractice action, a plaintiff must show that "[t]he health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances. . . ." W. Va. Code § 55-7B-3(a)(1); *see also MacDonald v. City Hosp., Inc.*, 715 S.E.2d 405, 423 n.22 (W.Va. 2011). The applicable standard of care and the

healthcare provider's deviation(s) thereof must be established by the "testimony of one or more knowledgeable, competent expert witnesses if required by the court." *Id*. § 55-7B-7.

Thus, Petitioner needed only to present expert testimony on what the standard of care was and how it was breached.[1] The Petitioner presented such evidence and the trial court relied upon such testimony in its deliberations of the fact, as evidenced by its well-reasoned decision. Specifically, the trial court stated the following:

> Accordingly, this Court finds that the services rendered by Dr. Hardy to A.F. fell below the applicable standard of care and did in fact cause A.F. to sustain the damages alleged by the Plaintiffs. Specifically, Dr. Hardy recognized that A.F. needed to be transferred to WMC's NICU shortly after A.F. was born. A.F.'s condition did not improve, and BMC did not have the requisite equipment or staff to care for a child in her condition.

(Op., p. JA280)

> Dr. Hardy should have transferred A.F. to WMC the same afternoon A.F. was born, and

[1] Additionally, Petitioner also needed to present expert testimony on the causative effects that any deviations of the standard of care resulted in; however, because the Fourth Circuit recognizes that causation is undisputed, this Court need only look at the issues related to the first two elements of a medical malpractice claim: 1) What is the standard of care? and 2) was the standard of care breached?

> she believed as much herself. Dr. Hardy allowed a nurse manager to persuade her not to transfer A.F. to another hospital. As a result, A.F. continued to struggle breathing, became cyanotic, and developed cerebral palsy. It is clear to this Court, and it so finds that the standard of care required that A.F. be transferred to a NICU and receive the level of care that is only available in a NICU, such as the one at WMC.

(Op., p. JA281)

Despite this clear statement rendered by the trial court, the Appellate Court overstepped its authority in reviewing a matter under Federal Rules of Civil Procedure 52(a) and relitigated the facts without considering the evidence and testimony in its entirety. The Appellate Court essentially cherry-picked one statement made by Dr. Partridge out of context of the testimony as given, and it created an analytical gap that did not exist.

The undisputed fact is that the child was NOT and COULD NOT be intubated while at BMC nor did the child receive the necessary enhanced oxygenation she needed. The first time this child received CPAP or intubation, that even the Fourth Circuit seems to agree was needed (the necessary "enhanced ventilation modalities") was when the *receiving* hospital's team administered intubation *when it arrived* to transfer the child to Winchester Medical Center ("WMC"):

Q.: So, as soon as they [the transportation team form Winchester] get there, pretty much they intubate this child, right?

A.: Yes.

Q.: That's doing what you said should have been done much earlier, is that correct?

A.: Correct.

(Partridge, JA497)

2. Deference Is To Be Given To The Trial Court's Findings

Federal Rule of Civil Procedure 52(a) provides that "[f]indings of fact shall not be set aside unless clearly erroneous, and due regard **shall** be given to the opportunity of the trial court to judge of the credibility of the witnesses." (emphasis added). As this Court has repeatedly stated for decades, "[t]he Rule recognizes and rests upon the unique opportunity afforded the trial court judge to evaluate the credibility of witnesses and to weigh the evidence. . . . Because of the deference due the trial judge, unless an appellate court is left with the 'definite and firm conviction that a mistake has been committed,' . . . it must accept the trial court's findings." *Inwood Labs. v. Ives Labs.*, 456 U.S. 844, 855, 102 S. Ct. 2182 (1982) *citing to Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969) and *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948) followed by *Bose Corp. v. Consumers Union*, 466 U.S. 485, 104 S. Ct. 1949 (1984). *See also*

Esley v. Cromartie, 532 U.S. 234, 242, 149 L. Ed. 2d 430, 121 S. Ct. 1452 (2001).

"The requirement that special deference be given to a trial judge's credibility determinations is itself a recognition of the broader proposition that the presumption of correctness that attaches to factual findings is stronger in some cases than in others." *Bose Corp. v. Consumers Union*, 466 U.S. at 500. "The conclusiveness of a 'finding of fact' depends on the nature of the material on which the finding is based." *Bose Corp.*, 466 U.S. at 500, n.16 citing to *Baumgartner v. United States*, 322 U.S. 665, 670-671 (1944). In this medical malpractice action, the nature of the material on which the findings were based were the medical records and the clear expert testimony of the Petitioner's expert witnesses that the fact finder expressly found to be far more credible than that of the Defendant's expert witnesses. As stated by this Court:

> The requirement that special deference be given to a trial judge's credibility determinations is itself a recognition of the broader proposition that the presumption of correctness that attaches to factual findings is stronger in some cases than in others. The same "clearly erroneous" standard applies to findings based on documentary evidence as to those based entirely on oral testimony . . . but the presumption has lesser force in the former situation than in the latter. Similarly, the standard does not change as the trial becomes longer and more complex, ***but the likelihood that the appellate court will rely on the***

> ***presumption tends to increase when trial judges have lived with the controversy for weeks or months instead of just a few hours***.

Bose Corp., 466 U.S. at 500 (emphasis added).

While there does exist a faint line between the application of ordinary principles of logic and common sense and the legal realm of a legal rule upon which a reviewing court must exercise its own independent judgement in the reasoning by which a fact is said to be "found" (*See Bose Corp*, 466 U.S. at 500 n.17), the issue before this Court does not approach that line. Instead, the Appellate Court chose to plainly ignore the facts in evidence that were relied upon by the fact finder, to create its own alternative facts to support its predetermined outcome of how it wanted the fact finder to find, and to grossly either mischaracterize or misunderstand the plain meaning of the words presented in the trial transcript of Petitioner's expert witnesses that were relied upon by the fact finder in rendering a well-reasoned, evidentiarily sound, and anything but a clearly erroneous opinion.

Furthermore,

> Although the meaning of the phrase "clearly erroneous" is not immediately apparent, certain general principles governing the exercise of the appellate court's power to overturn findings of a district court may be derived from our cases. The foremost of these principles, as the Fourth Circuit itself recognized, is that "[a] finding is 'clearly erroneous' when

although there is evidence to support it, the reviewing court on the entire evidence is left with the **definite and firm conviction that a mistake has been committed**." *United States v. United States Gypsum Co*., 333 U.S. 364, 395 (1948). This standard plainly does not entitle a reviewing court to reverse the finding of the trier of fact simply because it is convinced that it would have decided the case differently. The reviewing court oversteps the bounds of its duty under Rule 52(a) if it undertakes to duplicate the role of the lower court. "In applying the clearly erroneous standard to the findings of a district court sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues *de novo." Zenith Radio Corp. v. Hazeltine Research, Inc*., 395 U.S. 100, 123 (1969). If the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently. Where there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous. *United States v. Yellow Cab Co*., 338 U.S. 338, 342 (1949); *see also Inwood Laboratories, Inc. v. Ives Laboratories, Inc*., 456 U.S. 844 (1982).

. . .

The rationale for deference to the original finder of fact is not limited to the superiority of the trial judge's position to make

> determinations of credibility. The trial judge's major role is the determination of fact, and with experience in fulfilling that role comes expertise. Duplication of the trial judge's efforts in the court of appeals would very likely contribute only negligibly to the accuracy of fact determination at a huge cost in diversion of judicial resources. In addition, the parties to a case on appeal have already been forced to concentrate their energies and resources on persuading the trial judge that their account of the facts is the correct one; requiring them to persuade three more judges at the appellate level is requiring too much. As the Court has stated in a different context, the trial on the merits should be "the 'main event' . . . rather than a 'tryout on the road.' " *Wainwright v. Sykes*, 433 U.S. 72, 90 (1977). For these reasons, review of factual findings under the clearly-erroneous standard – with its deference to the trier of fact – is the rule, not the exception.

Anderson v. Bessemer City, 470 U.S. 564, 573-575, 105 S. Ct. 1504, 1511-1512 (1985) (emphasis added).

Noticeably, in its Opinion, the Appellate Court expressly ignored the role espoused in *Anderson* when stating in footnote 2 that "the standard we apply is effectively the same standard a trial judge applies in considering a motion for judgment as a matter of law under Federal Rules of Civil Procedure Rule 50 in the context of a jury trial." That is contrary to established law as such is *not* the role and function of an appellate court in reviewing the findings of fact issued by a trial

judge in a bench trial under the Federal Tort Claims Act. While there may be some similarities between the Rules, the Appellate Court was bound to review this matter under the law as pertains to F.R.C.P. 52.

In attempting to avoid the clear mandate that Rule 52(a) requires the presumption of accuracy of the fact finder, the Court of Appeals took a minimalistic view of the record as a whole to create a fictional analytical gap in the presented evidence in order to base its opinion upon *Miller v. Mercy Hosp., Inc.*, 720 F.2d 356, 361 (4th Cir. 1983). However, in looking to Fourth Circuit precedent, the Court failed to take note of *Wileman v. Frank*, 979 F.2d 30, 35 (4th Cir. 1992), in which that Court stated that "'*clearly erroneous' review is properly focused upon fact-finding process rather than directly upon fact-finding results.* The appellate function is to ensure that the process shall have been principled; the function is not authoritatively to find the 'facts' first instance, or to affirm or deny that the facts 'found' by the trial court are the 'actual' facts of the case." (emphasis in original).

The Appellate Court's clear error was in that it failed to appreciate that the trial court was not only allowed to sit through a week-long trial and listen to the testimony, evaluate the evidence, and judge the credibility of the witnesses who testified, ***but also*** to make "inferences from other facts" in applying her analytical process to derive her opinion. This process is very much akin to the *Daubert* standard, which is the trial court's opportunity to focus on the underlying *methodology* employed by an expert witness in

arriving at his or her opinion in order to determine whether the testimony is *admissible as opposed to correct*. *See Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 593, 113 S. Ct. 2786 (1993).

As a result, the Appellate court failed to look at *how* the trial court applied the evidence that was presented before it during a week-long trial in which the court heard testimony, balanced credibility, interjected questions of its own for clarification, weighed the evidence, and issued a reasoned opinion upon that evidence and the reasonable inferences therefrom. Instead, the Appellate court merely attempted to have the case relitigated and ignored the *entirety* of the evidence presented, the weight and inferences to the evidence that was given by the trial court, and the analytical process employed by the trial court in arriving at its opinion; demonstrated a clear misunderstanding of the facts that were contained within the record because it was not present at the trial; and interjected its own feelings on how it wished to rule on the case in spite of its duties to not act as a new fact finder and create a second jury deliberation.

The Court, on appeal, will generally look for clear error when reviewing decisions of facts. *Husain v. Olympic Airways*, 316 F.3d 829, 835 (9th Cir. 2002). This view is derived from the Federal Rules of Civil Procedure which state that an appeals court is *not* allowed to set aside a lower court's findings of fact (based on oral or other evidence) unless it is clearly erroneous. A Court of Appeals simply is *not* allowed to reverse a trial court's finding at all if there's any possibility, on

the record, when viewed in its entirety, that the lower court's finding is plausible.

In this case, it becomes clear than that if the plaintiff *did* present standard of care testimony, *did* present substantial evidence of what the standard of care was and that there was a breach, and *did* have support for the same, it would be gross error for the Fourth Circuit to interject its own views as to the case. We need, therefore, to examine whether there was standard of care testimony, whether there was evidence of a breach, and whether or not the Fourth Circuit is in error.

As we will see, it is abundantly clear that Petitioner is correct, i.e., there was evidence of the standard of care and its breach as well as "causation" testimony.

B. Facts

1. There Was No NICU Or Anyplace Else At BMC That Could Provide Enhanced Oxygenation

It is undisputed that when the child was born at BMC, BMC did not have a NICU. (JA260, 561+). It had a nursery. There is a vast difference. The hospital obviously could not provide that which it did not have – namely treatment generally available in an NICU.

This child was born on November 7, 2014 at approximately 8:50 a.m. (JA935). It was a difficult delivery with the child being in mild to moderate respiratory distress, crying, not vigorously moving around,

with a low oxygen level which concerned even the government's doctor. (JA940, 1009 et seq.). Being concerned with the respiratory status and noting an increased respiratory rate with grunting, flaring, and retracting (all signs of respiratory distress) and with the child also being the product of meconium aspiration (meaning the ingestion of meconium while *in utero*), the doctor decided that if the child started to breathe harder, needed more oxygen, failed to improve or got worse, then she would transfer the child to a NICU. (JA553, 561+, 568, 581). The doctor saw the baby at approximately 9:10 a.m. She indeed learned during the morning that the child was breathing faster and harder and thought that she needed to transfer the child to an NICU level facility which turns out to be Winchester Medical Center (WMC) in Virginia. Dr. Hardy stated herself that "she needed NICU care." (JA582, 587). Dr. Hardy herself testified that the child was in respiratory distress for the duration of her care and knew that A.F. would develop brain damage if inadequate amounts of oxygen reached her brain and everything she observed indicated the child needed to be transferred to a NICU. She did not transfer. (JA581). Instead, Dr. Hardy was persuaded by a nurse to consult with a doctor, who was a new neonatologist at the hospital, unknown to Petitioner and not a part of the Defendant's group. While a neonatologist, this doctor had just been hired by the hospital and was responsible for creating a NICU at the hospital *in the future*. This baby was the first newborn that he ever cared for at BMC. (JA894). It was undisputed that the hospital not only did not have a NICU, but it also did not have

a CPAP machine at the time or any ability to provide necessary enhanced oxygenation which the baby needed and which is the essence of a NICU. (JA892). Unfortunately, the child wasn't transferred to a NICU until more than 24 hours had passed and by that time her condition considerably worsened, leaving her with cerebral palsy.

2. The Circuit Court Plainly Erred In Stating Intubation Was Done At BMC Or Could Have Been Done

The physician who received the child at the NICU in Winchester, VA had his deposition testimony admitted into evidence. (JA786). He testified that as soon as the transport team that was sent from Winchester arrived at BMC, the first thing they did when they saw the child who had a low oxygen saturation, was cyanotic (blue), and had paradoxical breathing was to start the child on intubation and then onto a CPAP machine. (JA805, 821, 822). This was done the moment the transfer team arrived at BMC *by the transport team that had the capabilities to provide intubation, not by BMC*. In the roughly 36 hours since birth, the child had *not* been intubated or given CPAP or any other kind of enhanced oxygenation *because BMC did not have the ability to provide any such care*. Any suggestion to the contrary is not supported by the evidence and is wrong.

The Fourth Circuit erred on the facts as it noted at p. 11 of the Opinion that the child had been intubated at and by BMC. This was factually erroneous as

the child never got either CPAP or intubation or any enhanced ventilation while under the care of Defendant or anyone else at BMC (JA497, 856), which was necessary to provide the needed oxygen enhancement. The treating neonatologist at Winchester testified that what he observed was consistent with severe acute anoxic/hypoxic injury (JA843, 852 et seq.), the undisputed cause of the cerebral palsy. The issue of "causation" was never in question in that no one testified otherwise nor did the Fourth Circuit note that anything other than hypoxia caused this injury. The child had never received the necessary enhanced oxygenation to prevent brain cell death while at BMC and under the care of the Government employees.

The trial court noted that plaintiff's experts including Dr. Partridge, a Board-Certified Neonatologist, opined that had the child been in a NICU they would have had the ability to give oxygen adequately because a NICU can intubate and ventilate. (JA492-494). He also testified that putting the child on nasal cannula (as was done), is *not* intubation and not CPAP, and was a violation of the standard of care. (JA522, 543). He pointed out that the child was actually getting worse during Dr. Hardy's care. Another Board-Certified Pediatrician, Carol Miller MD, testified similarly, and, as the court noted, her testimony paralleled Dr. Partridge's testimony. (JA757). She too opined that the child needed care available in a NICU and that it was below the standard of care to not have the child transferred to a NICU and that had she been transferred she would have received the proper support,

namely intubation and CPAP. (JA767). The opinions were that it was this failure to get the child to a NICU so she could receive enhanced oxygenation that was the cause of the cerebral palsy.

3. There *Was* Extensive Evidence Concerning The Standard Of Care

On page 21 (JA277) of the trial court's opinion, it stated the correct law in West Virginia on medical malpractice. That was undisputed by the Fourth Circuit. Basically, a plaintiff must prove by a preponderance of the evidence that the healthcare provider, in this case Dr. Hardy, failed to exercise the degree of care, skill and learning required or expected of a reasonably prudent healthcare provider in the profession or class to which the healthcare provider belongs acting under the same or similar circumstances. The trial court found that Dr. Hardy's services "fell below the applicable standard of care and did in fact cause AF to sustain the damages alleged by the plaintiffs" (JA280); the court also noted that "[s]pecifically, Dr. Hardy recognized that A.F. needed to be transferred to WMC's NICU shortly after A.F. was born. A.F.'s condition did not improve, and BMC did not have the right equipment or staff to care for a baby in her condition." (JA280). As the trial court stated, "It is clear to this court, and it so finds that the standard of care required that A.F. be transferred to an NICU and receive the level of care that is only available in an NICU such as the one at WMC." (JA281).

The standard of care was that the child should have been transferred to WMC which had a NICU so that the child could receive proper ventilation, either by intubation or CPAP, also known as enhanced ventilation.

The Fourth Circuit erroneously stated at the Oral Argument and in its Opinion (Op., p. 11) where it referenced the Appendix pp. 571 and 895 that the baby **was** intubated or even "**could have been**" intubated for ventilation purposes. However, JA571 says just the opposite and JA895 says nothing of the sort. Not a scintilla of evidence exists that intubation had taken place or that it was even available in the nursery.[2]

The undisputed evidence is that the child was NOT and COULD NOT be intubated while at BMC and the child did not receive the necessary enhanced oxygenation she needed. The first time this child received CPAP or intubation, that even the Fourth Circuit seems to agree was needed (the necessary "enhanced ventilation modalities") was when the receiving hospital's team administered intubation *when it arrived* to transfer the child to Winchester.

> Q.: So, as soon as they [the transportation team from Winchester] get there, pretty much they intubate this child, right?
>
> A.: Yes.

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[2] Why, if intubation was available, would the facility always transfer a baby needing enhanced ventilation to Winchester? That is illogical. (Hardy, JA563, 570)

Q.: That's doing what you said should have been done much earlier, is that correct?

A.: Correct.

(Partridge, JA497)

Dr. Miller says the same thing at JA757-759; *see also* Medical Record, JA 1073-1075. Two experts said the child needed medical intubation hours earlier (at least 24 hours) than when provided. The child simply had not been intubated nor received CPAP while under the care of any physician at BMC, before being transferred, *because CPAP and intubation were not available at BMC*.

This Fourth Circuit said: "If in fact there is more than one acceptable method of treatment, the physician need not choose the best one." (Op., p. 9). That is an accurate statement of law in West Virginia; however, Dr. Hardy did not choose either of the acceptable methods. The two acceptable methods were either to intubate or administer CPAP in order to provide the proper and necessary ventilation/oxygenation. The undisputed fact is that Dr. Hardy did not have the ability to choose between intubation or CPAP because neither was available at BMC; thus, her only choice was to transfer the baby to WMC in compliance with the standard of care to attain intubation or CPAP or to deviate from the standard of care and deny the baby the ability to receive intubation or CPAP. She chose to deny the baby intubation or CPAP and that was below the standard of care, as **neither one** was given to this baby. The fact is every piece of evidence in this case

shows there was no CPAP or intubation given ***or even available***. Why did the Court not note the words of the new treating neonatologist, Dr. Purohit?

> Q.: When did you realize you didn't have CPAP.
>
> A.: Oh I knew that right from the beginning otherwise, I would have used it right away.

(JA914)

The enhanced ventilation that was desperately needed by the baby was not "used right away" because it was not available. That is a violation of the standard of care; that was clearly supported by the evidence; and that evidence was rationally relied upon by the trial court.

Dr. Hardy testified that if the "oxyhood" did not make the baby better in an hour or two then the baby would be transferred to a NICU; and the baby did NOT improve. (Hardy, JA553, 555)

> Q.: But doctor, do you understand that he didn't have the ability to give any higher level of care than you did in that situation?
>
> A.: No, he did. He had *nasal cannula* which was a different and potentially better.
>
> Q.: Excuse me, what?
>
> A.: A potentially better form of . . . of better oxygen delivery.

Q.: What was?

A.: Nasal cannula. Nasal cannula.

Q.: You couldn't do nasal cannula?

A.: No, we did not have it available before we went to a storeroom and got it out of a box.

(Hardy, JA586)

That's the testimony – they were able to only use nasal cannula out of a box, not intubation. They simply could not provide required enhanced ventilation. Thus, it was a fallacy for the Fourth Circuit to base its opinion on the erroneous "fact" that intubation was in fact available: as Dr. Hardy testified herself, *only nasal cannula was available*; not intubation.

When the Fourth Circuit stated "an oxyhood" is a device that provides supplemental oxygen (Op., p.4), such is just plain wrong and not supported by any evidence. There was no such evidence for the Court to cite because it's not true. "Oxyhood" is not the equal of intubation or CPAP. (Partridge, JA481)

The Fourth Circuit stated, at page 3 without citation, that "the Max Care Nursery offered specialized care to newborn infants including an oxygen-delivery system and equipment to provide intubation." Again, there was no evidence that (1) specialized care was offered; (2) that it could provide intubation; or (3) had an oxygen-delivery system. To be clear, each of these assertions are wrong and not the evidence.

Q.: Was there a special area where this child was going to be taken care of other than a nursery OR what you call max care?

A.: No.

(Hardy, JA587)

There was but one unit at BMC. A "Nursery." There is nothing designated "Max" Nursery. That was a defense phrase developed by the Government for trial; so too is the phrase "oxygen-delivery system" as the standard of care required "enhanced ventilation" and not simply a fan blowing in the baby's face. There was no NICU. There was no intubation, specialized care or enhanced ventilation. Let us look at the evidence.

Q.: But not the equivalent of a NICU.

A.: It's not. In this place it was not equivalent of an NICU because they didn't have an NICU.

(Miller, JA742)

4. There Was Extensive Testimony that the Standard Of Care Was Violated Causing Injury

The record is replete with "standard of care testimony" and violations thereof. *See also* J. Groh's Opinion. Eleven examples follow:

1. Q.: What – if she is in the NICU, what is she getting that she didn't get here?

A.: Most importantly is ***enhanced respiratory support***, because it's obvious the baby cannot adequately breathe on her own in this situation and so she needed much more support for her respiration. *That could be in the way of CPAP, which is a method of giving steady air pressure, or it could be intubating, which is what this baby needed, as placing the baby on a ventilator, to help with the breathing*.

. . .

Q.: . . . would you describe that would that be the standard of care?

A.: Yes.

Q.: That didn't happen right?

A.: **It did not happen.**

(Miller, JA755-756)

2. Q.: Would it be below the standard of care for them to not have care rendered in an NICU for the child?

A.: Yes, it is.

(Miller, JA747)

The violation of no intubation or CPAP merely continued to kill the baby's brain cells. (Miller, JA755-756).

That is standard of care, breach thereof and causation.

3. Q.: In your opinion did this occur, at least in part, during the time that Dr. Hardy had full responsibility for this child as a physician?

A.: Yes.

Q.: And in your opinion, doctor, had the child received the kind of care and treatment that you told us you believe the child needed and the deviation did not occur, in your opinion what effect would that have had on this child within a reasonable degree of medical probability?

A.: Had this baby been given the enhanced ventilation and respiratory support that was indicated almost immediately after birth, *but certainly during the time that Dr. Hardy was responsible for the baby's care*, the baby would not have gone on to develop ongoing hypoxemia, the apnea, the cyanosis.

(Miller, JA767)

There is no question: There was never any ability for the doctors to give enhanced ventilation. (Partridge, JA498)

4. A.: All the things that we were discussing would not have occurred, and the baby most likely would not have experienced the hypoxic-ischemic encephalopathy.

(Miller, JA768)

That is standard of care **and** the reason for the standard of care.

5. Q.: Are those the problems that you believe within reasonable degree of medical probability could have been avoided?

   A.: Yes.

(Miller, JA779)

Urging that Dr. Partridge opined "the child should have been transferred either to a higher level of care within Berkeley Medical Center or to an NICU" (Op., p. 9), to suggest it was acceptable to not transfer the baby to another hospital is disingenuous. There was no higher level of care at BMC. A NICU is a thing, not a person. A neonatologist without a NICU is like a surgeon without an OR; a pianist without a piano; a judge without a courtroom; or a Court without Rules. There was no enhanced ventilation (CPAP or intubation). That leaves only transportation to an NICU with CPAP, intubation and appropriate ventilation. That is what the many qualified medical experts said.

Moreover, looking at the nurse's notes (JA1011, et seq.), shortly *before* the baby *should have been* receiving enhanced ventilation available only after transfer out of BMC, we see the baby "grunting now intermittent"; "increased respirations and decreased SATS"; "SATS decreased to 89 to 91";[3] Newborn continued to "grunt and retract intermittently." That is all before Dr.

[3] "Sats" refers to the amount of oxygen in the blood and being supplied to the brain. It should not be 89, 87, 65, 68. It should be 93 and above.

Hardy had any assistance from anyone. Then *after* the child should have been transferred and received enhanced ventilation, the record says: newborn noted with period of apnea at 10 to 20 seconds, color dusky to trunk, with cyanosis noted to facial area DSAT to 65%, on 50% 02; apnea; DSATS to 68%; color dusky to trunk; "increasing episodes of DSATS"; stimulation ineffective SP02 DSATS to 35% on 50% 02; dusky color to trunk, facial area cyanotic. (Medical Records, JA1011 et seq.). This continued for another 24-hours and none of this would have happened if the baby had been transferred/transported around noon, according to the testimony.

6. Q.: Are those the problems that you believe within reasonable degree of medical probability could have been avoided?

   A.: Yes.

(Miller, JA768)

A.: She [Hardy] said, well I felt this baby needed to be taken care of in NICU, so she needed more.

Q.: So, transferring the baby to Winchester where there was an NICU is exactly what you said should have been done, right?

A.: Yes.

Q.: And if all that had been done, as she was even thinking with her patient, we never get to this or the cyanosis, this apnea and so on that occurs after that, correct?

A.: That's correct.

Q.: That all could have been avoided, right?

A.: Yes.

(JA779).

That is all standard of care and why it is standard of care.

7. Q.: Okay, well doctor, assuming that Dr. Miller has testified in this case that she believed that the child should have been sent to an NICU, which was in Winchester not here, should have been sent to the NICU *that morning*, certainly by the time Dr. Hardy came back, if you get to the NICU, what do they do in an NICU if anything that could prevent what we're talking about here, the grunting, the flaring, the drop in the stats? What do you do? . . .

A.: . . . and they can intubate and ventilate. [in a NICU] They can use mechanical ventilators, either cyclic ventilation or a high-frequent ventilation, which this child later received.

(Partridge, JA493)

A.: This child needed a physician at the bedside.

(Partridge, JA495)

Q.: This child needed to be in an NICU at *that point*?

A.: Absolutely.

(Partridge, JA496)

"That point" is clearly referring to the Noon period of time as that is what had been discussed, as it is specifically referencing Dr. Miller's testimony.

8. Q.: Okay, doctor, was there at that time (noon), assuming that she's testified that she came back to the hospital thinking that she was going to transfer the child to Winchester, was there anything that was shown in the record that would indicate that the child didn't need to be sent to Winchester in light of the respiratory distress or hyperglycemia and the blood gases and so on, is there anything in there that said that this child is going to get better?

A.: Not at that point. You can't tell and the child given the risk of the presumptive meconium . . . *that child should have been transferred*.

Q.: Okay, and that's within a reasonable degree of medical probability?

A.: Absolutely.

(JA500)

Any implication that Dr. Partridge said the baby did not have to be transferred until 11:00 p.m. is incorrect. But, knowing the Court was wrong, Defendant kept silent. The Government during Argument even

stated that Dr. Partridge said the first time the baby needed intubation was 8:00 p.m. That is simply not the evidence. The Court also erred during the Argument by suggesting the baby did not have to be transferred until 11:00 p.m. Dr. Partridge and Dr. Miller both said the child should have been transferred at around noon. (JA265, 500) The word "another" below is instructive.

> 9. Q.: Doctor, if you don't transfer the child at that point, is there *another time* that you say this child's got to go? And if so, when would that be?
>
> A.: . . . It is a confused transfer of care as I read it in the chart . . .
>
> Q.: And so it is your opinion doctor that at 11:15 at night this was the first time chronologically that this child needed NICU care correct?
>
> A.: **NO**. The child had already deteriorated and needed 100 percent saturation . . . I already expressed that *putting a child on cannula at this point and weaning* oxygen I felt inappropriate

(JA521).

> Q.: So, you looked through them again and you're making a different opinion that she should have been transferred before 23:15?
>
> A.: As I said, the child should have been transferred either to a higher level of care within Berkeley Medical Center or to an

> NICU . . . The child was getting worse during **her**[4] care, and that was her criteria for setting the child for a **higher level of care which was not available at Berkeley**. Both can be true.

(JA526)

Dr. Hardy did not even appropriately transfer the baby to anyone else. (Hardy, JA589, et seq.) The Medical Staff Rules required a note in the record and an order transferring. (unknown to Hardy, JA562) (Richardson, JA620-623). There is no Order (note). *See* trial court's Opinion, (JA261).

To suggest that somehow inappropriately attempting to transfer care to another doctor relieves Dr. Hardy of her duty to the baby is illogical. The only question is, did Dr. Hardy follow the standard of care before 2:45 p.m.? What another physician did is not relevant to whether Dr. Hardy was negligent.

To state that Dr. Miller said "enhanced ventilation" (Op., p. 10) could be accomplished with CPAP or intubation is correct. But, "nasal cannula" is NOT intubation and this child received neither CPAP nor intubation.

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[4] The only "her" was Dr. Hardy.

5. Further Evidence Of The Standard Of Care And Violation Thereof

Dr. Miller opined that the standard of care required A.F. to receive CPAP or intubation. Dr. Hardy testified that BMC did not have CPAP available and only had nasal cannula. In Dr. Miller's Opinion, A.F.'s inadequate breathing, respiration and oxygen delivery to the cells of the body, including the brain, were the result of Dr. Hardy's actions, which fell beneath the standard of care. (JA266)

10. Q.: Okay. Now, what kind of – I mean, we talked about nursery – maximum care and nursery and NICU

    What did this child need?

    A.: This child needed NICU care.

    Q.: Would it be below the standard of care, then, to not have care being rendered in a NICU for this child?

    A.: Yes, it is.

(Miller, JA747)

Dr. Partridge also opined within a reasonable degree of medical certainty that Dr. Hardy should have transferred A.F. at noon, the same day she was born – more than twenty-four hours before A.F. was actually transferred to WMC. (JA265)

11. Q.: . . . what do they do in a NICU, if anything, that could prevent what we're talking about here, the grunting, the flaring,

the drop in the SATS? What do you do? . . .

Q.: Well, my question goes to, if you have the child in the NICU at this point, are you able to give oxygen adequately?

A.: In a NICU?

Q.: Yes.

A.: Oxygen, close assessment, one-to-one nursing, blood gases, arterial blood gases, umbilical catheterization if they were worried that an apnea episode potentially was related to seizures, they could have looked at either EEG or amplitude integrated EEG. I don't know whether that specific NICU had that capacity. And they can intubate and ventilate. They can use mechanical ventilators, either cyclic ventilation or high frequent ventilation, which this child later received.

(JA492-494)

Q.: This child needed to be in a NICU at that point?

A.: Absolutely.

(JA496)

Judge Groh noted:

Accordingly, this Court finds that the services rendered by Dr. Hardy to A.F. fell below the applicable standard of care and did in fact cause A.F. to sustain the damages alleged by

> the Plaintiffs. Specifically, Dr. Hardy recognized that A.F. needed to be transferred to WMC's NICU shortly after A.F. was born. A.F.'s condition did not improve, and BMC did not have the requisite equipment or staff to care for a child in her condition. (Op., p. JA280)
>
> Dr. Hardy should have transferred A.F. to WMC the same afternoon A.F. was born, and she believed as much herself. Dr. Hardy allowed a nurse manager to persuade her not to transfer A.F. to another hospital. *As a result*, A.F. continued to struggle breathing, became cyanotic, and developed cerebral palsy. It is clear to this Court, and it so finds that the standard of care required that A.F. be transferred to a NICU and receive the level of care that is *only* available in a NICU, such as the one at WMC.

(Op., p. JA281)

All of the foregoing is certainly "substantial evidence" of standard of care and its violation.

To suggest that there wasn't substantial evidence in the record of a breach of the standard of care is simply wrong as can be seen from above. Both Dr. Miller and Dr. Partridge testified what the standard of care was and it wasn't followed.

6. Plaintiff's Experts Clearly Stated The Standard Of Care

While the Fourth Circuit wished to analyze this matter in a similar fashion as FRCP 50, that court failed to take note that the Defendant never challenged the sufficiency of the evidence presented by Petitioner and their experts at the trial court level or even in its appellate brief. In fact, on the 28th day after the entry of judgment by the trial court, the Defendant filed a Motion to Amend its findings of fact pursuant to FRCP 52(b) "to reflect the amount of the pre-verdict settlement of the other two defendants in its final judgment as required under W. Va. Code §55-7B-9."

Defendant never raised at any time an issue that the standard of care testimony was deficient because intubation was available. In fact, in the Government's own proposed findings of fact it acknowledged that intubation was NOT available as it described the nursery as "equipped with more advanced equipment, a radiant warmer, oxygen delivery system, suction, all of the equipment for placing an I.V., for placing an umbilical line, for doing a chest tube, for any sort of producer that a baby might need is all housed in that room." The Government also acknowledged that the only decision Dr. Hardy was forced to make was between utilizing an oxyhood or nasal cannula: "Dr. Hardy chose to deliver the supplemental oxygen by oxyhood. The reason Dr. Hardy chose the oxyhood is because it is the least invasive way of supplying supplemental oxygen to a baby, and also avoids the possibility of the baby becoming agitated by the nasal cannula and dislodging the cannula, which could lower

the oxygen saturation level." (Def Findings of Fact para 18 at p. 6). The Government *admitted* in its Findings of Fact that the only option was between oxyhood and nasal cannula *because* intubation was not available. Now the Fourth Circuit attempts to create the fiction that it was available.

NEVER, did anyone present in the court room for the week-long trial or throughout all of the post-trial motions was it ever contemplated, considered, or suggested that BMC had the equipment to intubate a baby such as this child. Had that issue ever been raised at any point in time prior to the questioning that transpired during the appellate argument, the clarification would have been made. That clarification, however, did not have to be made because it was crystal clear during the week-long trial and years-long litigation of the case that the trial court and trial counsel lived.

When plaintiffs' experts state that the standard of care required that the child be transferred to a NICU and the child was not transferred to a NICU that is evidence of a violation of the standard of care, which is what is required in West Virginia. There was clearly substantial evidence that Dr. Hardy breached the standard of care; it is there in black and white. To say it was not supported by substantial evidence is clearly an erroneous statement. To say that the breach was not supported by Petitioner's own expert testimony is not accurate as we have just shown. Petitioner's experts, Miller and Partridge (and also Drs. Lee and Rugino) provided that testimony on standard of care and breach thereof. To say Petitioner's experts did not

support the opinion is to ignore all of the evidence above. Each expert testified as to why it was necessary for the child to receive proper oxygenation via intubation and/or CPAP to prevent the cerebral palsy from occurring. That is meaningful criteria for why a transfer was necessary, and not one shred of evidence existed in this case suggested otherwise. For the Fourth Circuit to state that "neither expert appropriately said what was right before saying what was wrong" is wrong. The trial court said that what was right was that the child be transferred to a NICU where it could receive the oxygenation needed that it did not receive because the child was not transferred. The experts said what was right and necessary and then said that it wasn't done and why that was wrong and what it caused. The experts all stated that lack of proper oxygenation was wrong because the lack can, and did cause hypoxia and brain cell death, in this case.

CONCLUSION

There is no basis for anyone trying to impart justice to this cerebral palsy child to say that there wasn't evidence of the standard of care and its violation (and causation). This is a decision that is totally outside the concept of the rule of law. It is the essence of an Appellate Court trying to find a reason to not allow a child to receive justice even if it means re-litigating the case. Plaintiff went to great steps to present a pediatrician, neonatologist, a rehabilitation physician, and other experts as well as the treating neonatologist who tended

to this child when she was received in a NICU in another hospital. All say that the standard of care required the child be transferred promptly so that the child could receive the proper oxygenation via intubation and/or CPAP. All say that. The only evidence that existed of methods to provide oxygen to the baby indicate that there was only an option of an oxyhood or nasal cannula. To say that there was evidence that BMC could intubate the child is and was erroneous. That didn't happen and was negligence. To suggest otherwise is not this case. This child was entitled to have her case heard pursuant to the Federal Tort Claims Act by a trial judge and did so with extensive testimony involving the government doctor all of which is totally meaningless and ignored by the Fourth Circuit, and the trial judge who so painstakingly analyzed the case is criticized as not having done her job and being "mistaken."

The Fourth Circuit simply erroneously inserted its interpretation of the evidence which any fair-minded person would conclude not only was "plausible" but is the only proper interpretation of the evidence. That is not justice. It is not the law; and it robs this cerebral palsy child of justice.

This Court in order to preserve justice for a cerebral palsy child of any sort certainly needs to grant this petition for certiorari.

Respectfully submitted,

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