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SUPREME COURT OF TEXAS
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No. 14-0499

IN THE SUPREME COURT OF TEXAS

NAVARRO HOSPITAL, L.P. D/B/A NAVARRO REGIONAL HOSPITAL
Petitioner

V.

CHARLES WASHINGTON AND GWENDOLYN WASHINGTON,
EACH INDIVIDUALLY AND AS NEXT FRIENDS OF
CHARLES DONELL WASHINGTON
Respondents

On Petition for Review from the Tenth Court of Appeals at Waco, Texas
No. 10-13-00248-CV

RESPONSE TO PETITION FOR REVIEW

LEIGH PRICHARD BRADFORD
Texas. State Bar No. 24027752
KIRK PITTARD
Texas State Bar No. 24010313
LEIGHTON DURHAM
Texas State Bar No. 24012569
KELLY, DURHAM & PITTARD, LLP
P.O. Box 224626
Dallas, TX 75222
Telephone: (214) 946-8000
Facsimile: (214) 946-8433
lbradford@texasappeals.com
kpittard@texasappeals.com
ldurham@texasappeals.com

JAMES E. GIRARDS
State Bar No. 07980500
THE GIRARDS LAW FIRM
10000 N. Central Expy., Suite 400
Dallas, TX 75231
Telephone: (214) 346-9529
Facsimile: (214) 346-9532
jim@girardslaw.com

ATTORNEYS FOR RESPONDENTS

IDENTITIES OF PARTIES AND COUNSEL

PARTY	COUNSEL
Navarro Hospital, L.P. D/B/A Navarro Regional Hospital *Petitioner*	Jeffrey F. Wood Miranda A. Wilson JONES CARR MCGOLDRICK, LLP 5910 N. Central Expy. Suite 1700 Dallas, Texas 7520610 *Trial and Appellate Counsel*
Charles Washington and Gwendolyn Washington, Each Individually and as Next Friends of Charles Donell Washington *Respondents*	Leigh Prichard Bradford Kirk Pittard Leighton Durham KELLY, DURHAM & PITTARD, LLP P.O. Box 224626 Dallas, Texas 75222 *Appellate Counsel* and James E. Girards THE GIRARDS LAW FIRM 10000 N. Central Expy. Suite 400 Dallas, Texas 75231 *Trial Counsel*

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TO THE HONORABLE JUSTICES OF THE TEXAS SUPREME COURT:

This Response to Petition for Review is filed on behalf of Charles Washington and Gwendolyn Washington, each individually and as Next Friends of Charles Donell Washington, referred hereinafter as "the Respondents" or "the Washingtons." The Petitioner is Navarro Hospital,

L.P., D/B/A Navarro Regional Hospital, referred hereinafter as "the Hospital" or "Navarro Hospital."

STATEMENT OF THE RECORD

The Petitioner cites the Clerk's Record as (CR [page]). For purpose of consistency, the Washingtons will also refer to the Clerk's Record as (CR [page]). Citations to the Reporter's Record from the January 18, 2013, hearing on Defendants' Motion to remand are to (RR [page]). The Hospital's Petition for Review will be cited as (Pet. [page]).

RESPONDENTS' ISSUES PRESENTED

Issue One (Petitioner's Issue One Restated):

The Respondents' expert reports were written by a qualified physician and a hospital administrator and contain recitations of the appropriate standards of care and the manner in which those standards were breached when the Petitioner Hospital failed to provide the proper medical equipment to timely intubate Donell Washington. Did the court of appeals err in affirming the trial court's conclusion that the reports sufficiently set forth the standards of care and the corresponding breaches of those standards under the requirements of §74.351 of the Texas Civil Practice & Remedies Code?

Issue Two (Petitioner's Issue Two Restated):

The Respondents' expert report authored by a qualified physician causally linked the Hospital's breach of the appropriate standards of care, failing to adequately provide appropriate medical equipment and ensure proper policies, protocols and training were in place, to the resulting permanent brain damage suffered as a result of the failure to timely intubate Donell Washington. Did the court of appeals err in affirming the trial court's conclusion that this expert report satisfied the causation requirements set forth in §74.351 of the Texas Civil Practice & Remedies Code?

STATEMENT OF FACTS

In 2010, Charles Donell Washington ("Donell") was an accomplished musician leading a full and active life. (CR 7). On July 13, 2010, Donell was taken to the emergency department of Navarro Hospital by his parents, and presented with complaints of difficulty breathing, dizziness, nausea, vomiting and pain in his throat and right ear. *Id.* Donell also appeared depressed and had difficulty with verbal expression. *Id*. While stable, Donell was admitted to the Hospital for treatment and resolution of his symptoms. *Id*. Dr. Hibbs, the attending physician, ordered that Donell be given IV fluids, insulin and medications to address agitation and restlessness. *Id*. In order to receive these treatments, Donell was transferred to the Intensive Care Unit ("ICU") within the Hospital. *Id.*

In the ICU the following day, doctors noted Donnell becoming increasingly agitated and unresponsive to verbal stimuli. (CR 7). Correspondingly, Donell's blood pressure and heart rate elevated. *Id.* Later, on July 15, 2010, at approximately 2:25 a.m., Donell's heart rate and oxygen saturation level dropped suddenly. *Id*. In response, hospital staff placed him on 100 percent oxygen via an oxygen mask. *Id*. Within minutes, Donell's heart rate dramatically decreased to 39 and Hospital staff

called a Code Blue. (CR 8). Doctors responded to the Code Blue, commenced chest compressions and utilized an ambubag to ventilate Donell. *Id*.

During the Code Blue, the Hospital's physicians attempted to intubate Donnell, but were unable to accomplish this task. (CR 8). At no time during the Code Blue did the physicians utilize "difficult airway" equipment, which is standard practice and sometimes necessary to achieve intubation of a patient in Donell's condition. *Id*. At the time, the difficult airway equipment was apparently not in the room or was unavailable. *Id*. At approximately 3:16 a.m., forty-five minutes after the Code Blue was called, Dr. Stevener arrived and successfully intubated Donell. *Id.* By this time, Donell had extensive and permanent brain damage due to the delay in properly ventilating Donell and the failure to establish an adequate airway. *Id*.

The Washington family filed their healthcare liability claims, asserting claims for both negligence and gross negligence due to the permanent and irreparable injury suffered by Donell. (CR 8-9). The Washingtons specifically and directly alleged that the Hospital "failed to

have the difficult airway equipment readily available and failed to have and/or enforce adequate policies related to such equipment." *Id*.

As required by §74.351 of the Texas Civil Practice and Remedies Code, the Washingtons timely served two expert reports, authored by Edward Panacek, M.D. and Arthur Shorr, MBA, FACHE, to establish the basis for their claims against the Hospital and defendant physicians. (CR 45-79, 104-19). The Hospital filed objections to both expert reports and a motion to dismiss the Washingtons' claims. (CR 89-98, 120-32, 149-63). In response, the trial court conducted a hearing on the motion to dismiss and ultimately overruled the Hospital's objections and denied the motion. (CR 279). The trial court subsequently signed a written order deeming the expert reports sufficient to satisfy the requirements of §74.351. (CR 280). Upon the Hospital's interlocutory appeal, the Waco Court of Appeals affirmed the trial court's order and refused to overturn the trial court's ruling regarding the sufficiency of the expert reports or the denial of the motion to dismiss. *Navarro Hosp., L.P v. Washington*, No. 10-13-00248-CV, 2014 WL 1882763 *8 (Tex. App.—Waco May 8, 2014, pet. filed).

SUMMARY OF THE ARGUMENT

The Hospital's Petition for Review fails to highlight any appellate issues that require this Court's review or intervention. This appeal involves general and boilerplate objections to the Washington's expert reports. The two reports offered by the Washingtons constitute good faith efforts to inform the Hospital of the specific conduct upon which this case is based. Further, the reports, when considered together, supply the relevant standards of care that Donell Washington should have been afforded, the Hospital's and its physicians' breaches of those corresponding standards, and the causal links between those failures and Donell Washington's oxygen deprivation and resulting permanent brain injury. The experts who authored these Chapter 74 reports are qualified to render the necessary opinions in this case and their opinions satisfy the requirements set forth by this Court in *Certified EMS, Inc. v. Potts*, 329 S.W.3d 625 (Tex. 2013).

ARGUMENT AND AUTHORITIES

I. Standards for consideration on petition for review.

Conspicuously absent from the Hospital's Petition are any of factors or arguments indicating consideration by this Court is necessitated. *See* Tex. R. App. P. 56.1(a). The Hospital does not sufficiently articulate a ripe conflict between the courts of appeals regarding any aspect of Chapter 74. *Id.* at 56.1(a)(1). Nor does the Hospital present a conflict among the courts of appeals on another important point of law. *Id.* at 56.1(a)(2). There is no allegation questioning the validity or construction of Chapter 74 or any other applicable rule or statute. *Id.* at 56.1(a)(3). Certainly, the Hospital makes no effort to raise an issue rising to the level of constitutional importance or crisis. *Id.* at 56.1(a)(4). While the Hospital claims the trial court erred in exercising its broad discretion to deem the relevant expert reports sufficient, the Hospital fails to establish the trial court or court of appeals "committed an error of law of such importance to the state's jurisprudence that it should be corrected…." *Id.* at 56.1(a)(5). The Hospital's abuse of discretion claim fails to meet that standard and further fails to "present a question of state law that should be, but has not been," resolved by this Court. *Id.* at 56.1(a)(6).

The Hospital's claims are common boilerplate objections to the trial court's order dismissing the Hospital's request for a dismissal: the expert reports do not set forth adequate standards of care, the expert reports fail to establish breach of those standards, and the expert reports do provide adequate evidence of causation. All of these mundane issues and general objections were properly addressed by the trial court and the court of appeals and do not warrant review by this Court. The decisions by both courts adhere to the guidance provided by this Court in *Potts*. 329 S.W.3d 625. For these reasons, this Court should deny the Hospital's Petition for Review.

II. The trial court and court of appeals properly concluded the Washingtons' expert reports sufficiently set forth the relevant standards of care and the breaches of those standards.

The Hospital alleges in its first issue that the expert reports of both Panacek and Shorr failed to adequately set for the relevant standard of care and accompanying evidence of breach for both the physicians on duty and the Hospital. Within this argument the Hospital also contends that both Panacek and Shorr are unqualified to render opinions regarding the appropriate standards of care involved in this case. Both the trial court and the court of appeals found both experts qualified to render such testimony,

and also concluded both adequately addressed standard of care and breach in accordance with Chapter 74. Tex. Civ. Prac. & Rem. Code §74.351(a).

A. Dr. Panacek is qualified and his report sufficiently articulates the relevant standards of care and the breaches of those standards for both the treating physicians and the Hospital.

Qualifications

The Hospital's paragraph-long, cursory argument regarding Dr. Panacek's qualifications simply states that Dr. Panacek "failed to indicate his qualifications…" The court of appeals summarily dismissed this argument citing the following paragraph from Dr. Panacek's report:

> I am a physician licensed to practice medicine by the state of California. I received the MD degree at the University of South Alabama College of Medicine in Mobile, AL in 1981. I am a [Diplomat] of the American Board of Internal Medicine, the National Board of Medical Examiners, the American Board of Emergency Medicine and am a [Diplomat] in Critical Care Medicine. I am an instructor in Advanced Cardiac Life Support, and Advanced Trauma Life Support. I am a past Program Director of the Emergency Medicine Residency Program at the University of California Davis Medical Center in Sacramento, Ca. I am a Professor of Emergency Medicine at that same facility. My CV is attached to this report and is incorporated by reference. I have extensive experience in establishing and maintaining airways in patients, responding to Code Blues, and using standards of care related to airway management during Code Blue situations in the hospital setting, and these standards of care are common to internal medicine, emergency medicine and critical care medicine. I am familiar with the medical treatment of a patient similar to

> Charles "Donell" Washington in 2010 and am qualified by training and experience to render opinions regarding the appropriateness of his medical treatment. (CR 45).

This testimony demonstrates that Dr. Panacek is licensed and practicing physician, with expertise in both critical care and emergency medicine. It also proves Dr. Panacek's experience and expertise with regard to airway management and responses to Code Blue situations – the precise issues underlying the medical liability claims asserted in this case. Dr. Panacek goes further and also explains that he his familiar with the medical treatment of patients similarly situated as Donell Washington, as well as the airway equipment necessary for the advanced airway management that was necessary in this case. Accordingly, Dr. Panacek is unquestionably qualified to opine on the subjects and issues in this case. *See* Tex. Civ. Prac. & Rem. Code §74.402. The trial court and court of appeals correctly concluded the same.

Standard of Care

In articulating the relevant standards of care applicable to the Hospital[1], Dr. Panacek's report provides that:

> Airway management is one of the most critically important skills for an emergency or critical care practitioner to master because failure to secure an adequate airway can quickly lead to death or disability. Endotracheal intubation using rapid sequence intubation (RSI) is the cornerstone of emergency airway management. (CR 47).
>
> The relevant standards of care for hospitals treating Donell Washington during the admission of July 13, 2010, are such that the hospital must have specialized intubation equipment immediately available in all ICU and ER units, as well as available to each code blue. Such equipment includes endotracheal tubes of various sizes, a laryngoscope with blades of various sizes, Laryngeal Mask Airways, and naso- and oro-pharyngeal airways. Difficult airway equipment must be quickly available as well. Further, minimal standards of care require that the hospital have and/or enforce adequate protocols, or policies and procedures to assure the medical personnel and staff are aware of and trained to utilize this specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time. (CR 47-8).

While the Hospital makes a general claim that Dr. Panacek's report inadequately sets forth the relevant standard of care of the Hospital, it

[1] Dr. Panacek's report also outlines and details the standards of care and corresponding breach of those standards by the defendant physicians, which provides a vicarious, separate and second theory of liability against the Hospital. The Hospital does not challenge the report's opinions related to the individual physicians specifically.

provides no explanation or argument as to how the above specific, concise statement regarding the relevant standard of care is deficient – other than argue Dr. Panacek is unqualified to provide this opinion.

Breach of the Standard of Care

In effort to evaluate whether the defendant physicians and the Hospital breached the appropriate standards of care, Dr. Panacek examined the medical care provided Donell Washington by Navarro Hospital. In doing so, Dr. Panacek reviewed the medical records, diagnostic studies, laboratory results, and all related documentation contained within the Navarro Regional hospital chart. (CR 45). Following this review Dr. Panacek concluded:

> Had applicable standards of care been used on Donell Washington, the hospital would have had the [difficult airway equipment] in a crash cart on the unit where Donell Washington was located. When the Code Blue was called the crash cart would have been rolled into the room very quickly by the nurses as the Code Team was arriving. (CR 49).
>
> In order to comply with applicable standards of care….Navarro Regional Hospital…would have had specialized intubation equipment, to specifically include the intubation equipment listed above [difficult airway equipment], immediately available in the ICU unit where Mr. Washington was being maintained at the time the Code Blue was called. Moreover, Navarro Regional Hospital should have had and/or enforced protocols or policies and procedures assuring that the medical

> personnel and staff…were aware of and trained to utilized this specialized intubation equipment during a Code Blue… Unfortunately, the hospital failed to take these actions… (CR 50).

Interestingly, the Hospital does not challenge the applicability of the above standards to the Hospital's actions in the case or the Hospital's actual corresponding breach. Instead, the Hospital argues Dr. Panacek's opinions on breach are based on insufficient documentary evidence. This argument conflicts with the true requirements of Chapter 74 expert reports and mischaracterizes the burden on the Washingtons in submitting their reports. The Washingtons, along with their experts, are not burdened with marshalling their entire case and all relevant evidence in presenting the opinions contained within their expert reports. *See Christus Spohn Health Sys. v. Sanchez,* 299 S.W.3d 868, 867-77 (Tex. App.—Corpus Christi 2009, pet. denied). Opinions within Chapter 74 expert reports are not required to rise to the level of summary judgment evidence or to be presented as though the plaintiff were litigating its case on the merits. *See Am. Transitional Care Ctrs., Inc. v. Palacios*, 46 S.W.3d 873, 875 (Tex. 2001). Plaintiffs are limited and constrained when preparing initial expert reports by their very nature because these reports are required early in the

litigation process and before discovery occurs. *See In re Jorden*, 249 S.W.3d 416 (Tex. 2008). Dr. Panacek's opinions are based on all relevant evidence available to the Washingtons at the time this case was initially filed. While preliminary by nature, Dr. Panacek's report constitutes a good faith effort to provide sufficient notice to the Hospital of the specific breaches of the standard of care that the Washingtons are calling into question. *See Scoresby v. Santillan*, 346 S.W.3d 546, 556 (Tex. 2011).

The Hospital counters within this portion of its argument that the trial court failed to limit its inquiry to the four corners of the expert reports, contrary to this Court's holding in *Palacios*, 46 S.W.3d at 878. This assertion is based on the diagrams and descriptions of medical devices the Washingtons provided in the trial court in its response to the Hospital's motion to dismiss. (CR 166-68). However, the Hospital cites no evidence in the record, within the trial court's order or the court of appeals' opinion, that supports the argument that either of those court's relied on this additional evidence in arriving at their conclusion. In fact, neither court cites to the documentary evidence as a basis for its decision or conclusion regarding whether Dr. Panacek's report contains sufficient opinions regarding standard of care or breach.

B. Mr. Shorr is qualified and his report sufficiently articulates the relevant standards of care and the breaches of those standards by the Hospital.

Qualifications

The court of appeals affirmed the trial court's determination regarding Mr. Shorr's qualifications as well. Mr. Shorr is qualified to render opinions regarding the standards of care and the corresponding departures from those standards by the Hospital by its failure to have difficult airway equipment available and appropriate policies in place to ensure such equipment was available to treating physicians and that each physician was trained to utilize such equipment.

Mr. Shorr's expert report indicates he is Board Certified in Healthcare and Hospital Administration.[2] (CR 105). He has worked as a healthcare administrator for forty years, with many of these years devoted to the administration of acute-care hospitals. *Id.* Mr. Shorr provides information regarding peer review articles he has published in the field of hospital administration and indicates he provides consulting services to physicians and hospitals. *Id.* This level of education, experience and expertise

[2] Mr. Shorr's curriculum vitae is attached to his report and also details his extensive experience in hospital administration. (CR 112-19).

qualifies Mr. Shorr to opine on the Hospital's standard of care and its breach of those standards in failing to have the standard and adequate equipment and policies in place at the time of Donell's tragic failed intubation. *See* Tex. Civ. Prac. & Rem. Code §74.002(a)-(c); Tex. R. Evid. 702.

Standard of Care

Based on his expertise in the field of hospital administration and necessary hospital policies and procedures, Shorr explained in his report that the Hospital is directly responsible for providing safe and effective healthcare services and would be liable for the negligence of the defendant physicians. (CR 107). Shorr's report indicates that the relevant standards of care for hospitals are to ensure that its staff are competent and adequately trained to manage airways during a Code Blue situation. *Id*. The report also indicates hospitals should enforce protocols, policies, or procedures to ensure that medical personnel "are aware of and trained to utilize . . . specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time." *Id.*

The Hospital contends Shorr's opinions regarding the relevant standards of care are based solely on assumption and have no basis, but the

court of appeals noted Shorr, in addressing the appropriate standards of care, relied upon his expertise and cited "numerous regulations and accreditation standards for hospitals within his report, including those pertaining to hospital accountability for patient care, hospital requirements to have supplies and equipment needed for patient care readily available, duties of hospital staff to recognize and respond to changes in a patient's condition, and duties of the hospital to ensure that all staff are competent to carry out patient treatment." *Navarro Hosp.*, 2014 WL 1882763 *8. Shorr's opinions regarding the applicable standards of care for the Hospital are sufficient to meet the requirements of Chapter 74. Tex. Civ. Prac. & Rem. Code §74.351.

Breach of the Standard of Care

The Hospital also contends Shorr's opinions regarding breach of the relevant standards of care are insufficient and inadequate because they are based on assumptions and insufficient evidence. Shorr's report, however, indicates he reviewed the circumstances surrounding Donell's care, the Plaintiffs' petition, the Hospital's responses to interrogatories and requests for production, interrogatory answers of the defendant physician and Dr. Panacek's expert report. Shorr's conclusions regarding the Hospital's

breach of the standards of care are not insufficient assumptions, but are instead based on the evidence initially available to Shorr that directly supports Shorr's opinions. Shorr explains the Hospital: failed to ensure the availability of supplies and equipment needed to intubate and resuscitate Donell Washington in a timely manner; failed to ensure that the nursing and physician staff were able to recognize and respond to changes in Donell Washington's condition; and failed to ensure that its staff were competent to perform intubation in a timely manner. (CR 110-11). These opinions regarding the Hospital's breach are sufficient to meet the requirements of Chapter 74 and provide the Hospital notice of the conduct complained of by the Washingtons. Tex. Civ. Prac. & Rem. Code §74.351.

III. The trial court and court of appeals properly concluded Dr. Panacek's expert report causally links the Hospital and the physicians' breaches of the standards of care with the permanent brain damage suffered by Donell Washington.

In the context of the Hospital's argument regarding insufficient causation, the Hospital again questions the qualifications of Dr. Panacek, contending Dr. Panacek is unqualified to render expert testimony because his is not licensed to practice medicine in Texas. (Pet. 15). The Hospital cites no statutory authority or precedent to support its argument that Dr.

Panacek is unqualified because he is only licensed to practice medicine in California. Dr. Panacek's qualifications to render causation opinions, cited above, were affirmed by the trial court and the court of appeals and the Hospital offers no basis for overturning those decisions. This Court gives deference to the trial court on issues relating to an expert's qualifications and for this reason the trial court's determination should stand. *See Larson v. Downing*, 197 S.W.3d 303, 304-45 (Tex. 2006) (stating deference is given to the trial court on matter regarding expert qualifications); *Broders v. Heise*, 924 S.W.2d 148, 151 (Tex. 1996) ("The qualification of a witness as an expert is within the trial court's discretion. We do not disturb the trial court's discretion absent clear abuse of discretion.").

The Hospital's specific complaint on causation is actually more of a general objection, asserting Dr. Panacek's opinions on causation are conclusory and do not link any breach by the Hospital to the injuries suffered by Donell Washington. (Pet. 15). To the contrary, Dr. Panacek offers a detailed analysis linking the Hospital's failure to provide adequate airway equipment and training protocols to Donell resulting in permanent brain damage:

…[the Hospital] fell below applicable standards of care by failing to have, or failing to enforce, protocols, policies, and procedures to assure that medical personnel and staff were aware and trained to utilize specialized intubation equipment during code situations. Had such equipment been available it more likely than not would have been used on Donell Washington at the beginning of his Code Blue.

Had applicable standards been used…the hospital would have had the equipment identified above in a crash cart on the unit where Donell Washington was located. When the Code Blue was called the crash cart would have been rolled into the room very quickly by the nurses as the Code Team was arriving. [The physicians] would have taken steps to assure that an adequate airway was established and maintained during the Code Blue. These physicians would have intubated Donell Washington as soon as possible after they arrived at Washington's bedside by taking a laryngoscope from the crash cart, putting the appropriate blade on it, and then putting the blade into the patient's mouth and into his larynx, visualizing his vocal cords and inserting the plastic endotracheal tube into the patient's throat. . . At that point, these physicians should have gone to an LMA or naso- or oro-pharyngeal mask. An LMA is simply a tube with an inflatable mask on one end that is inserted into the patient's throat to achieve a seal over the tracheal opening so that oxygen can be forced into the patient's lungs. Almost certainly, these physicians would have been able to adequately ventilate this patient at that point. If for some reason, they could not accomplish this, then the physicians should have used a scalpel and made an incision in the anterior surface of Washington's neck, identified and cut through the cricothyroid membrane and intubated the patient through this opening. As this point, Washington would have been ventilated adequately until a definitive airway could be established. Brain damage due to lack of oxygen would more likely than not have been avoided.

> It is my opinion beyond a reasonable medical probability, based on my training and education and experience, that the negligent acts of [the physicians] and Navarro Regional Hospital. . . outlined above were each a proximate cause of Mr. Washington's profound brain damage and related sequelae. It is well accepted in the medical community at large that the brain requires a constant flow of oxygen to function normally. When the flow of oxygen is cut-off—and in a patient who is unconscious and not breathing—the blood oxygen levels drop. At a certain point, the low oxygen state causes the cells of the body to go into anaerobic respiration, rather than aerobic respiration based on the oxygen supply. This produces lactic acid as a by-product of anaerobic respiration. The lactic acid builds up and brain cells begin to die. A hypoxic-anoxic injury occurs when the flow of blood is disrupted, essentially starving the brain and preventing it from performing vital biomechanical processes. With complete cessation of oxygenation, the cells of the brain begin to die in approximately 4 to 6 minutes. Brain-cell death is not reversible. When oxygen deprivation is severe enough, a profound hypoxic-anoxic brain injury results via this mechanism of injury. This is what happened to Donell Washington as a result of his being without an adequate airway for approximately 46 minutes during the Code Blue. Subsequent workup confirmed this diagnosis of hypoxic-anoxic encephalopathy. . . The brain damage is permanent and quite severe. (CR).

This detailed causation opinion, linking the Hospital and its staffs' failures to Donell Washington's injury, is not a conclusory assumption as asserted by the Hospital. Instead, it methodically links the Hospital's failure to provide appropriate airway equipment and its failure to ensure training and procedures regarding the equipment were in place to the

resulting failed intubation of Donell and his resulting severe and permanent brain damage. This is precisely what is envisioned under Chapter 74 and the trial court and appellate court were correct in affirming the sufficiency of this causation opinion.

The Washingtons' expert reports constitute a good faith effort to inform the Hospital of the specific conduction complained of, the failure to (1) have specialized intubation equipment at the time the Code Blue was called; and (2) have and/or enforce policies, protocols and procedures for ensuring staff members are aware of and trained to utilized such equipment. Dr. Panacek's report also causally links these failures with the oxygen deprivation and resulting brain injury suffered by Donell Washington. The Hospital's Petition lacks any basis for overturning the trial court and appellate court decisions finding these reports sufficient to satisfy the requirements of Chapter 74. Tex. Civ. Prac. & Rem. Code §74.351.

CONCLUSION

Navarro Hospital's Petition for Review lacks any issues warranting review by this Court. The court of appeals properly affirmed the trial court's determination that the Washingtons' expert reports satisfy the

requirements of Chapter 74 and properly denied the Hospital's motion to dismiss. For these reasons, the Washingtons respectfully ask this Court to deny the Hospital's Petition for Review.

Respectfully submitted,

By: */s/ Leigh Prichard Bradford*

Leigh Prichard Bradford
State Bar No. 24027752
Kirk Pittard
Texas State Bar No. 24010313
Leighton Durham
Texas State Bar No. 24012569

KELLY, DURHAM & PITTARD, LLP
P.O. Box 224626
Dallas, Texas 75222
Telephone: (214) 946-8000
Facsimile: (214) 946-8433
kpittard@texasappeals.com
ldurham@texasappeals.com
lbradford@texasappeals.com

and

James E. Girards
State Bar No. 07980500

THE GIRARDS LAW FIRM
10000 N. Central Expy., Suite 750
Dallas, Texas 75231
Telephone: (214) 720-0720
Facsimile: (214) 720-00184
jim@girardslaw.com

Attorneys for Respondents

CERTIFICATE OF COMPLIANCE

This document complies with the typeface requirement of Tex. R. App. P. 9.4(e) because it has been prepared in conventional typeface no smaller than 14-point for text and 12-point for footnotes. This document also complies with the word-count limitations of Tex. R. App. P. 9.4(i) because it contains 4,303 words, excluding any parts exempted by Tex. R. App. P. 9.4(i)(1).

/s/ Leigh Prichard Bradford
Leigh Prichard Bradford

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument has this date been sent to all attorneys of record in the above-styled and numbered matter, said service being effected in the following manner:

Certified Mail/Return Receipt Requested	_____
Hand Deliver	_____
Telecopy	_____
Electronic Filing	xxxxxx
Regular Mail	_____

DATED: September 16, 2014

/s/ Leigh Prichard Bradford
Leigh Prichard Bradford