Mark H.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

JAMES H. HARPER, Administrator of the Estate of Sharon A. Harper, deceased,	)	
Plaintiff,	)	
v.	)	C.A. 90-0100-R
IVAC CORPORATION,	)	
Defendant.	)	

MEMORANDUM OPINION

This matter is before the Court on plaintiff's motion to alter or amend judgment, pursuant to Rule 59(e) of the Federal Rules of Civil Procedure. For the reasons enumerated below, this motion is DENIED.

BACKGROUND

On August 10, 1990, this Court held a hearing on plaintiff's and defendant's motions for summary judgment. Based on the briefs, affidavits, and arguments, this Court granted defendant's motion for summary judgment. Plaintiff contends that this decision was in error, and moves the Court to set aside that judgment. In particular, plaintiff alleges five points of error. They are: 1) this Court's finding of intervening negligence was inadequate to grant summary judgment, because the intervening negligence was not superseding; 2) this Court erred in finding that the 230 machine did not proximately cause Sharon Harper's death; 3) this Court

failed to rule on the sufficiency of defendant's responses to plaintiff's requests for admissions; 4) this Court erred in finding that the plaintiff's summary judgment motion relied on defendant's admissions; and 5) Court erred in giving defense counsel leave to file late responses to discovery.

FACTS

On May 18, 1983, Sharon A. Harper died in the Portsmouth Naval Regional Medical Center of an apparent overdose of intravenous Lidocaine. Ms. Harper had come to the hospital complaining of chest pain and shortness of breath. She was treated in the emergency room with a Lidocaine injection and a Lidocaine I.V. A maintenance I.V. was started in her other arm. After her condition stabilized, she was moved to another room. Although the identity of the I.V. controller is contested, the Court assumes for the purpose of defendant's summary judgment motion that Ms. Harper's I.V. was controlled by an IVAC 230 machine before she was moved.

After she was moved, Ms. Harper was found in distress with two gravity-fed, manually controlled I.V. bags in place. One, filled with saline, had the manual clamp nearly closed. The other, filled with Lidocaine, had the manual clamp wide open. Investigation revealed that Corpsman Holdsbrook had opened the door of the IVAC 230, completely removed the I.V. tube from the machine, and turned the machine off. The disconnected IVAC 230 was found turned off, with no tubes in place.

Certain other facts are essentially uncontested. All IVAC

230's sold to the Portsmouth Naval Medical Center had inscribed on the door latch "CLOSE I.V. CLAMP BEFORE OPENING DOOR." Nurse Pierce, who was in charge of Ms. Harper knew the dangers of Lidocaine over-infusion and the danger of "free-flow" when an uncontrolled I.V. line is left with the clamp wide open. Corpsman Holdsbrook was not allowed to disturb medicated I.V. lines.

DISCUSSION OF LAW

A. Intervening and Superceding Negligence

Plaintiff contends that defendant was negligent in failing to provide adequate warnings and incorporate a pinch-off mechanism. The adequacy of the warning provided is sharply contested, and this Court is inclined to find that the warning given by defendant is adequate as a matter of law. See Pfizer v. Jones 221 Va. 681, 272 S.E.2d 43 (1980). Nonetheless, even assuming that the warning was inadequate, the Court finds that the actions of the corpsman in disconnecting the IVAC 230 constituted intervening and superseding negligence.

Under Virginia law, there must be a continuing and unbroken sequence between the negligence and the harm. Beale v. Jones, 210 Va. 519, 171 S.E.2d 851 (1970); Wallace v. Jones, 168 Va. 38, 190 S.E 82 (1937). Intervening negligence must supersede the defendant's negligence, if any, and not derive from it. APV Crepaco, Inc. v. Alltransport Inc., 683 F.Supp. 1031 (E.D.Va. 1987) (finding that failure to inspect containers did not cause accident). The Virginia case of Banks v. City of Richmond, 232 Va.

130, 348 S.E.2d 280 (1986), is instructive. There, the Virginia Supreme Court considered an explosion caused when a maintenance man used a cigarette lighter to search for a gas leak. The Court found that the City's negligence in failing to turn off the gas was insulated and superseded by the negligence of the maintenance man. Banks at 136, 348 S.E.2d at 284.

This Court finds the actions of corpsman Holdsbrook analogous to those of the maintenance man in Banks. The actions of the corpsman were grossly negligent and unforeseeable. The corpsman not only opened the door on the machine without closing the clamp, but completely disconnected the I.V. controller. This action led in direct, unbroken sequence to Ms. Harper's death.

Although plaintiff presents some evidence suggesting that IVAC Corporation was aware that the IVAC 230 door was sometimes opened without the clamp first being shut, there is no evidence indicating the defendant could foresee that hospital staff would completely disconnect the machine and leave the I.V. in place. Indeed, based on hospital policy, IVAC Corporation legitimately expected that no Navy corpsmen would adjust or disconnect any medicated I.V.s.

A machine manufacturer has no duty to anticipate that untrained personnel will inore policy to disconnect a critical medical device without assistance. The corpsman's actions were in no way precipitated or caused by defendant's negligence. Plaintiff's have failed to show that any additional warnings or modifications would have prevented the corpsman from disconnecting the machine. His negligence was both intervening and superseding.

B. Proximate Cause

Additionally, the uncontested facts show that any negligence on behalf of IVAC was not the proximate cause of Ms. Harper's unfortunate death. Plaintiff argues that IVAC was negligent in in failing to provide adequate warnings. Additionally, plaintiff contends that IVAC had a duty to install a pinch-off mechanism to shut off flow to the patient when the door was opened. Yet even if the Court assumes that defendant was negligent in both respects, this negligence did not proximately cause the death of Ms. Harper.

Virginia law defines proximate cause as that act or omission which immediately caused or failed to prevent the injury. Banks, 232 Va. at 136, 348 S.E.2d at 284. Ms. Harper died from a free-flow of Lidocaine, which came from a manual I.V. line left with the clamp wide open. At the time this infusion occurred, the IVAC 230 was completely disconnected. The manual I.V. bag was functioning as an independent system. No aspect of the IVAC 230 caused the over-infusion. The machine was completely disconnected.

The corpsman testified that he believed that the IVAC 230 had to be disconnected before the patient was moved. He ignored or failed to see the warning advising him to close the manual clamp before opening the door. Instead, he pulled the entire I.V. tube out of the machine, and shut the machine off. With no controller in place, the I.V. administered a lethal dose of Lidocaine. Under these circumstances, a pinch-off clamp would have no effect. There is no indication that any additional warnings would have mattered.

The machine was disabled before the injury was done. It was not the proximate cause.

CONCLUSION

Both intervening negligence and proximate cause focus on the issue of foreseeability. Plaintiff contends vigorously that defendant could foresee, and indeed had actual notice, that nurses were forgetting to close the manual clamp when the IVAC 230 door was opened. What plaintiff fails to show, and cannot show, is that the specific actions of corpsman Holdsbrook were foreseeable.

The uncontroverted evidence shows that medical personnel were generally aware of the dangers of free-flow, and that corpsmen were not allowed to alter or disconnect medicated I.V.s. The evidence conclusively shows that corpsman Holdsbrook acted contrary to hospital policy, and in an unpredictable and dangerous manner, when he arbitrarily disconnected an I.V. controller without authority or assistance. His actions did not constitute misuse of the machine, but a wanton decision that the machine was completely unnecessary. IVAC Corporation has no duty to prevent their machine from being disabled in this fashion.

REMAINING ISSUES

Granting defendant's motion for summary judgment clearly moots plaintiff's motion for summary judgment, since the uncontradicted facts establish the absence of proximate cause. Even assuming that defendant's responses to plaintiff's requests for admissions were

insufficient, none of the defendant's admissions effect the resolution of summary judgment. Plaintiff's summary judgment motion fails in the absence of proximate cause.

The issue of defendant's late responses to plaintiff's request for admissions has been thoroughly briefed and argued. The standard set forth by Rule 36(b) allows such responses when "the presentation of the merits of the actions will be subserved thereby and the party who obtained the admission" has failed to show prejudice. Plaintiff has admitted that no prejudice exists, thus the sole issue is subserving a presentation of the merits. It is clear that several of the defendant's admissions would serve to compromise a complete presentation of the merits of this case. The Court therefore allowed those admissions to be withdrawn. In any event, this argument is also moot, since none of the admission alter the uncontested facts showing the absence of proximate cause.

Despite small factual differences, both parties agree about the general sequence of events resulting in the death of Ms. Harper. These events reveal that the sole cause of her death was the negligence of corpsman Holdsbrook, not any act or omission of IVAC Corporation. Defendant's motion to alter or amend judgment is therefore DENIED.

Let the Clerk send a copy of this Memorandum Opinion to all counsel of record.

DATE

UNITED STATES DISTRICT JUDGE