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DIVISION III
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No. 318141

COURT OF APPEALS, DIVISION III

OF THE STATE OF WASHINGTON

BEVERLY VOLK, et al., *Appellants*,

v.

JAMES B. DEMEERLEER, et al., *Respondents*.

APPELLANTS' APPEAL BRIEF

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I. INTRODUCTION

This matter involves claims that negligence in the psychiatric care and treatment of a patient was a proximate cause of and/or substantial factor in: the murder of a patient's one-time female companion and one of her sons; the attempted murder of another of her sons; and the infliction of great emotional distress on another of her sons. The patient, soon thereafter, committed suicide. Hereinafter, these unfortunate occurrences will be, collectively, referred to as "the Incident."

It is claimed that Spokane Psychiatric Clinic, P.S. ("the Clinic") and Dr. Howard Ashby ("Dr. Ashby") of the Clinic failed, over a nine year period of treatment of its patient Jan DeMeerleer ("DeMeerleer") to: properly assess DeMeerleer's mental state; follow-up on his multiple expressed thoughts of suicide and homicide; and take appropriate clinical actions on those expressed thoughts, during the period of care and treatment.

On summary judgment the appellants' claims were dismissed from which the appeal arises.

II. ASSIGNMENTS OF ERROR

Assignments of Error

No. 1

The trial court erred by entry of the Amended Order on

Defendants' Summary Judgment Motions dismissing appellants'/ plaintiffs' claims on June 21, 2013.

Issues Pertaining to Assignments of Error

No. 1

Whether, in Washington, a psychiatrist may be liable to a third-party for damages where: (a) competent medical testimony is presented to support a finding of proximate causation resulting from the breach of the standard of care; and (b) the psychiatrist knew or should have known that the patient was a foreseeable risk of harm to the third-party.

No. 2

Whether, in Washington, a psychiatrist may be liable to a third-party for damages where: (a) competent medical testimony is presented to support a finding that a breach of the standard of care was a substantial factor in causation of a loss of chance of survival or a better outcome; and (b) the psychiatrist knew or should have known that the patient was a foreseeable risk of harm to the third-party.

No. 3

Whether RCW 71.05.120 works to shield a psychiatrist from liability to a third-party, under the facts and circumstances of this case, where the psychiatrist is not acting on behalf of the State of Washington or a public agency as defined in the statute.

III. STATEMENT OF THE CASE

A. Undisputed Factual Summary

This appeal arises from and relates to claims of professional negligence in the psychiatric treatment of DeMeerleer by Dr. Ashby and the Clinic.

In September of 2001, DeMeerler, then a 30-year old married father of a young girl, began psychiatric treatment at the Clinic. At that time DeMeerleer related to Dr. Ashby that: he had previously been diagnosed with bipolar disorder ("BPD"); had made one or more legitimate attempts at suicide; and had been civilly committed at a mental institution, all prior to his relocation to Spokane, from the Mid-West. (CP 85-86).

During the course of treatment and therapy with Dr. Ashby and the Clinic, DeMeerleer's marriage failed and caused him distress and homicidal thoughts toward his ex-wife and her new male companion. (CP 87); DeMeerleer caused his family to alert Dr. Ashby that he had homicidal thoughts and had taken action on them by laying in wait with loaded firearms in order to attempt to take retribution on one or more individuals he suspected of damaging one of his vehicles (CP 87-88); and was also known to have extended periods of manic behavior, depression,

and mixed affect, especially when it concerned pre and post divorce relationships with his ex-spouse and then with Ms. Schiering. (CP 85-89). During psychiatric sessions with Dr. Ashby, it was DeMeerleer's practice to discuss his mental status, including thoughts of homicide and suicide. However, during the course of treatment, Dr. Ashby never once formally assessed DeMeerleer for risks of suicide or harm to others. (CP 87-91). DeMeerleer was treated exclusively by prescription medication and clinical counseling sessions. (CP 87-90). In the last clinical visit with Dr. Ashby in April of 2010, DeMeerleer appeared to be in obvious distress, and presented with suicidal thoughts. However, DeMeerleer was not scheduled by Dr. Ashby for follow-up assessment or treatment. (CP 89-90).

In the early morning hours of July 18, 2010, DeMeerleer, a psychiatric patient of Dr. Ashby and the Clinic for almost nine years, murdered Rebecca Leigh Schiering and her nine year old son, Phillip Lee Schiering, by gunshots to the head, and attempted to murder one of Rebecca Leigh Schiering's other sons, Brian Winkler. DeMeerler did not murder or attempt to murder Rebecca Leigh Schiering's other nine year old son, Jack Alan Schiering. (CP 27-32). Later that day, DeMeerleer was found by a Spokane County Sheriff's Department S.W.A.T team in the garage of his house, dead, by an apparent self-inflicted gunshot to his

head. This tragic sequence of events is hereinafter referred to collectively as "the Incident."

Various litigation was filed by the Personal Representative of the Estates of Decedents Rebecca Leigh Schiering and Phillip Lee Schiering and survivors Bryan Winkler and Jack L. Schiering which was consolidated into a single, amended complaint on May 22, 2012. (CP 27-32). Prior to that time, Dr. Ashby and the Clinic moved for summary judgment. (CP 57-59 and 60-62). The plaintiffs responded with competent expert psychiatric testimony, uncontested by opposing expert testimony, that negligence by errors and omissions in treatment of DeMeerleer by the Clinic and Dr. Ashby was a proximate cause of and/or substantial factor in the causation of the Incident. (CP 82-92). Plaintiffs argued that third parties could recover damages from a treating psychiatrist and clinic, for harm caused by a patient, where: the psychiatrist breached the standard of care in failing to properly assess and follow-up on treatment of a patient for suicidal and homicidal thoughts and actions; and knew or should have known that an the third party was forseeably at risk for harm from the patient. (CP 70-81). Defendant/Respondents argued that such causes of action are not recognized in Washington, under the common law, and even if so, RCW 71.05.120 would bar such a cause of action. (CP 249-59). On June 21, 2013, the trial court granted defendants/respondents summary

judgment motion and dismissed plaintiffs/appellants' claims by entry of judgment, giving rise to this appeal. (CP 274-77).

B. Undisputed Factual Detail

As of 2001, DeMeerleer had married, fathered a child, and was residing in Spokane County. DeMeerleer began treatment with the Clinic on September 13, 2001. (CP 85). DeMeerleer disclosed to Dr. Ashby that he had previously had suicidal ideas upon which he acted, in attempting suicide, the mitigation of which required extended in-patient psychiatric therapy and treatment. (CP 85-86). DeMeerleer also reported that he had recently played "Russian Roulette" with a loaded firearm, recently during the Summer of 2001. (CP 86). At the time DeMeerleer began treatment with the Clinic, it was also disclosed that he had previously had homicidal ideas. In a written submission believed to be provided to Dr. Ashby as part of the June 27, 2002 session, DeMeerleer assessed his manic mental state to include, but not be limited to the following characteristics:

1. Despises lesser creatures; no remorse for my actions/thoughts on other living creatures.
2. Delusional and psychotic beliefs argued to the point of verbal abusive and fighting.

3. No need for socialization; in fact, prefers to psychotically depopulate the world (i.e. "do Your Part" [CYP] terrorist philosophies).
4. Wants to destroy; pounds on computer keyboard, slams phone receiver, swings fists.
5. Has no use for others; everyone else in world is useless.
6. Reckless driving; no fear of danger in any circumstance, even "near misses."
7. Acts out fantasies of sex with anyone available. (CP 86)

DeMeerleer's then-current spouse also assessed, in a written submission at that same time, that DeMeerleer's hypomanic and manic mental state was as follows:

1. Makes mistakes on projects (i.e. breaking something) and quickly moves into dangerous rage; actually easily slips into depression after this type of trigger.
2. Severe lack of sleep coupled with dreams of going on killing or shooting sprees.
3. Drives automobiles very fast (at least 20 to 30 MPH above speed limit) without a seat belt while showing no fear at all when in dangerous situations; applies even with a child in the car.

4. Expresses severe "road rage" at other slower drivers, even as a passenger (he's NOT driving).
5. Has an "all or nothing" attitude; will actually verbally express "Live or Die!" (CP 86-87)

When DeMeerleer expressed suicidal and homicidal ideas on several occasions while being treated by Dr. Ashby, no thorough inquiry was made by Dr. Ashby as to the nature and extent of the ideas, such as: planning; access to weapons; prior attempts; acting out, etc; stress; access to victims; and so forth. (CP 87).

At the time DeMeerleer began clinical treatment with Dr. Ashby, and during treatment, issues of DeMeerleer's sexuality and sexual experimentation were identified by DeMeerleer. (CP 87). A review of the police records confirm that a significant issue in DeMeerleer's estrangement from Ms. Schiering was: his interest in pornography; his experimentation with homosexuality and/or bi-sexuality; and Ms. Schiering's disdain for these activities. (CP 87). The Clinic's clinical records and chart notes, however, reflect no inquiry into issues of DeMeerleer's sexuality, even though excessive sexual preoccupation is a well-known symptom of BPD. (CP 87).

During treatment by Dr. Ashby and the Clinic, after the failure of his marriage, DeMeerleer expressed homicidal ideas toward his former

spouse and her then-current boyfriend. (CP 87). Subsequently, DeMeerleer's family was greatly concerned about his access to firearms, and his acting upon homicidal ideas. (CP 87). DeMeerleer's mother's sent a letter to Dr. Ashby and the Clinic dated September 24, 2005. (CP 87). The following is an excerpt from that letter:

> We were all extremely concerned that Jan's reaction to vandalism to his "beater" pickup truck was dangerous and unrealistic. Jan placed two powerful guns (a .357 pistol and a shotgun, both with lots of ammunition) into his car and then drove himself to the area where this theft had been perpetrated in order to "wait" for the thieves to return. Jan's two fathers (biological and step) and I do have a huge issue with Jan hauling loaded guns around in case he finds the guys who ripped into his truck! ***Jan assured us that he no longer has visions of suicide but that he has now progressed into a homicidal mode.*** Believe me, Dr. Ashby, we are NOT comforted by this information! Jan's several guns were removed from his home (by his two fathers) and taken to Moscow. (CP 88)

DeMeerleer had been placed on various psychotropic drugs by Dr. Ashby which at times regulated his bi-polar state, and at other times did not. This was due either to efficacy, and/or DeMeerleer's known penchant for failing to take medications (non-compliance), especially in times of his manic and/or mixed mood states. Based on toxicology results, DeMeerleer was non-compliant with taking his medications at the time of the Incident. (CP 88). Dr. Ashby was aware of DeMeerleer's issues of non-compliance. (CP 88).

During treatment by Dr. Ashby, it was known to him that, after his failed marriage, DeMeerleer struck up an apparent serious relationship with Ms. Schiering and her biological children with the intention of marrying Ms. Schiering and becoming a step-father to her biological children. (CP 85). However, DeMeerleer's coping ability was apparently tested severely by Ms. Schiering's autistic son, Jack, to the extent that DeMeerleer physically attacked Jack by striking the then 9 year old squarely in the mouth with his fist. This apparently caused Ms. Schiering to separate from DeMeerleer. (CP 88).

Dr. Ashby initially appeared to have diagnosed DeMeerleer with a mild form of BPD (cyclothymic personality disorder). (CP 85). Dr. Ashby also considered evaluating DeMeerleer's obsessive compulsive traits, but it is not apparent that this was done. An evaluation may have indicated a concurrent borderline personality disorder, which shares some symptomology with BPD, but is not considered as serious a mental illness as BPD. (CP 85). Generally, in the context of a BPD diagnosis, and throughout treatment by Dr. Ashby and the Clinic, DeMeerleer frequently appeared to have been mentally unstable. (CP 85). However, no systematic or focused inquiry into DeMeerleer's psychiatric symptoms was made, and no solid treatment plan with periodic follow-up was initiated by Dr. Ashby, other than adjustment of medications. (CP 85-86).

DeMeerleer was clinically seen by Dr. Ashby on June 11, 2009, and appeared to be in distress. (CP 88). His medication and medication levels were changed, but no follow-up was scheduled. (CP 88). DeMeerleer also phoned the Clinic on December 1, 2009, in obvious distress due to loss of employment and separation from Ms. Schiering, and specifically expressed his desire to get back into counseling, and medication management. (CP 88). The Clinic referred him to local community based medical and mental healthcare, but advised him to come to the Clinic for counseling and a medication check if the referrals didn't work out. (CP 88). DeMeerleer returned to the Clinic on April 16, 2010, appeared to be in the middle of frequent mood cycling, and reported he was mending his relationship with Ms. Schiering. (CP 88). He also stated he was having depression related suicidal ideas. (CP 88-89). Apparently, no focused inquiry was made by Dr. Ashby. Instead, Dr. Ashby relied on DeMeerleer's self-report that he wouldn't act on his suicidal ideas. (CP 89). At DeMeerleer's last appointment, on April 16, 2010, he was noted to suffer from an unstable mood, as well as having intrusive ideas about suicide. (CP 89). There is no evidence that DeMeerleer's suicide risk was assessed at this time. There is also no evidence that any follow-up appointment was made for DeMeerleer, in order to adequately monitor his clinical condition. (CP 89).There is also no evidence that Dr. Ashby or the

Clinic ever conducted an evaluation of suicide risk during the nine years of treatment with and by Dr. Ashby and the Clinic. (CP 89-90).

IV. SUMMARY OF ARGUMENT

DeMeerleer was well known to Dr. Ashby and the Clinic to have suicidal and homicidal thoughts, and to have acted on them on several occasions. DeMeerleer was also known to have suicidal and homicidal ideas concerning failed relationships. For eight months or more prior to the Incident, Dr. Ashby and the Clinic knew of DeMeerleer's suicidal ideas related to his loss of employment and separation from Ms. Schiering, and his anger toward one of her nine year old fraternal twin sons, who was autistic. Dr. Ashby and the Clinic breached the applicable standard of care in failing to assess DeMeerleer for risk of suicide and/or homicide over the entire course of his treatment by Dr. Ashby and the Clinic. Dr. Ashby and the Clinic specifically breached the standard of care in the months leading up to and subsequent to DeMeerleer's last clinical visit on April 16, 2010, by failing to: schedule follow-up appointments; failing to assess him for risk of suicide and/or homicide; and failure to monitor his mental state and compliance with medication over time. Collectively, Dr. Ashby and the Clinic's failure to meet the standard of care in psychiatric treatment was a proximate cause of and/or substantial factor in the Incident. Washington law allows for such third-party medical negligence claims. Washington

law further allows for claims to be presented based on proximate and substantial factor causation. Finally, Washington law does not prohibit or exempt respondents from appellate claims.

V. ARGUMENT

A. **The Expert Medical Testimony, Applied to The Facts and Circumstances of DeMeerleer's Course of Psychiatric Care and Treatment and the Incident Allows for Appellants' Claims**.

Appellants have presented competent medical testimony as to the breach of the standard of care in DeMeerleer's psychiatric treatment by Dr. Ashby and the Clinic, and of resulting damages caused thereby. ***The declaration provided by appellant's psychiatric expert witness, Dr. Knoll, is the only medical testimony given in this matter. Respondents provided no expert testimony to challenge Dr. Knoll's conclusions that Dr. Ashby and the Clinic breached the applicable standard of care.*** The declaration further addresses forseeability of harm to those actually harmed by DeMeerleer, and proximate causation and/or substantial factor in causation attributable to the negligence of Dr. Ashby and the Clinic.

Dr. Knoll testified that timely, appropriate, and focused psychiatric inquiry of DeMeerleer during clinical sessions most likely would likely have resulted in him having incurred more appropriate and intensive clinical or institutional psychiatric treatment and/or detention. (CP 89.

This until such time as treatment was demonstrably effective and/or risk of harm to himself had been appropriately mitigated. (CP 89). An adequate suicide risk assessment does not rely solely on the patient's denial of suicidal ideas, but involves an assessment of both the aggravating and mitigating factors in the context of the individual circumstances and patient's clinical status. (CP 89). A psychiatrist simply asking about suicide ideas does not ensure accurate or complete information will be received. (CP 89). It is considered the standard of care for the mental health professional to perform an adequate suicide risk assessment. (CP 89). A systematic assessment of suicide risk is a basic, essential practice that informs the mental health professional about proper treatment and management. (CP 89). It is pertinent that in clinical practice, it is observed that some patients, who first express suicidal ideas in clinical session, are found also to have homicidal ideas during risk assessment for suicide. (CP 89). Also, it is with unfortunate observed frequency that some who are known or believed to be suicidal commit homicide, concurrent with suicide. (CP 89-90).

The Clinic's records indicate that, despite DeMeerleer's worsening condition, he was not monitored and evaluated in a minimally adequate manner over time with follow up appointments. (CP 90). When a patient presents with significant factors for suicide and/or harm to others, and

especially with a history of action on ideas of suicide (prior attempt at suicide, and Russian Roulette) and homicide (prior armed attempt to lay in wait to extract justice on car prowlers) as DeMeerleer did, it is critical to monitor psychiatric status and response to treatment closely. (CP 90). Ongoing monitoring of clinical condition is needed to determine the patient's symptoms, response to treatment, suicide risk, homicide risk and need for hospitalization. (CP 90). The records indicate that DeMeerleer did not receive timely follow-up during his periods of apparent psychological distress. Given DeMeerleer's unstable BPD, life stressors, past suicide attempts, past actions to realize homicide, noncompliance (in taking medication) and "intrusive" suicidal ideas, it was below the standard of care to fail to monitor him in a timely manner. (CP 90). Had Dr. Ashby and the Clinic met the standard of care, it is patent that DeMeerleer would have been in regularly scheduled clinical follow-up over the summer of 2010. (CP 90). During that period, and prior to the incident, an exchange of e-mails between DeMeerleer and Ms. Schiering reveal the relationship had crumbled, and that DeMeerleer was emotionally crushed and mentally desperate and unstable. (CP 90). DeMeerleer's records with the Clinic clearly demonstrate that he routinely raised and addressed issues pertaining to his then current relationship(s) during clinical sessions. (CP 90). This is evident in his early records with

the Clinic, first in his and his then-current spouses' attempts to remain together, and then on to his dark, intrusive homicidal thoughts toward her, and her new interest, once she had rejected him. (CP 90). DeMeerleer's next relationship was with Ms. Schiering, who was then substituted as a clinical topic by DeMeerleer. (CP 90). Had DeMeerleer been in clinical session during the summer of 2010, Dr. Ashby would have been able to inquire about his thoughts and emotions about his current relationship with Ms. Schiering and her children, and any ideas of suicide and/or homicide. (CP 90). Recall that DeMeerleer had disclosed suicidal and homicidal ideas during several prior clinical sessions. (CP 91). Had Dr. Ashby and the Clinic properly monitored DeMeerleer, resulting in an adequate risk assessment for suicide and/or homicide, intensive clinical or institutional psychiatric treatment, and/or detention, the risk and occurrence of the Incident would have been mitigated. (CP 91).

B. Third Parties May Recover Damages for Medical Negligence in Washington Under Certain Circumstances.

It is long settled law in Washington that a physician may have liability for the harm caused third parties as a result of the physician's negligence in the care and treatment of his or her patient, when the physician knew or should have known that the negligent treatment of the patient may present a foreseeable risk of harm to a third party. In *Kaiser v. Suburban Transp. Sys.*, the Washington Supreme Court addressed

medical negligence in the context of a physician's alleged failure to warn his patient, a public transit bus driver, of the potential side effects of a prescription drug which could affect his driving, and, therefore, endanger passengers.

> ***The plaintiff, Gertrude M. Kaiser, was injured while a passenger on a Suburban Transportation System bus when the bus driver, Richard Wagner, lost consciousness and the bus struck a telephone pole. This lapse of consciousness can be attributed to the side effects of a drug (pyribenzamine) which had been prescribed by his doctor, Jack Faghin, for the treatment of a nasal condition. The driver testified that the doctor gave him no warning concerning possible side effects of the drug, and that he took the first pill on the morning of the accident.*** A few miles before the accident he felt groggy and drowsy, and then he noticed that his lips and tongue were dry. He blacked out or went to sleep shortly before his bus left the road.
>
> ***The plaintiff (respondent and cross-appellant), brought this action against the bus company and the driver, and, in the alternative, against the doctor and the doctor's employer, Group Health Cooperative of Puget Sound, defendants (respondents). The bus company and driver answered and cross-complained against the doctor and Group Health, alleging that the sole cause of the accident was the negligence of the doctor.*** The doctor and Group Health denied negligence and claimed that the driver was hypersensitive to pyribenzamine.

Kaiser v. Suburban Transp. Sys., 65 Wn.2d 461, 462-63,398 P.2d 14 (Wash. 1965) (emphasis added)

In *Kaiser*, the trial court dismissed the physician and his employer, Group Health Cooperative, from the litigation. The Supreme Court reversed stating:

> There is evidence in the record that ***the doctor failed to warn his patient, whom he knew to be a bus driver, of the dangerous***

> ***side effects of drowsiness or lassitude that may be caused by the taking of this drug.*** This evidence was sufficient to submit the issue of the doctor's negligence to the jury.

Kaiser, Id. at 65 Wn.2d 461 (emphasis added).

It is implicit in the *Kaiser* decision that third parties who are reasonably foreseeable to be at risk of harm from a physician's patient, where the physician's negligence may be causal, may bring claims for damages against the physician if the risk of harm becomes an actuality. In this, the Supreme Court left no uncertainty:

> We are convinced from this record, however, that the plaintiff is entitled to judgment as a matter of law on the issue of liability against either the bus company and the driver, or Group Health and the doctor, or both, depending upon certain factual determinations by the jury which we hereinafter specify in our directions for remand.
>
> The judgment of the trial court entered upon the jury verdict is reversed and remanded for a new trial on all issues subject to the following:
>
> ***The jury should be directed that (a) in the event it finds no warning was given the bus driver as to the side effects of the drug, it shall bring in a verdict against Group Health and the doctor;*** (b) in the event the jury finds the bus driver failed to exercise the highest degree of care, even though he was given no warning as to the side effects of the drug, the jury shall also bring in a verdict against the bus company and the driver; and (c) in the event the jury finds that a warning of the side effects of the drug was given to the bus driver, then the verdict shall be against the bus company and the driver only.

Kaiser, Id. at 65 Wn.2d 461 (emphasis added).

Eighteen years after the Kaiser decision, the Supreme Court confirmed the broad applicability of the *Kaiser* decision to the medical community, including psychiatrists. In 1983, the Washington Supreme Court stated, with specific reference to the *Kaiser* decision, as follows:

> ***We have not yet considered whether a psychiatrist has a duty to protect against injuries caused by a patient. In Kaiser v. Suburban Transp. Sys., 65 Wn.2d 461, 398 P.2d 14, 401 P.2d 350 (1965), we allowed a cause of action against a doctor favoring a third person who was injured by the doctor's patient where the doctor failed to warn his patient, a bus driver, of the side effects of a drug prescribed for the treatment of a nasal condition. The plaintiff, a bus passenger, was injured when the driver lost consciousness and struck a telephone pole. We held that since the doctor should reasonably have foreseen the harm resulting from his failure to warn of the side effects of the drug the bus passenger was entitled to present evidence that the doctor's negligence was the proximate cause of her injuries.***
>
> The seminal case regarding the duty of a psychiatrist to protect against the conduct of a patient is *Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).* In *Tarasoff* the plaintiffs alleged the defendant therapists had a duty to warn their daughter of the danger posed to her by one of the therapists' patients. The *Tarasoff* plaintiffs were parents of Tatiana Tarasoff, a young woman killed by a psychiatric patient. Two months prior to the killing, the patient informed his therapist that he intended to kill a young woman. Although the patient did not specifically name Tatiana as his intended victim, plaintiffs alleged, and the trial court agreed, that the defendant therapists could have readily identified the endangered person as Tatiana.
>
> Applying *Restatement (Second) of Torts § 315* (1965) to the facts before it, the *Tarasoff* court held the patient-therapist relationship was sufficient to support the imposition of an affirmative duty on the defendant for the benefit of third persons. *Tarasoff, 17 Cal. 3d at 435.* ***The Tarasoff court ruled that when a psychotherapist determines, or, pursuant to the standards of the profession, should determine, that a patient presents a serious***

danger of violence to another the therapist incurs an obligation to use reasonable care to protect the intended victim against such danger. *Tarasoff, 17 Cal. 3d at 435.* According to the *Tarasoff* court, discharge of the duty may require the therapist to take whatever steps are necessary under the circumstances, including possibly warning the intended victim or notifying law enforcement officials. *Tarasoff v. Regents of Univ. of Cal., supra.*

Although the *Tarasoff* decision did not emphasize the identifiability of the victim, subsequent California decisions have limited the scope of the therapist's duty to readily identifiable victims. *See Thompson v. County of Alameda, 27 Cal. 3d 741, 752-54, 614 P.2d 728, 167 Cal. Rptr. 70 (1980)*; *Mavroudis v. Superior Court, 102 Cal. App. 3d 594, 600-01, 162 Cal. Rptr. 724 (1980).* Other courts, however, have required only that the therapist reasonably foresee that the risk engendered by the patient's condition would endanger others. *See, e.g., Semler v. Psychiatric Inst., 538 F.2d 121, 124* (4th Cir.), *cert. denied, 429 U.S. 827 (1976)*; *Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 194 (D. Neb. 1980)*; *Williams v. United States, 450 F. Supp. 10401046 (D.S.D. 1978). In Lipari, for example, the court emphasized the importance of foreseeability in defining the scope of a person's duty to exercise due care. See Lipari v. Sears, Roebuck & Co., supra.* In *Lipari* a psychiatric patient entered a nightclub and fired a shotgun into a crowded dining room causing injuries to plaintiff and killing her husband. The *Lipari* court found the defendant therapist had a duty to any person foreseeably endangered by the negligent treatment of the psychiatric patient. *Lipari v. Sears, Roebuck & Co., supra.*

In the present case, we follow the approach utilized in Lipari v. Sears, Roebuck & Co., supra, and Kaiser v. Suburban Transp. Sys., supra. Consequently, we conclude Dr. Miller incurred a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by Larry Knox's drug-related mental problems. At trial Dr. Miller testified that Knox was a potentially dangerous person and that his behavior would be unpredictable. He also testified that if Knox used angel dust again he was likely to continue having delusions and hallucinations, especially if he quit taking the drug Navane. Dr. Miller testified he knew of Knox's reluctance to take Navane, and he thought it quite likely Knox would revert to using angel dust again. Nevertheless, Dr. Miller

failed to petition the court for a 90-day commitment, as he could have done under *RCW 71.05.280*, or to take other reasonable precautions to protect those who might foreseeably be endangered by Knox's drug-related mental problems.

Petersen v. State, 100 Wn.2d 421, 426-29; 671 P.2d 230 (1983) (emphasis added)

C. RCW 71.05.120 is Inapplicable to Bar Appellants' Claims and Serves to Validate Them.

After the Petersen case, in 1987, the legislature amended RCW 71.05.120 (1) to abrogate the holding of *Peterson* as to the liability of the state and those acting on behalf of the state, with respect to the civil mental health commitment process, only. The statute, as amended, now reads as follows:

§ 71.05.120. Exemptions from liability

(1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

Further, even if the statute were worded to exempt all mental health actions and treatments, not just mental health commitments, the

statute would still be inapplicable, as it clearly is intended only to exempt the state and its agents. Former Justice Phillip Talmadge specifically noted, in his concurring opinion in *Hertog v. City of Seattle*, 138 Wn.2d 265, 293 n.7, 979 P.2d 400 (1999), that "the Legislature statutorily abrogated our holding in *Petersen* in Laws of 1987, ch. 212, § 301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State." Note that Justice Talmadge does not reference private mental health practitioners or psychiatrists, and only refers to the liability of the State.

Finally, the Division I Court of Appeals has considered the issue of general application of RCW 71.05.120(1) subsequent to the 1987 amendment. It ruled the terms of RCW 71.05.120 are restricted to the mental health commitment procedures of RCW Chapter 71.05, only, thus disposing of Defendant's arguments to the contrary. The Court stated:

> Tobis further argues that the Legislature has expressed an intent to impose liability on state employees to protect identifiable victims from the violent behavior of mental patients. In support of this contention, Tobis cites a recent amendment to RCW 71.05.120. This statute now reads in part:
>
> Exemptions from liability. (1) No officer of a public or private agency . . . nor any public official performing functions necessary to the administration of this chapter . . . nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, release, or detain a person for evaluation and treatment: *Provided*, That such duties were performed in good faith and without gross negligence. (2) *This section does not relieve a person from . . . the duty to warn or*

> *to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.* (Italics ours.)
>
> Tobis offers no evidence that the Legislature intended this amended statute, which is part of the chapter dealing with mentally ill individuals (RCW 71.05), to apply to procedures affecting those individuals who have been criminally committed (RCW 10.77). ***This court cannot construe this amended statute as applying to procedures not contained in RCW 71.05.*** Had the Legislature intended to include proceedings under RCW 10.77, it would have so stated.
>
> *Tobias v. State, of Washington, et. al.*, 52 Wn. App. 150, 157-8; 758 P.2d 534; (1988) (emphasis added)

D. Appellants May Recover Damages Where Negligent Psychiatric Care and Treatment May be Proved as a Proximate Cause.

The *Kaiser* and *Petersen* cases allow for such claims, apparently in tort under the common law. As such, proof of the breach of the standard of care would be on a more probable than not basis, with proximate causation determined as it ordinarily is, i.e. "but for." In doing so, the third party's burden of proof and measure of damages appear to be no different than that of a patient claiming medical negligence.

E. Appellants May Also Recover Damages Where Negligent Psychiatric Care and Treatment May be Proved as a Substantial Factor in Causation (Loss of Chance).

This Court first recognized a claim for loss of a chance in *Herskovits v. Group Health Cooperative of Puget Sound,* 99 Wn.2d 609,

664 P.2d 474 (1983), where six justices concluded that the plaintiff had established a prima facie claim based upon a decrease in the statistical chance of survival. See *Herskovits*, 99 Wn.2d at 614 (Dore, J., lead opinion); *id.* at 634 (Pearson, J., concurring). *Herskovits* involved a wrongful death and survival action based on a healthcare provider's failure to diagnose and treat. See *id.* at 611 (lead opinion). There, the plaintiffs claimed the decedent had a loss of chance of survival. The defendants moved for summary judgment, and the plaintiff responded with evidence that the alleged negligence left the decedent with a decreased five year survival probability, from 39% to 25%. See *id.* at 610-11. There was no dispute that the decedent's five-year survivability never exceeded 50%. The decedent passed on approximately three years after the alleged negligence. See id. at 611. The trial court granted summary judgment based upon the estate's failure to produce evidence that the alleged negligence more likely than not caused the decedent's death. See *id.* at 611-12.

The Supreme Court reversed and remanded the matter for trial. The lead opinion by Justice Dore, representing two justices, and the concurring opinion by Justice Pearson, representing four justices, conclude that, as a matter of public policy, negligent healthcare providers should be

at risk if they caused a loss of chance, which has put recovery of health beyond the possibility of realization. [1]

In the concurrence, Justice Pearson justifies this policy choice, explaining that failure to recognize loss of chance

> subverts the deterrence objectives of tort law by denying recovery for the effects of conduct that causes statistically demonstrable losses .... A failure to allocate the cost of these losses to their tortious sources ... strikes at the integrity of the torts system of loss allocation.

Id. at 634 (quoting King, supra at 1377; ellipses in original).

Justice Dore notes, in the lead opinion, that "[t]o decide otherwise would be a blanket release from liability for doctors and hospitals anytime there was less than a 50 percent chance of survival, regardless of how flagrant the negligence." Id. at 614.

In *Herskovits v. Group Health Cooperative of Puget Sound,* 99 Wn.2d 609, 664 P.2d 474 (1983), the concurring opinions propose implementing this policy choice in different ways. The lead opinion addresses adjustment in causation to accommodate loss of a chance,

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1 See Herskovits at 614 (Dore, J., lead opinion, stating "[t]he underlying reason is that it is not for the wrongdoer, who put the possibility of recovery beyond realization, to say afterward that the result was inevitable"); id. at 634 (Pearson, I, concurring, stating "the all or nothing approach gives certain defendants the benefit of an uncertainty which, were it not for their tortious conduct, would not exist"); see also id. at 642-43 (Dolliver, I, dissenting, recognizing "the court is called upon to make a policy decision"); see generally Joseph H. King, Causation, Valuation, and Chance in Personal Injury Torts Involving Pre.existing Conditions and Future Consequences, 90 Yale L. I 1353, 1378 (1981) (explaining that"[d]estruction of a chance should also be compensated for reasons of fairness").

qualitatively, while the concurring opinion addresses the degree of injury attributable to the negligence, resulting in an adjusted calculation of damages, quantitatively. Arguably, neither opinion standing alone is precedential or binding in areas of discord. See *Spain v. Employment Dec. Dep't*, 164 Wn.2d 252, 260 n.8, 185 P.3d 1188 (2008) (where "a plurality of the court may be persuasive to some but has little precedential value"). The Court of Appeals has, variously, referenced *Herskovits'* lead and concurring opinions. See *Sharbono v. Universal Underwriters Ins. Co.*, 139 Wn. App. 383, 421-22, 161 P.3d 406 (2007) (loss of chance determined by the substantial factor test of proximate cause, citing the lead opinion in *Herskovits*); *Shellenbarger v. Brigman*, 101 Wn.App. 339, 348-49, 3 P.3d 211 (2000) (loss of chance described as "a compensable interest", relying on the concurrence in *Herskovits*); *Zueger v. Public Hosp. Dist. No.2*, 57 Wn.App. 584, 789 P.2d 326 (1990) ("if *Herskovits* stands for anything beyond its result, we believe the plurality represents the law on loss of the chance of survival").

Subsequently, in *Daugert v. Pappas,* 104 Wn.2d 254, 704 P.2d 600 (1985), a legal malpractice case in which the court found loss of chance inapplicable, the Supreme Court noted that loss of a chance is a distinct type of injury:

The primary thrust of *Herskovits* was that a doctor's misdiagnosis

> of cancer either deprives a decedent of a chance of surviving a potentially fatal condition or reduces that chance. A **reduction in one's opportunity to recover (loss of chance) is a very real injury which requires compensation.**

See *id.* at 261 (emphasis added); see also *id.* at 261-62 (stating "a doctor's misdiagnosis of cancer causes a separate and distinguishable harm, *i. e.* , diminished chance of survival").

In *Mohr v. Grantham,* 172 Wn.2d 844, 853-54; 262 P.3d 490 (2011), then, the Supreme Court confirmed the *Herskovits* loss of chance of survival as a post mortem action related to an alleged reduction in longevity (i.e. life expectancy), in the context of a wrongful death action. However, *Mohr* expanded on *Herskovits*, by allowing for a loss of chance claim for harm which is less than death, including, but not limited to, disability. Such claims may be made in the context of an *inter vivos* action, or by a PR's action on behalf of an Estate. In all cases, a substantial (significant) factor test may be applied as an exception to the "but for" test of causation.

> Though this court has not reconsidered or clarified the rule of *Herskovits* in the survival action context or, until now, considered whether the rule extends to medical malpractice cases where the ultimate harm is something short of death, the *Herskovits* majority's recognition of a cause of action in a survival action has remained intact since its adoption. "Washington recognizes loss of chance as a compensable interest." *Shellenbarger v. Brigman,* 101 Wn. App. 339, 348, 3 P.3d 211 (2000); *see Zueger v. Pub. Hosp. Dist. No. 2 of Snohomish County,* 57 Wn. App. 584, 591, 789 P.2d 326 (1990) (finding that the *Herskovits* "plurality represents the law on a loss of the chance of survival");16 David K. DeWolf &

> Keller W. Allen, Washington Practice: Tort Law and Practice § 4.10, at 155-56, § 15.32, at 488 (3d ed. 2006) *("Washington courts recognize the doctrine of 'loss of a chance' as an exception to a strict application of the but-for causation test in medical malpractice cases.").* In *Shellenbarger*, the Court of Appeals reversed summary judgment of a medical malpractice claim of negligent failure to diagnose and treat lung disease from asbestos exposure in its early stages. *101 Wn. App. at 342.* Expert witnesses testified that had Shellenbarger received non-negligent testing and early diagnosis, which would have led to treatment, he would have "had a 20 percent chance that the disease's progress would have been slowed and, accordingly, he would have had a longer life expectancy." *Id. at 348.* The court concluded, "We find no meaningful difference between this and *Herskovits'* lost chance of survival." *Id. at 349.*

Based upon the facts which may be received in evidence at trial, appellants should be allowed to claim damages to be assessed by proximate causation and/or substantial factor. The trier of fact will be the final arbiter of the nature and degree of causation and resulting damages. The two standards of causation represent separate injuries and harm, and thus separate instances and levels of damages, in the alternative and/or cumulative, depending on the specific facts as applied to each individual claimant.

VI. CONCLUSION

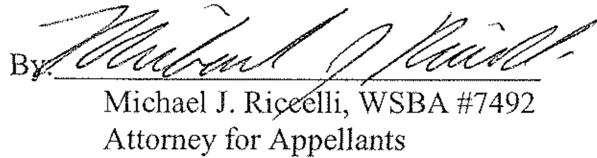
Appellants have presented competent medical testimony to place the issue of Dr. Ashby's and the Clinic's breach of the standard of care and causation of injury and harm, and resulting damages before a trier of fact. The facts, when viewed most favorably toward appellants,

substantiate the claims of appellants. Washington law allows for such third-party medical negligence claims and for causation and damages to be assessed by the trier of fact based on proximate causation and/or the substantial factor test.

Therefore, appellants respectfully request this appellate court to reverse the trial court's dismissal of their claims and remand this matter back to the trial court for further proceedings.

RESPECTFULLY SUBMITTED this 14th day of October, 2013.

MICHAEL J RICCELLI PS

By 

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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of October, 2013, I caused a true and correct copy of the Brief of Appellants to be served on the following counsel for Respondent/Defendants in the manner indicated below:

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