No. _____

IN THE

Supreme Court of the United States

Oral Moore,

Petitioner

v.

United States of America

Respondent

MOTION FOR ORDER GRANTING LEAVE TO FILE NOTICE OF BELATED APPEAL

Comes Petitioner, Oral Moore, by his attorney, Larry J. Steele, and for his Motion for Order Granting Leave to File Notice of Belated Appeal, states:

1. The undersigned underwent gallbladder removal surgery on July 2, 2024 and experienced complications. *(See Exhibit A)*

2. Because of the complications in the removal of his gallbladder, the undersigned lost track of time.

3. The petition for rehearing by the panel was denied April 25, 2024 in the United States Court of Appeals for the Eighth Circuit, Case No. 23-2251.

4. The undersigned requests an Order allowing leave to file a belated appeal within a reasonable time.

WHEREFORE, Petitioner prays the Court enter an Order granting Petitioner leave to file notice of a belated appeal.

Respectfully submitted,

Larry J. Steele
Ark. Bar No. 78146
Attorney for Petitioner
LARRY J. STEELE PLC
P.O. Box 561
225 West Elm Street
Walnut Ridge, AR 72476-0561
(870) 886-5840; (870) 886-5873 fax
Email: steelelaw7622@sbcglobal.net

CERTIFICATE OF SERVICE

I, Larry J. Steele, hereby certify that on August 2, 2024, I mailed a copy of the foregoing MOTION FOR ORDER GRANTING LEAVE TO FILE NOTICE OF BELATED APPEAL, by U.S. Mail, postage prepaid, to the following:

Ms. Lindsey Mitcham Lorence
United States Attorney's Office
425 West Capitol Avenue, Suite 500
Little Rock, AR 72201
Email: lindsey.lorence@usdoj.gov

Larry J. Steele

St. Bernards HEALTHCARE

The Heart of Great Medicine

07/25/24

Dear Sir/Madam,

I am the record holder here at St.Bernards Surgical Associates and these records are keep on the daily course of business.

Thank you,
GREGORY L LYNCH, MD

St. B Surgical Associates
1005 E Matthews Ave
JONESBORO, AR 72401
870-935-1242

GLL, MD

PENGAD 800-631-6989
EXHIBIT
A

St. Bernards HEALTHCARE
The Heart of Great Medicine

Surgical Associates
1005 E Matthews Ave
Jonesboro, AR 72401

Patient Name: STEELE,LARRY JOE
DOB: 03/31/1946
Attending Provider: LYNCH,GREGORY L MD

Account #: AV0011435641
Med Rec #: SM04283768
Age/Sex: 78

Status: Signed
Report #: 0620-00551
Service Date: 06/20/24

cc:

~

HPI

SA Gallbladder HPI

Consult, Post-up, Follow-up or Referral: Referral
Referring provider:
Paul Vellozo
Possible gallbladder problem/s: cholelithiasis
Patient complaints: nausea, vomiting, abdominal pain (epigastric radiating into mid abdomen around umbilicus), heartburn, indigestion, reflux and other (diarrhea due to diabetic medications)
Pain quality: aching
Severity of symptoms: moderate and stable
Duration: Onset 3 weeks ago

Diagnostic studies

abdominal CT (5/31/24 CT A/P: There is a small fat-containing periumbilical hernia. The stomach and small bowel are unremarkable. Moderate amount of retained stool is present. Diverticulosis of the descending and sigmoid colon without diverticulitis. The appendix is normal. Impression: Diverticulosis without div)
Findings: cholelithiasis

HPI Comments

Details:
5/31/24 CT A/P: There is a small fat-containing periumbilical hernia. The stomach and small bowel are unremarkable. Moderate amount of retained stool is present. Diverticulosis of the descending and sigmoid colon without diverticulitis. The appendix is normal.
Impression: Diverticulosis without diverticulitis. Cholelithiasis. Gallbladder ultrasound may be helpful for further evaluation.

Ambulatory Intake

Visit Reasons: K80.20 Gallstones
Interpreter required: No
Has the patient fallen in the last 90 days?: No
Smoking risk assessment performed?: Yes
Does patient have a history of postoperative surgical site infection?: No

Allergies/ Med Reconciliation

Allergies

Sulfa (Sulfonamide Antibiotics) Allergy (Mild, Verified 06/20/24 09:53)
Rash
Tetanus Vaccines and Toxoid [Tetanus Vaccines & Toxoid] Allergy (Unknown, Verified 06/20/24 09:53)
Unknown

Home Medications

- Last Reconciled 06/20/24 by LIBBY N MARTIN, RN

amlodipine 5 mg PO DAILY
aspirin 81 mg PO QDAY
chlorthalidone 50 mg PO DAILY
cyanocobalamin (vitamin B-12) 1,000 mcg IM COMMENTS
ketoconazole 2% 1 applic topical ONCE
ketoconazole 2% 1 applic topical BID
losartan 50 mg PO DAILY
metformin ER 500 mg PO BID
nebivolol (Bystolic) 10 mg PO DAILY
ondansetron 4 mg PO Q8H PRN 5 days
oxybutynin chloride 5 mg PO BID
potassium chloride ER 10 mEq PO DAILY
semaglutide (Rybelsus) 14 mg PO QDAY
simvastatin 10 mg PO HS
tamsulosin 0.4 mg PO DAILY
testosterone cypionate 200 mg IM Q21D
tramadol 50 mg PO Q8H PRN

PFSH

Surgical History (Updated 06/20/24 @ 09:59 by LIBBY N MARTIN, RN)

History of bilateral knee replacement

Family History (Reviewed 06/20/24 @ 09:53 by LIBBY N MARTIN, RN)
Other
Family history non-contributory

Social History (Reviewed 06/20/24 @ 09:53 by LIBBY N MARTIN, RN)
Have You EVER Used Tobacco Products: Former Tobacco User
Alcohol Use in the Past 12 Months: No
History of Drug Use in the Past 12 Months: No

Active Problem List

All Active Problems (Updated 06/20/24 @ 10:06 by FARRAH WRIGHT, RN)

Umbilical hernia (Acute Medical) K42.9
History of tonsillectomy (Acute Surgical) Z90.89
Sleep apnea (Acute Medical) G47.30
Hyperlipidemia (Acute Medical) E78.5
Cholelithiasis (Acute Medical) K80.20
Dermatophytosis (Acute Medical) B35.9
S/P revision of total knee (Acute Surgical) Z96.659
Renal mass (Chronic Medical) N28.89
Chronic kidney disease (CKD) (Chronic Medical) N18.9
HTN (hypertension) (Chronic Medical) I10
Osteoarthritis (Acute Medical) M19.90
Diabetes mellitus (Acute Medical) E11.9
Hypotension (Acute Medical) I95.9
Acute renal failure (Acute Medical) N17.9
UTI (urinary tract infection) (Acute Medical) N39.0

Ambulatory ROS

Status of ROS
Reports: 10 or more systems reviewed and unremarkable except as noted in History and below

Ambulatory Vital Signs

	06/20/24 09:53
Height	5 ft 9 in
Current Weight	223 lb 4 oz
BMI	32.9
Respiration	18

Physical Exam

Constitutional
no apparent distress, healthy appearing, alert and well nourished
Head, Ears, Nose, Mouth, Throat
Head and scalp: normocephalic and atraumatic
Neck & C-Spine
normal visual inspection and trachea midline
Respiratory
normal respiratory effort and clear to auscultation bilaterally
Cardiovascular
regular rate and regular rhythm
Gastrointestinal
normal to inspection, nondistended, normoactive bowel sounds present, soft to palpation, non-tender and hernia present (soft, reduced umbilical hernia present)
Extremity
normal to inspection and gait normal
Neurological
oriented to person, oriented to place and oriented to time
Speech: speech normal
Psychiatric
mental status grossly normal, calm attitude/behavior, normal affect and good judgement present
Skin
no rashes or lesions noted

Assessment & Plan

(1) Cholelithiasis:
Code(s):
K80.20 - Calculus of gallbladder without cholecystitis without obstruction , Gallstones
Qualifiers:
Cholelithiasis location: gallbladder **Cholecystitis presence:** without cholecystitis **Biliary obstruction:** without biliary obstruction **Qualified Code(s):** K80.20 - Calculus of gallbladder without cholecystitis without obstruction
(2) Umbilical hernia:
Code(s):
K42.9 - Umbilical hernia without obstruction or gangrene
Qualifiers:

Obstruction and gangrene presence: without obstruction or gangrene **Qualified Code(s):** K42.9 - Umbilical hernia without obstruction or gangrene

Plan

78 yo male presents with symptomatic cholelithiasis. I have discussed the diagnosis, indications for removal of the gallbladder. Indications, benefits, and risks of surgery discussed with the patient including, but not limited to, bleeding, infection, bile leak, bile duct injury, retained stones, possible need for open procedure, bowel injury.Short term and long-term complications were discussed including post-cholecystectomy syndrome. All questions were addressed. Patient verbalized understanding of potential risks, and is agreeable to proceed. The robotic vs open cholecystectomy will be scheduled in the near future.

Orders:

Referrals

Schedule Surgery	K80.20 - Calculus of gallbladder without cholecystitis without obstruction , Gallstones

Coding

Level of Care Code

99204 (45-59 min)

Exam

Comprehensive

Diagnoses

Calculus of gallbladder without cholecystitis without obstruction K80.20
- Cholelithiasis location: gallbladder
- Cholecystitis presence: without cholecystitis
- Biliary obstruction: without biliary obstruction

Umbilical hernia without obstruction and without gangrene K42.9
- Obstruction and gangrene presence: without obstruction or gangrene

<Electronically signed by GREGORY L LYNCH MD> 06/20/24 1136
<Electronically signed by FARRAH WRIGHT RN> 06/20/24 1011

GLLYNCH
DD/DT: 06/20/24 / 1002
Report #: 0620-00551
Patient Status: DEP AMB

St. Bernards Medical Center
225 East Washington Ave Jonesboro, AR 72401
870-207-4100

Operative Report
Medical Records

Patient Name: STEELE,LARRY JOE
Med Rec # SM04283768
Age/Sex: 78 M
Admit Date: 07/02/24
Discharge Date:

Account #: SV0212737167
DOB: 03/31/1946
Attending Doctor: LYNCH,GREGORY L MD

cc:

DIAMOND,KEVIN M MD
~

STATUS: Signed

Report #: 0702-00699

Admit Date: 07/02/24

Operative Report`

Procedure Start/ End Times Procedure Start Time: 11:39 Procedure End Time: 13:07 Procedure Date: 07/02/24 **Report Body** Report Body:

Date of procedure: 7/2/2024
Preoperative diagnosis: Symptomatic cholelithiasis
Postoperative diagnosis: Severe acute cholecystitis
Procedure: Da Vinci assisted laparoscopic cholecystectomy
Surgeon: Dr. Logan Lynch
Assistant: Farrah Wright, RN
Anesthesia: General endotracheal anesthesia plus local
Estimated blood loss: Minimal
Urine output: See anesthesia record
IV fluids: See anesthesia record
Findings: Critical view obtained
Specimens: Gallbladder
Drains: None
Complications: None apparent

Indications for procedure: 78-year-old male that was referred to me for what was thought to be symptomatic cholelithiasis. Here his symptoms were consistent with this. He had imaging that was consistent with cholelithiasis. I recommended a da Vinci assisted laparoscopic cholecystectomy. He and I discussed the operation in great detail including the risks. He has a good understanding of this and is agreeable to proceed.

The risks, benefits, and alternatives to the procedure were discussed in detail and all questions answered to the patient's satisfaction. Informed consent was obtained.

Procedure in detail: The patient was brought to the operative theater and placed in the supine position. The patient then underwent uneventful induction of general endotracheal anesthesia. A timeout was performed during which we discussed pertinent patient information and all members of the operative team were in agreement. The patient was then prepped and draped in standard sterile fashion.

Anesthesia had previously placed an OG tube and then the patient was placed in reverse Trendelenburg position. I first accessed the abdomen through the use of the Veress needle at Palmer's point. A drop test was performed and found to be satisfactory, as were the pressures and flows on the monitor.

The abdomen was accessed in the left upper quadrant using an 8 mm optical trocar. There was no injury secondary to the Veress needle and therefore it was removed. I placed 3 additional 8 mm trocars across the mid abdomen all under direct visualization. The da Vinci robot system was deployed, docked, targeted, and my instruments were brought in under direct visualization. I then took my place at the console.

Initially, it was impossible to identify the dome of the gallbladder due to inflammatory adhesions of the transverse colon mesocolon and the duodenum to the liver edge. I was able to take these down using combination of cautery and blunt dissection. Eventually I was able to identify the dome of the gallbladder. I was unable to grasp it due to extreme and inflammation, edema and friability of the tissue. I decompressed the gallbladder by making a cholecystotomy using the scissors and decompressed it with the suction irrigator. This facilitated grasping of the dome of the gallbladder and it was elevated up over the liver. I then began my dissection of adhesions away from the gallbladder wall which was carried out using a combination of blunt dissection and cautery. It was impossible to reach the cystic duct without putting him at risk for injury to the bile duct and/or hepatic arteries therefore I elected to perform a subtotal cholecystectomy. I amputated the gallbladder about a third of the way up using cautery. Hemostasis was ensured. Identified the cystic duct from the inside of the gallbladder and closed this using a running 3 oh STRATAFIX suture. I then closed the infundibular pouch over this using a 2 oh strata fix suture in running fashion. I inspected this thoroughly and there was no evidence of any leak. I confirmed this with the use of firefly.

I dissected the remainder of the gallbladder away from the liver bed using Bovie electrocautery. I obtained hemostasis as I went. After removing the gallbladder from the liver bed, I placed it in a Endo Catch bag, removed from the abdomen, and passed it off the table as a specimen. I ensured hemostasis. A 19 French Blake drain was placed through my left-sided port and placed in proximity to the infundibular pouch. I then irrigated the operative field until the irrigant returned clear. I removed my working ports under direct visualization, allowing the insufflation to escape. My trocar sites were hemostatic. I anesthetized the skin using quarter percent Marcaine. I closed the skin