

NO. A120799

**STATE OF MINNESOTA
IN COURT OF APPEALS**

Craig A. Kellogg and
Kristin B. Kellogg,

Appellants,

v.

Scott D. Finnegan,

Respondent.

**BRIEF OF APPELLANTS
CRAIG A. KELLOGG AND KRISTIN B. KELLOGG**

Mark D. Streed, Esq. (#170069)
MESHBESHER & SPENCE, LTD.
7300 Hudson Blvd., #110
Oakdale, MN 55128
651.578.8055

Attorneys for Appellants

Karen Cote, Esq. (#219824)
BRETT W. OLANDER & ASSOCIATES
30 East 7th Street, Suite 3100
St. Paul, MN 55101
651.229.5069

Attorneys for Respondent

TABLE OF CONTENTS

	<u>PAGE</u>
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
LEGAL ISSUES.....	1
STATEMENT OF THE CASE AND FACTS.....	2
ARGUMENT	9
I. District Court erroneously concluded that Respondent did not owe a duty of care	9
A. Standard of Review.....	9
B. District Court failed to charge Respondent with a duty of care pursuant to Minn. Stat. § 169.14 (2011).....	11
II. District Court’s duty analysis is contrary to precedent holding that a <i>prima facie</i> case of negligence is established upon evidence that the defendant motorist fell asleep, which necessarily presumes that a duty was owed.....	15
III. District Court exceeded its authority by adjudicating facts and wrongly concluding that the collision was unforeseeable, to reach its erroneous holding that Respondent did not owe a duty	20
A. District Court overlooked evidence, adjudicated fact disputes, and did not view evidence in a light most favorable to Appellants	24
IV. District Court erroneously relied on <i>Echagdaly</i> , and by doing so wrongly supplanted the “sudden incapacity” doctrine into its decision.....	28
CONCLUSION	33
INDEX TO APPENDIX.....	36

The appendix to this brief is not available for online viewing as specified in the *Minnesota Rules of Public Access to the Records of the Judicial Branch*, Rule 8, Subd. 2(e)(2).

TABLE OF AUTHORITIES

Minnesota Supreme Court

<i>A.J. Chromy Constr. Co. v. Commercial Mech. Servs., Inc.</i> , 260 N.W.2d 579 (Minn. 1977).....	10
<i>Austin v. Metro. Life Ins. Co.</i> , 152 N.W.2d 136 (Minn. 1967).....	20
<i>Connolly v. Nicollet Hotel</i> , 254 Minn. 373, 95 N.W.2d 657 (1959).....	10, 22
<i>DHL, Inc. v. Russ</i> , 566 N.W.2d 60, 59-70 (Minn. 1997).....	10
<i>Domagala v. Rolland</i> , 805 N.W.2d 14 (Minn. 2011).....	24
<i>Hardgrove v. Bade</i> , 190 Minn. 523, 252 N.W. 334 (1934).....	16, 17
<i>Jablinske v. Eckstrom</i> , 247 Minn. 140, 76 N.W.2d 654 (1956).....	11
<i>Kapla v. Lehti</i> , 225 Minn. 325, 30 N.W.2d 685 (1948).....	11
<i>Larson v. Larson</i> , 373 N.W.2d 287, 289 (Minn. 1985).....	10
<i>Patterson v. Wu Family Corp.</i> , 608 N.W.2d 863 (Minn. 200_).....	10
<i>Trudeau v. Sina Contracting Co.</i> , 241 Minn. 79, 62 N.W.2d 492 (1954).....	15
<i>Whiteford by Whiteford v. Yamaha Motor Corp., U.S.A.</i> , 582 N.W.2d 916 (Minn. 1998).....	20

Minnesota Court of Appeals

<i>Echagdaly v. Metro Council Transit Operations</i> , C4-99-77, 1999 WL 508661 (Minn. Ct. App. July 20, 1999) (unpublished opinion).....	9, 28, 29, 31
<i>Grandnorthern, Inc. v. W. Mall P'ship</i> , 359 N.W.2d 4144 (Minn. Ct. App. 1984).....	10
<i>Veld v. Steffl</i> , 363 N.W.2d 821 (Minn. Ct. App. 1985).....	11

Foreign Case Authority

<i>Goodrich v. Blair</i> , 132 Ariz. 459 (Ct. App. 1982).....	30
<i>Bushnell v. Bushnell</i> , 131 A. 432 (Conn. 1925).....	16, 17
<i>Ferkel v. Bi-State Transit Development Agency</i> , 682 S.W.2d 91 (Mo. Ct. App. 1984).....	31, n.7

<i>Henry v. Knudsen</i> , 692 S.E.2d 878 (N.C. Ct. App. 2010)	31, n.7
<i>Howle v. PYA/Monarch, Inc.</i> , 344 S.E.2d 157 (S.C. Ct. App. 1986)	31, n.7
<i>Karl v. Terbush</i> , 881 N.Y.S.2d 207 (App. Div. 2009).....	31, n.7
<i>Keller v. Wonn</i> , 87 S.E.2d 453 (W.Va. 1955).....	30
<i>Lewis v. Smith</i> , 517 S.E.2d 538 (Ga. App. Ct. 1999).....	30
<i>McCall v. Wilder</i> , 913 S.W.2d 150 (Tenn. 1995)	30

Minnesota Statutory Authority

Minn. Stat. § 169.14 (2010).....	9, 11, 12, 13
----------------------------------	---------------

Secondary Authority

Timothy E. Travers, Annotation, <i>Liability for Automobile Accident Allegedly Caused by Driver's Blackout, Sudden Unconsciousness, or the Like</i> , 93 A.L.R. 326 (1970 and Supp. 2005).....	29
4 Minn. Prac., Jury Instr. Guides – Civil, CIVJIG 25.10 (5th ed.).....	11
4A Minn. Prac., Jury Instr. Guides – Civil CIVJIG 65.25 (5th ed.).....	11

LEGAL ISSUES

1. Under Minn. Stat. § 169.14, subd. 1 (2010), does a motorist owe a duty of due care to ensure that they are fit to drive after experiencing chronic and alarming medical symptoms that would place a reasonable person on notice that they may have a medical condition that potentially makes it unsafe to drive?

District Court answered this question in the negative.

2. Without regard to Minn. Stat. § 169.14, subd. 1 (2010), does a motorist owe a duty of due care when it is foreseeable that they may fall asleep or lose consciousness while driving?

District Court answered this question affirmative, by implication, but nevertheless concluded that it was unforeseeable that Respondent would fall asleep or lose consciousness at the wheel, which was District Court's basis for holding that Respondent does not owe a duty.

3. Should District Court's grant of summary judgment be reversed if District Court exceeded the standard of review Under Minn. R. Civ. P. 56.03 by (a) resolving material fact disputes and (b) failing to view evidence in a light most favorable to the non-moving party?

District court resolved material fact disputes and failed to view the evidence in a most favorable light to Appellants, the non-moving party, and therefore must be reversed.

STATEMENT OF THE CASE

The above-captioned matter is before this Court on appeal from Washington County District Court, Honorable Mary E. Hannon, by Appellants Craig A. Kellogg and Kristin B. Kellogg. Appellants seek reversal of District Court's March 13, 2012 Order granting Respondent Scott D. Finnegan's Motion for Summary Judgment.

Appellants initiated a negligence action against Respondent for injuries sustained, and damages incurred, after Respondent lost control of his vehicle, crossed the center median and crashed head-on into a vehicle operated by Appellant Craig A. Kellogg.

Respondent defended by alleging that he suffered an unforeseen seizure, which caused him to lose consciousness and lose control of his vehicle. Respondent argued that he had no duty to anticipate the unforeseeable—the alleged seizure—and therefore he could not be held negligent.¹

On November 17, 2011, Respondent filed a Motion for Summary Judgment. Appellants filed their responsive memorandum on December 5, 2011. On December 16, 2011, the matter was heard before the Honorable Mary E. Hannon. On March 13, 2012, District Court granted Respondent's Motion for Summary Judgment, concluding that the collision was unforeseeable and therefore Respondent did not owe a duty of care. Appellants filed their Notice of Appeal on May 7, 2012.

¹ Whether Respondent truly experienced a seizure versus merely falling asleep at the wheel is just one of the material fact issues in dispute.

STATEMENT OF THE FACTS

On November 11, 2009, Respondent lost control of his vehicle while driving westbound on Valley Creek Road in Woodbury, Minnesota. His vehicle veered across the median, entered the wrong lane, and crashed into Appellant Craig A. Kellogg's eastbound vehicle. Appellant Craig A. Kellogg sustained serious bodily injuries and incurred substantial medical bills as a result.

Val Huerta, a City of Woodbury paramedic, arrived on scene and examined Respondent. Respondent was awake and conversant and admitted to Huerta that he fell asleep.² (A.A. 88). This was not the first time that Respondent fell asleep while driving. (A.A. 74). Respondent also admitted to being seriously sleep deprived throughout the days preceding the collision. Dr. Eric Salata, who treated Respondent after the crash, noted that he "reports significant sleep deprivation recently." (A.A. 141).

Respondent's Health and Medical History

Respondent Scott Finnegan is forty-three-years-old. (A.A. 65). He is a registered nurse and licensed to practice in Colorado and Minnesota. He worked as a nurse most recently in Colorado between the years 2007 and 2009. (A.A. 67). During this period, however, Respondent's fine motors skills began to noticeably deteriorate. (A.A. 70). Respondent began experiencing symptoms associated with ataxic gait. He also developed chronic hand trembles and his coordination and fine motor skills steadily deteriorated. (A.A.

² None of the emergency personnel responding to the collision determined that Respondent suffered a seizure. Huerta concluded that Respondent did not suffer one because "[t]ypically, when someone has a seizure, they're . . . we call it a postictal phase . . . but he [referring to Respondent] didn't have all the signs of a postictal phase." (A.A. 87). Likewise, Eric DeBaker, an emergency medical technician, did not observe any signs indicating that Respondent had a seizure. (A.A. 92).

71). These symptoms impacted him daily, especially with his nursing career. For instance, his hand trembles made it difficult to administer needles and IVs. Respondent “thought [that his symptoms would] go away . . .”, but they did not. (A.A. 71).

Respondent found it increasingly difficult to perform his work duties due to his symptoms, i.e., ataxic gait and deteriorating fine motor skills and coordination.

(A.A. 71). Because his gradually symptoms worsened, Respondent was unable to physically perform his job duties. (A.A. 71). This prompted Respondent to move to Woodbury, Minnesota to live with his mother. (A.A. 65-66, 98).

Respondent also has a significant history of head trauma, including instances where he was rendered unconscious. (A.A. 70). Respondent has experienced the following head traumas: he was involved in a moped crash, which left him unconscious after being ejected from his seat; he cracked his head on a brick fireplace, causing a brick to fall out; he slammed his head on a nightstand after falling out of bed; he split his head open after diving into a pool; he has been knocked out in a fight and taken many blows to the head; and he smacked his head after falling in the shower. (A.A. 70).

Respondent’s family members corroborated his history of traumatic brain injury. (A.A. 96-97, 101-02).

Importantly, Respondent chose not to consult with any medical professionals for diagnostic testing of his worsening symptoms of ataxic gait and deteriorating fine motor skills and coordination.³ After the collision, however, Respondent underwent a CT scan and

³ Surely, Respondent’s nursing education, training and experience is relevant in assessing his awareness and knowledge of the potential significance of these neurologically related symptoms, his choice to forgo medical help, as well as his choice to withhold significant

MRI of his brain, both revealing significant cerebellar atrophy. (A. A. 144-46). On October 16, 2009, just twenty-six days before the crash, Respondent presented to Nurse Practitioner Sonja Hannigan at Southside Community Health Services to treat depressive and sleeping problems. (A.A. 127). Respondent chose to withhold aspects of his medical history including symptoms of ataxic gait, deteriorating fine motor skills and coordination as well as his history of traumatic brain injury. (A.A. 71). Based on the information that Respondent provided concerning depression and sleeping issues, however, Hannigan prescribed Citalopra (commonly known as Celexa), an anti-depressant, and Trazodone, a nighttime sleep aid. (A.A. 129).

Then, on November 3, 2009, Respondent presented to Arnette R. Mari, a nurse, at Allina Medical Clinic in Woodbury, Minnesota. Respondent sought treatment for an ankle and foot injury. (A.A. 83, 131). Again, however, Respondent chose to withhold his symptoms and medical history. Indeed, Respondent admitted that he did not disclose his history of multiple traumatic brain injuries, symptoms of ataxic gait, and deteriorating fine motor skills and coordination when he met with Arnette and Hannigan. (A.A. 73-74).

Both Hannigan and Arnette would have significantly altered their treatment plans had Respondent completely and accurately disclosed his symptoms and medical history. (A.A. 80, 85).

information about his own medical history when he was seen by medical professionals in Minnesota just weeks before the collision.

Respondent's Prescription Medication and Alcohol Usage

As a registered nurse Respondent knew the importance of taking prescription medication as directed. (A.A. 71). Moreover, consumer drug information for Trazodone provides the following warning:

Do not drink alcohol. Trazodone can increase the effects of alcohol, which could be dangerous. Trazodone may impair your thinking or reactions. **Be careful if you drive or do anything that requires you to be alert.**

(A.A. 117) (emphasis provided). Likewise, consumer drug information for Celexa provides that:

Try to take the medicine at the same time each day, follow the directions on your prescription label. . . . Celexa can cause side effects that may impair your thinking or reactions. **Be careful if you drive or do anything that requires you to be awake and alert.**

(A.A. 123-24) (emphasis provided). Respondent was aware of these side effects. (A.A. 71).

Moreover, Nurse Practitioner Hannigan testified that mixing alcohol with Celexa and Trazodone is inadvisable. She testified that the medications “don’t work if you drink” and that mixing alcohol with Trazodone “could make [Respondent] sleepier.” (A.A. 80).

Respondent chose not to take his medications as prescribed. Respondent’s mother, Karen Finnegan, testified that Respondent took Trazodone and Celexa erratically. (A.A. 98-99). Ms. Finnegan tried to get Respondent to follow directions but he would not “because he didn’t feel like it.” (A.A. 99). She also testified that she warned Respondent to not mix his prescriptions with alcohol, especially while in the early stages of treatment, but he ignored her advice. (A.A. 99). It should be noted that Ms. Finnegan was also a long-time registered nurse. (A.A. 98).

And, Respondent's family members testified that Respondent habitually abused alcohol during this time period. His sister, Laura Lewis, was concerned about Respondent's alcohol abuse. (A.A. 103). His brother-in-law, Paul Lewis, perceived that Respondent drank excessively. (A.A. 113).

Furthermore, Respondent testified that Trazodone and Celexa likely contributed to the collision. In relevant part:

Q: And your concern was that the Celexa and Trazodone contributed to the collision?

A: Yeah, I mean yes.

...

Q: And you knew that one of the side effects of Celexa and Trazodone was dizziness or blacking out or falling asleep. Correct? Because you'd read the contraindications?

A: Yes, I knew it was a possibility.

(A.A. 76).

Respondent's Pre-Collision Behavior

Respondent reported going to sleep around 11:00 p.m the night before the collision and recalls awaking at about 6:00 p.m. the next day. (A.A. 141). After awaking, Respondent felt confused and was not thinking clearly. His sister recalled their mother mentioning that Respondent seemed confused. (A.A. 49). Respondent's brother-in-law testified that Respondent described that he was not thinking clearly before the crash. (A.A. 112). When Respondent got into his vehicle he forgot how to engage the clutch, which was unusual because he had always driven manual transmission, making it second-nature to push in the clutch. (A.A. 144). Respondent explained that:

Well, I went to put the car in reserve and it wouldn't go. And I'm like, what the—oh, forgot to put in the clutch. So then I put in the clutch, I put the car in reverse and I started going. I thought it was just a little mental error.

(A.A. 73).

At the crash scene Respondent was awake and he conversed with paramedic Heurta.

Respondent admitted that he had “fallen asleep.” (A.A. 88).

Respondent's Post Collision Treatment and Diagnosis

After the collision Respondent was transported to Woodwinds Health Campus in Woodbury, Minnesota. During his initial assessment, Respondent revealed his history of multiple traumatic brain injuries. He underwent a CT scan of head, which revealed “some cerebellar atrophy” (A.A. 141).

After his initial assessment, Respondent was treated by a neurologist, Dr. Thomas R. Jacques. Dr. Jacques reviewed the CT scan and concluded that “it show[ed] severe significant cerebellar atrophy especially for somebody of 40 years old.” (A.A. 144).

The next day Respondent underwent an MRI of his head, which confirmed “mild to moderate generalized cerebellar atrophy.” (A.A. 146.) Subsequently, Respondent presented to Dr. Laura Li, who recommended that Respondent refrain from driving because of his pronounced cerebellar atrophy. (A.A. 75-76). Respondent followed Dr. Li's recommendation and he no longer drives. (A.A. 76).

ARGUMENT

I. DISTRICT COURT ERRONEOUSLY CONCLUDED THAT RESPONDENT DID NOT OWE A DUTY OF CARE.

District Court erred for four reasons. First, District Court failed to charge Respondent with a duty of care under Minn. Stat. § 169.14 (2011).

Second, District Court overlooked material disputed fact issues from which Appellants established a *prima facie* case of negligence (i.e., evidence that Respondent's own acts and omissions contributed to him falling asleep while driving supports a *prima facie* case of negligence), which necessarily means that Respondent owed a duty of care.

Third, District Court exceeded the standard of review by adjudicating disputed facts and concluding that the collision was unforeseeable, which was its basis for holding that Respondent did not owe a duty of care.

Fourth, District Court mistakenly used *Echagdaly v. Metro. Council Transit Operations*, C4-99-77, 1999 WL 508661 (Minn. Ct. App. July 20, 1999) (unpublished opinion) as legal authority to support that Respondent did not owe a duty or, alternatively, that Respondent was not negligent. *Echagdaly*, however, does not use the word "duty". *See id.* Instead, *Echagdaly* applied the "sudden incapacity" defense to relieve the at-fault motorist of negligence. Because "sudden incapacity" does not resolve the existence of duty, District Court's reliance on *Echagdaly* was erroneous. Alternatively, District Court erred by relieving Respondent from negligence because *Echagdaly* is factually distinguishable from this case.

A. Standard of review.

When reviewing District Court's order granting summary judgment this Court determines whether (1) District Court correctly applied the law and (2) whether District

Court correctly concluded that there were no genuine issues of material fact. *Patterson v. Wu Family Corp*, 608 N.W.2d 863, 866 (Minn. 2001).

Put differently, this Court must determine whether District Court properly applied the standard of review for summary judgment to the facts presented to the court. “The function of the district court on a motion for summary judgment is not to weigh evidence.” *DHL, Inc. v. Russ*, 566 N.W.2d 60, 59-70 (Minn. 1997) (internal citation omitted). Conversely, a district court looks to the record—the pleadings, depositions, answers, admissions, and affidavits—to determine whether there are genuine issues of fact. *Grandnorthern, Inc. v. W. Mall P’ship*, 359 N.W.2d 4144 (Minn. Ct. App. 1984).

District Court must resolve all doubts and factual inferences against the moving party. *Id.*

Finally, to grant summary judgment, the moving party must prove that no genuine issues exist and that it is entitled to judgment as matter of law. *Id.*

Additionally, since the issue of whether one party owed “a duty” to another is a question of law, it is an issue that is reviewed *de novo*. *Larson v. Larson*, 373 N.W.2d 287, 289 (Minn. 1985). As such, this court is not bound by District Court’s legal conclusions. *A.J. Chromy Constr. Co. v. Commercial Mech. Servs., Inc.*, 260 N.W.2d 579, 582 (Minn. 1977). And while courts generally determine duty, when it is a close call the issue is for the jury. *Connolly v. Nicollet Hotel*, 254 Minn. 373, 385, 95 N.W.2d 657, 666 (1959).

B. District Court failed to charge Respondent with a duty of care pursuant Minn. Stat. § 169.14 (2011).

Minn. Stat. § 169.14 (2011) charges all motorists with a duty of due care. In pertinent part, § 169.14 provides that:

Every driver is responsible for becoming and remaining aware of the actual and potential hazards then existing on the highway and **must use due care in operating a vehicle.**

Id. at subd. 1. (emphasis provided). *See also Jablinske v. Eckstrom*, 247 Minn. 140, 144, 76 N.W.2d 654, 657 (1956) (even when a motorist has a right of way, they must exercise due care); *Kapla v. Lehti*, 225 Minn. 325, 334, 30 N.W.2d 685, 691 (1948) (“the driver of an automobile is required always to exercise due care.”); *Veld v. Steffl*, 363 N.W.2d 821, 823 (Minn. Ct. App. 1985) (a motorist must “exercise due care to avoid a collision.”).

Failure to use due care pursuant to § 169.14, subd. 1 is negligence. “Minnesota courts have defined negligence as the failure to exercise ‘due or ordinary care.’” 4 Minn. Prac., Jury Instr. Guides—Civil CIVJIG 25.10 (5th ed.). And a “violation of a traffic law is [generally] negligence” 4A Minn. Prac., Jury Instr. Guides—Civil CIVJIG 65.25 (5th ed.).

Minn. Stat. § 169.14, subd. 1 imposes two obligations on a motorist. First, “[e]very driver is responsible for becoming and remaining aware of the actual and potential hazards then existing” Second, every driver “must use due care in operating a vehicle.” *Id.*

The phrase “actual and potential hazards” is not limited to road or weather conditions. Logically, a motorist may, through their own acts or omissions, create “actual and potential hazards.” If a motorist, by their own acts or omissions, brings or creates

hazards on the roadway “then [they necessarily exist] on the highway.” In such an event, the motorist is “responsible for becoming aware” of that hazard.

For instance, a semi-truck carrying oversized cargo creates an “actual and potential hazard[d]” by impeding the natural flow of traffic and increasing the likelihood of a catastrophic injury should a collision or accident occur. In turn, the semi-truck driver must recognize the hazard they created and then exercise due care. The driver would likely exercise due care by equipping the trailer and cargo with flashing lights and signage indicating “oversized load”. Likewise, a motorist driving on tread-barren tires creates an “actual and potential hazard” by making a collision more likely should the driver need to break or maneuver quickly, especially during inclement weather. A motorist with tread-barren tires must be aware of that “actual and potential hazard” and then exercise due care. In essence, the operators are assuming the risks they have created, i.e., the “actual and potential hazards”, when they affirmatively elect to drive in such situations.

Respondent Scott Finnegan created an “actual and potential hazard” by driving an automobile while experiencing troubling and ongoing medical symptoms without having sought a medical diagnosis. To be sure, Respondent’s steadily deteriorating fine motor skills, i.e., hand trembles, and coordination, as well as symptoms of ataxic gait, created foreseeable actual and potential hazards in driving. More alarming is that those symptoms are often suggestive of a serious neurological condition, which surely poses an even greater hazard. In essence, Respondent’s deteriorating physical and neurological conditions made himself a highway hazard. By operating a motor vehicle Respondent assumed a risk by putting a hazard—himself—onto the roadway, where it “then existed.” Respondent owed a duty to

other motorists to become and remain aware that he was a hazard when operating a motor-vehicle due to his serious neurological symptoms, i.e., deteriorating motor skills, and the then undiagnosed medical condition.

More importantly, “due care” under § 169.14 includes a duty to ensure that one is physically and mentally fit to drive. It is commonsense that if one has a duty to exercise due care while operating a motor-vehicle then one also has a duty to exercise due care when deciding whether he or she is mentally and physically fit to drive at all. If there are known conditions or facts that create an increased risk of, for example, falling asleep or having a seizure at the wheel, then the operator assumes the risk of such an event happening.

Here, Respondent knew that something was seriously wrong with him. Indeed, Respondent had trouble performing his duties as a nurse because of his symptoms. He was not suffering from a fleeting, mild malady, but rather experiencing chronic, worsening, and alarming symptoms. Yet, he ignored the risk of harm to himself and others that his undiagnosed medical condition could potentially create while operating a motor-vehicle.

Perhaps Respondent was unaware of how his symptoms would evolve beyond hand trembles and deteriorating coordination and fine motor skills. Perhaps he was completely indifferent about his own health issues. But, driving is a privilege, not a right. And there are few everyday tasks more inherently dangerous than operating a motor-vehicle. When a driver’s health issues create potential hazards **to others on the roadway** then the driver has a duty to exercise reasonable care for the safety of others. If Respondent wanted to continue reasonably exercising his driving privileges then he should have sought medical

care, specifically for his deteriorating motor skills, secured a diagnosis and then determined whether he should drive at all.

While an adult is responsible for making their own health care decisions, including choosing to ignore health problems, a motorist who ignores worrisome symptoms should not be rewarded when their undiagnosed medical condition causes or contributes to them losing consciousness, losing control of their vehicle, and causing a collision. District Court, by holding Respondent did not owe a duty to others, essentially rewarded his decision to drive after ignoring ominous medical symptoms. District Court's holding is bad policy and contrary to a duty of due care that any motorist owes or should owe.

After the collision, Dr. Thomas Jacques, a neurologist, evaluated Respondent. (A.A. 144-45). Dr. Jacques reviewed an CT scan of Respondent's brain, which revealed "severe significant cerebellar atrophy especially for somebody of 40 years old." (A.A. 144). Respondent subsequently presented to Dr. Laura Li, who recommended that Respondent refrain from driving because of his pronounced cerebellar atrophy. (A.A. 75-76). Respondent followed Dr. Li's recommendation and he no longer drives. (A.A. 76).

It should not take a collision to force a motorist to finally seek treatment and address the question of whether it is safe or not for them to drive. Respondent would be blameless if he lost consciousness due to a sudden, unknown, medical condition that had never produced symptoms. But that is not what happened here. A duty to assess actual and potential hazards **includes an ongoing duty to self-assess whether one is fit to drive.** This duty does not arise only after a motorist causes a collision when medical symptoms should have placed a reasonable person on notice that something was seriously wrong.

Otherwise, the purpose of imposing a duty—compelling individuals to use reasonable care so as to avoid harming others—would be frustrated.

In any event, § 169.14, subd. 1 is patently clear: every driver owes a duty of due care. That duty is owed without regard to unexpected events that may occur causing or contributing to a collision. If a sudden emergency does occur and causes or contributes to a collision the “at-fault” motorist is still said to have owed a duty, although they may be relieved from negligence. *See Trudeau v. Sina Contracting Co.*, 241 Minn. 79, 86, 62 N.W.2d 492, 497(1954) (explaining that the existence of an emergency excuses negligence and is “ordinarily a question of fact.”). Put differently, because a motorist **always** owes a duty of due care, an “emergency defense” does not rebut the existence of duty; rather, it relieves their negligence. *See id.*

Based on the preceding, District Court erred by failing to charge Respondent with a duty pursuant to § 169.14 and therefore must be reversed.

II. District Court’s duty analysis is contrary to precedent holding that a *prima facie* case of negligence is established by evidence that the defendant motorist fell asleep.

Appellants have essentially presented two theories of liability. The two theories overlap in many respects. First, Respondent could have merely fallen asleep at the wheel due to erratically taking prescription medication and/or sleep deprivation, both of which he was aware.⁴ Second, Respondent could have lost consciousness and then lost control of his vehicle due to known physical symptoms and an as-of-yet diagnosed medical condition (his

⁴ Note that Respondent’s medications, Celexa and Trazodone, may cause sleepiness/drowsiness. (A.A. 119, 124).

medical condition could have caused or contributed to Respondent's sleep deprivation—hence the overlap). This section only addresses Appellants' first theory of liability.

District Court wrote that “[w]hether it was a seizure or falling asleep or a blackout of some sort [that caused Respondent to lose control of his vehicle] is not ultimately relevant” (A.A. 52). This is incorrect; whether Respondent fell asleep is relevant because it proves or disproves Appellants' theory of the case. More importantly, if there is material evidence that, when viewed in a light most favorable to the non-moving party, shows Respondent fell asleep, then a *prima facie* case of negligence is established. If there is a *prima facie* case of negligence then a duty was implicitly owed.

District Court mischaracterized two leading cases concerning the liability of a sleeping motorist. District Court cited *Bushnell v. Bushnell*, 131 A. 432, 434-35 (Conn. 1925) and *Hardgrove v. Bade*, 190 Minn. 523, 526, 252 N.W. 334, 335 (1934) for the proposition that “some courts have held that where a defendant falls asleep at the wheel, foreseeability should be presumed” and therefore duty is presumed. (A.A. 57). Actually, *Bushnell* and *Hardgrove* hold that a motorist **always owes a duty of care** and that falling asleep while driving is *prima facie* evidence of negligence. See *Bushnell*, 131 A. at 435; *Hardgrove*, 190 Minn. at 525-27.

Bushnell resolved whether a motorist can act negligently—or breach their duty of care—by falling asleep at the wheel. 131 A. at 434-5. *Bushnell* held that a motorist may be negligent for falling asleep while driving but not negligent if “stricken by paralysis, or seized by an epileptic fit.” *Id.* The rationale for the distinction is that sleep rarely comes unheralded whereas medical emergencies can occur suddenly and without warning. *Id.* The

court went further, writing that “**the mere fact of his going to sleep while driving is a proper basis for an inference of negligence sufficient to make out a prima facie case, and sufficient for a recovery, if no circumstances tending to excuse or justify his conduct are proven.**” *Id.*

The question in *Hardgrove* was whether “defendant was guilty of **gross negligence** within the meaning of the North Dakota statute.” *Id.* (emphasis provided) **The court did not analyze duty; instead it acknowledged that a motorist owes a duty of “ordinary care” when operating an automobile.** *Id.* The court held that falling asleep while driving could constitute gross negligence. *Id.* And “[w]hether, under the circumstances, defendant was guilty of gross negligence in permitting himself to fall asleep [is] an issue properly submitted to the jury.” *Id.*

Bushnell and *Hardgrove* are not legal authority for the proposition that a duty is sometimes owed because falling asleep is sometimes presumptively foreseeable. Instead, *Bushnell* and *Hardgrove* support that (1) all motorists owe a duty of due care and (2) falling asleep while driving is *prima facie* evidence of negligence. District Court’s characterization of *Bushnell* and *Hardgrove* is therefore erroneous.

Moreover, this court should do what District Court failed to do: look at **all** the evidence that Appellants produced, view it in a light most favorable to Appellants, and ask whether a reasonable person could conclude that: (1) Respondent’s erratic taking of his prescription medication was affecting his alertness and/or contributing to his sleep deprivation; (2) Respondent knew he was sleep deprived; and (3) Respondent fell asleep while driving.

Appellants produced the following evidence. Immediately upon waking up at the crash scene, Respondent admitted that he fell asleep at the wheel. (A.A. 88). Respondent admitted to falling asleep while driving on at least one other occasion. (A.A. 88). Respondent reported significant sleep deprivation during the days preceding the collision. (A.A. 141). Family members testified that Respondent appeared confused before getting into his car. (A.A. 110, 112). Before leaving the driveway, Respondent had an unusual “mental error,” i.e., forgetting how to engage the clutch and put his vehicle in reverse. (A.A. 73).

Moreover, Respondent sought treatment for depression and sleeping problems less than a month before the collision. (A.A. 127, 128). In part because of withholding pertinent medical history, Nurse Practitioner Hannigan prescribed Celexa and Trazodone to Respondent. (A.A. 129) **Trazodone, which is designed to make people sleep, should not be mixed with alcohol and even when used as prescribed may impair thinking or reactions.** (A.A. 117, 119). Consumer drug information urges carefulness when driving after consuming Trazodone. (A.A. 119). Trazodone should be taken only as prescribed. (A.A. 118). Likewise, Celexa may impair thinking or reactions and consumers are encouraged to use extra caution when driving. (A.A. 123-24).

Nurse Heddle of Allina Medical Clinic, who met with Respondent before he was prescribed these medications, testified that one should exercise caution for several weeks after initially taking Celexa and Trazodone because the body needs time to acclimate. (A.A. 115-16). Mixing the prescriptions with alcohol should be avoided. (A.A. 117, 124).

Despite all these contraindications, of which Respondent was very aware, he did not take his prescriptions as directed and mixed them with alcohol. (A.A. 98-99). And he continued to drive a car when sleep deprived and experiencing impaired thinking.

When the aforementioned evidence is viewed most favorably to Appellants, a reasonable person could easily conclude that Respondent was (1) on potent prescription medications; (2) that he was assuming dangerous risks by not taking them exactly as prescribed; (3) that he was sleep deprived; and (4) he likely fell asleep while driving. Respondent, in fact, admitted as much. It is befuddling, and contrary to a fair review of the evidence, as to how District Court could conclude that Respondent owed no duty and therefore breached no duty. The “actual and potential hazards” presented by Respondent’s sleep deprivation, erratic taking of sleep-inducing prescription medications, his mental errors and feelings of confusion before getting behind the wheel were all known to Respondent. He had a duty to assess those risks and their affect on his ability to safely operate a motor-vehicle.

Additionally, the evidence permits a reasonable person to conclude that Respondent, by his own acts and omissions, contributed to or exacerbated his sleep deprivation. Respondent erratically consumed Trazodone and Celexa. He also occasionally mixed these medications with alcohol. All of these decisions, which Respondent independently and voluntarily made, impaired his body’s ability to acclimate to a powerful sleep aid. After several weeks of erratic Trazodone treatment, Respondent’s sleep deprivation persisted, if not worsened. A reasonable inference is that sporadically taking Trazodone and Celexa and

mixing them with alcohol worsened Respondent's sleep troubles, thereby making it **more likely, and definitely foreseeable**, that he would fall asleep while driving.

Appellants did establish a *prima facie* case of negligence pursuant to *Bushnell* and *Hardgrove*. If a *prima facie* case of negligence is established, it follows that a duty was owed. As such, this Court must reverse District Court's decision holding that that Respondent did not owe a duty.

III. District Court exceeded its authority by adjudicating facts and wrongly concluding that the collision was unforeseeable, to reach its erroneous holding that Respondent did not owe a duty.

District Court acknowledged that Appellants' and Respondent's theories concerning the cause and foreseeability of the collision were supported by facts. (A.A. 49-50). Nevertheless, District Court concluded that it was unforeseeable that Respondent would lose control of his vehicle and cause a collision, and therefore he did not owe a duty. (A.A. 52). It is difficult to ascertain how District Court reached its holding without weighing evidence and adjudicating facts.

District Court framed "duty" as follows: "there can be no duty unless the harm Plaintiff suffers is foreseeable." (A.A. 52). Citing *Austin v. Metro. Life Ins. Co.*, 152 N.W.2d 136, 138 (Minn. 1967). District Court then explained that "a danger is foreseeable if it is objectively reasonable to expect." (A.A. 52). Citing *Whiteford by Whiteford v. Yamaha Motor Corp., U.S.A.*, 582 N.W.2d 916, 918 (Minn. 1998). Here, District Court viewed the harm or danger as Respondent "los[ing] control of his vehicle." (A.A. 52). Because District Court concluded that the collision was unforeseeable (because it was unforeseeable that

Respondent would lose consciousness at the wheel) it held that Respondent did not owe a duty of care. (A.A. 52).

Appellants did present evidence that Respondent (1) knew he was erratically taking powerful prescription medications, both of which had contraindications that warned of diminished effects on reaction time, thinking and causing drowsiness, (2) knew that he was sleep deprived and (3) admitted immediately after the crash that he had fallen asleep while driving. Put differently, there is strong evidence that the risk of Respondent falling asleep while driving was not only foreseeable but, in fact, he increased that risk. Respondent should have been charged with a duty under District Court's framework. Because District Court failed to view the evidence in a proper light it proceeded to err in its analysis and conclusion.

Alternatively, evidence also supports that it was foreseeable that Respondent's then undiagnosed medical condition, i.e., cerebellar brain atrophy, would cause or contribute to him losing control of his vehicle. For well over a year before the crash Respondent had been experiencing classic symptoms of a serious worsening neurological condition. His hands would tremble, his gait became unbalanced, and his coordination and fine motor skills were deteriorating. Respondent—a medical professional himself—was well aware that these symptoms began manifesting two years before the collision, persisted and even worsened. Despite the seriousness of those symptoms, Respondent chose not have them clinically assessed.

Respondent also began experiencing sleep deprivation and depression in addition to this undiagnosed neurological condition. Respondent has a long and significant history of

head trauma, which is also linked to cerebral atrophy. All told, Respondent's symptoms and background made it all but conclusive—especially to a medical professional like Respondent—that he was suffering from **some** type of serious and worsening neurological condition. Yet he chose not to do anything about it, except seek prescription medications for **other** health issues, medications that appear to have exacerbated his issues with drowsiness, dulled mental perceptions and clouded thinking.

Importantly, it was objectively reasonable to foresee that Respondent's then undiagnosed neurological condition would manifest itself in ways other than his daily symptoms, i.e., diminishing motor skills. Admittedly, without a diagnosis it would have been difficult to foresee what **precise** manifestation (e.g., a stroke, a seizure, or blackout) would occur beyond Respondent's daily symptoms. But, given that Respondent's symptoms had been presenting and worsening for about two years, it was highly probable that **something** more serious than his daily symptoms would occur. *See Nicollet Hotel*, 254 Minn. at 381-82, 95 N.W.2d at 664 (1959) (providing that “it is not necessary that the defendants should have notice of the particular method in which an accident would occur, if the possibility of an accident was clear to the person of ordinary prudence.”).⁵

Put another way, the odds that an individual who is not experiencing any neurological symptoms would succumb to a sudden blackout, seizure or other neurological event is remote—too remote to be legally foreseeable. But, the odds that a person who is experiencing chronic neurological symptoms and with a long history of multiple traumatic

⁵ Hence, the test is whether it was foreseeable that **some** neurological event, e.g., blackout, seizure, etc., would occur causing Respondent to lose control of his vehicle, not whether it was foreseeable that a particular neurological event would occur.

brain injuries would succumb to a seizure or other neurologic event are high—high enough to be legally foreseeable.

Yet, per District Court's analysis, evidence that Respondent was experiencing neurological symptoms was insufficient to make it foreseeable that he would succumb to a neurological event while driving; for a neurological event to be foreseeable Respondent must have had a diagnosis. Essentially, for Respondent to have owed a duty, a physician must have **told him** that it was highly likely that he could suffer a neurological event like a seizure at any moment, including while driving. Once again, this analysis effectively rewards the individual who ignores the symptoms and does not seek a diagnosis and treatment.

Respondent chose to bury his head in the sand, ignore his symptoms, never seek a diagnosis, and kept driving his car (while taking—or not taking—strong prescription medications), all of which put others at risk. In comparison, a reasonably prudent individual in Respondent's shoes would have sought treatment, which would have included CT scan and/or other diagnostic testing. Hence, a reasonable person in Respondent's shoes would have sought medical treatment, undergone testing and secured the diagnosis of significant brain atrophy—a serious neurological condition indeed. Using District Court's analysis, this fictional reasonable person would have been charged with a duty of due care if their diagnosis was similar to Respondent's. Because Respondent chose not to seek treatment of his known and worsening symptoms, however, he did not receive his diagnosis of brain atrophy before the collision, and therefore does not owe a duty of care under District Court's analysis. In essence, Respondent was rewarded for his deceptive conduct whereas a reasonable person would have been exposed to liability.

Last, and importantly, when foreseeability is a “close call” then the issue is reserved for the jurors. *Domagala v. Rolland*, 805 N.W.2d 14, 27 (Minn. 2011). The evidence here permits a reasonable person to conclude that it was objectively reasonable to recognize the increased risk or likelihood of Respondent suffering a neurological event while driving. *See id.* at 26. Put differently, because Respondent was experiencing worsening neurological symptoms for at least two years, it was more than just conceivably possible that he would suffer a seizure, stroke, blackout, or other neurological event. *See id.* Because there is a genuine disagreement regarding the foreseeability of Respondent suffering a severe neurological event while driving, the triers of fact—the jury—and not the court should resolve the existence of duty.

A. District Court overlooked evidence, adjudicated fact disputes, and did not view evidence in a light most favorable to Appellants.

District Court appears to have overlooked (or ignored) Appellants’ argument and evidence in support thereof that the crash was caused by Respondent, for reasons that were both foreseeable and within his control, by falling asleep at the wheel. In other words, District Court decided a material fact issue, i.e., that Respondent suffered an unforeseen seizure.

For instance, after acknowledging that evidence supports Appellants’ theory, District Court wrote that “[Respondent] had never had a seizure before, and he had not yet been diagnosed with brain atrophy.” (A.A. 52) (emphasis provided). By writing that Respondent had not experienced a seizure before, District Court implicitly stated that Respondent suffered one on November 11, 2009. **Whether Respondent actually had a seizure or simply fell asleep is a disputed fact issue**, however.

Furthermore, District Court also wrote that “[t]his was his first indication that he was not fit to drive . . .” (A.A. 52). Given the context, it is hard ascertain what else besides a seizure that “first indication” could reference. Also, while there may be a difference between a medical directive specifically declaring a person medically unfit to drive a motor vehicle and a person who fully **knows** that he is taking strong prescription medications (erratically) or is experiencing varying degrees of confusion and dulled thinking all while dealing with significantly deteriorating motor skill function, the later individual, while still legally licensed to drive, assumed the **increased foreseeable risk** of something bad happening while he is operating a car. Why is this so? Because his physical condition makes himself a “hazard” to others on the roadway with him.

Additionally, District Court later wrote that “[i]n the moment, however, a reasonable person would not see such a “mental error” as a sign that a seizure is imminent” (A.A. 54) (emphasis provided). Once again, District Court’s analysis shows it decided that Respondent suffered a seizure despite strong evidence to the contrary—evidence that supports that it is more plausible that he merely fell asleep at the wheel.

District Court also appears to have viewed evidence in a vacuum instead of in the aggregate. When assessing evidence that Respondent was consuming Trazodone and Celexa, District Court concluded that taking these “medications does not make what happened to him foreseeable” because Respondent was not “instruct[ed] . . . to cease driving altogether.” (A.A. 54). District Court explained that “[a]lthough it is certainly inadvisable to take medication other than directed, doing so does not making losing

consciousness while driving foreseeable.” (A.A. 54). But what about becoming sleep deprived, confused, sleep, drowsy, dulled senses and reactions? It is well known that all of those side effects are foreseeable when taking Trazodone and Celexa, especially when not taking them strictly as prescribed. (A.A. 119, 124).

In its analysis District Court not only failed to view evidence of Respondent’s erratic prescription medication consumption in a light most favorable to Appellants, but also completely ignored the known side effects of Celexa and Trazodone. Respondent chose to take these powerful prescription medications when **he** wanted to take them, **not** as prescribed. Viewed most favorably to Appellants, these facts show that Respondent exacerbated the medications’ side effects, e.g., drowsiness, dulled reactions, etc., and worsened his sleep problems and sleep deprivation.⁶ This dovetails with Respondent’s admissions to medical personnel that he was sleep deprived and fell asleep at the wheel. In other words, these material facts (when considered) makes Appellants’ theory that Respondent merely fell asleep highly probable.

Likewise, District Court did not view evidence of Respondent’s admittedly strange “mental error” of not remembering how to engage the clutch to shift his car in the minutes before the crash in a light most favorable to Appellants. (*See* A.A. 54). Evidence of Respondent’s “mental error” infers that he was confused, groggy, not alert, sleep deprived and not thinking clearly. All of these are foreseeable side effects of Trazadone and Celexa. The logical conclusion from all of this is that Respondent should have recognized he was

⁶ Note that alcohol “can increase some of the side effects of Celexa.” (A.A. 124). Nurse Heddle also testified about the dangers of mixing prescription medications with alcohol as well as the importance of strictly taking medications as prescribed. (A.A. 115).

impaired due to his sleep issues and/or the effects of the medications and that he assumed the associated risks and proceeded to fall asleep at the wheel.

Further, District Court misconstrued evidence of Respondent's troubling medical history and his failure to disclose pertinent medical history to Nurse Practitioner Hannigan. Once again, District Court looked at this evidence in isolation, writing that "this Court cannot agree that Defendant's medical history makes this collision foreseeable." (A.A. 55). District Court also wrote that "[t]he Court therefore declines to impose a duty on [Respondent] to report all historical medical information about himself at every medical appointment." (A.A. 57).

District Court's statement seems to demonstrate a lack of understanding of the significance of Respondent's symptoms of seriously deteriorating motor skills. Those are ominous signs of a serious neurological disease/disorder. Nurse Practitioner Hannigan testified that she would have acted differently and referred Respondent to neurology had he been forthright about his history of traumatic brain injury and his neurological symptoms. (A.A. 80). In other words, Respondent would not have been prescribed Trazodone and Celexa had he revealed symptoms of axiatic-like gait, deteriorating motor skills and coordination, and a history of multiple traumatic brain injuries. Instead, he would have undergone a neurological evaluation and had his condition of advanced brain atrophy diagnosed.

Instead, Respondent's deceit and incomplete medical history disclosures led to Nurse Practitioner Hannigan prescribing medications (that he took erratically, i.e., negligently), which in turn contributed to or exacerbated his sleep problems and sleep deprivation, and

his falling asleep at the wheel, which caused the collision. All of those facts are in evidence. When viewed in the proper light, summary judgment should have been denied.

IV. District Court erroneously relied on *Echagdaly*, and by doing so wrongly supplanted the “sudden incapacity” doctrine into its duty analysis.

District Court relied heavily on *Echagdaly v. Metro. Council Transit Operations*, C4-99-77, 1999 WL 508661 (Minn. Ct. App. July 20, 1999) (unpublished opinion) to support that Respondent did not owe a duty and was therefore not negligent. (A.A. 53). The word “duty,” however, never appears in the *Echagdaly* opinion. *See id.* Nor was duty implicitly discussed. *See id.*

Instead, *Echagdaly* applied the “sudden incapacity” defense to hold that a defendant driver was not negligent. *Id.* Importantly, “sudden incapacity” is a defense to negligence and not a test for duty. District Court, therefore, improperly used *Echagdaly* to support its holding that Respondent did not owe a duty.

Alternatively, District Court erred even if it applied *Echagdaly* to relieve Respondent from negligence rather than holding he did not owe a duty. “Sudden incapacity” is an affirmative defense that must be **conclusively established** to prevail at summary judgment. That places the burden on Respondent to **prove** that he suffered an unforeseen seizure. In this case there is a material fact dispute concerning the cause and foreseeability of Respondent losing control of his vehicle. As such, Respondent is not entitled to summary judgment relief under the “sudden incapacity” doctrine.

In *Echagdaly*, the at-fault driver rammed a parked public bus after suddenly losing consciousness. *Id.* Plaintiff argued that the at-fault driver “blacked out” due to drug use

whereas defendant argued it was due to an unforeseen seizure. *Id.* The plaintiff failed to produce any evidence supporting that defendant's "black out" was caused by drug use, however. *See id.* Conversely, defendant presented a **physician's opinion** that the at-fault driver suffered a seizure. As a result, the only conclusion that district court and court of appeals could reach was that the at-fault driver suffered a seizure. *Id.*

Next, the court of appeals decided what affect the at-fault driver's seizure, of which the driver had no forewarning, had on plaintiff's negligence action. The court of appeals applied the "sudden incapacity" doctrine, writing that "[a]lthough no Minnesota courts appear to have addressed the issue of negligence if a driver unexpectedly blacks out, tort treatises and case law outside this jurisdiction support finding the driver not negligent." *Id.* at *1. (emphasis provided). Notably, the court did not hold that the driver did not owe a duty. Rather, the court excused the at-fault motorist from negligence.

The *Echagdaly* court correctly observed that other jurisdictions and tort treatises recognize that a motorist who is suddenly and **unforeseeably** incapacitated while driving cannot be said to have acted negligently. The defense of "sudden incapacity" (sometimes referred to as "sudden loss of consciousness" or "Act of God") is summarized in Timothy E. Travers, Annotation, *Liability for Automobile Accident Allegedly Caused by Driver's Blackout, Sudden Unconsciousness, or the Like*, 93 A.L.R. 326 (1970 and Supp. 2005). "The cases decided under negligence theories have uniformly held that a **sudden loss of consciousness while driving is a complete defense to an action based on negligence or gross negligence, if such loss of consciousness was not foreseeable.**" *Id.* (emphasis provided). *See also*

McCall v. Wilder, 913 S.W.2d 150, 154-55 (Tenn. 1995) (describing the doctrine and then listing twenty-six states that have adopted it, albeit with variations in application).

Additionally, *Goodrich v. Blair*, 132 Ariz. 459 (Ct. App. 1982), *review denied*, June 22, 1982, explained how “sudden incapacity” meshes with the “reasonable man standard of care” framework. In pertinent part, the court wrote that

[The defense of sudden incapacity] shifts the point of inquiry away from the moment of negligent driving, and causes the jury to consider the defendant’s decision to drive at all. If the defendant’s health was such that a reasonably prudent man would not risk driving a car, then the defendant is negligent by merely undertaking the task of driving, regardless of subsequent events. . . . [T]he jury must determine that, at the time the person chooses to drive and does drive his car, the physical incapacity was not reasonably foreseeable.

Id. at 461. (emphasis provided). This is also very appropriate to the analysis that should be applied to Respondent’s acts/omissions leading to his decision to get behind the wheel and drive on November 11, 2009.

Conceptually, the “sudden incapacity” defense involves burden-shifting. *Keller v. Wonn*, 87 S.E.2d 453 (W. Va. 1955). If there is *prima facie* case of negligence, then the burden is “upon the defendant to show the sudden illness or attack, and to further show that the illness or attack was unanticipatable and unforeseen.” *Id.* If a defendant establishes a *prima facie* defense of “sudden incapacity” then the burden shifts to the plaintiff to rebut the defense. *Lewis v. Smith*, 517 S.E.2d 538, 541 (Ga. Ct. App. 1999), *cert. denied* Sept. 17, 1999. **Jurors**, however, resolve fact disputes concerning whether a sudden illness or attack occurred and if it was foreseeable. *See Keller*, 87 S.E.2d at 461-62. Only when the evidence conclusively shows that the defendant had “no reason to foresee or anticipate the sudden attack” should a directed verdict or summary judgment be granted. *See id.*

Moreover, the “sudden incapacity” defense does not apply to a driver who merely falls asleep because of exhaustion. Instead, it applies only when there is evidence of a document, proven, medical type of emergency—heart attack, seizure, fainting and the like.⁷

Given the preceding, District Court erred by relying on *Echagdaly* because the court essentially inserted the “sudden incapacity” defense into its duty analysis, which is not what *Echagdaly* says.

District court also wrote that *Echagdaly* is “a case very factually similar to this one.” (A.A. 53). The facts, however, are only vaguely similar.

In *Echagdaly*, the defendant presented conclusive evidence that the at-fault driver suffered a seizure. Conversely, the plaintiff could only cite a statement by defendant’s physician that the at-fault driver “could have had cocaine or marijuana in his system around the time of the accident.” *Echagdaly*, 1999 WL 508661, at *1. Because plaintiff’s evidence was merely speculation there was only one reasonable conclusion to draw: the at-fault driver had a seizure.

In this case, however, Respondent has not even conclusively shown that he suffered a seizure—let alone an **unforeseen** seizure. Respondent presented the following evidence.

⁷ See *Ferkel v. Bi-State Transit Dev. Agency*, 682 S.W.2d 91, 92 (Mo. Ct. App. 1984) (applying “sudden incapacity” when the at-fault driver fainted and had no warning of an impending loss of consciousness); *Henry v. Knudsen*, 692 S.E.2d 878, 882 (N.C. Ct. App. 2010) (defendant driver employed “sudden incapacity” to argue that his loss of consciousness was unforeseen and caused by congestive heart failure); *Karl v. Terbush*, 881 N.Y.S.2d 207, 207 (App. Div. 2009) (plaintiff used defendant’s medical records, which indicated episodes of “dizziness, lightheadedness and weakness which increased in frequency shortly before the accident,” to argue that defendant’s “sudden incapacity” was foreseeable) *Howle v. PYA/Monarch, Inc.*, 344 S.E.2d 157, 158-59 (S.C. Ct. App. 1986) (defendant driver raised “sudden incapacity,” arguing that he went into a diabetic coma just prior to the collision).

Respondent's brother-in-law thought he saw "saliva, spit, foam or something around his mouth" shortly after the collision. (A.A. 5-6). Respondent seemed "out of it" after the collision, which is **sometimes** consistent with a person having a seizure. (A.A. 7). **Witnesses** reported to EMTs that they **thought** Respondent had a seizure. (A.A. 6). And, medical records merely **suggest** that Respondent had a seizure.⁸ (A.A. 6); (*see also* A. A. 141-45). Finally, Respondent has since been diagnosed with brain atrophy, which can trigger seizures. (A.A. 141-45). Appellants do not dispute that if this evidence is viewed in a light most favorable to Respondent, that one could possibly conclude that Respondent suffered a seizure. But, that does not entitle Respondent to summary judgment.

And, importantly, Appellants' theories are also supported by evidence. First, a reasonable juror could conclude that Respondent just plain fell asleep at the wheel.⁹ In other words, jurors could conclude that Respondent **did not** suffer a seizure.¹⁰ Second, a reasonable juror could conclude that even if Respondent suffered a blackout or seizure-like event, then it was **foreseeable** given Respondent's neurological medical symptoms, of which

⁸ No medical opinion concluding that Respondent did, in fact, suffer any kind of seizure—foreseen or unforeseen—has been submitted in support of Respondent's theory.

⁹ Respondent admitted to City of Woodbury EMT Huerta that he fell asleep. (A.A. 88). Respondent has fallen asleep while driving on at least one other occasion. (A.A. 74). Respondent also admitted to being sleep deprived preceding the collision and, in fact, sought treatment for sleep deprivation. (A.A. 128, 141). Respondent was prescribed two power prescription medications—Trazodone and Celexa. (A.A. 129). He did not strictly follow directions for consuming these medications and mixed them with alcohol, which is warned against. (A.A. 99, 115, 119, 124). And, his medications, even when used as directed, may cause drowsiness, confusion, sleep problems, among other things. (A.A. 119, 124).

¹⁰ Respondent has not offered any medical opinion that he, in fact, suffered a seizure. Instead, the clinical records reflect that Respondent was treated **as if** he suffered one. (*see* A.A. 141-145). Indeed, Respondent's treating neurologist, Dr. Jacques, noted that "[a]t this time the gentleman [referring to Respondent] **presents with a possible seizure**" (A.A. 145).

he was well aware (and which he chose to ignore—at his own risk).¹¹ Because there is more than one plausible conclusion as to what actually caused Respondent to lose control of his vehicle and cause a crash, District Court erred by relieving Respondent from negligence under the “sudden incapacity” doctrine.

CONCLUSION

Respondent knew he had trouble sleeping, sought medical help, but withheld vital medical history. That was his choice. Respondent was experiencing strange and troubling medical symptoms but refused to get a diagnosis. That was his decision. Respondent was prescribed powerful medications, including a nighttime sleep aid. These medications came with specific directions but he ignored them. He was advised against mixing his pills with alcohol. But he mixed them anyway. Respondent experienced sleep deprivation after starting Trazodone treatment yet continued to erratically take the medication. Just before entering his vehicle, Respondent was confused, not thinking clearly, and forgot how to engage the clutch. Yet, he decided to drive. Respondent risked that he would stay awake and alert. Respondent risked that his medical symptoms would not manifest themselves on the roadway and cause or contribute to losing consciousness. Respondent gambled poorly and either fell asleep or lost consciousness due to a neurological event while driving, causing

¹¹ About two years before the crash Respondent started becoming aware of his symptoms, i.e., ataxic gait and diminished fine motor skills and coordination. (A.A. 70). His symptoms made it difficult to perform his job as a nurse. (A.A. 71). Respondent also has a long history of traumatic brain injury. (A.A. 70). His symptoms made it difficult to perform his job as a nurse. (A.A. 71).

a collision that severely injured Appellant Craig A. Kellog, a man who was completely blameless and simply in the wrong place at the wrong time.

Based on the preceding, Appellants respectfully request that this court reverse District Court's grant of summary judgment. District Court erroneously concluded that Respondent did not owe a duty of care.

First, **all** motorists are charged with a duty of due care, which includes seeking medical diagnosis for serious, worsening, medical symptoms that affect motor skills to ensure that one is fit to drive. Conversely, by choosing to ignore those symptoms and choosing to keep driving, Respondent assumed the risk of those symptoms, i.e., "hazards," affecting his ability to safely operate a motor-vehicle.

Second, Appellants' evidence, when viewed in a light most favorably to Appellants, permits a reasonable person to conclude that Respondent fell asleep at the wheel after days and weeks of sleep deprivation. This establishes a *prima facie* case of negligence which **presumes** that a duty was owed.

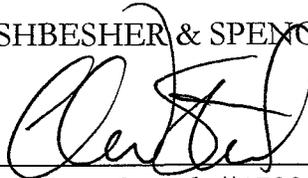
Third, District Court exceeded the scope of summary judgment by adjudicating fact disputes and concluding that the collision was unforeseeable and therefore that Respondent did not owe a duty of care.

Fourth, District Court wrongly supplanted the affirmative defense of "sudden incapacity" into its duty analysis. Alternatively, even if it was proper to employ the "sudden incapacity" doctrine, District Court erred in its application. For these reasons, District Court must be reversed.

Respectfully submitted,

MESHBESHER & SPENCE, LTD.

Dated: 6/4/12

By:  _____

Mark D. Streed, #170069
Attorneys for Plaintiff
7300 Hudson Blvd., #110
Oakdale, MN 55128
651.578.8055