

Nos. A031635 and A040205

State of Minnesota
In Supreme Court

Kelci Stringer, individually, and as Personal Representative of the Estate of Corey Stringer, and as Trustee for the Heirs and Next-of-Kin of Corey Stringer, and Kodie Stringer, a Minor, through his Parent and Natural Guardian, Kelci Stringer, and Cathy Reed-Stringer and James Stringer,

Appellants,

vs.

Minnesota Vikings Football Club, LLC, and Fred Zamberletti and Chuck Barta and Paul Osterman and

Respondents,

and

Dennis Green and Michael Tice, and W. David Keowles, M.D. and Mankato Clinic, Ltd., and Sheldon Burns, M.D., and David Fischer, M.D., and Orthopaedic Consultants, P.A., and Edina Family Physicians, a professional association, and Johns Does 6 through 30, Natural Persons or Entities Whose Names or Identities are Unknown to Plaintiff,

Defendants.

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STATEMENT OF ISSUES

Korey Stringer died of heat-stroke during the 2001 Minnesota Vikings training camp. His widow, Kelci Stringer, claimed that Stringer's death resulted from the gross negligence of Paul Osterman and Fred Zamberletti, Viking trainers who were supposed to care for Stringer when he collapsed on the practice field and subsequently lapsed into a fatal coma. She presented evidence, including expert opinions, that Osterman and Zamberletti failed to assess Korey Stringer's condition and failed to provide him with any meaningful care. Did Kelci Stringer present sufficient evidence of gross negligence to create a jury question?

The district court granted summary judgment based on its conclusion that Osterman and Zamberletti did not owe a personal duty to Korey Stringer, and its determination that there was insufficient evidence of gross negligence. The court of appeals rejected the district court's conclusion regarding personal duty, but sustained the judgment by applying a legal definition of gross negligence inconsistent with the Worker's Compensation statute, and this Court's decisions.

Apposite authorities:

Minn. Stat. § 176.061, subd. 5(c)

State v. Bolsinger,
221 Minn. 154, 21 N.W.2d 480 (1946)

State v. Meany,
262 Minn. 491, 115 N.W.2d 247 (1962)

DLH, Inc. v. Russ,
566 N.W.2d 60 (Minn. 1997)

Hardgrove v. Bade,
190 Minn. 523, 252 N.W. 334 (1934)

STATEMENT OF CASE

This action arises out of the death of Korey Stringer, a football player for the Minnesota Vikings. Plaintiff/appellant Kelci Stringer, trustee for Korey's heirs and next of kin, challenges the summary judgment entered by the Hennepin County District Court, the Honorable Gary Larson presiding, in favor of defendants Paul Osterman and Fred Zamberletti.¹

Kelci Stringer sued Osterman and Zamberletti under Minn. Stat. § 176.061, subd. 5(c), which allows a worker or his heirs to sue a "co-employee working for the same employer" for injuries or death resulting from the co-employee's "gross negligence." (A11-37; 38-71.)² The district court granted summary judgment in favor of Osterman and Zamberletti, and other defendants. (A72-174.) The district court allowed Kelci Stringer's claims against Dr. Knowles to proceed; that claim was ultimately settled, and final judgment was entered on September 8, 2003. (A175-77.) Kelci Stringer filed a timely appeal.

The court of appeals found that Osterman and Zamberletti owed Korey Stringer a personal duty under the statute,³ but that Kelci Stringer had offered insufficient evidence of gross negligence. (A1-8.) This Court granted Kelci's Petition for Further Review,

¹ Kelci Stringer sued a number of other defendants. Most of those claims were either settled or dismissed by the trial court. Plaintiff limits her claims in this Court to the gross negligence of Osterman and Zamberletti.

² In this brief, references to "A" are to the Appellants' Appendix.

³ See Wicken v. Morris, 527 N.W.2d 95 (Minn. 1995); Dawley v. Thisius, 304 Minn. 453, 231 N.W.2d 555 (1975); Behr v. Soth, 170 Minn. 278, 212 N.W. 461 (1927).

which challenged the court of appeals' conclusion concerning the gross negligence of Osterman and Zamberletti. (A9-10.) The Court also granted Respondents' Cross-Petition, which raised the personal duty issue.

STATEMENT OF FACTS

A. Overview

On August 1, 2001, Korey Stringer, a Pro Bowl football player in the prime of his career as an offensive tackle for the Vikings, died of complications from heat stroke. Stringer suffered heat exhaustion on July 30, 2001, the first day of the Vikings' 2001 training camp in Mankato, Minnesota, while practicing in dangerously hot and humid conditions. He suffered heat exhaustion while practicing again on July 31, 2001, which progressed into heat stroke. Stringer collapsed on the field while practicing in what the National Weather Service warned would be life-threatening conditions. He died 15 hours after collapsing.

Kelci Stringer presented evidence that Osterman and Zamberletti, members of the Vikings training staff, repeatedly ignored the many classic symptoms of severe heat illness that Stringer exhibited, and failed to offer any meaningful treatment to him. Zamberletti also undertook to treat Korey Stringer without eliciting any history or performing any examination, administering an uncalled-for treatment that actually exacerbated Stringer's already critical condition.

The underlying facts of this case are hotly contested. The following facts are stated in a light most favorable to Kelci Stringer, and are fully supported by the record.

B. The Co-Employees

Paul Osterman and Fred Zamberletti are athletic trainers employed by the Minnesota Vikings. (A205.) Athletic trainers are considered health care providers under Minnesota law, and are licensed by the Board of Medical Practice. Minn. Stat. §§ 148.7802, 148.7808 (2004). Zamberletti was the Vikings' medical services coordinator, and Osterman, an assistant athletic trainer. Both were trained in preventing, recognizing, and treating heat-related illness, including heat stroke. (A229-30; 248.) Osterman and Zamberletti were co-employees of Korey Stringer.

C. The Recognition and Treatment of Exertional Heat Stroke

Exertional heat stroke is a life-threatening medical emergency. (A47.) Classic symptoms of heat stroke include an elevated temperature (normally 104-105°F in the early stages, 106-107°F or higher in the advanced stages), panting like a dog, heavy sweating even after activity has ceased, and an altered mental status characterized by apathy, incoordination, confusion, belligerence, or irrational or bizarre behavior. (A418; 452-53.) The collapse of an athlete usually is a sign of advanced heat stroke, requiring immediate evaluation for cause. (A323; 452-53.) Once heart and respiratory function are confirmed, the next step is to rule out heat stroke by measuring rectal temperature, which is especially important with a football player in full uniform on a day when there are heat warnings. Prolonged observation without evaluation only allows the organs to be exposed to high core temperatures for a longer duration and decreases the chance for survival. (A323-24.)

The standard of care requires an athletic trainer to be able to recognize and treat exertional heat stroke. (A324.) Vikings Head Trainer Chuck Barta admitted: "There are no excuses for heat stroke deaths if the proper precautions are taken." (A210.) The key to successful treatment is early detection and immediate cooling. Every minute counts. (A452-53.) The severity of tissue damage from heat stroke is a function of the severity and duration of the elevated temperature, called "degree-minutes." As the core body temperature rises, the cells and organs begin to overheat. The cell energy systems fail and the cell membranes begin to leak. The greater the degree-minutes, the more extensive the tissue damage and the greater the risk of organ failure. (A323-24.)

The brain, in particular, is a very temperature-sensitive organ and, when it begins to fail, an athlete will collapse to the ground as a protective mechanism to stop continued heat production from exercise. (A323.) By the time an athlete's legs give out and he collapses, core body temperature can be 108°F or higher. (A452.) If the brain remains hot and the hypothalamus is affected, the chance for recovery diminishes. (A323-24.) Permanent brain damage in survivors correlates directly with the duration of hyperthermia and, conversely, survival without brain damage occurs in most patients for whom heat stroke is recognized early and hyperthermia is reduced quickly by appropriate treatment. (A384-85.) The standard of care for treating exertional heat stroke requires immersing the athlete in an ice water tub, calling for an ambulance immediately, and monitoring closely his temperature, mental status, and vital signs. (A314; 471; 453.)

It is undisputed that none of these steps were timely taken by Osterman or Zamberletti. Kelci Stringer asserted in the litigation that the evidence instead showed

that the co-employees were oblivious to Stringer's life threatening condition until it was too late, and guilty of negligence of the grossest kind.

D. Stringer's Known Risk Factors for Heat-Related Illness

At 340 pounds, Stringer was a huge man particularly susceptible to the effects of heat. While with the Vikings, he had a history of significant heat-related illnesses during training camp; the Vikings training staff was fully aware of that history. (A193.) On at least two occasions prior to 2001, Stringer required medical treatment for heat-related illnesses during training camp.

According to Vikings' head coach Mike Tice, heading into the 2001 training camp, Stringer was in the best shape of his career. (A184a-184b.) He was not, however, acclimatized to the heat, a fact that would become immediately obvious once practices began on July 30. Lack of acclimatization is a critical risk factor for heat-related illness. (A317.) The risk of exertional heat stroke rises in unacclimatized people who, with unaccustomed exertion in high relative humidity and intense heat, can raise their core temperature to dangerous levels in 20 to 30 minutes. (Id.) Any qualified athletic trainer would appreciate that Stringer was an "at-risk" player given his history of heat-related illness, his size, and his lack of heat acclimatization. (A319-20; 341-42.)

Defendants' own expert, Dr. E. Randy Eichner, M.D., has written that teams must "bird-dog the big guys," particularly "on Day 1 or 2 of two-a-days," and assume that "huge linemen can be heat bombs." (A541-53.) These risk factors are exacerbated by practicing in extremely hot weather, particularly in full uniform. Wearing full football gear causes large fluid loss and inhibits evaporation needed for cooling. (A319-20; 452.)

Even football players given free access to water replace only one-half of the fluid volume lost during practice. Without monitored rehydration, there can be no assurance of return to a properly hydrated state. (A419; 452.) Moreover, as defendants' expert Dr. Eichner has noted, hydration, though critical, is "not sufficient to prevent heat stroke." (A452.)

E. Stringer's Episode of Heat Exhaustion on July 30

At 4:45 p.m., on July 30, 2001, while the Vikings were practicing, the temperature, dewpoint, and heat index were the highest recorded in Mankato on any training camp date during the previous decade. (A705-06.) During that practice, offensive line coach Mike Tice noticed that Stringer seemed to be struggling and looked sluggish. Stringer was slow getting back in line, not his usual talkative self, and wore an anguished look on his face. Stringer told Tice his stomach was "killing" him. (A185-86.) Soon, Stringer was doubled over, throwing up. (A467.) Vomiting is a common symptom of heat exhaustion and can be an early sign of heat stroke. (A452.) When Stringer threw up again, Tice called for an athletic trainer and removed Stringer from practice.

Chuck Barta responded to Tice's call. (A194-95.) As Barta walked toward Stringer, Stringer vomited again. (Id.) Barta talked briefly with Stringer, who looked sick and again complained of an upset stomach. Barta told Stringer he should go to the trailer near the field to cool down. (Id.) After a minute or two, as they talked, Stringer vomited again. (A198.) At that point, Barta led him to the trailer. (Id.)

Barta walked inside the trailer with Stringer. Zamberletti already was there assisting Fred Robbins, a defensive lineman who, like Stringer, was suffering from heat-related illness. Barta told Zamberletti that Stringer had been vomiting and was being

brought to the trailer “to cool down.” Once inside the trailer, Barta left Stringer with Zamberletti. (A198.) Zamberletti attended to Robbins, but not to Stringer, although he spoke to and observed Stringer. (A247.)

Osterman was also in the trailer when Stringer entered. (A231.) Osterman did not undertake any assessment of Stringer. (Id.) Osterman did give him some water. (A232.) Osterman also talked briefly to Stringer. Stringer expressed frustration about having to be in the trailer. (Id.)

After returning to the practice field, Barta asked Dr. Knowles, the training camp physician, to check Stringer and Robbins. (A199-200.) When he entered the trailer, Dr. Knowles examined and treated Robbins, who had complained of a headache. Osterman put ice packs on Robbins’ body. (A262-63.) (*See discussion, infra about the failure to provide such treatment to Stringer the following day as he developed fatal heat illness.*) After a while, Dr. Knowles told Osterman he could take both players into the Taylor Center, where the locker room and athletic training room (“ATR”) were located. (A232.) Dr. Knowles’ notes confirmed that Stringer had experienced an episode of heat exhaustion. (A232; 259-60; 537.)

F. Stringer’s Increased Risk of Heat Stroke on July 31, Due to His Heat Exhaustion the Previous Day

July 31, 2001 was predicted to be another high-risk, hot, humid day. Practice was scheduled to begin at 8:45 a.m. That morning, the National Weather Service issued two “heat advisories” for Mankato forecasting heat index values of 105 to 110, as well as a “weather message” for “dangerously hot and humid conditions.” The weather message

stated that “extremely humid conditions will team up with hot weather to produce potentially life-threatening conditions.” Eleven Vikings players, including Stringer, would suffer heat-related illness on July 31. (A209.)

Unlike the previous practice, undertaken in shorts and “shells” (A207-08; 654), on the morning of July 31 Stringer was due to practice in a full football uniform which included a helmet, evaporation-resistant shoulder pads, a dark heat-absorbing jersey, full football pants, and a rubber knee sleeve. (A469.) In the opinion of the experts (both plaintiff’s experts and defendants’ expert), if Stringer returned to full practice on July 31 after having suffered heat exhaustion the previous day, he definitely would be at increased risk of developing exertional heat stroke. (A343-44; 362; 453.) This was especially true if he were to practice in full equipment. In addition, according to defendants’ own expert, Dr. Eichner, an athlete’s over-motivation can be an added risk factor for heat stroke. (A451-53.) Tice testified that, because Stringer had vomited and left practice the previous day, Stringer was motivated to complete the July 31 morning practice, as any athlete of his caliber would be. (A187-88.)

Dr. Eichner (relying in part on articles published by plaintiff’s experts, see n.5, infra), also stated in a published article about heat stroke in sports that “a prime time for heat stroke is the day *after* an exhausting and dehydrating day in the heat,” and teams should “hold them out” unless body temperature is checked and has returned to “normal.” (A451-53.) Even after the player is cleared to resume practicing, he should be monitored by the athletic training staff for signs that heat illness has continued or returned, should be required to take water and cooling breaks, preferably in a shady area, and should be

removed from practice if any symptoms return. (A419-20.) Such monitoring is critical to early detection of heat-related illness, which is vital to successful treatment. (A321-22.)

Osterman and Zamberletti, who were aware of Stringer's episode of heat illness on July 30, failed to act upon that knowledge the following day, as Stringer became critically ill and lapsed into a fatal coma.

G. The July 31 Morning Practice

Stringer reported for practice as scheduled on the morning of July 31. He threw up again during practice. Matt Birk, the Vikings' center, was standing beside him at about 10:25 and saw him vomit clear fluid. (A255.) Stringer returned to practice and turned an ankle at about 10:30. (A202-03.) After checking the ankle, Barta taped it and sent him back to practice. (A204.)

Formal practice ended at 11:10. Barta left the field to bandage a scrape on head coach Dennis Green's knee. Before leaving, he gave his cell phone to Osterman and told him to call Zamberletti in the ATR if "anything comes up." (A228.) The cell phone included a card with emergency telephone numbers. (Id.) Osterman put the phone in his pocket. He never used it to call Zamberletti or Barta, or to dial 911, as the morning's events unfolded. (A218-19.)

After the formal practice ended, Tice put the offensive linemen through additional drills. Stringer performed eight pass protection drills with the other linemen, and then went down on one knee. (A256.) Cory Withrow, another offensive lineman, asked him if he was okay. Stringer grunted, but did not respond. Withrow asked if he wanted a trainer; he thought Stringer shook his head no, but Withrow was not sure. (A250.)

At approximately 11:15 a.m., Stringer walked 40 to 50 yards toward the blocking dummy known as "Big Bertha," but collapsed on the field 20 to 30 feet before reaching it. He rolled first onto his right side, then onto his back, holding his stomach, then his head, and then threw his arms over his head. Stringer remained on the ground up to five minutes, moaning quite audibly the entire time. (A179-80.) A photograph taken at approximately 11:15 a.m. shows Stringer lying on the ground with a washed-out appearance and pale blue palms and lips. (A469.) Stringer was making a "deep, agonizing groan" while on the ground. (A181; 240.) Birk asked Stringer if he wanted an athletic trainer. This time, Stringer said "yes." (A257.) Withrow thought to himself "something is wrong" and called out "trainer." (A251.) Billy Robin McFarland, the photographer, could tell that Stringer was in trouble. (A183.) At approximately 11:20 a.m., Osterman and intern Dan Kearney responded to the call for a trainer. (A189; 213-14.)

H. The Lack of Care by Osterman and Zamberletti Following the July 31 Morning Practice

McFarland's photograph shows Osterman, wearing sunglasses, standing beside Kearney and peering over the collapsed Stringer. (A469.) Osterman asked Stringer how he was doing, but got no response. (A214.) Osterman did not know, or ask anyone, how long Stringer had been on the ground. (A215; 234-35.) No one from the Vikings helped Stringer while he was on the ground. (A181-82.) On his own, Stringer got to one knee, raised himself up off the ground, and struck at "Big Bertha," pushing through it and walking away. (A252-53.)

Even though he felt Stringer was “fine,” Osterman steered him to the trailer to cool off, instead of to the ATR, where ice water tubs had been set up for cooling players. (A215-16.) Osterman believed that taking Stringer to the trailer was a preventive measure. (Id.) No later than 11:25 a.m., Stringer entered the trailer with Osterman. (A220.) Kearney left to retrieve water for Stringer. (A217.) Stringer sat down on one of the treatment tables inside the trailer. He and Osterman did not speak during Kearney’s absence, and Osterman did nothing for him while waiting for Kearney. (A217.)

Between 11:25 and 11:30 a.m., Kearney arrived with water. He stayed a minute or so, leaving Stringer alone again with Osterman. (A218.) Ten to fifteen minutes had elapsed since Stringer had collapsed to the ground outside.

Osterman said to Stringer, “You need to drink some water, Korey.” Stringer complied, drinking one or two sips. (A218.) Stringer got off the treatment table and lay down on the floor, his first unexplained movement inside the trailer. (Id.) Despite his training, and notwithstanding Stringer’s uncharacteristic detachment (which was markedly different from Stringer’s behavior the prior day when Osterman saw him in the trailer suffering from heat illness, and Stringer expressed his frustration to Osterman), Osterman did not ask Stringer any questions, try to secure a history, check any of Stringer’s vital signs, or otherwise examine him. (Id.) He just “let Korey relax” for ten minutes. (Id.)

Between 11:35 and 11:40 a.m., ten minutes after Kearney left and while Stringer still was on the floor, Stringer sat up and asked Osterman to take off his shoes and socks

and cut off his tape, which took Osterman two minutes or “a little longer.” Stringer said “Thank you.” These were the last words he spoke. (A219-20.)

Osterman still had not done any kind of assessment of Stringer’s condition (A220), even though he noticed Stringer was still sweating in a cool trailer almost a half-hour after ceasing significant activity. (A219; 222.) Osterman thought “everything was normal.” (A222.) Osterman did not consider placing ice (located just outside the trailer) on Stringer (which had been done for Fred Robbins the day before when he was being treated for heat-related illness) or fanning him. Osterman thinks Stringer drank some more water during this period. (A221.)

Stringer got up off the floor and sat on the table again, his second unexplained movement inside the trailer. At approximately 11:47 a.m., Stringer began “humming” to himself and bobbing his head back and forth to the “music.” This went on for a few minutes. (A220.) In a statement written shortly after the events, Osterman stated that Stringer also moved his arms in time to the “music.” Osterman did not view this behavior or Stringer’s detachment as signs of altered mental status. (A220-21.)

Ten minutes “or longer” after Osterman finished removing Stringer’s shoes, socks, and tape, Osterman called the ATR and asked one of the athletic trainers to bring the cart to pick up Stringer. At least 20 minutes, “maybe more,” had passed since they entered the trailer. Osterman said, “Korey, we’re going to bring the cart here and we’re going to take you inside.” Stringer did not respond. Osterman said nothing else to him. (A221.) Despite an almost complete lack of communication with Stringer, Osterman still did not

believe anything was seriously wrong. (A222.) Osterman called for the cart simply as a matter of procedure. (A221.)

Before the cart arrived, Stringer got off the table again, still without saying anything, and went over toward the trailer door, and lay down again. (A222.) This was his third unexplained movement in the trailer. Stringer had said nothing since "thank you" at least ten minutes earlier. Osterman still did not view Stringer's detachment or unexplained movements as signs of altered mental status. Osterman testified that he believed he may have applied an ice towel to Stringer's head after Stringer lay on the floor for a while, but Stringer pushed it away without saying anything. If in fact Osterman did this, it was his only attempt to cool Stringer beyond taking him to the air-conditioned trailer. (A219; 222.)⁴

It took five to ten minutes for Kearney to arrive with the cart. (A222.) Osterman estimated that thirty minutes had elapsed since Osterman and Stringer entered the trailer. Osterman said, "Korey, the cart's here. Let's get up." But Stringer was "unresponsive" and "semi-conscious," and did not move. (A223.) Osterman testified, "That was the first sign that something was going wrong. . . . I really wasn't sure what was going on at that point. I was pretty confused." (A224.)

Osterman and Kearney tried to lift Stringer, but could not do it. (A223.) Instead, they rolled him onto his side. Osterman said to Kearney, "Hurry up. Get me some ice

⁴ The cooling effect from sitting in an air-conditioned trailer was dramatically insufficient to effectively lower Stringer's body temperature during this critical time period. Stringer's cooling rate in the trailer was calculated at 0.01 to 0.02 of a degree F. per minute. (A447.)

towels and go get Fred.” At this point, Osterman was concerned that Stringer was “going into” heat exhaustion. (A223-24.) Osterman’s belated concern was also misplaced. Heat exhaustion often precedes heat stroke; collapse and stupor, however, are signs of advanced heat stroke, well past heat exhaustion. (A453.)

After at least 30 minutes in the trailer with Stringer, Osterman finally checked Stringer’s pulse; he did not count the beats, and thought Stringer’s pulse was “weak” but “steady.” (A224.) Osterman did not take Stringer’s temperature or even consider doing that. (A224.) Stringer was still sweating after thirty-five minutes in the trailer and his skin felt “cool and moist.” (A225.) Wet skin accompanying an athlete’s collapse is considered an advanced feature of exertional heat stroke. (A453.) Osterman still took no steps to cool Stringer.

When Kearney arrived at the ATR (where Zamberletti was supposed to be), Zamberletti was not there. Kearney instead found him in the equipment manager’s office, about 100 feet from the ATR. (A243.) From the time Osterman dispatched Kearney, it took several minutes, perhaps as long as five, for Kearney and Zamberletti to arrive back at the trailer. (A238-39.) As the cart pulled up, Stringer’s breathing became shallow and speedy. (A226.) Osterman did not tell Zamberletti anything about what had occurred or how long Stringer had been in the trailer. (Id.) Nor did Zamberletti ask Osterman any questions. Observing that Stringer’s breathing was rapid and shallow, Zamberletti said, “Oh, he’s hyperventilating.” (A226; 242.) Zamberletti thought Stringer had “just fainted” or experienced a seizure from “an insect bite” or “some medication.” (A246.) Without eliciting a history or any information about Stringer’s condition,

Zamberletti instructed Kearney to put a plastic zip-lock bag over Stringer's nose and mouth and hold it there, which Kearney did for about a minute and a half. (A226; 239.) Stringer's breathing did not improve. (A239.)

Zamberletti told Osterman to go outside and "call the van." (A244.) Osterman called a public relations intern and asked her to bring the PR van to take Stringer to the hospital. After Osterman returned from calling for the van, Zamberletti told him, "Get Dr. Knowles on the telephone." (A245.) Osterman called Dr. Knowles, but only spoke to his nurse, who said she would have him call Zamberletti. (A226.) Shortly thereafter, Dr. Knowles called back and spoke to Zamberletti, who said he was "bringing Korey in." (A245-46.) Dr. Knowles said, "Go directly to the emergency room." (A246.) From the time Zamberletti sent Osterman out to call for the van until the end of his conversation with Dr. Knowles, three or four more minutes passed. (Id.) Osterman suggested calling for an ambulance. (A226.) Zamberletti walked back inside the trailer and, seeing that Stringer was "not responding" to the "bagging," finally told Osterman, "Call for the ambulance." (A246.)

Osterman finally called for an ambulance at 12:00 noon, about 45 minutes after Stringer's collapse due to heat stroke. At this point, Osterman thought Stringer's condition was "kind of disturbing" (A226), noting a "glazed stare" in Stringer's eyes. (A227.) While waiting for the ambulance, Osterman, Zamberletti, and Kearney did nothing to help cool Stringer or give him any other aid.

On the way to the hospital, approximately an hour after Stringer had ceased activity, his pulse rate was a rapid 140 beats per minute and he was comatose. The

ambulance arrived at the hospital at 12:24 p.m. At 12:35 p.m., Stringer's body temperature was finally checked. It measured 108.8°F. (A538-50.) Thirteen hours later, at 1:40 a.m. on August 1, 2001, Stringer died of complications from heat stroke. (A528.)

I. The Experts' Opinions Concerning the Gross Negligence of Osterman and Zamberletti

1. Osterman

Kelci Stringer presented detailed expert opinions from well-qualified professionals⁵ establishing that there were abundant signs, evident when Stringer was still on the field and while he was in the trailer but not yet comatose, that he was suffering from heat stroke, but Osterman inexplicably failed to recognize any of them. Two of plaintiff's experts opined that Osterman's direct contact with Stringer on July 31 "was marked by an incredible inability to recognize what was taking place and what needed to be done." (A457; 522.) To support this, plaintiff's experts documented 25 acts and

⁵ Plaintiff's experts were eminently qualified to render their opinions. William Roberts, M.D., is President of the American College of Sports Medicine, and writes the weather practice guidelines for the Minnesota State High School League. (A736-38.) James P. Knochel, M.D., is board certified in internal medicine and has written and taught extensively on heat-related illness, including a 1975 article: "Dog days and siriasis. How to kill a football player." (A386-415.) Pope L. Moseley, M.D., M.S., is one of the nation's leading authorities on the impact of heat on people. (A424-45.) Mark Popil, M.D., F.A.C.E.P. is a board certified emergency room physician with extensive experience treating heat stroke, in both a field and hospital setting. (A347-50.) E. Lee Rice, D.O., F.A.A.F.P., F.A.C.S.M., F.A.O.A.S.M., is a team physician, including formerly for the San Diego Chargers; he has extensive experience evaluating and treating players for heat illness. (A366-81.) Frank Grimaldi, Jr., MSED, ATC/L is an athletic trainer with similar experience dealing with heat illness. (A357-60.) The Defendants' expert, Dr. Eichner, relies upon the Knochel article and a Roberts article in his article: "Heat Stroke in Sports: Causes, Prevention, and Treatment." See p. 20, infra.

omissions by Osterman during the hour he spent with Stringer – most of it alone – following the player’s collapse.

In chronological order, Osterman (1) gathered no history or information about why Stringer was on the ground; (2) failed to recognize Stringer’s pallor; (3) attached no significance to his labored breathing and audible groans on the ground, which lasted up to 5 minutes; (4) attached no significance to Stringer’s collapse; (5) attached no significance to Stringer’s non-responsiveness on the ground; (6) gave no help to Stringer on the ground; (7) failed to prevent Stringer from practicing more after the collapse; (8) failed to note Stringer’s uncoordinated strike at Big Bertha or his gait while stumbling through and away from it; (9) personally directed Stringer to the trailer, not to the Taylor Center where ice water immersion was available; (10) did not check, monitor or measure Stringer’s vital signs or temperature; (11) did not note the significant difference in Stringer’s demeanor versus the previous day (*i.e.*, his desire not to be in the trailer on July 30 versus his apathy, detachment, and stupor on July 31); (12) engaged in no conversation or real interaction with Stringer (other than removing his tape, shoes, and socks when requested), asking him no questions to gauge lucidity; (13) instituted no effective cooling methods, only *possibly* an ice towel after Stringer was lapsing into a coma, stopping that when Stringer pushed it away; (14) attached no significance to Stringer’s unexplained back-and-forth table/floor movements; (15) made no use of the bags of ice just outside the trailer; (16) did not use his cell phone to tell anyone of Stringer’s on-field collapse; (17) delayed 20 minutes before calling for the cart to transport Stringer; (18) delayed at least 40 minutes before calling for an ambulance; (19)

attached no significance to Stringer's continuing deterioration and heavy sweating so long after stopping activity; (20) misinterpreted Stringer's head movements and noises as "music" instead of disorientation and detachment; (21) allowed himself to become "pretty confused" about what was happening to Stringer; (22) sent Kearney to get Zamberletti when Stringer became non-responsive and semi-conscious, instead of calling 911; (23) gave no information to Zamberletti about Stringer's condition when he arrived; (24) responded to Stringer's non-responsiveness by making time-wasting phone calls, first for a van to drive Stringer to the hospital and second to Dr. Knowles' office, rather than immediately calling 911 (almost 10 minutes passed between the time Stringer became non-responsive and the time Osterman called for the ambulance); and (25) performed no cooling while awaiting the ambulance. (A457-59; 522-24.)

Osterman's inaction was so "glaring," his conduct "so far below the standard of care," that Dr. Pope Moseley concluded Osterman had "breached the standard of care in every way possible." (A417; 421.) According to Dr. Knochel, another of plaintiff's experts, these acts and omissions "show that Paul Osterman did not recognize the signs of heat stroke, much less know what to do when those signs confronted him," all of which are "inexcusable acts for an athletic trainer." (A459.) Dr. Roberts opined that Osterman's "failure to diagnose Stringer's condition and its underlying cause, and to take effective steps towards dealing with the most likely cause is inexplicable and defies any rational explanation." (A325.) Despite the many symptoms and warning signs that Stringer exhibited on the field and in the trailer, and the fact that Osterman knew Stringer had suffered heat exhaustion the prior day, and had been practicing for two and one-half

hours in dangerous weather conditions, Osterman did no meaningful evaluation for heat stroke following Stringer's collapse. As a result, Stringer suffered the consequences of being too hot for too long – he died. (A323-24.)

Frank Grimaldi, an athletic trainer with 25 years of experience, agreed that Osterman “completely failed to assess the situation on the field” and that, “[o]nce in the trailer, Osterman did no examination to see what was wrong with Stringer.” (A353-54.) Grimaldi described simple tests that Osterman could have performed and the signs that Stringer was exhibiting, all of which pointed to something wrong and the need for emergency assistance. (A354.) He also noted that Osterman had every opportunity, with the cell phone in his pocket, to seek assistance. (*Id.*) Grimaldi concluded that Osterman “demonstrated a complete lack of care in dealing with Stringer.” (A356.)

Even the published views of defendants' expert, Dr. Eichner, support a claim that Osterman was grossly negligent. Dr. Eichner's article (which relied on studies performed by Dr. Knochel and Dr. Roberts, *see n.5 supra*) noted that heat stroke always is a threat when athletes exert themselves in temperatures above 80 degrees and humidity above 40 percent, conditions that were surpassed in Mankato on July 30 and 31. Dr. Eichner stated that “heat stroke is often slow to evolve,” but that “the vigilant observer can detect early warning signs and avoid the worst outcome.” (A452.) Vomiting and altered mental status are early warning signs; collapse usually a late one. Stringer exhibited all three, but Osterman paid no attention. In treating heat stroke, “every minute counts. . . . No faster way to cool exists than dumping the athlete into an ice water tub . . . With fast cooling, survival rate approaches 100%.” (A453.) But Osterman instituted no cooling measures.

The symptoms of advanced heat stroke are “collapse with wet skin, core temperature over 106-107°F and striking CNS changes,” including delirium, stupor, and coma. (A452.) Stringer exhibited these signs, but Osterman still failed to recognize that he was suffering from heat stroke.

2. Zamberletti

Zamberletti shared in Osterman’s inexplicable and fatal failure to diagnose and treat Stringer’s condition. Grimaldi opined: “When Zamberletti arrived, he should have immediately recognized the serious nature of the situation and sought emergency medical assistance. Zamberletti took no effective steps to assess Stringer’s condition or its root cause.” (A355.) In particular, Grimaldi noted, Zamberletti failed to secure a history from Osterman.

Having no idea what caused Stringer’s condition or what treatment had occurred before he arrived, Zamberletti undertook wholly contraindicated therapy, ordering Kearney to hold a plastic bag over Stringer’s nose and mouth, which Kearney did for about one and a half minutes. Grimaldi opined that, both separately and in combination, the additional delay in securing appropriate treatment and the pursuit of contraindicated therapy substantially contributed to Stringer’s death. (A356.) Grimaldi also noted that Zamberletti completely failed to consider heat stroke as the most likely cause of Stringer’s condition, assuming instead that he was suffering from a fainting spell, a seizure, or an insect bite. While Zamberletti instituted a harmful therapy and wasted time calling for a van and telephoning Dr. Knowles’ office instead of summoning an ambulance, Stringer’s heat stroke continued to ravage his body. (A355.)

Plaintiff's medical experts substantiated the additional injury done by Zamberletti's ill-conceived and contraindicated "bagging" of Stringer. Dr. Knochel stated that this action "would impair oxygen intake and reduce carbon dioxide removal, causing, respectively, cerebral hypoxia and respiratory acidosis and would serve as a means to further aggravate the brain injury that occurs with heat stroke." (A383.) Dr. Moseley concurred, adding, "This maneuver likely worsened Mr. Stringer's acidosis and also contributed to Mr. Stringer's death." (A422.) In addition, since "outcome is inversely related to the time the subject spends with an elevated temperature, this delay significantly affected Mr. Stringer's outcome." (A422; see also 345; 364; 325.)

As with Osterman, these experts opined that Zamberletti's conduct went far beyond mere negligence. Grimaldi described it as "a complete lack of care in dealing with Stringer." (A356.) Dr. Knochel described Zamberletti's acts as "inexcusable." (A460.) Dr. Lee Rice, a former NFL team physician and another plaintiff's expert, opined that Zamberletti's actions "represent a totally unacceptable failure to meet even the most minimal level of competence by an athletic trainer." (A364.)

ARGUMENT

Summary of Argument

Korey Stringer's death, and the events that led to it, received massive publicity. The public was incredulous over Stringer's death, and for good reason. Heat-related deaths are completely preventable. Vikings head trainer, Chuck Barta, agreed that there are "no excuses for heat-stroke deaths" if proper precautions are taken. One of defendants' own experts, Dr. Randy Eichner, has written that "[e]arly recognition and fast treatment of evolving heat-stroke can save lives." Yet Korey Stringer died from exactly this preventable condition.

Plaintiff's experts identified numerous and egregious failures committed by Osterman and Zamberletti. Among the most glaring were Osterman's failure to take Stringer's temperature (108.8° when taken at the ER), monitor his mental and physical status, take any effective steps to cool Stringer, or even call 911 on the cell phone in his pocket when he was "confused" by Stringer's situation. Osterman admittedly failed to observe any signs of heat-stroke (signs which were readily apparent), and thought everything was "normal" until Stringer lapsed into a fatal coma. Zamberletti, whom Osterman finally sent for, directed that a plastic bag be placed over Stringer's mouth and nose while Stringer lay unconscious on the floor. Zamberletti never asked Osterman what happened, and did not secure a history or undertake any examination; instead, he assumed that Stringer was "hyperventilating," perhaps from a bug bite. Zamberletti's conduct (cutting the oxygen flow to Stringer's dying brain) not only failed to help Stringer's condition, but in the opinion of several experts, exacerbated it, contributing to

Stringer's death. Based upon these and other errors and omissions, plaintiff's experts concluded that Osterman and Zamberletti had demonstrated a complete lack of care in treating Stringer.

The Legislature has unambiguously provided that an employee can recover from a co-employee upon showing that "the injury resulted from the gross negligence of the co-employee or was intentionally inflicted by the co-employee." Minn. Stat. § 176.061, Subd. 5(c) (2004). In using the phrase "gross negligence" as an alternative basis for co-employee liability, the Legislature recognized the difference between intentional or even willful misconduct, and grossly negligent conduct. See Minn. Stat. § 645.17(4) (2004); Prior Lake Am. v. Mader, 642 N.W.2d 729, 737 (Minn. 2002) (citations omitted) ("Words and phrases which have acquired an established meaning by judicial construction are deemed to be used in the same sense in a subsequent statute relating to the same subject matter.") In this case, however, the lower courts ignored the Legislature's carefully articulated legal standard and evaluated plaintiff's evidence under a far different and much more restrictive test.

I. STANDARD OF REVIEW

This Court reviews the granting of summary judgment *de novo*. Summary judgment is properly granted when the record shows no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Minn. R. Civ. P. 56.03 (2003); DLH, Inc. v. Russ, 566 N.W.2d 60, 69 (Minn. 1997). It is not the trial court's function to decide factual issues, but to determine if any exist. Id. at 70. Both the trial court and a reviewing court must view the facts in a light most favorable to the

nonmoving party, drawing all reasonable inferences in that party's favor. Id. at 69; Fabio v. Bellomo, 504 N.W.2d 758, 761 (Minn. 1993).

The function of the reviewing court is to determine whether there are any genuine issues of material fact and whether the trial court erred in its application of the law. Betlach v. Wayzata Condo., 281 N.W.2d 328, 330 (Minn. 1979). The reviewing court need not defer to the district court's decision on issues of law, such as the existence of a duty or the construction of a statute. Kornberg v. Kornberg, 542 N.W.2d 379, 384 (Minn. 1996).

II. PLAINTIFF SUBMITTED SUFFICIENT EVIDENCE TO ESTABLISH THAT KOREY STRINGER'S ILLNESS AND DEATH RESULTED FROM THE CO-EMPLOYEES' "GROSS NEGLIGENCE"

In Behr v. Soth, 170 Minn. 278, 212 N.W. 461 (1927), this Court held that an employee may bring an action against a co-employee for the latter's negligence. In 1979, the Legislature narrowed the right of an injured worker to sue a fellow employee, limiting such claims to those arising out of the co-employee's gross negligence or intentional conduct. "A co-employee working for the same employer is not liable for a personal injury incurred by another employee unless the injury resulted from the gross negligence of the co-employee or was intentionally inflicted by the co-employee." Minn. Stat. § 176.061, subd. 5(c) (2004). Although it narrowed the grounds for liability of co-employees, the Legislature nonetheless expressly provided a tort remedy for Minnesota employees injured by the gross negligence of their fellow workers. The courts are obligated to give effect to that legislative judgment, and may not limit or frustrate the statute based on judicial perceptions of public policy. See Pususta v. State Farm Ins.

Cos., 632 N.W.2d 549, 552 (Minn. 2001) (stating the court's primary objective when interpreting a statute is to give effect to the legislature's intention as expressed in the statute's language).

The question presented by this appeal is not whether Kelci Stringer showed gross negligence as a matter of law. It is whether, viewed in a light most favorable to plaintiff, the evidence submitted would support a jury verdict finding gross negligence under the statute. The answer clearly is “yes.”

A. The Correct Legal Definition of “Gross Negligence”

Over 100 years ago, this Court recognized that gross negligence fell between ordinary negligence and willful and wanton misconduct. Sloniker v. Great N. Ry. Co., 76 Minn. 306, 308, 79 N.W. 168, 169 (1899). This view was affirmed in Wirig v. Kinney Shoe Corp., 461 N.W.2d 374, 381 (Minn. 1990) (distinguishing defendant’s conduct as “constitut[ing] gross negligence but not negligence rising to the level of willful indifference”). Despite that distinction, the court of appeals held: “Respondents’ actions may reflect poor judgment or lack of reasonable care, but there is no basis to conclude respondents disregarded the risk to Stringer altogether in a manner ‘equivalent to willful and intentional wrong.’” Stringer v. Minn. Vikings Football Club, 686 N.W.2d 545, 552 (Minn. Ct. App. 2004) (quoting State v. Chambers, 589 N.W.2d 466, 478 (Minn. 1999)). But the court of appeals analyzed the statute with one eye closed - liability exists for gross negligence *or* willful and intentional harm, dramatically different legal standards. Under the proper gross negligence standard, plaintiff presented a clear jury issue.

1. Case Law Defines “Gross Negligence” Differently Than Did the Lower Courts

Minnesota appellate courts have defined gross negligence as “negligence in a very high degree,” Dakins v. Black, 195 Minn. 91, 94, 261 N.W. 870, 872 (1935), “negligence of the highest degree,” High v. Supreme Lodge of the World, 214 Minn. 164, 170, 7 N.W.2d 675, 679 (1943), and “something between ordinary negligence and reckless conduct.” State v. Bolsinger, 221 Minn. 154, 160, 21 N.W.2d 480, 485 (1946); see also State v. Brehmer, 281 Minn. 156, 161, 160 N.W.2d 669, 673 (1968) (defining gross negligence “as a very high degree of negligence. . . . Negligence, even though extreme negligence, is all that is required”).

In State v. Meany, 262 Minn. 491, 495, 115 N.W.2d 247, 251 (1962), this Court noted that the meanings of the terms “reckless” and “grossly negligent” were “exhaustively reviewed” in Bolsinger, in the criminal context.

Briefly stated, we concluded that “grossly negligent,” as used in our criminal negligence statute, means with very great negligence or without even scant care but not with such reckless disregard of probable consequences as is equivalent to a willful or intentional wrong.

Id. at 496, 115 N.W.2d at 252 (citing Bolsinger, 221 Minn. 154, 21 N.W.2d 480). Although it is beyond ordinary negligence, gross negligence still is a species of negligence and of a less aggravated character than willful and wanton conduct and deliberate indifference. The court of appeals got off the track of these cases, however, and ended up with a definition of “gross negligence” for this case that is totally at odds with prior law.

The court of appeals initially noted that this Court “first provided a detailed definition for gross negligence” in Bolsinger, which quoted and adopted a Massachusetts decision, Altman v. Aronson, 121 N.E. 505, 506 (Mass. 1919). Stringer, 686 N.W.2d 551-52. The court of appeals then stated that Bolsinger’s definition of gross negligence has been applied to co-employee cases such as this. Id. at 552 (citing Ackerman v. Am. Family Mut. Ins. Co., 435 N.W.2d 835, 840 (Minn. Ct. App. 1989)). Next, the court asserted that this Court “revisited the gross negligence standard” in Chambers, adding: “Based on a narrow indirect quotation from Bolsinger, the Chambers court defined gross negligence as action ‘without even scant care but not with such reckless disregard of probable consequence as is equivalent to a willful and intentional wrong.’” Id. (quoting Chambers, 589 N.W.2d at 478-79).

Left out of the court of appeals’ review of the law was Meany, in which this Court actually said, summarizing Bolsinger, that gross negligence “means with very great negligence *or* without even scant care *but not* with such reckless disregard of probable consequences as is equivalent to a willful and intentional wrong.” Meany, 262 Minn. at 496, 115 N.W.2d at 252 (emphasis added). Chambers quoted only the portion of this language from Meany dealing with scant care or reckless disregard, but did so in the context of rejecting a claim for a lesser included offense. Chambers, 589 N.W.2d at 478-79. The Court clearly was not narrowing the well-established definition of gross negligence.

Bolsinger, Meany, and Chambers all hold that gross negligence does not equal and is of a less aggravated character than willful and intentional misconduct. Nevertheless,

the court of appeals concluded that Kelci Stringer could not prove gross negligence without evidence that defendants acted “in a manner ‘equivalent to a willful and intentional wrong.’” Stringer, 686 N.W.2d at 552. This characterization of gross negligence is so far from the original Bolsinger definition as to be utterly and irretrievably wrong.⁶ By equating gross negligence with willful and intentional conduct, the court of appeals turned around totally the shared language of Bolsinger, Meany, and Chambers. These decisions did not hold that a plaintiff must show “willful and intentional” conduct in order to prove gross negligence. In fact, they said the exact opposite. They confirmed that a plaintiff could prove gross negligence without showing that the defendant acted in a manner “equivalent to a willful and intentional wrong.” By

⁶ Although this arguably is the court of appeals’ most extreme departure from the “gross negligence” definition found in Bolsinger, Meany, and Chambers, it is not the first such departure. For example, in Gabrielson v. Nelson, No. C6-94-1387, 1994 WL 694863, at *2 (Minn. Ct. App. Dec. 13, 1994) (citing an earlier version of the same CIVJIG relied on in this case), the court of appeals, as it did in this case, disregarded the first half of that definition, stating, “For illustrative purposes, gross negligence is demonstrated by a showing that a person acted ‘without even slight care.’” The court of appeals also disregarded the first half of the “gross negligence” definition in Anderson v. ROI Properties, Inc., No. C3-92-2539, 1993 WL 319066, at *2 (Minn. Ct. App. Aug. 24, 1993), stating, as it essentially did in the instant case, “Gross negligence is the absence of even slight care. . . . Gross negligence is, in effect, no care at all.”

To be fair, the court of appeals’ mischaracterizations of gross negligence, as in Gabrielson, Anderson, and this case, have not been a constant. For example, in Beehner v. Cragun Corp., 636 N.W.2d 821, 829 (Minn. Ct. App. 2001), the court of appeals correctly stated that “[g]ross negligence is ‘very great negligence or absence of even slight care, but [it is] not equivalent to wanton and willful’ conduct,” and accurately referred to gross negligence no less than five times as “greater-than-ordinary negligence.” Id. at 830; see also State v. Miller, 471 N.W.2d 380, 383 (Minn. Ct. App. 1991); Ackerman, 435 N.W.2d at 840 (quoting Bolsinger, 221 Minn. at 159, 21 N.W.2d at 485; High, 214 Minn. at 170, 7 N.W.2d at 679).

equating “gross negligence” with “willful and intentional” conduct, the court of appeals contradicted a long line of Minnesota decisions, including not only Bolsinger, Meany, and Chambers, but also a host of other decisions from various areas of Minnesota law.⁷

This distorted reading of the law precludes a finding of gross negligence so long as the defendant took *some* action that might be considered an effort to avoid the harm. This “any care will do” standard allows a wrongdoer to escape liability regardless of how ineffectual or feeble the attempt to exercise care is, or even how harmful it might be. That is not the law nor should it be.

The lower courts erroneously applied this unduly narrow definition of gross negligence so that even the minimal, misguided, and ill-conceived efforts by the defendants do not, *as a matter of law*, rise to the level of gross negligence. Hence the bizarre conclusion that the trifling steps (Osterman touching the comatose Stringer’s forehead with a cold towel) and in some instances the grossly contraindicated actions (Zamberletti’s “bagging”) taken by defendants in response to Stringer’s perilous condition were enough to avoid liability, when in fact they fell miles short of anything approaching reasonable care.

⁷ For example, when considering “willful indifference” in the punitive damages context, the courts drew careful distinctions among the concepts of intentional wrong, willful indifference, and gross negligence/negligence. See Ulrich v. City of Crosby, 848 F. Supp. 861, 868 (D. Minn. 1994) (willful indifference does not equal, and in fact is greater than, gross negligence; citing Minnesota cases); Wirig v. Kinney Shoe Corp., 461 N.W.2d at 381 (willful indifference does not equal intentional conduct); Herbst v. N. States Power Co., 432 N.W.2d 463, 467, 469 (Minn. Ct. App. 1988) (holding that the evidence was sufficient to support a finding of gross negligence but not a finding of willful indifference); Utecht v. Shopko Dept. Store, 324 N.W.2d 652, 654 (Minn. 1982) (willful indifference does not equal negligence).

Gross negligence simply does not equate to the lack of any care at all. Although a defendant's total lack of care may be gross negligence, a plaintiff may also establish gross negligence without showing that the defendant failed to exercise any care at all. By foreclosing a finding of gross negligence unless plaintiff could show that Stringer's co-employees used no care at all in dealing with his condition, the lower courts in effect required Kelci Stringer to prove that Osterman and Zamberletti acted with willful and wanton conduct or deliberate indifference, both of which are higher burdens than imposed by the statute or by this Court's decisions.

2. The Civil JIG on Gross Negligence Is Incomplete and Inaccurate

The district court and the court of appeals were significantly influenced by the definition of "gross negligence" found in the most recent version of the Civil Jury Instruction Guide.

Based on a narrow indirect quotation from *Bolsinger*, the *Chambers* court defined gross negligence as action "without even scant care but not with such reckless disregard of probable consequences as is equivalent to a willful and intentional wrong." *Id.* This definition was later adopted by the Minnesota District Court Judges Association in the guideline jury instruction for gross negligence. *See 4 Minnesota Practice, CIVJIG 25.35 (1999)* ("Gross negligence occurs when a person does not pay the slightest attention to the consequences, or uses no care at all.")

Stringer, 686 N.W.2d at 552. This suggested jury instruction states a significantly narrower definition of gross negligence than is consistent with this Court's decisions.

The notes to CIVJIG 25.35 cite *State v. Chambers*, 589 N.W.2d 466 (Minn. 1999) and quote it as "defin[ing] 'gross negligence' as 'without even scant care'" 4 *Minnesota Practice, Jury Instruction Guides – Civil, CIVJIG 25.35, authorities* (4th ed.

1999). But Chambers in no way suggested that the definition of gross negligence no longer included the alternative formulations “very great negligence” or “negligence of the highest degree.” In fact, as the notes point out, Chambers was quoting State v. Meany, 262 Minn. 491, 496, 115 N.W.2d 247, 252 (1962). Id. Referring to Bolsinger, Meany repeated the formulation of “grossly negligent,” as “*with very great negligence* or without even scant care but not with such reckless disregard of probable consequences as is equivalent to a willful and intentional wrong.” Meany, 262 Minn. at 496, 115 N.W.2d at 252 (emphasis added).

As noted previously in this Brief (supra, at p. 28), Chambers dealt with a murder conviction where the defendant sought a lesser-included offense. The truncated definition of gross negligence in Chambers was used not to announce a change in the law, but rather to distinguish defendant’s conduct, which the Court said was *more* culpable than even the most restrictive definition of gross negligence. See 589 N.W.2d at 478-9. If this Court had meant to dramatically change the law in Chambers, it presumably would have announced its intention to do so. The opinion is silent, however, in that regard.

The Civil JIG is also inconsistent with the Criminal JIGs, which define “gross negligence” as “very great negligence *or* with the absence of even slight care” or similar terms. See, e.g., 10 Minnesota Practice, Jury Instruction Guides – Criminal, CRIMJIG 11.63, 11.69, 18.26 (4th ed. 1999) (emphasis added). This language is consistent with the formulation of gross negligence articulated by this Court in Bolsinger and Meany.

The statement in the Civil Jury Instruction Guide that the proper definition of gross negligence is “the absence of even slight care” is an incorrect statement of

Minnesota law. It is not controlling authority⁸ in this case, and should not have formed a basis for the decisions of the lower courts.

3. The Rule of Law Applied by the Lower Courts Is Unsound

Even if the lower courts were correct in their reading of Chambers, a rule that *any care at all* is enough to avoid a finding of gross negligence, no matter how ill conceived, misguided, or wrongheaded the care might be, is not what the law should be. Under such a standard, even the most contraindicated care imaginable for Stringer – *e.g.*, causing him to sweat more, as doctors treated dehydration decades ago, applying leeches to remove “bad blood,” or, as Zamberletti essentially did, smothering him while he already was suffocating – would be sufficient to avoid a finding of gross negligence.

Defining “gross negligence” *solely* by reference to the level of care needed to avoid liability for it – *i.e.*, that any care at all rules out gross negligence – is problematic for a number of reasons. First, “slight care” is inherently difficult to define. Lauritsen v. Am. Bridge Co., 87 Minn. 518, 522, 92 N.W. 475, 476 (1902) (dismissing as “too subtle” the “refined distinctions of the doctors of the civil law discriminating between ordinary care and slight care in issues of negligence”).

⁸ Even the Jury Instruction Guides—Civil, Fourth Edition, discourages “reliance on the Fourth Edition as a repository for the substantive law,” calling it merely “a good place for the practitioner to *start* his or her research,” and adding that, “like any other book devoted largely to practice,” it “has its own built-in limits, especially if it becomes the exclusive source for the practitioner’s research.” Id. at XXIX. See also State v. Peterson, 673 N.W.2d 482 (Minn. 2004) (citing Range v. Van Buskirk Constr. Co., 281 Minn. 312, 314 n.3, 161 N.W.2d 645, 647 n.3 (1968)) (“The content of [the criminal jury instruction] guides does not control over statutory or case law.”)

Second, this approach turns the history of “gross negligence” inside out. Ironically, the term “gross negligence” apparently originated as a way to define “slight care,” the level of care traditionally required of gratuitous bailees. In the 1703 case of Coggs v. Bernard, 92 Eng. Rep. 107 (1703), Lord Holt in essence defined slight care according to the degree of negligence that would betray its absence. Seemingly relying on Roman law, he stated that one entrusted with personal property solely for the benefit of a bailor would be answerable for the property’s loss only if “guilty of gross neglect.” See Ferrick Excavating & Grading Co. v. Senger Trucking Co., 484 A.2d 744 (Pa. 1984). This notion was imported into the American law of bailments, including that of Minnesota. See McKibbin v. Wis. Cent. Ry. Co., 100 Minn. 270, 274, 110 N.W. 964, 966 (1907); Story on Bailments § 23 (“When the bailment is for the sole benefit of the bailor, the law requires only slight diligence on the part of the bailee, and of course makes him answerable only for gross neglect.”)

It may have been fitting at common law to measure a gratuitous bailee’s compliance with the duty of slight care by examining the degree of the bailee’s negligence in handling of the property, for it is plausible to assume that a bailee’s gross negligence would reliably show a lack of even slight care. But in the context of this case, where two licensed health care providers are accused of grossly negligent treatment of an extremely ill and helpless person, ruling out gross negligence as long as each defendant used “some care” would lead to incongruous results, like those mentioned above.

This formulation of the test for “gross negligence” is also manifestly inconsistent with the application of the rule of gross negligence in other cases. See State v. Al-

Naseer, 678 N.W.2d 679 (Minn. Ct. App. 2004) (affirming finding of gross negligence for inattentive driving); State v. Pelawa, 590 N.W.2d 142, 145 (Minn. Ct. App. 1999) (finding gross negligence was shown by a “sufficient degree of inattention to the road”); State v. Hegstrom, 543 N.W.2d 698, 703 (Minn. Ct. App. 1996) (“[a] sufficient degree of inattention to the road could constitute a lack of ‘slight care’ that is gross negligence”); State v. Boldra, 292 Minn. 491, 492, 195 N.W.2d 578, 579 (1972) (finding gross negligence where defendant drove through stop sign).

In Beehner v. Cragun Corp., 636 N.W.2d 821 (Minn. Ct. App. 2001), the court of appeals held that unsuccessfully attempting to keep a dog from coming with horses on a trail ride, knowing that the dog might spook a horse, created a fact issue of gross negligence. In Aero Properties, LLC v. Discover Aviation Days, No. C6-01-1765, 2002 WL 1544249 (Minn. Ct. App. July 16, 2002), installing a tent without using enough stakes or inspecting the installation provided a basis for gross negligence.

Here, the trainers were well aware of the life-threatening heat and humidity in which Stringer was practicing, and knew that heat-related illness presented a significant risk of death if not promptly and effectively treated. Yet, they provided Stringer a meaningless amount of help, despite his serious condition. It is impossible to square the decision in this case with prior gross negligence decisions. On one hand, allowing a dog to run with horses or carelessly erecting a tent may be gross negligence; on the other, letting an apparently healthy professional athlete go into a fatal coma without providing any meaningful aid is not, *as a matter of law*.

Minnesota law has never sanctioned an “any care will do” standard for health care providers duty-bound to treat a helpless and desperately ill person, or for anyone else. There simply is no coherent rationale, nor any evidence of legislative intent, endorsing such a standard. To embrace that concept would be to abandon both precedent and logic, with no compelling reason to discard either.

B. The Record Establishes a Factual Basis for Plaintiff’s Gross Negligence Claim

1. The Lower Courts Inappropriately Failed to View the Evidence in a Light Most Favorable to Kelci Stringer

On summary judgment, it is not the court’s function to decide factual issues, but to determine if any exist. Both the trial court and a reviewing court must view the facts in a light most favorable to the nonmoving party, drawing all reasonable inferences in that party’s favor. See discussion, supra, at pp. 24-25. These bedrock principles were largely ignored by the lower courts, which recited the evidence as though they were reviewing the sufficiency of the evidence after a jury verdict adverse to Kelci Stringer. They did not adhere to the rule that the evidence must be viewed in a light most favorable to the party opposing summary judgment, and that all reasonable inferences that may be drawn from the evidence must be drawn in favor of that party. A few examples that compare the court of appeals’ recitation of the facts with those facts that Kelci Stringer presented, and the inferences that can be drawn from those facts, amply demonstrates the failure of the lower courts to view the record in the manner the law requires of them.

OSTERMAN	
What the Court of Appeals Stated as the Evidence:	What The Evidence and All Favorable Inferences Show, When Viewed Favorably To Plaintiff:
<p>“At approximately 10:30 a.m., Stringer vomited again but continued to participate in practice. While working out on a large blocking dummy, Stringer dropped to one knee. Osterman checked Stringer who refused assistance.” 686 N.W.2d at 548.</p>	<p><i>Stringer showed early and serious signs of heat illness that Osterman ignored.</i></p> <p>The day after he had suffered from a serious episode of heat illness, an episode of which both Osterman and Zamberletti were aware, Stringer practiced in life threatening heat, in full equipment. He vomited from the heat during the formal practice, and then collapsed to one knee during extra drills. He was unresponsive to his teammates, who called for a trainer. Osterman did not examine Stringer at that time. <u>See</u> Statement of Facts, <u>supra</u>, pp. 9-11.</p>
<p>“Shortly thereafter, Stringer lay down on the practice field. Osterman and another trainer were called to assist Stringer.” 686 N.W.2d at 548.</p>	<p><i>The signs that Stringer’s condition was clearly serious and worsening were overlooked or ignored by Osterman, and downplayed by the Court of Appeals.</i></p> <p>After going to one knee and being unresponsive to his teammates, Stringer stumbled 40 to 50 yards toward “Big Bertha,” but collapsed before reaching it. Stringer lay on the ground up to five minutes, making a deep, agonizing moaning sound the entire time. Collapse is a sign of advanced heat illness. Osterman only asked Stringer how he was doing, but got no response; he did nothing to follow up, and did not know, or ask anyone, how long Stringer had been on the ground. Osterman attached no significance to his collapse, non-responsiveness or pallor. <u>See</u> Statement of Facts, <u>supra</u>, pp. 11-12, 18.</p>

“Stringer got up and struck the blocking dummy once more; then Osterman escorted Stringer to the first aid trailer.” 686 N.W.2d at 548.

Osterman failed to assist Stringer prior to taking him to the trailer as a “precaution.”

On his own, Stringer raised himself up off the ground, took a feeble, uncoordinated swing at “Big Bertha,” pushing through it and walking away. Osterman still didn’t believe anything was wrong with Stringer, and in fact, thought he was “fine” when he clearly was not. Rather than taking Stringer to the ATR where ice water tubs were set up to treat players suffering from the heat, Osterman took Stringer to the first aid trailer only as a precaution, and not because he recognized that anything was wrong. See Statement of Facts, supra, pp. 12, 19.

“Osterman gave Stringer water, and he took a few sips. Stringer lay down on the floor of the trailer at some point later.” 686 N.W.2d at 548.

While in the trailer with Stringer, Osterman made no effort to assess Stringer’s condition.

When they arrived at the trailer, Osterman’s only action was to send Kearney for some water. On the prior day, when Osterman had been present in the trailer with Stringer, he heard Stringer express his frustration at being in the trailer; this time, Stringer was almost completely and unusually silent. Despite his training, and notwithstanding Stringer’s uncharacteristic detachment, Osterman did not ask Stringer any questions, try to secure a history, check any of Stringer’s vital signs, or otherwise examine him. He just “let Korey relax.” Over the 40 minutes they were in the trailer together, Osterman allowed Stringer to slip further and further into a condition that would prove fatal. See Statement of Facts, supra, pp. 12-13, 19.

“Osterman then gave Stringer iced towels to cool down.”
686 N.W.2d at 548.

Osterman made no effort to cool Stringer before Stringer lapsed into a coma.

The cooling effect of being in an air-conditioned trailer was minimal, a fact that any competent athletic trainer should know. While in the trailer, Osterman did not consider placing ice (located just outside the trailer) on Stringer (as he did for Fred Robbins the day before) or fanning him. Osterman *believes* he applied an ice towel to Stringer’s head (he was not certain of that fact), but Stringer pushed it away from his forehead without saying anything. This occurred only after Stringer had collapsed near the trailer door. See Statement of Facts, *supra*, pp. 12-14, 19-20.

As Osterman removed Stringer’s shoes and socks, “he observed that Stringer was sweating and his skin was moist. Stringer moved to an examination table for a few minutes, where he was observed humming and bobbing his head. Later, he moved back to the floor. Osterman did not find this behavior unusual.” 686 N.W.2d at 548.

Osterman thought Stringer was “fine” right up until Stringer collapsed in a coma, despite obvious signs to the contrary.

Osterman, who was basically alone with Stringer for roughly 40 critical minutes in the trailer, made no assessment of Stringer’s condition, even to the extent of basic vital signs, until after Stringer became semi-conscious. Stringer was still sweating some 15 to 20 minutes after concluding significant exertion and entering an air-conditioned trailer, a symptom of heat-illness. Stringer was detached and said almost nothing, another sign of heat illness. Stringer moved from the table to the floor and back for no apparent reason; Osterman did not consider this behavior unusual or a sign of one of the classic heat stroke symptoms - altered mental status and bizarre or irrational behavior. Nor did

	<p>Osterman recognize the stark contrast with Stringer’s conduct the day before. <u>See</u> Statement of Facts, <u>supra</u>, pp. 12-15, 19-20.</p>
<p>In determining that there was insufficient evidence to reach the jury on gross negligence, the Court relied upon the assertion that: “Osterman observed Stringer’s condition, gave him water, removed his shoes, and applied ice towels.” 686 N.W.2d at 552.</p>	<p><i>Osterman’s failure to assess Stringer’s condition, his failure to take any effective steps to cool Stringer, and his failure to timely transport Stringer all constituted grossly negligent breaches of the applicable standards of conduct.</i></p> <p>From the time he found Stringer collapsed on the practice field until Stringer was placed in the ambulance, Osterman did nothing that would effectively cool Stringer, or slow the progress of the life-threatening condition that Stringer was undeniably experiencing. He also took no steps to assess Stringer’s condition. It was not until Stringer had collapsed that Osterman even realized that there was a problem. Osterman testified, “That was the first sign that something was going wrong. . . . I really wasn’t sure what was going on at that point. I was pretty confused.” In the opinions of well-qualified expert witnesses, Osterman’s conduct was so far below the standards expected of him as to constitute no care at all. <u>See</u> Statement of Facts, <u>supra</u>, pp. 15-17, 18-21.</p>
ZAMBERLETTI	
<p>What the Court of Appeals Stated as the Evidence:</p>	<p>What The Evidence Shows, When Viewed Favorably To Plaintiff:</p>
<p>When Zamberletti arrived, he saw Stringer was breathing rapidly and concluded Stringer was hyperventilating. 686 N.W.2d at 548.</p>	<p><i>Zamberletti jumped to an incorrect diagnosis without gathering any information at all about Stringer’s condition.</i></p> <p>Zamberletti was aware of Stringer’s heat-exhaustion the prior day, but didn’t ask for any history of the events</p>

	<p>that led to Stringer laying comatose on the floor of the first aid trailer. He performed no examination, and did nothing to check Stringer's vital signs. Instead, he jumped to the wholly unwarranted conclusion that Stringer suffered from an insect bite, and was hyperventilating. <u>See</u> Statement of Facts, <u>supra</u>, pp. 15-17, 21-22.</p>
<p>Zamberletti "felt that Stringer's skin was cool and sweaty." 686 N.W.2d at 548.</p>	<p><i>Zamberletti ignored readily apparent symptoms.</i> Zamberletti observed that Stringer's skin was cool and sweaty long after Stringer had ceased exertion (at least 40 minutes), a classic sign of heat-related illness. He paid no attention to the symptom. He was also aware that Stringer had experienced heat illness during the prior day's practice. He ignored that fact as well. <u>See</u> Statement of Facts, <u>supra</u>, pp. 8, 16-17, 21-22.</p>
<p>"To treat this condition [hyperventilation], Zamberletti instructed another trainer to place a plastic bag around Stringer's mouth for 45 to 60 seconds." 686 N.W.2d at 548.</p>	<p><i>Zamberletti's inappropriate treatment of Stringer only worsened his condition.</i> At Zamberletti's direction, Stringer was "bagged" for up to a minute and a half, twice as long as the court of appeals stated. This ill-conceived and baseless treatment actually significantly exacerbated Stringer's condition, by cutting off the flow of oxygen to Stringer's brain, and reducing Stringer's ability to blow off carbon dioxide. The improper treatment caused Stringer's condition to worsen, and contributed to his death. <u>See</u> Statement of Facts, <u>supra</u>, pp. 16-18, 21-22.</p>

<p>“Zamberletti then made emergency arrangements to transport Stringer to the hospital.” 686 N.W.2d at 548.</p>	<p><i>Zamberletti caused needless delays in Stringer receiving emergency care.</i></p> <p>The “bagging” was not only directly harmful, but it delayed further proper treatment of Stringer. Zamberletti further delayed medical treatment for Stringer when he instructed Osterman to call for the public relations van to transport Stringer to the hospital. It was Osterman, not Zamberletti, who finally suggested calling the ambulance. Zamberletti also further delayed getting Stringer the urgent care that he needed by calling Dr. Knowles’ office and waiting for a return call. While waiting for the ambulance, Zamberletti (as well as Osterman) did nothing to help cool Stringer or give him any other aid. <u>See</u> Statement of Facts, <u>supra</u>, pp. 16-17, 21-22.</p>
<p>In determining that the Plaintiff’s failed to show sufficient evidence to reach the jury on gross negligence, the Court relied upon the assertion that: “he attempted to treat Stringer for hyperventilation and then arranged emergency transportation to the hospital.” 686 N.W.2d at 552.</p>	<p><i>Zamberletti’s treatment of Stringer for a condition he did not have, his failure to treat Stringer for the life-threatening condition he did have, and the critical delays Zamberletti caused in getting Stringer to the hospital all constituted grossly negligent breaches of the applicable standards of conduct.</i></p> <p>Zamberletti’s conduct was wrong on every level. In the opinion of plaintiff’s experts, Zamberletti’s conduct demonstrated a complete lack of care, and a total failure to meet even the most minimal level of competence. <u>See</u> Statement of Facts, <u>supra</u>, pp. 21-22.</p>

The court’s opinion concludes that “the uncontroverted record establishes that respondents were cognizant of potential adverse consequences arising from Stringer’s condition and took some steps to care for him.” Stringer, 686 N.W.2d at 552. But

Osterman actually testified that he did not think Stringer was suffering from heat-stroke, and didn't realize that there was a problem until Stringer lapsed into a coma, a point in time when Stringer's condition was extremely grave; Zamberletti treated Stringer for hyperventilation, compounding the damage to Stringer's already dying brain. With due respect to the court of appeals, it is not possible to reconcile, on the one hand, the inaccurate and cursory statements made by the court of appeals with, on the other hand, the rule that the facts and inferences are to be viewed in a light most favorable to the party opposing summary judgment.

2. The Evidence Presents a Jury Question

This Court has held repeatedly that questions of negligence, including questions of gross negligence, are to be resolved by the jury. "Whether, under the circumstances, defendant was guilty of gross negligence in permitting himself to fall asleep was an issue properly submitted to the jury." Hardgrove v. Bade, 190 Minn. 523, 526, 252 N.W. 334, 335 (1934). "[I]t is only in the clearest of cases that the question of negligence becomes one of law." Martinco v. Hastings, 265 Minn. 490, 501, 122 N.W.2d 631, 640 (1963). "In each case, except when reasonable minds may not differ, the degree of care required, and whether it was exercised, are questions for the jury." Id. at 491, 122 N.W.2d at 634.

Given Stringer's condition when Osterman and Zamberletti were responsible for providing care to him on July 31, 2001, and the level of attention his condition then required, could a jury reasonably find that their conduct toward him constituted "negligence of the highest degree," negligence that was "substantially and appreciably higher in magnitude than ordinary negligence," "materially more want of care than

constitutes simple inadvertence,” or an act or omission “respecting legal duty of an aggravated character as distinguished from a mere failure to exercise ordinary care?” Viewing the evidence as a whole, and in a light most favorable to Kelci Stringer, the answer is overwhelmingly “yes.”

Plaintiff presented evidence, in great volume and detail, which provided a basis for a jury to find gross negligence. From Osterman’s maddening inattentiveness and inertia for 45 minutes while Stringer displayed classic heat stroke symptoms, his brain “cooked,” and he slipped into a coma, to Zamberletti’s failure to ask Osterman for any history, his foolish suffocation of an already suffocating man, and his inexcusable delay in calling 911, the co-employees did nothing meaningful to help Stringer. In fact, they caused his condition to worsen. In the hour and a quarter from the time of his collapse until his arrival at the hospital, Stringer’s core body temperature reached an astounding 108.8°F, if not higher, without defendants noticing. Osterman and Zamberletti’s total lack of meaningful care, their failure to follow the most basic procedures for preventing, recognizing, and treating heat stroke, their wholly unwarranted delays, and the harmful mistreatment combined to kill a professional athlete in his prime.

As Vikings’ head trainer Chuck Barta admitted, “There are no excuses for heat stroke deaths if the proper precautions are taken.” (A210-11.) On this record, there was no excuse for letting Korey Stringer die. It took more than ordinary negligence to cause Stringer’s death. The gross negligence of these defendants presents a clear jury question under the properly stated legal test.

CONCLUSION

The summary judgment in favor of the co-employees was based on a fundamentally flawed legal formulation of "gross negligence." The lower courts have declared that nothing short of willful and intentional conduct will permit an injured employee to sue a co-worker. Applying this definition of gross negligence, there is no liability as a matter of law when a healthy, vigorous professional athlete is allowed to die from heat-related illness without receiving even minimal evaluation or treatment, and in fact is subjected to grossly inappropriate and harmful treatment. It is truly a re-writing of Minnesota law if a defendant can avoid a claim of gross negligence by showing that he or she exercised "scant care" no matter how completely unreasonable that care was.

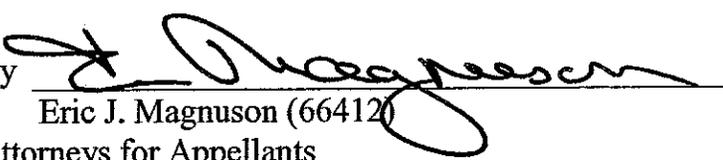
Applying the correct legal standard of gross negligence, and viewing the evidence in a light most favorable to Kelci Stringer, a jury could conclude that Osterman and Zamberletti each acted toward Korey Stringer in a manner far exceeding ordinary negligence. The summary judgment should be reversed and the case remanded for trial.

Respectfully submitted,

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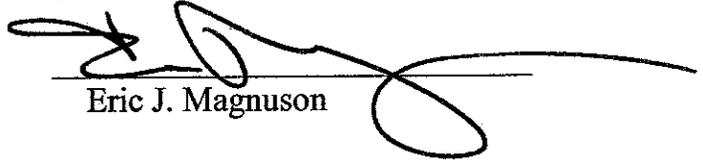
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CERTIFICATION

This Brief is 12,577 words in length and was prepared using Microsoft Word.



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