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IN THE SUPREME COURT OF THE STATE OF DELAWARE

RODNEY L. MACDOUGALL and DIANE M. MACDOUGALL,	:	
	:	Case No. 44, 2013
Plaintiffs Below, Appellants,	:	
v.	:	
MAHAFFY & ASSOCIATES, INC., a Delaware corporation and SCHNEIDER ELECTRIC USA, INC., a Delaware Corporation,	:	
Defendants Below, Appellees.	:	

CORRECTED OPENING BRIEF OF PLAINTIFFS BELOW, APPELLANTS, RODNEY AND DIANE MACDOUGALL

Appeal from the Decision of the Superior Court in and for Sussex County, C.A. No.: S10C-06-010 THG

BIFFERATO GENTILOTTI LLC

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Dated: March 25, 2013

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NATURE AND STAGE OF THE PROCEEDINGS

On June 14, 2008, Appellant Rodney MacDougall was injured while working in the course and scope of his employment with Tudor Electric Inc. ("Tudor") at the Delaware Hospital for the Chronically Ill ("DHCI") in Smyrna, Delaware. MacDougall was attempting to replace a circuit breaker in an outdoor switchboard which became energized causing him to sustain severe electrical burns to his hands, arms, torso and chest. He was transported by helicopter from DHCI to Crozer Burn Center where he spent several months. He has undergone multiple amputations of his fingers, and extensive skin grafting to his hands, arms and mid section. His injuries are catastrophic.

Mr. and Mrs. MacDougall filed suit against a number of defendants some of which have been voluntarily dismissed, dismissed by Court order, or settled.

Appellants appeal a January 22, 2013 decision issued by the Honorable T. Henley Graves in the matter of MacDougall v. Mahaffy & Associates, Inc., C.A. No. S10C-06-010 in which the Court granted summary judgment in favor of Appellees Mahaffy & Associates, Inc. ("Mahaffy") and Schneider Electric USA, Inc. ("Schneider"). A copy of the decision is attached at Exhibit A. There was no oral argument.

This is Appellants' opening brief in support of their appeal seeking reversal of the January 22, 2013 decision.

SUMMARY OF ARGUMENT

The Superior Court erred, as a matter of law, when it concluded that no liability could be established by Appellants against Appellees.

I. The Court found that Mahaffy had a duty to coordinate and direct the replacement of a breaker at DHCI and it satisfied its obligation by assigning that work to Tudor. Appellants submit that Mahaffy did not properly fulfill its obligation and breached its duty proximately causing MacDougall injury. What was required of Mahaffy to discharge its duty and whether it satisfied its obligation are issues of fact not subject to summary disposition.

The lower Court also erred when it concluded, as a matter of law, that Schneider owed no duty. Appellants assert that such a determination is not appropriate for summary judgment.

II. The Court ruled, as a matter of law, that MacDougall's conduct in replacing the breaker was the sole proximate cause of his injuries thus relieving Mahaffy and Schneider of any liability for their negligence. Appellants contend that the Court erred because reasonable minds can differ as to whether MacDougall's conduct was a superseding intervening cause thereby creating an issue of fact.

STATEMENT OF FACTS

Beginning in 2006, the State of Delaware began electrical improvements and upgrades to DHCI. Tudor was contracted by the State to perform electrical work at the facility and prepare the medical buildings so that they could be connected to new electrical equipment that included a new generator. Mahaffy was hired by the State to be the architect/engineer of the project which meant that it was responsible for designing the new electrical system and overseeing the installation of the new equipment. As part of the design of the electrical system, Schneider authored a Short Circuit and Protective Device Coordination Study ("Coordination Study" or "Study") and manufactured certain equipment installed at DHCI, including the breaker which MacDougall was attempting to replace.

A. The Coordination Study

In January of 2006, Schneider was contracted to create the Coordination Study. According to the Schneider Senior Application Engineer who authored the Study, Henry Wang, the purpose of coordination study is to prevent over current conditions that could disrupt an electrical system. He testified, "in the electrical panel in your house, if you have a short-circuit or overload somewhere in one of the rooms, one of the receptacles, you don't want to trip out the main, you trip the feed breaker. . . ." A-4, p.16. The purpose of a

coordination study is to make sure that if you plug something into the wall in your home and it draws too much power, the breaker in the room will trip causing a loss of power to that room instead of the entire house. Wang specifically testified that a purpose of the Study was to eliminate breakers tripping. A-20, pp. 78-79.

The President and Chief Engineer for Mahaffy during the DHCI project was Ed Fayda. Fayda was the quarterback of the electrical upgrades and improvements at DHCI. In addition to designing the entire electrical system, Fayda testified that Schneider was required to create the Coordination Study and submit it to him for review. A-47, p. 35. Wang testified that Fayda's involvement in the Study was atypical because of the substance of his comments. A-16, p. 64, A-17, p. 65. Completion of the Coordination Study was a significant joint effort by Wang and Fayda.

B. The CPS "Training"

Mahaffy was contractually required to ensure the State employees charged with maintaining the new equipment were properly trained. A-96, §3.4.17. Earl Smith, a generator technician for Cummins Power Systems ("CPS"), came to DHCI to provide a demonstration of the equipment inside the generator room.

Smith testified that he spoke to Fayda and MacDougall but that the primary person to be trained was Wesley Wolfe, the master electrician employed by the State at DHCI who would be charged with maintaining the equipment. A-132-139.

Smith's demonstration included a start-up of the generator, how to check fluid levels, change the radiator coolant, and a general overview of how the generator operated. Id. Smith did not explain how to shutdown the generator or "rack-out" any of the equipment (to rack-out a breaker means to physically disengage it from the electrical system which is an aspect of a lock-out/tag-out procedure and is necessary to perform a shutdown of the system). A-144. Further, Smith testified that he specifically told Fayda and Wolfe that if the equipment inside the generator housing was going to be shutdown, his expectation was that CPS would be involved. Id.

C. Substantial Completion

By January of 2008, the DHCI upgrades and improvements had been "substantially completed" pursuant to the contract between the State and Mahaffy. The State took ownership of the new equipment at that time. Tudor's work was complete and had been accepted as of January 2, 2008 when the warranty period began. A-151-152. This date was significant because it meant that Mahaffy was representing to the State that the work it was hired to do, which included completion of the Coordination Study, was

complete and the new system was operational. It also meant that Tudor had completed its contract work which had been accepted by both the State and Mahaffy. Any additional work to be performed by Tudor was limited to punch list items and warranty issues.

D. Nuisance Tripping

On April 1, 2008, Tudor provided notice that a breaker in an outdoor transfer switch was "nuisance tripping." The letter requested that "someone from [Schneider] come down and check the breaker and settings." A-153. Resolving this issue was critical because when the breaker tripped, two of the DHCI medical buildings, which contained patients on oxygen and life support, lost power. Id.

The breaker could not handle the inrush current because the Coordination Study was based on assumptions instead of raw data that would have accurately identified the applicable inrush current. A-20, p.79.

E. The Coordination Study Error and Concession

Wang researched the tripping issue and worked together with Fayda to obtain the data to attempt to calculate the actual inrush current. A-154-161. Once the new calculations were complete using data instead of assumptions, a new breaker was specified and the Study was updated. There are several internal Schneider emails addressing the issue which all contain the subject line "SPD Concession - Del Hosp For Chronically Ill -

Field Office Error." In one email, the Schneider Project Manager for DHCI, Sean Walsh, stated:

> It was determined that the [breaker] is not right for the application. The [coordination study] made assumptions based on a typical transformer. We supplied a transformer from Olsun that has a higher inrush . . . *From what I have dug up this should have been caught during the study had we not made assumptions.*

A-162-164. (emphasis added).

As a consequence of the error, Schneider absorbed $8,446 which was the cost of the replacement breaker. Id.

F. Mahaffy Assigned the Replacement to Tudor

On April 29, 2008, after Schneider identified a replacement breaker, Fayda sent an email to Tudor (and the "DHCI team") directing it to replace the breaker. A-165-167.

G. NFPA 70E

NFPA 70E, *Standard for Electrical Safety in the Workplace* (2004), sets forth the standards for safe work practices. With regard to safety training, §110.6(B) requires classroom or-on-the-job training (ideally both) depending on the degree of risk to the employee. A-172. The higher the risk, the more intensive the training. Section 110.6(D)(1) requires that a "qualified person" shall be "trained and knowledgeable of the construction and operation of equipment or a specific work method and be trained to recognize and avoid the electrical hazards that might be present with respect to that equipment or

work method." Id. It is undisputed the breaker replacement was a multi-employer task requiring a complex lock-out/tag-out. A-170, §110.4(B), A-180, §120.2(D)(3). When using outside contractors such as Tudor, a coordination meeting is required to identify the hazards, appropriate safety precautions, the selection of a qualified person in charge, the assignment of various tasks, and the creation of a written plan of execution. A-170, §110.4(B)

H. The Incident

MacDougall was at DHCI on the day of the incident to replace the breaker. By this time, the State had been the owner of the equipment for more than five months and the State's master electrician at DHCI, Wesley Wolfe, had been responsible for maintaining the equipment. Wolfe is dead and was unable to provide testimony beyond a one page statement. A-183. The parties will never know what Wolfe did when he attempted to shutdown the system.

Prior to commencing the work, MacDougall confirmed the system was not energized through the use of two separate voltage meters. As he attempted to use his tools to remove tamper proof screws which held the breaker in place, the system re-energized and his tool came in contact with the energized bus bars causing him serious injury.

ARGUMENT

I. MAHAFFY FAILED TO PROPERLY DISCHARGE ITS DUTY TO COORDINATE AND DIRECT THE REPLACEMENT AND SCHNEIDER OWED A DUTY

A. Questions Presented

1. Whether the lower Court erred in concluding, as a .matter of law, that Mahaffy properly discharged its duty to coordinate and direct the breaker replacement? A-461-463.

2. Whether the lower Court erred in concluding, as a matter of law, that Schneider owed no duty? A-476-478.

B. Standard and Scope of Review

This Court reviews summary judgment decisions from the trial court *de novo* for purposes of determining whether, considering the facts and inferences in the light most favorable to the non-moving party, any genuine issues of material fact existed below for the jury to resolve. Jones v. Crawford, 1 A.3d 299 (Del. 2010).

C. Merits of the Argument

1. The Court Erred By Concluding Mahaffy Properly Discharged Its Duty

The issue which forms a basis of this appeal is the Court's overreaching conclusion that Mahaffy discharged its duties.

On that narrow issue, the Court ruled as follows:

> Mahaffy coordinated the replacement, per its obligation, by directing Tudor, the contractor, to replace the faulty breaker with the new one being shipped. A shutdown was necessary so Mahaffy coordinated with Tudor and DHCI to make certain life-supporting portable oxygen generators

would be powered by the generator when the main utility was shut down and the equipment de-energized.

Ex. A, p. 10. The Court concluded that the simple act of sending an email directing Tudor to replace the breaker and to assist DHCI with a shutdown of the facility was sufficient for Mahaffy to fulfill its obligation. A-165-167.

The Court erred by failing to properly consider or afford any deference to the opinions of Appellants' liability expert, Roger W. Bybee. In fact, the Court stated that he offered "nothing whatsoever" which required Mahaffy's presence during the replacement.[1] Ex. A, p. 10. The Court also ruled that Tudor was contractually bound to follow safe work practices and therefore it was reasonable for Mahaffy to assume that MacDougall would replace the breaker safely. Id. This assumption, the Court implies, provided Mahaffy with additional justification that its duty was discharged when it simply assigned the work to Tudor.

What was required of Mahaffy to properly direct and coordinate the replacement and whether it satisfied its obligation are issues of fact. It was improper for the Court to make such a determination.

[1] Ignoring the testimony of Bybee on the issue is tantamount to a *sua sponte* dismissal of his opinions. There was no challenge to the reliability or scientific basis supporting his conclusions.

Notwithstanding, the Court's rationale ignores a critical and undisputed fact -- the work performed by MacDougall on June 14, 2008 was after Tudor's work was substantially complete and had been accepted by the State and Mahaffy, and was therefore outside of the scope of Tudor's contractual obligations. The Court's conclusions improperly limit Bybee's opinions, ignore the standards applicable to Mahaffy's role in the replacement, are factually incorrect, and draw inferences against MacDougall rather than in his favor as the non-moving party.

2. The Replacement Was After Substantial Completion

Tudor's work pursuant to its contract with the State was completed as of January 2, 2008. A-151-152. This undisputed fact is significant as the work Tudor was contracted to perform was substantially complete (with the exception of warranty and punch list items) and had been accepted by both Mahaffy and the State. On this issue Bybee opines,

> In the construction industry and on this project in particular, this means that Mahaffey represented to the Owner [the State] that the Tudor installation is complete and accepted by Mahaffey on behalf of the Owner and the Owner will be given Beneficial Occupancy shortly, wherein the Owner takes over the operation and maintenance of the Facility while Tudor is in the warranty period for any defect (actual or latent) that may be discovered during the warranty period. Tudor is **not** responsible, in any way, for errors or omissions in either the Engineer's [Mahaffy's] design nor the selection, specification or suitability issues concerning the [Schneider] coordination study.

A-187 (emphasis in original). Notably, neither Schneider's employee-expert, Lyle Lickiss, nor Mahaffy's expert, Sidney Rubin, have refuted that the replacement was after Tudor's work was substantially complete and had been accepted.

3. The Work Was Outside the Scope of Tudor's Contractual Obligations

The replacement attempted by MacDougall was not warranty or punch list work flowing from Tudor's contractual obligations. Rather, the replacement was only necessary because of the nuisance tripping caused directly by the negligent design of the electrical system. This much is undisputed and was accepted by the trial Court. Therefore, Mahaffy's directive to Tudor to replace the breaker and assist DHCI staff with a shutdown of the facility was new work, completely unrelated to Tudor's original contractual obligations.

Bybee testified that "[MacDougall] was not doing installation on the day that Rodney was hurt. What he was doing was the effects of, as I called it, replacement. It is a maintenance kind of thing and that's beyond the scope of what Tudor is doing." A-253, p. 148. Mahaffy was not permitted to "suddenly change Tudor's position and scope of work six months or four months after substantial completion certificates had already been signed." A-252, p. 143. Bybee testified, "[i]f an error is made by the architect in his design or in his

activities associated with that construction, then he is not allowed to unilaterally push that over onto the contractor to correct." Id. at 142. It is because the replacement "was to correct a deficiency in the calculations and the equipment" it was Mahaffy's responsibility to direct and coordinate this work, create a safe environment and, according to Bybee, that required Mahaffy and Schneider to be involved. A-254, p. 150.

The distinction missed by the Court, which undermines its reasoning that Mahaffy could assume MacDougall could safely replace the breaker, is that the replacement work was new, much different and required knowledge, skill and training well beyond that which was necessary for the scope of work pursuant to the original contract. The replacement did not involve connecting wires from the facility to new equipment that was not yet operable (i.e. the installation work Tudor performed); significantly, the replacement required MacDougall to now be part of a multi-employer complex lock-out/tag-out procedure and the shutdown of a newly installed and operational electrical system that was not under Tudor's ownership or control. Moreover, at no time was MacDougall trained on the specific equipment involved as expressly mandated by NFPA 70E.

4. Mahaffy Failed to Properly Discharge Its Duty

Bybee testified that both Mahaffy and Schneider were on the

frontline of the problem with the coordination study and should have been integral to the breaker replacement. He testified,

> On a multi-employer worksite, such as DHCI, the first thing that has to happen is there has to be a meeting between the owner of the property and the, and all contractors who will be on site and they have to have a complete damage assessment or hazard assessment and that has to be a documented meeting.

A-246, p. 119.

It is undisputed that this was a multi-employer task and required a complex lock-out/tag-out pursuant to NFPA 70E, §120.2(D)(3). A-180. Such a procedure is led by a "qualified person" who "shall be trained and knowledgeable of the construction and operation of equipment or a specific work method and be trained to recognize and avoid the electrical hazards that might be present with respect to that equipment or work method." A-172-174, §110.6(d)(1). In a complex lock-out/tag-out, a qualified individual shall be the single person in charge and a written plan of execution is required. A-180, §120.2(D)(3). In a multi-employer setting such as DHCI where outside contractors such as Tudor are engaged to perform work, "the on-site employer and the outside employer(s) shall inform each other of existing hazards, personal protection equipment/clothing requirements, safe work practice and procedures, and emergency/evacuation procedures applicable to the work to be performed. This coordination shall include a

meeting and documentation." A-170, §110.4(B). No such communication or meeting ever took place.

Bybee testified, "if I were the engineer on this job -- [Schneider] would have been required to go to the scene, do the replacement. And if they had an issue with the workforce or whatever, they would have to hire a contractor that they felt was qualified to do that work, if they didn't want to do that work themselves." A-231, p. 58.

With regard to Fayda he opined, "as the design engineer and having an important part of the short-circuit analysis and coordinating, as well as the equipment that went there, he, he should have been one of all of the people, if not [Schneider], that was there that day. A-236, p. 79. He continued,

> And when the error was admitted by, by Schneider, and this is not something that I'm saying, they admitted there was an error, an office error in that situation, and [Fayda] should have been there to make sure that the error was taken care of. Because if in the situation that you were speaking of earlier, if there is a situation where there was an error by [Schneider] and [Fayda], he should have been there and should have had [Schneider] there to do the replacement. And I think that Mahaffy needed to be there at all times during that replacement.

A-254, pp. 149-150. According to Bybee, the replacement of this breaker was of sufficient magnitude that both Mahaffy and Schneider needed to be involved. As Bybee stated, "this was an important event in the life of DHCI." A-254, p. 151.

Mahaffy was the designer of the electrical system; the quarterback of the project. Because Tudor's work had been completed and accepted and this was a new task not within the scope of Tudor's original contractual obligations, and because this was a Mahaffy and Schneider error, Mahaffy had a duty (and was expressly required by NFPA 70E) to convene a meeting with Schneider, CPS, the State and Tudor to coordinate the facility shutdown and direct the replacement. Fayda had a duty to determine who was qualified to lead the effort and to perform certain required tasks. As the person most knowledgeable, Fayda had a duty to require and direct the creation of a written lock-out/tag-out protocol. Furthermore, knowing that CPS requested to be present for any shutdown of the system or the warranty would be invalidated, Fayda had a duty to insist it be involved. At a minimum, and given his contractual obligations, role in the design error, experience, knowledge of the project, the dangers associated with high voltage electricity, and the specific issues involved with the replacement, Fayda should have been involved and present at DHCI on June 14, 2008.

As it relates to Tudor, Mahaffy's coordination and direction of the replacement consisted of a single email directing it to do the work. Mahaffy's contractual obligations and the duties created by its negligent design, the standards imposed by NFPA 70E with regard to coordinating a multi-employer

complex lock-out/tag-out, and Bybee's well-grounded expert opinions, all establish that, in a light most favorable to MacDougall, Mahaffy had a clear obligation to do more. Simply, Mahaffy's actions were insufficient to fulfill its obligation.

Regardless of whether Mahaffy breached its duty, *what* was required of Mahaffy to discharge that duty and *whether* it met its obligation are genuine issues of fact. It was improper for the Court to usurp the jury's function, ignore Bybee's expert testimony in terms of what was required and make that determination as a matter of law.

5. Schneider Owed A Duty[2]

The Court concluded that Schneider owed no duty. The Court's conclusion is inconsistent with its recognition of the fact that the coordination study was negligently designed directly as a result of Schneider supplying faulty information on which the wrong breaker was installed. Once the Court recognized the joint error by Mahaffy and Schneider, to conclude that Mahaffy owed a duty to "fix its error" while Schneider did not, is incorrect, ignores competent expert testimony, and does not lend itself to summary adjudication.

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[2] Section 4 above sets forth more fully Bybee's detailed testimony and opinions regarding Schneider's duty with respect to replacement. Bybee opined that given the joint nature of the design error, Schneider's duty ran concurrent with that of Mahaffy.

Schneider's negligence created a duty to participate in and be present for the replacement, and ensure it was carried out by qualified personnel. It is undisputed that Schneider knew that to perform the replacement, a complex lock-out/tag-out of the electrical system and a shutdown of the facility was necessary. It also knew that Mahaffy directed both State personnel and Tudor to perform this work. A-165-167. Finally, it is undisputed that Schneider knew that NFPA 70E required that the personnel assigned to perform the breaker replacement must be trained on the "specific work method and be trained to recognize and avoid the electrical hazards that might be present with respect to that equipment or work method." A-172-174 §110.6(D)(1).

Bybee testified, "this was a Schneider error and it was required that Schneider repair it, not that somebody else do it at Schneider's request." A-244, p. 112. Bybee opined that

> once [Schneider] discovered the "field office error" in the defective equipment after being alerted to the problem by Tudor on 4/01/08, [Schneider] was consciously indifferent for the safety of the workers at DHCI, including [MacDougall], by refusing to intervene immediately after 04/24/08. [Schneider] allowed untrained and inexperienced workmen including [MacDougall] to be exposed to an unreasonable risk of injury on 06/14/08.

A-199. At a minimum, Schneider had a duty to participate in and be present for the replacement of the breaker -- if not do the work itself.

II. REASONABLE MINDS CAN DIFFER AS TO WHETHER MACDOUGALL'S CONDUCT WAS SUPERSEDING INTERVENING

A. Question Presented

Whether the trial Court erred by concluding, as a matter of law, that MacDougall's conduct was the sole proximate cause of his injuries? A-470-472; A-478.

B. Standard and Scope of Review

This Court reviews summary judgment decisions from the trial court *de novo* for purposes of determining whether, considering the facts and inferences in the light most favorable to the non-moving party, any genuine issues of material fact existed below for the jury to resolve. Jones v. Crawford, 1 A.3d 299 (Del. 2010).

C. Merits of the Argument

1. Applicable Law

The law of proximate cause in Delaware is well settled and is determined "on the facts of each case, upon mixed questions of logic, common sense, justice, policy and precedent." McKeon v. Goldstein, 164 A.2d 260, 262 (Del. 1960). A proximate cause is one in which a "natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury and without which the result would not have occurred." Duphily v. Delaware Electric Cooperative, Inc., 662 A.2d 821, 829 (Del. 1995)

(citing Restatement (Second) of Torts §440 (1965); W. Page Keeton, et al., Prosser and Keeton on Torts §44 (5th ed. 1984)).

"The mere occurrence of an intervening cause, however, does not automatically break the chain of causation stemming from the original tortious conduct. This Court has long recognized that there may be more than one proximate cause of an injury." Id. (citing Laws v. Webb, 658 A.2d 1000, 1007 (Del. 1995); Moffit v. Carroll, 640 A.2d 169, 175 (Del. 1994); McKeon, 164 A.2d at 262).

Superseding causation, like proximate cause, is fact-driven and "considerations of foreseeability and what a reasonable person would regard as highly extraordinary are factual questions ordinarily reserved for the jury." Duphily, 662 A.2d at 830-31. A superseding cause "is by definition, the sole proximate cause of an injury." Id. at 833 (citing Sears, Roebuck & Co v. Huang, 652 A.2d 568, 573 (Del. 1995) ("if one defendant's negligence is found to be the sole proximate cause of the plaintiff's injury, it is a supervening cause which shields the other defendants from liability.")).

This Court has held that "only when there can be no reasonable difference of opinion as to the conclusion to be reached on the question of whether an intervening cause is abnormal, unforeseeable, or extraordinarily negligent, should

the question be determined by the Court as a matter of law." Id. at 831.

a. Superseding Causation is Generally an Issue of Fact

A wealth of settled Delaware law confirms that proximate cause is regularly decided by the trier-of-fact. In Tingle v. Ellis, the Superior Court considered whether a minor *plaintiff's* actions were a superseding cause. 1999 Del. Super. Lexis 317 (Del. Super. Aug. 10, 1997), Ex. B. The Court found the following facts: Shawn Tingle and Josh Wharton, another minor, were dove hunting near the Ellis' farm in Sussex County, Delaware; Tingle and Wharton met up with two other minors, Aaron Ellis and David West; Ellis' father asked the boys to retrieve a tractor from another farm and directed them to use a pick-up truck; the boys got into the truck with the minor Ellis in the driver seat, Tingle in the middle, and Wharton in the passenger seat with West on his lap; in the truck was a shotgun owned by Ellis' father which was located in the middle of the cab with the barrel pointed to the floor and the stock leaned against the seat; the location of the gun impeded use of the manual transmission shift and to operate the truck it needed to be moved; Tingle attempted to move the gun from his left to his right using his right hand; and as he did, the gun discharged, severely injuring his right foot. Id. at *2-3.

The Court considered whether Tingle's actions in handling the gun were foreseeable or whether they were so abnormal, unforeseen or extraordinarily negligent to be a superseding intervening cause thus relieving the Ellis family from liability. The Court specifically noted the following facts applicable to the plaintiff:

- Tingle was a licensed hunter who had taken a hunting safety course and was familiar with weapons and gun safety;
- Tingle's father had provided him access to four weapons and on the day of the incident he possessed a .20 gauge shotgun, a .12 gauge shotgun, a muzzle loader and a BB gun;
- Tingle testified he knew it was safe practice to always determine if a gun was loaded or the safety was engaged;
- Tingle testified he knew it was never safe to pass a gun over the plane of his body;
- Tingle was aware that it was common on farms for people to store guns in vehicles; and
- Tingle had no knowledge as to whether Ellis' father typically left his guns loaded, used the safety, or otherwise followed safe gun practices.

Id. at *3-6. An expert in gun safety testified that the three basic tenants to handling a gun are: "(1) always keep the gun pointed in a safe direction, (2) keep your finger off the trigger; and (3) treat the gun like it is loaded." Id. at *5. The expert concluded that Tingle should have "exercised more caution." Id.

Despite the existence of compelling facts and expert opinion supporting the conclusion that Tingle proximately caused his own injuries, the Court denied summary judgment and stated:

> I am satisfied that a jury could reasonably find that the minor's actions in handling the loaded gun in a crowded pick-up and the gun's discharge were reasonably foreseeable events. I also believe a reasonable jury could find negligent behavior on the part of the minor. Thus, this is a classic case in which the negligence of both parties may be the proximate cause of this accident. It is for the jury to sort this out, not a judge ruling as a matter of law.

Id. at *19.[3]

Delaware courts have also considered whether the negligence of parties other than a plaintiff could be superseding. In West v. Flonard, the Superior Court considered whether the actions of a co-defendant negligent driver were superseding to the negligence of a contractor and apartment complex owner. 2011 Del. Super. Lexis 81, *2 (Del. Super. Feb. 17, 2011), Ex. C.

Briefly, this case involved an unoccupied vehicle that began moving which ultimately pinned an apartment complex resident between the vehicle and a passenger van causing death. Id. at *2. The claims against the contractor stemmed from ongoing construction at the complex and the contractor's failure to properly block off the entrance and exit to the complex's circular driveway. Id. With regard to the apartment complex,

[3] Similarly, the Court denied summary judgment and refused to find the actions of a *plaintiff* superseding in Hufford v. Moore, 2007 Del. Super. Lexis 367 (Del. Super. Nov. 8, 2007), Ex. D.

the claims were based on the decision to locate a resident unloading area at the bottom of an incline. Id.

The Court found the following facts regarding the co-defendant driver: that while delivering medications to elderly residents, he ignored signs and other warnings prohibiting use of the driveway, parked in a closed area partially blocked by a construction dumpster, left the car running, in neutral, unoccupied, and with the emergency brake engaged (because the car's gear shift was not working properly), and parked on an incline 20 feet above a patient unloading area that was obvious. Id. at *4. Despite convincing facts that it was the driver's negligence which ultimately placed his car in an improper location that caused death, the Court ruled these actions were insufficient to break the causal chain. Id. The Court noted that the driver's conduct was "risky", but stated that, "reasonable minds could differ as to whether [his] conduct was 'so extraordinarily risky and unforeseeable' that it broke the causal connection between Defendants' alleged negligence and the Decedent's injury." Id. at *6-7.

b. Superseding Causation at Summary Judgment is Rare

There are two Delaware cases in which the Court ruled, as a matter of law, that a *plaintiff's* conduct was so abnormal,

unforeseeable or extraordinarily negligent as to break the causal nexus.

In Baker v. East Coast Properties, Inc., plaintiff Baker was injured when he suddenly was awoken by his front door alarm, "jumped out of bed" and fell because his "legs gave way." 2011 Del. Super. Lexis 508, *10 (Del. Super. Nov. 15, 2011), Ex. E. The Court found the following facts: Baker moved into the defendant's apartment complex which provided housing for the elderly and those specifically suffering from ambulatory difficulties; he was legally blind and suffering from Parkinson's disease which caused him walking difficulties and a propensity to fall because his knees and legs often buckled; maintenance personnel repeatedly entered his apartment causing him to purchase an audible motion sensitive alarm which he had hung on his interior front door knob; and the alarm emitted an audible sound when the door was opened for the purpose of alerting Baker when someone had entered his apartment. Id. at *2-3.

At approximately 9:00 am, an employee of defendant entered Baker's apartment causing the alarm to sound. Baker testified that the sound of the alarm, which the Court noted operated precisely as intended, startled him and caused him to jump out of bed and take three steps. Id. at *10. His legs then gave way causing him injury. Id.

Acknowledging that it was the entry of defendant's employees which caused the alarm to sound, the Court ruled that "[i]t was not reasonably foreseeable that Baker would install a device that would cause him to panic to such an extent that he would forget that he was unable to walk without assistance." Id. at *10-11. In deciding superseding causation, the Court noted that Baker *conceded* "that the sound emitted from the self-installed alarm (of which [defendant] had no notice) directly caused Baker's injuries." Id. at *11.

In Sims v. Bradley, both plaintiff and defendant were attending a party on Friday evening. 2007 Del. Super. Lexis 561, *1 (Del. Super. June 29, 2007), Ex. F, aff'd 945 A.2d 1169 (Del. 2008). When the defendant left the party, she backed her vehicle into plaintiff's car causing damage to the latch which attached plaintiff's convertible top to the windshield. Id.

The Court found the following facts: plaintiff became aware of the damage when she attempted to leave the party and determined that driving the car, utilizing only one latch, was unsafe; she left her car at the property on Friday night and returned the following day to meet both the defendant (who had realized what happened) and the police; once the accident was reported, plaintiff then left the property and drove her vehicle with the top down because she had determined that driving it with the top closed was unsafe because both sides could not be

latched; instead of taking the vehicle to a mechanic for repair, the plaintiff then chose to drive the car to dinner on Saturday evening, some ten miles from her home; and following dinner, she closed the top and utilized the one working latch. Id. at *2-3.

At her deposition, the plaintiff testified that she had changed her mind regarding the condition of the vehicle and had determined that it was safe to drive half-latched. Id. Her reasoning, she testified, was that it was raining. Id. On Monday, with the top still closed and half-latched, she chose to drive the vehicle on several errands. Id. at *4. During her travels, "'[t]he car became like a parachute with the air in it' and was 'picked up and thrown into [a] tree.'" Id. at *4.

The Superior Court specifically noted that the plaintiff had identified the structural damage preventing the top from being fully latched and had originally concluded that operating the vehicle half-latched was unsafe. Id. The Court ruled:

> Plaintiff's operation of her car in light of her awareness that the car was unsafe to drive constituted an intervening cause . . . sufficient to break the causal connection between any negligence on the Defendant's part and Plaintiff's injuries. That is, Plaintiff's actions were not reasonably foreseeable as a matter of law.

Id. The Court further stated, "[p]erhaps Plaintiff would be entitled to present her case to a jury if Plaintiff had merely driven the car long enough to relocate it to a safe location while she made arrangements for its repair." Id. at *9.

However, the Court ruled that plaintiff's negligence in continuing to use the vehicle to drive to dinner and run errands in a half-latched position that she knew was unsafe but then later determined was safe without any reasonable basis, was "so flagrant in nature that it served to break the causal connection. . . ." Id.

The rulings in Baker and Sims demonstrate that negligence is not only unforeseeable, but extraordinary when a plaintiff understands and appreciates the hazards, and consciously and affirmatively disregards the known risk of harm. In purchasing an alarm that emitted an audible sound, the plaintiff in Baker was aware that someone opening the door would sound the alarm. The potential for the alarm to sound was known to him yet he disregarded the risk that it would cause him to panic. In Sims, the plaintiff appreciated the danger of driving her vehicle in an unsafe condition. She drove the vehicle anyway, disregarding the hazards she understood.[4]

Unlike the plaintiffs in Baker and Sims, MacDougall did not understand and appreciate the hazards he confronted, and therefore could not have disregarded the risk of harm he faced.

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[4]Notably, neither case involved expert opinion indicating that the plaintiff, in view of a lack of qualification, failed to appreciate the hazard.

2. MacDougall Was Not Qualified and Unable to Understand and Appreciate the Risk of Harm

The lower Court's finding of superseding causation ignores the factual record, including competent expert testimony regarding MacDougall's lack of qualification.

Bybee testified that neither MacDougall nor Wolfe were qualified to perform the tasks assigned to them on June 14. A-225, p. 36. He also does not believe MacDougall's employer, Bobby Tudor was qualified. Id. When asked whether it is the employee's obligation to determine whether he is qualified to do certain work, Bybee testified,

> Absolutely not. The [unqualified] employee doesn't have enough information or training or experience to determine whether they have enough information. And as I say in my report, if you can't recognize and understand or appreciate the hazard, you can't guard against it.

A-226, pp. 37-38. The Court ignored Bybee's opinions that MacDougall's status as a master electrician is irrelevant.

> No, I don't expect better of a master electrician, just like I would not expect a podiatrist, say a foot doctor, even though he has an M.D., to be able to do brain surgery. And they're both M.D.'s. And that's what we are talking about when we're talking, when you're comparing master electricians.
>
> * * *
>
> What they're specifically qualified for and experienced in and trained in, that's their specialty and that's why -- they can all be master electricians, but master electricians and qualified persons have all levels, and they may be qualified for a group of things to do and not

> qualified for others. And in this particular case, no, I don't think the fact that they [Rodney and Wolfe] were master electricians had anything to do with their knowledge.

A-234, p. 69.

MacDougall's employer, Bob Tudor, agrees. In his letter of May 4, 2009 to Schneider he states:

> At the time of the accident that caused the damage, no one at the scene had knowledge of where the crank handle was located to draw out the breakers. Since that time there has been a demonstration and we have learned where the handle is and how to safely crank out the breakers.

A-281-282.

Mahaffy's expert supports Bybee's conclusion. When asked whether MacDougall's status as a master electrician and his years of experience should have alerted him to the hazards present at the site on June 14 and specifically whether he should have stopped working and asked for help before continuing, Rubin stated, "[s]ometimes you don't know what you don't know." A-299. P. 66.

Schneider's expert's lends further support to Appellants' argument that MacDougall lacked the necessary qualifications to appreciate the hazard he faced. Lickiss states, "Rodney MacDougall, if believed, was not qualified to work on the Schneider Electric/Square D switchboard equipment due to his

lack of knowledge about the design of the equipment and his inability to recognize and avoid the hazards involved." A-346.[5]

Unlike MacDougall, Baker *understood, appreciated and intended* that his motion sensitive alarm would emit a sound and hung it on the door anyway. Sims demonstrated she *knew* the car was unsafe to drive yet intentionally drove it anyway in an unsafe condition. Conversely, the record confirms that MacDougall lacked the necessary qualification to appreciate the risk of injury associated with the assigned task. Despite his status as a master electrician and role at DHCI, the fact that he could not appreciate the hazard and did not possess the requisite training made it entirely foreseeable that he would act in a manner which could cause a risk of injury.

Irrespective of this factual record and the general consensus among the experts that MacDougall was unqualified to perform the replacement, the Court nevertheless stated, "[t]here is nothing in the record to suggest or infer that Tudor [MacDougall] did not know what it was doing as the contractor." Ex. A., p. 11. This statement is not only inaccurate, but ignores the factual record, demonstrating that the lower Court improperly drew all inferences in favor of the moving party.

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[5] In his expert deposition, Lickiss confirmed his belief that MacDougall testified truthfully reinforcing his opinion that MacDougall was unqualified. A-376, p. 112.

3. MacDougall's Conduct Was Foreseeable

The Court found MacDougall's conduct was unforeseeable. The lynchpin of the Court's decision is its acceptance that MacDougall was a master electrician who was familiar with the equipment and was therefore, de facto qualified.

The facts, viewed in a light most favorable to MacDougall, suggest that reasonable minds could differ:

- Neither MacDougall nor the DHCI employees received training relative to shutting down, disengaging, or the procedures for lock-out/tag-out of the newly installed electrical system at DHCI;

- NFPA 70E has certain standards with regard to multi-employer complex lock-out/tag-out procedures and MacDougall's expert opined that they were not followed by Mahaffy and Schneider;

- Tudor was assigned this work via a single email and neither Tudor nor MacDougall received any further direction or coordination from Mahaffy or Schneider regarding the replacement;

- Mahaffy and Schneider did not conduct a meeting to coordinate the replacement and MacDougall's expert testified this violated Mahaffy's contractual obligations and NFPA 70E requirements;

- There is general consensus among the experts that MacDougall was not qualified to perform a complex lock-out/tag-out on the equipment at DHCI on June 14, 2008;

- Bybee testified that MacDougall could not recognize or appreciate the hazards he confronted on June 14, 2008 and therefore was unable to take reasonable measures to protect himself against those hazards;

- Absent a finding that MacDougall was suicidal or intentionally tried to hurt himself, no reasonable person

> could conclude that MacDougall understood the risk he confronted but simply ignored it;
>
> * * *

As additional support for its rejection of Appellant's argument, the Court provides a hypothetical example of superseding cause. The Court's analogy is distinguishable and overly simplistic. In the Court's example, the mechanism of injury is a mechanic's failure to engage a vehicle's emergency brake when repairing a design defect. Appreciation of the risk of injury in that circumstance is obvious to a lay person, much less an auto mechanic. Clearly it is unforeseeable that a trained and skilled auto mechanic would fail to engage the emergency brake while working on a car.

More on point is an example in which a mechanic is repairing a defectively designed transmission in a rare sports car. The mechanic has no experience with the complex transmission. During the repair, the tool he was using came in contact with the fuel injector, which was situated in a location unique to the type of car, causing the engine to catch fire. Given his unfamiliarity and lack of training on this car, he was unable to appreciate the risk of harm. As with MacDougall, it is entirely foreseeable that the mechanic's conduct could result from the initial design defect.

* * *

The overwhelming evidence confirms that MacDougall did not and could not understand and appreciate the hazards he confronted. He did not consciously and affirmatively disregard the risk of harm -- he was unable to guard against it. As noted by Schneider's expert, Lickiss, the best evidence of that fact is the event itself:"[a]ll I know is that based on the results of what happened they, they were not qualified and they didn't execute." A-374, p. 102.

The foreseeability of MacDougall's conduct as a proximate cause of his injuries is an issue of fact properly left within the province of the jury. The facts and analysis in the instant case most closely mirror that employed by the court in Tingle. Similarly, a jury will have the ability to find MacDougall 51% comparatively negligent. When considering the rigorous standard for summary judgment, the Defendants have not established MacDougall's degree of negligence to be 51% *as a matter of law.*

Reasonable minds can differ as to whether MacDougall's conduct was so abnormal, unforeseeable or extraordinarily negligent. The Court erred when it ruled that MacDougall's actions were the sole proximate cause of his injuries. There are unresolved issues of fact which should be decided by the jury.

CONCLUSION

WHEREFORE, for the reasons set forth above, Appellants Rodney and Diane MacDougall respectfully request that this Honorable Court reverse the lower court ruling and remand this matter for trial.

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