IN THE COURT OF CRIMINAL APPEALS OF TEXAS

NO. PD-0047-20

DOROTHY A. HOLLOWAY, Appellant

v.

THE STATE OF TEXAS

ON APPELLANT'S PETITION FOR DISCRETIONARY REVIEW FROM THE FOURTH COURT OF APPEALS BEXAR COUNTY

WALKER, J., filed a dissenting opinion, in which KEEL, J., joined.

DISSENTING OPINION

Appellant, Dorothy A. Holloway, was diagnosed with congestive heart failure, and a doctor prescribed a LifeVest for Appellant to wear. The LifeVest is an external defibrillator that is to be worn at all times, except when showering. While Appellant was driving a vehicle without wearing the LifeVest, she suffered a cardiac arrest and crashed into another vehicle, causing the death of the other vehicle's driver, Kristian Maldonado. Appellant was charged and convicted of manslaughter. On appeal, she challenged the sufficiency of the evidence, but the court of appeals affirmed the manslaughter conviction. *Holloway v. State*, No. 04-18-00481-CR, 2019 WL 6888534 at *1 (Tex.

App.—San Antonio Dec. 18, 2019) (mem. op., not designated for publication). The court of appeals held that the evidence was sufficient for a jury to conclude that Appellant's driving without the LifeVest medical device after using methamphetamine caused her cardiac arrest and thus Maldonado's death, and that the evidence was sufficient for the jury to conclude Appellant was aware that there was a substantial and unjustifiable risk that someone would die if she drove without the LifeVest after using methamphetamine.

From the evidence referenced by the court of appeals, it is doubtful that Appellant was reckless. The evidence shows that Appellant was not aware of a risk that her failure to follow her doctors' medical instructions could cause somebody else's death. And while Appellant's cardiac arrest while driving did, in fact, cause Maldonado's death, it is far from clear that Appellant's failure to follow medical instructions was what caused her cardiac arrest. I would grant Appellant's petition for discretionary review, and I respectfully dissent to the Court's refusal to do so.

I — Recklessness

A person commits the offense of manslaughter if he recklessly causes the death of an individual. TEX. PENAL CODE Ann. § 19.04. Manslaughter is a result-oriented offense. *Britain v. State*, 412 S.W.3d 518, 520 (Tex. Crim. App. 2013); *Schroeder v. State*, 123 S.W.3d 398, 400–01 (Tex. Crim. App. 2003). As such, the defendant's culpable mental state must relate to the result. *Britain*, 412 S.W.3d at 520.

"A person acts recklessly, or is reckless, with respect to . . . the result of his conduct when he is aware of but consciously disregards a substantial and unjustifiable risk that . . . the result will occur." TEX. PENAL CODE Ann. § 6.03(c). With manslaughter, then, the evidence must show that the defendant "was aware of, but consciously disregarded, a substantial and unjustifiable risk that the

victim would die as a result of his conduct." *Schroeder*, 123 S.W.3d at 401. Because the defendant must be aware of the risk, recklessness requires the defendant to actually foresee the risk involved and consciously decide to ignore it. *Williams v. State*, 235 S.W.3d 742, 751 (Tex. Crim. App. 2007). This distinguishes recklessness from criminal negligence, which assesses blame for the failure to foresee the risk that an objectively reasonable person would have foreseen. *Id.* at 752.

From my reading of the court of appeals's opinion, it seems that the evidence which the court of appeals found sufficient to support recklessness does not include any evidence that Appellant was actually aware of a substantial and unjustifiable risk that someone would die as a result of the alleged act—failing to follow her doctors' orders.

As recounted by the court of appeals, the evidence showed that in August 2015, Appellant was diagnosed with congestive heart failure after a hospital emergency room admission. Appellant's ejection fraction, the measure of how much blood the heart pumps with each heart beat, was between thirty and thirty-five percent, while, according to the court of appeals's opinion, a normal ejection fraction is sixty to seventy percent.[1] Appellant's thirty-five percent level put her at risk of cardiac arrest. When she was discharged from the hospital, Appellant was given multiple prescriptions and informed about her condition and its risks. Most importantly, the discharge instructions did not tell Appellant that she should avoid driving.

As for what Appellant was actually told about her condition and its risks, Justice Martinez

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[1] A review of the record shows that varying ranges for a normal ejection fraction were given. Among the State's witnesses, Dr. Dent testified that 70 % was normal. Dr. Alkatheep testified that "anything more than 55 percent" is normal, and 50–55% is considered "low normal." Dr. Metha also testified that "normal for the heart is 55 percent or higher." Dr. Santillano testified that normal for an adult is about 60 percent, and anything below that is abnormal.

Appellant's defense expert testified that a normal ejection fraction was "50 to 60 percent or more."

explained in her dissenting opinion below that a cardiologist saw Appellant for shortness of breath and edema, which is swelling of the ankles, feet, and legs. The cardiologist testified that he would typically counsel a patient with congestive heart failure about a treatment plan, which would include the removal of fluids through the use of medication and a change in diet, and the plan would ensure compliance with taking medication. Appellant's other treating physician from August 2015 testified that her treatment plan in the hospital consisted of breathing treatments and also reaffirmed that Appellant was prescribed diuretics which promote fluid loss and assist breathing as well as blood pressure medicine. The physician also recommended that Appellant undertake "lifestyle changes," including weight loss, exercise, and consumption of low salt foods. The medical records from the August 2015 hospital visit show that the physician instructed Appellant upon discharge "to present to the nearest Emergency Department or call 911 should their symptoms return or worsen." Appellant's discharge paperwork instructed her to call a physician for shortness of breath and increased swelling. The discharge paperwork also included "Heart Healthy Instructions." These provide that Appellant should call her doctor if she has any of the following symptoms:

- Trouble breathing, especially during activity or when lying flat
- Waking up out of breath at night
- Frequent dry, hacking cough, especially when lying down
- Feeling tired, weak, faint or dizzy
- Swollen feet, ankles and legs
- Nausea, with stomach swelling, pain and tenderness
- If you experience chest pain, call 911 to go to the nearest EMERGENCY DEPARTMENT immediately.

The instructions also state:

> DO NOT SMOKE OR USE TOBACCO PRODUCTS. Tobacco is probably the single most dangerous thing you can do to your health. Nicotine robs the heart of oxygen and contracts blood vessels, which raises heart rate and blood pressure. If you smoke or use tobacco products, discuss alternatives with your doctor. The most

important thing is that you continue to try to quit until you are successful!

Appellant was readmitted to the hospital in November 2015. Her attending physician testified that Appellant "presented with shortness of breath of two days duration." The physician elicited Appellant's "social history," which was documented on medical records as follows:

> The patient admits to smoking 1 pack per day for more than 20 years. The patient denies any alcohol, and currently not using any drugs. She used methamphetamine about 1–1/2 years back when she lost her mother.

The physician testified that he diagnosed Appellant with "acute systolic congestive heart failure," which signified a worsening of her congestive heart failure and a chronic condition. Appellant's ejection fraction had decreased to twenty-five to thirty percent. According to the physician, he would have counseled:

> compliance with the medications, monitoring of her symptoms, following up with the doctors. And mainly lifestyle modification will be including the amount of fluids that they take, water or any fluid and the salt intake and quitting the smoking and they are taking alcohol or doing recreational drugs asking them to quit.

The cardiologist who treated Appellant in November 2015 noted on medical records that she was "drinking Big Red" during her stay. According to the cardiologist, this fact was important because:

> When someone comes in for congestive heart failure, they have an accumulation of fluid on their body because their heart cannot pump that fluid out, so to speak. When you talk to patients with congestive heart failure you tell them what to do and what not to do. One of the things they cannot do is drink soda, eat excessive sodium, and you counsel them on diet. And so my comment here was to imply that she was not being compliant.

The November 2015 medical records also reflect that the cardiologist discussed fluid restrictions of 1,500 milliliters per day and reduced salt intake with Appellant. The cardiologist testified that his medical partner ordered Appellant a LifeVest during her November 2015 hospital stay. A LifeVest is an external cardiac defibrillator capable of shocking a patient's heart in the event of a cardiac

arrest. The LifeVest warns the patient if the patient's heart rate is at a level where a shock is impending. The patient, however, can manually override the shock. Appellant was trained on using the LifeVest and instructed to wear it at all times except when she showered. Specifically, the cardiologist treating Appellant at the hospital testified as follows:

> Q. Okay. And how often should you wear the LifeVest?
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> A. All the time except for in the shower.
>
> Q. Okay. And does that include when you're driving?
>
> A. Yes.
>
> Q. Why is it important that they wear the LifeVest at all times -- let me rephrase that. Why is it important that Dorothy Holloway wears the LifeVest at all times?
>
> A. She has congestive heart failure with a depressed ejection fraction. When you have congestive heart failure with a depressed ejection fraction you're at risk for cardiac arrest, for sudden cardiac death. Generally, that's from an irregular heart rhythm and as a result this LifeVest can monitor the heart rhythm and shock the heart into a normal rhythm if the device picks up the rhythm.

The cardiologist further testified that if Appellant drove without the LifeVest upon her discharge in November of 2015, she was at risk for sudden cardiac death. When asked whether Appellant was made aware of that risk, the cardiologist testified as follows:

> A. It's my understanding when she's counseled by the fitting person, that they discuss that. I discuss that as well with my patients, typically.
>
> Q. And when you say you discuss it, do you discuss that based on her diagnosis she is at risk for sudden cardiac death?
>
> A. For dying, yes.

However, while the cardiologist testified that Appellant was at risk for her own sudden cardiac death if she drove without wearing the LifeVest, he did not remember telling Appellant not

to drive. The November 2015 hospital discharge information states the same "Heart Healthy Instructions," as the August 2015 discharge information. The discharge information also states that Appellant should call her physician for "Chest pain," "Shortness of breath," and "Increased swelling."

Viewed in the light most favorable to the verdict, the evidence shows that Appellant was repeatedly warned about consequences to her own health from continued tobacco smoking, failure to modify her diet, failure to take medicine as prescribed, and consumption of methamphetamine. However, the warnings Appellant received about noncompliance focused primarily on a return of or worsening of her previous symptoms. Some warnings she received also suggest a gradual onset of symptoms. For example, Appellant was instructed to call 911 and head to her nearest emergency room if symptoms returned. These warnings suggest Appellant would have time to act before becoming debilitated. Appellant was not warned that she posed a substantial and unjustifiable risk of death to other drivers if she failed to comply with medical instructions to curb her tobacco smoking, end her methamphetamine consumption, take heart medication, and modify her diet.

The strongest evidence that suggests Appellant's awareness of a risk that someone would be killed if she drove relate to the LifeVest. Appellant was instructed to wear her LifeVest at all times except when showering. Appellant was told by her cardiologist that she was at risk for sudden cardiac death, and the LifeVest's purpose was to prevent sudden cardiac death by shocking her. A reasonable person may have understood the cardiologist's warning of sudden cardiac death to imply a risk of sudden loss of consciousness. A reasonable person may also have understood this risk to be heightened if doctors' warnings were not followed. But while the instructions relating to the LifeVest could be reasonably understood to mean that, if a cardiac arrest occurred, the risk of death

would be high, the same medical instructions do not necessarily indicate that the risk of a cardiac arrest in the first instance was high. The bottom line is that while Appellant's failure to foresee a risk that a reasonable person would have comprehended could be criminally negligent, her failure is not recklessness. *Compare* TEX. PENAL CODE Ann. § 6.03(c) (criminal recklessness), with *id.* § 6.03(d) (criminal negligence).

This case is thus unlike other cases that held drivers criminally reckless for failing to follow medical instructions. In those cases, the patient's risk as a driver were stated explicitly by medical professionals. *See, e.g.*, *Robertson v. State*, 109 S.W.3d 13, 19 (Tex. App.—El Paso 2003, no pet.) (evidence legally sufficient to support manslaughter conviction where the defendant was aware of his risk as a driver; he was instructed not to drive until approved to drive by a neurologist). Some cases impute knowledge based on prior experiences of loss of control while driving, a factor not present here. *See, e.g.*, *Robertson*, 109 S.W.3d at 21 (defendant had a history of automobile accidents caused by seizures).

In sum, the medical warnings Appellant received were too general and unfocused to establish her actual awareness of a substantial and unjustifiable risk she posed to fellow drivers from sudden cardiac arrest. And without awareness of a risk, she cannot consciously disregard that risk. Certainly, a rational jury could infer that Appellant had a "devil may care" attitude toward her health. The evidence showed that Appellant smoked tobacco, drank Big Red soda, failed to take her prescribed heart medication, and used methamphetamine, even though her doctors warned her of the adverse consequences for these actions and omissions. However, those warnings, by and large, told Appellant that those behaviors increased her risk of suffering a repeat of her prior symptoms. The doctors' warnings did not tell her that those behaviors put her at risk of a cardiac arrest while driving.

Finally, I am skeptical of a finding of recklessness based simply on a person going about their daily life while "knowing that there is a risk of heart failure." As recklessness is defined in the Penal Code, the risk which must be consciously disregarded "must be of such a nature and degree that its disregard constitutes a gross deviation from the standard of care that an ordinary person would exercise under all the circumstances as viewed from the actor's standpoint." TEX. PENAL CODE Ann. § 6.03(c).

The problem of attributing the culpable mental state of recklessness to the medical condition of "heart failure" is that heart failure and cardiac arrest are separate concepts. Heart failure is a condition that does not come and go, and it is characterized by a weakening of the heart muscle, causing a significant decrease in the flow of blood pumped by the heart. The heart of a person with significant heart failure may pump half as much blood as a "normal" heart would. In contrast, cardiac arrest occurs when the heart stops beating.

Due to how commonly people engage in activities, such as driving, while in heart failure, I believe the simple act of driving does not constitute a "gross deviation from the standard of care that an ordinary person would exercise." Many people have heart failure, and cardiac arrest is a known risk of heart failure. It is an unfortunate fact of life, especially among older persons, that there is a risk of cardiac arrest due to heart failure. They know that their hearts are no longer what they were in their younger years, but they can and do engage in the activities of everyday life, including driving. By and large, these activities are done without incident. Indeed, while Appellant had heart failure, there was no evidence that she previously experienced a cardiac arrest after being diagnosed with heart failure months earlier. *Contra Robertson*, 109 S.W.3d at 21 (defendant had a history of past automobile accidents following seizures while driving). In my opinion, driving while also knowing

that there is a risk of cardiac arrest due to heart failure is not, without more (such as doctors' instructions not to drive), such a gross deviation from the ordinary standard of care to make a person criminally reckless.

II — Causation

Manslaughter requires not only that the defendant be reckless, but that the defendant's reckless act cause the death of an individual. Even though it is unquestioned that Appellant's cardiac arrest while driving led to Maldonado's death, the indictment did not allege that she drove recklessly and that such reckless driving was the cause of death. Instead, the indictment alleged four specific manners and means, and the State was therefore required to prove that Appellant caused the death in one of those four specific manners and means or a combination of the four. The evidence does not seem to support a finding that one of the specifically alleged manners and means or any combination of the four were the cause of death.

As we held in *Malik*, the sufficiency of the evidence to support a conviction should be measured by the elements of the offense as defined by the hypothetically correct jury charge for the case. *Malik v. State*, 953 S.W.2d 234, 240 (Tex. Crim. App. 1997). A hypothetically correct jury charge is one that accurately sets out the law, is authorized by the indictment, does not unnecessarily increase the State's burden of proof or unnecessarily restrict the State's theories of liability, and adequately describes the particular offense for which the defendant was tried. *Id.*

The law of a hypothetically correct jury charge that is "authorized by the indictment" must be the statutory elements of the offense as modified by the charging instrument. *Curry v. State*, 30 S.W.3d 394, 404 (Tex. Crim. App. 2000). If the indictment specifically charges an element, such as the identity of the victim or the use of a particular manner and means, a hypothetically correct jury

charge cannot simply quote or track the language of the statute. *Id.* at 404–05. An indictment would not "authorize" a conviction on less than proof of such specifically alleged elements, and, once alleged, those elements have to be proved. *Id.* at 405.

The indictment in this case charged that:

> on or about the 6th of December, 2015, DOROTHY A HOLLOWAY, did recklessly cause the death of an individual, namely, Kristian Maldonado, by disregarding a known risk of heart failure, and/or operating a motor vehicle contrary to medical instructions, and/or failing to follow medical aftercare instructions, and/or operating a motor vehicle after consuming an illegal substance, which acts and omissions resulted in the motor vehicle driven by DOROTHY HOLLOWAY to collide with the motor vehicle driven by Kristian Maldonado.

Thus, the State was required to prove not just the bare statutory elements of manslaughter that she recklessly caused Maldonado's death, but that she did so by one or more of the four alleged manner and means:

1. by disregarding a known risk of heart failure,
2. by operating a motor vehicle contrary to medical instructions,
3. by failing to follow medical aftercare instructions, or
4. by operating a motor vehicle after consuming an illegal substance.

From what I gather, the evidence in this case is not sufficient to show that Maldonado's death was "caused" by any one or a combination of the alleged acts.

First, "by disregarding a known risk of heart failure" is, essentially, an allegation that Appellant was reckless as to a risk of heart failure,[2] and this recklessness was the cause of

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[2] On this allegation, it seems to me that the medical knowledge of the drafter of the indictment may be limited. As discussed above, while they are related, "heart failure" and "cardiac arrest" are two distinct concepts. An allegation that a person disregarded a known risk of heart failure would imply that heart failure is similar to cardiac arrest, consisting of discrete events that have a risk of occurring. But heart failure is a constant condition. Once Appellant was diagnosed with heart

Maldonado's death. But as discussed above, the evidence as to recklessness seems lacking.

Second, the evidence does not support an inference that Appellant operated a motor vehicle contrary to medical instructions. The medical instructions that Appellant's doctors gave her did not tell her not to operate a motor vehicle.

Third, Appellant's failure to follow her doctors' aftercare instructions cannot be reasonably inferred as a cause of the cardiac arrest that led to Maldonado's death. As discussed above, the aftercare instructions were designed and intended to prevent a recurrence or worsening of her medical conditions. The instructions did not warn her that failing to follow the instructions would cause her to suffer a cardiac arrest, such that her failure to follow them can be deemed "the cause" of her cardiac arrest.

Additionally, there is the matter of the LifeVest. The evidence, instead of showing that the failure to wear the LifeVest caused Appellant's cardiac arrest that led to the death, showed that the LifeVest's purpose is to treat cardiac arrest after it has already occurred. The LifeVest detects an arrhythmia and, upon detection, issues a high-pitched alarm alerting the wearer to press a button on the device. If the wearer fails to press the button, presumably due to being unconscious, the device administers a shock to attempt to revive the wearer. If the wearer is conscious, the wearer is to press the button to prevent the shock.

As such, the LifeVest does not normally prevent cardiac arrests. But what if Appellant was wearing the LifeVest while driving? Even if she suffered the cardiac arrest, wouldn't the LifeVest have revived her, and then, after being revived, wouldn't Appellant have been able to quickly

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failure, she was in heart failure at all relevant times here. There is no "risk" of heart failure left to be disregarded. Appellant's risk, instead, was a risk of cardiac arrest.

recover, resume control of the vehicle, and thus prevent the fatal crash? Unfortunately, the process takes thirty seconds from the beginning of an arrhythmia to the shock, which is far too long to have been of use while driving. Furthermore, the evidence showed that the shock from a LifeVest does not result in immediate recovery. Instead, Appellant's expert explained that it may take several minutes to regain consciousness after a shock from the LifeVest. And the LifeVest may not have achieved even that in Appellant's case, because Appellant did not regain consciousness after paramedics administered shocks at the scene, even though their efforts restored her normal heart rhythm. She regained consciousness later at the hospital.

Thus, it is doubtful that Appellant's failure to wear the LifeVest was what caused her to experience a cardiac arrest while driving, causing the accident that resulted in Maldonado's death. The evidence shows that the LifeVest is a treatment for cardiac arrest after one has already occurred. Wearing a LifeVest rarely prevents cardiac arrest, and the failure to wear one cannot cause cardiac arrest. Even if Appellant wore the LifeVest, her cardiac arrest would still have happened. She would still experience the arrhythmia and would still speed down the highway for up to half a minute before the LifeVest would even shock her. Even if Appellant immediately regained control upon shock, that is still a long period of uncontrolled highway speed.

Ironically, I think the LifeVest itself would be a contributor to the fatal accident had Appellant been wearing it. As one of the doctors testified, the shock from the LifeVest is "quite painful" and "equivalent to having a mule kick you in the chest" or getting "hit with a baseball bat in the chest." How many drivers can maintain control on the highway after getting kicked by a mule or struck with a baseball bat? Such a shock to a driver on the highway would seem to pose just as much, if not more, of a danger to others as a driver like Appellant having a cardiac arrest.

At best, the State's evidence showed that the LifeVest addressed a risk Appellant alone faced—the risk to herself of death following a cardiac arrest. Whether or not she wore the LifeVest had no bearing on the risk to other drivers that Appellant posed due to her potential to suffer a cardiac arrest. Thus, regarding the third alleged manner and means, the evidence was insufficient to prove that Appellant's failure to follow aftercare instructions, either by failing to follow doctors' instructions generally or by failing to wear the LifeVest, caused the cardiac arrest.

Finally, the State alleged, as the fourth alternative manner and means, that Appellant caused Maldonado's death by driving after consuming an illegal substance. While the evidence showed the presence of amphetamine in Appellant's system, from which the jury could infer that Appellant consumed methamphetamine at some point prior to driving, the evidence did not show when she consumed the methamphetamine, how much she consumed, whether that particular consumption of methamphetamine was the cause of the cardiac arrest or otherwise had an effect on her driving, or that Appellant was intoxicated.

The court of appeals, instead of considering whether the evidence was legally sufficient under a hypothetically correct jury charge that is authorized by the specific manners and means alleged in the indictment, concluded that the evidence was sufficient to show that Appellant caused Maldonado's death "by driving without the LifeVest after using methamphetamine." This allegation seems to be a combination the third ("by failing to follow medical aftercare instructions") and fourth ("by driving after consuming an illegal substance"). But as just discussed, the evidence seems insufficient to support either basis—the failure to wear the LifeVest did not cause the cardiac arrest,

and likewise there is no proof that methamphetamine consumption caused the cardiac arrest.[3]

III — Conclusion

I would grant Appellant's petition. The court of appeals affirmed a conviction for manslaughter, "by driving without the LifeVest after using methamphetamine," on evidence that was insufficient to prove that those acts caused the death. The evidence did not show that Appellant was aware of a substantial and unjustifiable risk of death resulting from any of the alleged acts, which,

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[3] But what if Appellant's methamphetamine use in the past caused her generally poor heart condition? The court of appeals entertains that notion by finding that, "[a]lthough the jury was presented with evidence that various factors could cause congestive heart failure, the jury could have found Holloway's heart failure was caused by long-term use of methamphetamine." The court of appeals seems to suggest that a rational jury could conclude, beyond a reasonable doubt, that the cardiac arrest in this case was caused, not necessarily by methamphetamine use immediately prior to driving, but by long-term methamphetamine use.

This treads close to allowing Appellant's conviction to stand based on what would constitute jury speculation. We explained in *Hooper* that:

> Under the *Jackson* test, we permit juries to draw multiple reasonable inferences as long as each inference is supported by the evidence presented at trial . . . [A]n inference is a conclusion reached by considering other facts and deducing a logical consequence from them. Speculation is mere theorizing or guessing about the possible meaning of facts and evidence presented. A conclusion reached by speculation may not be completely unreasonable, but it is not sufficiently based on facts or evidence to support a finding beyond a reasonable doubt.

Hooper, 214 S.W.3d 9, 15–16.

In this case, as Justice Martinez pointed out in her dissenting opinion, various doctors testified that Appellant's non-ischemic heart failure could have been caused by a number of factors, including genetics, uncontrolled hypertension, cardio-toxins like chemotherapy, excessive alcohol consumption, certain medications and drugs, stress, other medical issues like thyroid disease, and infections. The court of appeals majority says the long-term methamphetamine cause is "particularly supported by evidence showing Holloway underwent a heart catherization procedure, and the results showed the decreased ejection fraction was not caused by any blockage." How is that anything other than mere theorizing or guessing about the possible meaning of the lack of a blockage? *Hooper*, 214 S.W.3d at 16.

generally, revolve around her failure to heed her doctors' instructions and advice. The record shows that Appellant's doctors told her nothing about the risks of driving. Instead, the doctors told her that if she did not correct her behaviors, her health conditions would worsen. Furthermore, it is questionable whether the evidence was sufficient to show that Appellant caused Maldonado's death by any one of or any combination of the alleged acts. Because the Court today lets the court of appeals's decision stand, I respectfully dissent.

Filed: June 17, 2020
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