NOT TO BE PUBLISHED

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Yuba)

VICTORIA DUKET et al., Plaintiffs and Appellants, v. FREMONT RIDEOUT HEALTH GROUP, Defendant and Respondent.	C082606 (Super. Ct. No. YCSCCVPO0000894)

Judy Duket died after receiving care for 13 months in the intensive care unit of a hospital operated by Fremont Rideout Health Group (Fremont). Judy's family (plaintiffs)[1] sued Judy's surgeon, Dr. Ozeran, and Fremont for medical negligence. Plaintiffs also asserted a cause of action against Fremont for violation of the Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst. Code, § 15600 et

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[1] Plaintiffs are Victoria Duket, Therisa Wolfe, Geoffrey Duket, Troy Brewer, Julia Huhn, and Kelsey Huhn. For the sake of clarity we refer to individual members of the Duket family by their first names.

seq.) (Elder Abuse Act). Plaintiffs dismissed Dr. Ozeran before trial. A jury trial resulted in a defense verdict.

On appeal, plaintiffs contend (1) the trial court erred in refusing to give their proposed negligence per se jury instruction, and (2) the trial court abused its discretion in granting motions in limine to exclude evidence regarding the hospital's conduct around the time of Judy's care. We note plaintiffs do not challenge the jury's findings that Dr. Ozeran and Fremont were not negligent in their care for Judy.

We conclude the trial court did not err in refusing to give the proposed negligence per se jury instruction. The proposed instruction was erroneous as a matter of law because it did not inform the jury the presumption of negligence arising out of regulatory violations is rebuttable. Because the jury rejected the negligence claim, it did not reach the issue of whether negligence had been committed with recklessness, oppression, fraud, or malice. Any error in excluding evidence on those topics was therefore harmless. The possibility of regulatory violations in the general practices of Fremont was also not admissible to show Judy received negligent care. Accordingly, we affirm the judgment.

BACKGROUND

As this court has previously noted, "In every appeal, 'the appellant has the duty to fairly summarize all of the facts *in the light most favorable to the judgment*. (*Foreman & Clark Corp. v. Fallon* [(1971)] 3 Cal.3d [875,] 881.) Further, the burden to provide a fair summary of the evidence "grows with the complexity of the record. [Citation.]" (*Western Aggregates, Inc. v. County of Yuba* (2002) 101 Cal.App.4th 278, 290.)' (*Boeken v. Philip Morris Inc*. (2005) 127 Cal.App.4th 1640, 1658 . . . .)" (*Myers v. Trendwest Resorts, Inc*. (2009) 178 Cal.App.4th 735, 739, italics added.) Here, plaintiffs have set forth the facts consistent only with their own theory of the

case that was rejected by the jury when it returned a defense verdict. Consistent with the rules of review, "we set out the facts in the light most favorable to the jury's verdict." (*Yale v. Bowne* (2017) 9 Cal.App.5th 649, 652.)

Judy had a history of gallstones, but she avoided seeking treatment for them. In addition to gallstones, Judy had "quite a few medical problems" including morbid obesity, diabetes, a hysterectomy, heart problems, and high blood pressure. Judy had a pacemaker and had previously had her knees replaced. She had only one kidney remaining because the other had been cancerous. She also suffered from anxiety.

In October 2008, Judy experienced three days of abdominal pain, trouble with eating, and nausea. On October 12, 2008, she was admitted to Fremont's emergency room. Dr. Ozeran performed nonemergency gallbladder surgery on Judy.

Fremont's Case

The surgery and post-surgical care at Fremont were reviewed by Dr. Eric London. Dr. London works as a general surgeon in Sacramento, performing approximately 500 to 600 operations per year. He specializes in surgeries performed on the abdomen. Dr. London reviewed Judy's medical records and Dr. Ozeran's deposition testimony. On this basis, Dr. London opined Dr. Ozeran had done "a nice job of documenting everything and going through her history and physical quite thoroughly."

Although Judy had a relatively benign exam during her admission to the ospital, she was experiencing severe discomfort. Dr. Ozeran explained the medical risks of gallbladder surgery to Judy and her family. Judy elected to have the surgery. Dr. Ozeran performed the surgery that revealed a three centimeter gallstone. Dr. London testified the surgery was "absolutely indicated" for Judy's condition.

During the surgery, the small bowel – which had been tightly adhesed – was injured in several places. After Dr. Ozeran did "a nice job" of taking out the gallbladder, he cut the scar tissue from previous surgeries to locate the injury to the intestine. Due to dense adhesions, there were multiple injuries to the bowel. After resectioning the bowel, Dr. Ozeran checked three times for further injuries before completing the operation.

Dr. Ozeran and other surgeons monitored the wound for several days. Judy developed an infection at the wound with brown and foul drainage. This did not necessarily indicate any problem with the initial surgery. After a scan, Dr. Ozeran performed another surgery on October 22, 2008 – a colectomy in which he resectioned a part of the colon. During the surgery, Dr. Ozeran found a hole in the sigmoid colon. Because this problem was "some distance away" from the prior surgical site, Dr. London thought it might not have been related to the initial surgery. Although complications arose over the next few days, Dr. London testified that he did not believe the condition required a transfer to another facility.

Dr. Ozeran performed several additional surgical procedures on Judy. Dr. London reviewed the medical records and declared he "was impressed" with the follow through and diligence of Dr. Ozeran: "[H]e just continued. And he took her to the operating room on multiple occasions just for debridements, to try to keep her wounds clean, to try to help her because she couldn't tolerate the dressing changes at the bedside." Dr. London concluded he had "no standard of care issues with the surgical management of this patient."

Dr. Subil Go is a kidney specialist. Dr. Go testified that Judy "posed as the most challenging and most complicated patient I may have seen in my practice." Judy required kidney dialysis starting on October 24, 2008. She was in intensive care and was not producing any urine. Dr. Go determined she was experiencing renal

failure. The first series of dialysis went well. She was able to continue without dialysis from November 2008 until April 2009 when her kidney failed. At that point, she needed dialysis until she died. Judy was receiving nutrition and antibiotics in a liquid form and all of the fluid had to be removed by dialysis. In August 2009, Dr. Go determined Judy had a poor prognosis due to fluid buildup in her lungs and oxygen desaturation.

Dialysis requires a clean environment and Dr. Go would not have permitted it if he had observed a problem with the catheter or soiling around Judy's groin. Dr. Go found her state to consistently be one of cleanliness. The dialysis catheter never became infected. Over the course of observing Judy on a frequent basis for a year, Dr. Go found the nurses giving her care were hypervigilant about her needs and condition. Whenever he observed Judy, Dr. Go found she was receiving appropriate care from her nurses.

Dr. Timothy Albertson is a professor of medicine and anesthesiology and emergency medicine and pharmacology and toxicology at University of California at Davis. He had previously been in charge of the UC Davis Medical Center intensive care facility for approximately 20 to 25 years. Dr. Albertson reviewed Judy's medical records and noted there were "[s]omewhere around 59,000 pages." Dr. Albertson thus directed his attention to the intensive care unit care that Judy received. As a result of his review of Judy's records, Dr. Albertson noted she received a "huge" amount of care during the 13 months she was in Fremont's hospital.

In response to a question of whether Judy's nurses should have been "going around or up the chain of command or somehow over the head of the surgeon to get [Judy] transferred," Dr. Albertson testified this would have been "incredibly unusual." When Judy developed a problematic stoma, it was not clear the outcome would be poor. Dr. Albertson "would be shocked if an ICU nurse would go to a supervisor and

say we have to transfer a patient based on" the condition of the stoma. Based on the records of care by several physicians attending to Judy, Dr. Albertson opined there was never a point at which the nurses should have prompted a transfer to another facility. Moreover, he stated: "It's a big deal to move a patient from one hospital to another, particularly from an ICU to an ICU. There's risks involved." Dr. Albertson concluded that "it would not have made a difference" because there were "many comorbidities and confounders in this case."

Based on the duration of Judy's survival in the intensive care unit for 13 months, Dr. Albertson testified that it showed quality of care by the nurses. "It's remarkable to be able to have a patient chronically critically ill go 13 months. It's incredibly unusual. Most patients who have prolonged hospitalizations have one organ that's not working and have a placement problem or something. [Judy was] a woman who was chronically critically ill." Regarding Judy's nursing care, Dr. Albertson further testified: "Particularly when you look at the autopsy and you fail to see any evidence of pressure sores or decubitus ulcers on the buttocks or in the pressure areas . . . . It's remarkable, it's remarkable. And, I think many hospitals would be proud to be able to have a patient go that long and not show decubitus ulcers and survive that long."

Based on the autopsy, Dr. Albertson concluded Judy died of heart failure. Despite the numerous surgeries, the autopsy revealed "there were no abscesses in the belly, there was no evidence of infection." Her multisystem failure was not related to the quality of nursing care she received. Dr. Albertson did not come across any deviations in the standard of care Judy received from her nurses in the intensive care unit. He also did not see any violation of state standards on staff ratios for Judy.

Dr. Ozeran testified Judy "was the patient I had in the hospital the longest in my entire career by a factor of ten. . . . [¶] She had more challenges than any patient I've ever treated, and she probably went back to the operating room many more times than any other patient I've treated." Dr. Ozeran discussed the risks of surgery with Judy and her family. The surgery turned out to be a "very atypical" procedure. Dr. Ozeran concluded that "[d]espite the severity of the patient's illness and the duration of the operative procedure, she suffered no obvious ill effects to the procedure due to her medical issues." Judy was placed in the intensive care unit for overnight observation – a plan that Dr. London found to be appropriate. Dr. Ozeran chronicled the care Judy received after the surgery, including the instructions he provided to her nurses. In April 2009, Dr. Ozeran attempted to transfer Judy to two other facilities but "they basically said they wouldn't do anything different than we would do, so they had no reason to take her."

Terri McLain testified she was a nurse who had many interactions with Judy from January 2009 until her death. McLain detailed the daily care routine Judy received from her nurses. She testified that she was a diligent nurse for Judy and felt good about the care she provided.

Plaintiffs' Case

Plaintiffs introduced testimony to show Dr. Orezan and Judy's nurses were negligent in their care for her. In turn, they argued Fremont was vicariously liable for the negligence of its doctor and nurses. Plaintiffs also attempted to show Fremont's staffing policies amounted to recklessness that virtually guaranteed deficient care for its patients.

Plaintiffs called Dr. Kathryn Locatell, who testified Judy's gallbladder condition was not acute. Dr. Locatell would have had a discussion with Judy and encouraged her to lose some weight before having the gallbladder surgery as an

elective procedure. She also believed the nurses failed to properly monitor the incision after the surgery. The charting and documentation by the nurses was inadequate. Dr. Locatell also faulted the nurses for not being sufficient patient advocates for Judy. She also testified that the nurses did not adequately monitor Judy's stoma. When the stoma turned black, Dr. Orezan should have transferred Judy to another facility with "a higher level of care." Nonetheless, Dr. Locatell found it "remarkable" that Judy lived another year. She concluded that "if [Judy] had gotten the right surgical care and the right nursing care at the right time, I think she could have survived – would have survived."

Plaintiffs also called Sandra Hegelin, a geriatric clinical nurse specialist. Hegelin reviewed Judy's medical records and concluded her nurses did not engage in "enough patient advocacy to really protect" Judy "from harm" and "policies and procedures were not followed." Hegelin opined that "most of those breaches in policy and procedure were also breaches in the standard of care." She stated an individualized care plan should have been developed for Judy – including for wound management, skin assessment, and addressing her family. Dr. Ozeran should have transferred Judy to another facility when requested to do so by Judy's family. And he should have consulted with an infectious disease specialist sooner. Dr. Locatell believed the staffing ratio for Judy was too low, and should have been a two-to-one ratio instead of the one-to-one ratio that was provided in the intensive care unit.

Judy's daughter, Julia, testified about observing her mother's care. Julia noted some of the care Judy received "was good" but she also noticed many deficiencies. Among the deficiencies, Julia observed that after the colostomy, the surgical site leaked – sometimes with feces. Once the surgical site was not monitored for five or

six hours. However, Julia never saw the colostomy bag more than three-quarters full. Also the nurses always changed the bags in the same way.

DISCUSSION

I

Plaintiffs' Proposed Instruction on Negligence Per Se

Plaintiffs contend the trial court committed reversible error by refusing their proposed jury instruction on negligence per se based on Fremont's violation of California nursing regulations. We disagree.

A.

Proposed Jury Instruction

Plaintiffs proposed that the jury be instructed on negligence per se as follows: "If you decide: [¶] 1. That Defendant Fremont Rideout Health Group violated any of the below regulations, and [¶] 2. That the violation was a substantial factor in bringing about the harm, *then you must find that Fremont Rideout Health Group was negligent*. [¶] If you find that Fremont Rideout Health Group did not violate any of these regulations or that the violation was not a substantial factor in bringing about the harm, then you must still decide whether Fremont Rideout Health Group failed to use the degree of care that a reasonable person in the same situation would have used in light of the other instructions." (Italics added.)

The proposed negligence per se jury instruction also stated that the proposed regulations they believed were violated were: California Code of Regulations, title 16, section 1443.5 (knowledge and care plans for nursing competency) and 1443.5(3) (skills necessary for nursing competency), and title 22, section 70215(a)(1) (documentation required), 70215(a)(2) (implementation of nursing care plan), 70215(a)(3) (patient assessment), and 70215(b) (planning and delivery of patient care). The jury instruction indicated its sources as: "CACI No. 3103; *Norman v.*

Lifecare Centers of America, Inc. (2003) 107 Cal.App.4th 1233, 1246; Cal. Evid. Code § 669(a) (failure to exercise due care is presumed if a person violates regulation)."

B.

Duty to Instruct

"A party is entitled to request that the jury be instructed correctly on any theory of the case that is supported by substantial evidence." (*Nevarrez v. San Marino Skilled Nursing & Wellness Centre, LLC* (2013) 221 Cal.App.4th 102, 112.) " ' "Although a party is entitled to instructions on his [or her] theory of the case, if reasonably supported by the pleadings and the evidence, instructions must be properly selected and framed. The trial court is not required to give instructions which are not correct statements of the law or are incomplete or misleading." [Citation.]' " (*Nevarrez*, *supra*, at p. 116, quoting *Conservatorship of Gregory* (2000) 80 Cal.App.4th 514, 522.)

Moreover, "a trial court has no duty to modify or edit an instruction offered by either side in a civil case and if there is error in the charge proposed, the court may reject the entire instruction." (*Green v. County of Riverside* (2015) 238 Cal.App.4th 1363, 1370.) Likewise, an attorney has no duty to correct the legal mistakes of opposing counsel for the benefit of the opposing party. (See *Goodman v. Kennedy* (1976) 18 Cal.3d 335, 342, 346 [holding that an attorney does not incur liability for conscious nondisclosure absent a duty of disclosure]; Cal. State Bar Opinion No. 2013-189, at p. *4 <http://www.calbar.ca.gov/Portals/0/documents/ethics/Opinions/CAL%202013-189%20%5B11-0002%5D%20v.1.pdf> [as of Nov. 12, 2019], archived at <https://perma.cc/UX8K-Q27M> ["Attorneys generally owe no duties to opposing

counsel nor do they have any obligation to correct the mistakes of opposing counsel"].)

C.

Negligence Per Se

Evidence Code section 669 provides in pertinent part: "(a) The failure of a person to exercise due care is presumed if: [¶] (1) He [or she] violated a statute, ordinance, or regulation of a public entity . . . . [¶] . . . [¶] (b) This presumption may be rebutted by proof that: [¶] (1) The person violating the statute, ordinance, or regulation did what might reasonably be expected of a person of ordinary prudence, acting under similar circumstances, who desired to comply with the law . . . ." (See *Norman v. Life Care Centers of America, Inc.* (2003) 107 Cal.App.4th 1233, 1251 (*Norman*) [holding that "a regulatory violation is presumed to constitute negligence and that presumption will be conclusive unless the defendant rebuts it"].)

We conclude the trial court properly refused to give the negligence per se jury instruction as proposed by plaintiffs in this case. The proposed jury instruction disallowed any rebuttal of the presumption that failure to follow nursing and health care regulations constitutes negligence. Instead, the proposed instruction informed the jury that proof establishing violation of health care regulations necessarily amounts to negligence by Fremont. Because the proposed instruction omitted the rebuttable presumption of Evidence Code section 669, it was erroneous as a matter of law. The trial court was correct to reject an instruction that omitted an essential qualifier. (*Merrill v. Buck* (1962) 58 Cal.2d 552, 563.)

We reject plaintiffs' reliance on *Norman*, *supra*, 107 Cal.App.4th 1233. *Norman* involved an action for elder abuse against a skilled nursing facility that failed to prevent multiple falls even after it knew about the fall risk of its patient. (*Id.* at pp. 1236-1238.) The patient appealed a defense verdict, in part, based on the argument

the trial court erred in refusing a negligence per se jury instruction. (*Id.* at pp. 1238, 1240.) The *Norman* court held the trial court erred in refusing the instruction because the patient had introduced evidence the nursing facility had violated health care regulations. (*Id.* at p. 1243.)

The proposed instruction in *Norman, supra,* 107 Cal.App.4th 1233 would have informed the jury, in relevant part, that negligence per se was presumed "unless [defendant] proves by a preponderance of the evidence that he or she did what might reasonably be expected of a person of ordinary prudence, acting under similar circumstances, who desired to comply with the law. In order to sustain such burden of proof, the defendants must prove by a preponderance of the evidence that they were faced with circumstances which prevented compliance or justified noncompliance with the regulations." (*Id.* at p. 1240.) In contrast to the proposed instruction in *Norman*, the instruction submitted by the plaintiffs in this case did not inform the jury the presumption of negligence was rebuttable. The instruction submitted in this case also did not explain the burden of proof by which Fremont could surmount that presumption.

For similar reasons, we reject as inapposite plaintiffs' reliance on *Fenimore v. Regents of the University of California* (2016) 245 Cal.App.4th 1339, *Klein v. BIA Hotel Corp*. (1996) 41 Cal.App.4th 1133 (*Klein*), and *Daum v. SpineCare Medical Group, Inc.* (1997) 52 Cal.App.4th 1285 (*Daum*). *Fenimore* involved the question of what sort of proof constitutes "something more than negligence" and suffices to prove a cause of action of elder abuse. (*Fenimore*, *supra*, at p. 1347.) The case did not address the rebuttable presumption for a theory of negligence per se. (*Id.* at pp. 1347-1350.)

In *Klein*, a plaintiff advanced a claim of negligence per se against a residential care facility. (41 Cal.App.4th at p. 1140.) The *Klein* court reversed a grant of

summary judgment on grounds that the motion had not actually addressed the claim of negligence per se. (*Ibid.*) In reversing, *Klein* confirmed that "presumption [of negligence per se] may be rebutted by proof that the violator did what might reasonably be expected of a person of ordinary prudence, acting under similar circumstances, who desired to comply with the law." (*Ibid.*) Nothing in *Klein* negates the rebuttable nature of the presumption of negligence per se under Evidence Code section 669.

Daum involved a medical malpractice action based on a claim the physician did not inform the patient that he was undergoing an experimental medical procedure. (52 Cal.App.4th at p. 1298.) The trial court refused to instruct on negligence per se. (*Ibid.*) After examining the evidence, the *Daum* court concluded there was substantial evidence of regulatory violations to support the proposed negligence per se instruction. (*Id.* at p. 1312.) In so holding, the *Daum* court "[e]mphasize[d] that not every technical regulatory violation is presumptively negligent." (*Id*. at p. 1304, fn. 5.) And, even when a regulatory violation is available to prove negligence per se, the violation is nonetheless rebuttable. (*Ibid*.) *Daum* does not excuse plaintiffs' omission of the rebuttable nature of the presumption of negligence per se from their proposed jury instruction in this case.

Plaintiffs argue there was ample evidence at trial to show Fremont violated numerous state regulations governing health care. Regardless of whether the evidence sufficed to warrant a negligence per se jury instruction, the instruction submitted by plaintiffs was legally erroneous. And, as we have noted, the trial court did not bear responsibility for correcting the submitted instruction. (*Green v. County of Riverside*, *supra*, 238 Cal.App.4th at p. 1370.)

We also reject the plaintiffs' suggestion that the trial court should have given the erroneous instruction and then shifted the burden for correct jury instructions to

Fremont to propose a supplemental instruction to apprise the jury that the presumption of negligence per se is rebuttable. Fremont's attorney had no duty to correct a mistake of law in a jury instruction proposed by plaintiffs. (See *Goodman v. Kennedy*, *supra*, 18 Cal.3d at pp. 342, 346.)

In sum, we determine the trial court properly rejected plaintiffs' proposed jury instruction on negligence per se as an inaccurate statement of law.

II

Exclusion of Evidence Relating to the Elder Abuse Cause of Action

Plaintiffs argue that the "trial court's neutering of the elder abuse cause of action through motions in limine should be reversed becau[s]e it deprived [plaintiffs] of due process." Specifically, they argue the trial court erred in granting Fremont's motions in limine numbers 8 through 13, 15 through 18, and 23[2] to exclude evidence that Fremont acted despicably and with willful and reckless disregard of all its patients. We note plaintiffs' argument does not elaborate on the due process assertion or provide any due process legal authority. In any event, we reject the contentions on additional grounds as explained below.

A.

Recklessness, Malice, Fraud, and Oppression

In the trial court, plaintiffs argued: "This is an elder abuse case where Plaintiffs must meet the high burden of proving that [Fremont] acted 'despicably' and with 'willful and conscious disregard of the rights and safety' of its patients and its managing agents authorized, ratified and participated in such despicable conduct

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[2] Although plaintiffs' summary of the argument identifies one of the challenged in limine motions as number 27, the argument portion of the opening brief makes clear that the challenged instruction is actually number 23.

[(Welf & Instit. Code § 15657(c) (adopting standard set forth in Civil Code Section 3294)] [¶] Plaintiffs will meet this burden, in part, by introducing overwhelming testimony that [Fremont] was so focused on expansion and corporate greed building a regional campus, decertifying its nurses unions, and increasing executive pay that it habitually and intentionally ignored serious quality issues identified by the California Department of Health (CPDH), the Center for Medicare and Medicaid Services (CMS) and the Joint Commission on the Accreditation of Health Organizations (JCAHO), putting all of its patients at incredible risk." (Original emphasis selectively retained.)

In seeking to introduce evidence that Fremont acted despicably, plaintiffs argued: "This evidence is plainly relevant to show that Judy Duket's death was not an isolated unforeseen, occurrence where one patient 'fell through the cracks' in an otherwise well managed hospital, but rather the product of a widespread, systemic, pervasive dysfunction and lack of quality control resulting from [Fremont's] policies prioritizing revenue and expansion while shortchanging its vulnerable patients." The rationale for relevance argued by plaintiffs was that the evidence was necessary to show "recklessness," "malice," "fraud" and "oppression" as it related to their cause of action for elder abuse.

Plaintiffs sought to introduce this evidence because they sought enhanced remedies under the Elder Abuse Act. The Elder Abuse Act "establish[es] heightened remedies—allowing not only for a plaintiff's recovery of attorney fees and costs, but also exemption from the damages limitations otherwise imposed by Code of Civil Procedure section 377.34." (*Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148, 155 (*Winn*).) To recover these enhanced remedies, "[a] plaintiff must prove, by clear and convincing evidence, that a defendant is liable for either physical abuse under section 15610.63 or neglect under section 15610.57, *and* that the defendant

committed the abuse with 'recklessness, oppression, fraud, or malice.' (§ 15657.)" (*Winn*, *supra*, at p. 156, italics added.)

Here, plaintiffs attempted to show neglect *and* recklessness, malice, oppression, or fraud. However, the jury expressly rejected the claim that Dr. Ozeran and Fremont were negligent. Because the jury did not find any negligence, the jury did not consider whether plaintiffs also proved recklessness, malice, oppression, or fraud.

The jury's finding that neither Dr. Ozeran nor Fremont had been negligent rendered irrelevant the evidence directed at the enhanced remedies under the Elder Abuse Act. The enhanced remedies are available only for negligence that is aggravated by recklessness, oppression, fraud or malice. (*Winn, supra,* 63 Cal.4th at pp. 155-156.) In the absence of negligence, the exclusion of evidence relating only to the enhanced remedies cannot constitute reversible error. (*Piedra v. Dugan* (2004) 123 Cal.App.4th 1483, 1493-1494 [holding that order granting in limine motion was harmless error because the evidence was directed to an issue the jury never reached].)

B.

State of Mind

Plaintiffs next argue that records of the California Department of Health, the Center for Medicare and Medicaid Services, and Joint Commission on the Accreditation of Health Organizations regarding violations of regulations by Fremont were admissible under Evidence Code section 1101, subdivision (b), "to show state of mind." We are not persuaded.

Evidence Code section 1101 provides: "(a) Except as provided in this section and in Sections 1102, 1103, 1108, and 1109, evidence of a person's character or a trait of his or her character (whether in the form of an opinion, evidence of reputation, or evidence of specific instances of his or her conduct) is inadmissible when offered to

prove his or her conduct on a specified occasion. [¶] (b) Nothing in this section prohibits the admission of evidence that a person committed a crime, civil wrong, or other act when relevant to prove some fact (such as motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake or accident, or whether a defendant in a prosecution for an unlawful sexual act or attempted unlawful sexual act did not reasonably and in good faith believe that the victim consented) other than his or her disposition to commit such an act."

As this court has previously explained, "pursuant to [Evid. Code,] section 1101, 'evidence that a person is a competent or skilled [professional] (or the inverse), whether proven by reputation, opinion or specific acts, *is not admissible to prove the defendant was negligent on a particular occasion*.' (*Hinson v. Clairemont Community Hospital* (1990) 218 Cal.App.3d 1110, 1120, disapproved on other grounds in *Alexander v. Superior Court* (1993) 5 Cal.4th 1218, 1228, fn. 10.) A trial centers on a specific incident, not the defendant's general behavior. ' " 'A doctor's reputation for skill and ability will not exonerate him [or her], where gross negligence and want of the application of skill is alleged and proved. Nor can the fact that a doctor is reputed to be negligent or unskillful be allowed as proof to establish negligence or unskillful treatment in a particular case, because he [or she] may have treated that case with unusual skill and care.' " [Citations.]' (*Hinson, supra*, at p. 1121.) For that reason, evidence of a defendant's prior negligence in medical treatment is inadmissible to prove negligence in a particular. (*Id*. at p. 1122; see also [Evid. Code,] § 1104 ['evidence of a trait of a person's character with respect to care or skill is inadmissible to prove the quality of his conduct on a specified occasion'].)" (*Bowen v. Ryan* (2008) 163 Cal.App.4th 916, 924 (*Bowen*), italics added.)

Plaintiffs argue the administrative agency records were admissible to show Fremont's directors were "on notice that its facilities had serious quality

deficiencies, raising the question of what [Fremont] did to investigate and/or remedy the problems." We reject this argument for two reasons. First, this proposed evidence was not admissible to establish that Judy's treating physician and nurses were negligent in providing care *to her*. (*Bowen*, *supra*, 163 Cal.App.4th at p. 924.) Second, the proposed administrative agency reports evidence were not relevant because it went to proof of the second element for the Elder Abuse Act enhanced remedies, an element the jury never reached because it found there was no negligence.

C.

Habit and Custom

Plaintiffs alternatively argue the administrative agency records were "admissible as evidence of habit or custom or records which are used as the basis of an expert's opinion" under Evidence Code section 1105.

The argument is forfeited because plaintiffs do not identify which administrative agency records they believe to have established evidence of habit or custom. Plaintiffs also do not describe which habits or customs of Fremont they believe they should have been able to introduce under Evidence Code section 1105. And plaintiffs offer no citation to the record either where (1) the documents they sought to admit under Evidence Code section 1105 might be found, or (2) identify and describe these documents in an offer of proof. These omissions preclude review of their claim, which we deem forfeited. (*Paiva v. Nichols* (2008) 168 Cal.App.4th 1007, 1037; *Western Aggregates, Inc. v. County of Yuba* (2002) 101 Cal.App.4th 278, 290.)

DISPOSITION

The judgment is affirmed. Fremont Rideout Health Group shall recover its costs on appeal. (Cal. Rules of Court, rule 8.278(a)(1) & (2).)

HOCH, J.

We concur:

BLEASE, Acting P. J.

MAURO, J.

IN THE

Court of Appeal of the State of California

IN AND FOR THE

THIRD APPELLATE DISTRICT

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