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Court of Appeals No. 51827-9-II

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IN THE WASHINGTON STATE COURT OF APPEALS
DIVISION II

LISA SAMUELS,
Plaintiff/Appellant/Petitioner

v.

MULTICARE HEALTH SYSTEM, GLORIA LEM, CITY OF TACOMA
Respondents.

PETITION FOR REVIEW TO THE WASHINGTON SUPREME COURT

By:

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IDENTITY OF THE PETITIONER

The Petitioner, Lesa Samuels, was the plaintiff at the trial court level. Ms. Samuels resolved her claims against cetain of the other original defendants, (Gloria Lem ARNP and Multicare Health Systems), but alleges that acts, errors, and omissions of employees of defendant City of Tacoma's Fire Department also caused injuries to her. The Pierce County Superior Court, however, termintated Samuels' case against the City via summary judgment, so Samuels appealed the Superior Court's grant of summary judgment to Division 2 of the Court of Appeals.

CITATION TO THE COURT OF APPEALS DECISION

Ms. Samuels is petitioning the Supreme Court to review those poritons of the Court of Appeals' November 1, 2019 decision in Case No. 51827-9-II captioned as *Lesa M. Samuels v Multicare Health System, Gloria N. Lem, Does 1-10, and City of Tacoma,* which upheld the trial court's summary judgment dismissal of Samuels' claims against Defendant City of Tacoma wherein the trial court ruled that there were no triable issues of fact concering whether the Fire Department's employees were (a) grossly negligent or (b) their acts, errors, or omissions deprived them of the qualified immunity otherwise available to first responders under RCW 18.71.210, thus allowing suit and trial under an ordinary negligence standard.

ISSUES PRESENTED FOR REVIEW

1. Did the trial court and the majority of the Court of Appeals panel contravene Supreme Court precedent in affirming the trial court determination that there were no triable issues of fact concerning the gross negligence of the City of Tacoma's EMTs and paramedics and granting summary judgment dismissal of Samuels' claims on that basis?

2. Did the trial court and the entirety of the Court of Appeals panel err in affirming the trial court determination that there were no triable issues of fact regarding whether the City of Tacoma's paramedics / EMTs were entitled to qualified immunity under RCW 18.71.210, thus presenting a gross negligence standard rather than an ordinary negligence standard, and granting summary judgment dismissal of Samuels' claims on that basis?

II. STATEMENT OF THE CASE

The following testimony and evidence was considered at summary judgment and by the Court of Appeals:

Background - On December 24, 2015, a five member team from the Tacoma Fire Department, (the City of Tacoma), responded to a 911 report that Lesa Samuels believed she was having a stroke. CP 568-69 and 607. According to the testimony of Lesa Samuels and Arnold Williams, the responders did not tell Samuels what was causing her symptoms but that she was "not having a stroke." See "Facts" section, infra. As a result, Samuels declined the first responders' offer to transport her to the hospital. *Id.*

Twelve days later on January 5, 2016, Ms. Samuels self-reported to Tacoma General Hospital where it was determined that she had, indeed, suffered a recent stroke. CP 6, 143-45, 167, 708, and 735. Specifically, she suffered a "posterior circulation stroke … in the left midbrain probably secondary to vertebral artery dissection." CP 6 and 143-45.

Ms. Samuels' stroke expert, Dr. Lombardi, testified that Samuels likely suffered an initial stroke event on December 24, 2015, the stroke event would very likely have been correctly diagnosed on that day if Samuels had been taken to an emergency room, and that treatment would have very likely begun immediately. CP 143-47.

Events of 12/24/15 - On December 24, 2015, Arnold Williams and Lesa Samuels were at home in their apartment in Tacoma. CP 710 - 13. Ms. Samuels had started feeling a squeezing headache in the week prior to December 24, 2015. CP 710.

On December 24, 2015, Ms. Samuels worked a 10:30 a.m. to 6:30 p.m. shift at a retirement home while experiencing such a headache. CP 711-12 and 745. After work, Ms. Samuels returned home, had dinner, watched a little television, and talked to Mr. Williams. CP 711 - 12 and 745. Around 10:00 p.m., Ms. Samuels took a shower. CP 711 and 745.

As she was shampooing her hair, Ms. Samuels felt a rush of dizziness. CP 712. Ms. Samuels got dizzy and fell back into one wall of the shower

and then tried to wash off, but fell back again into the other wall of the shower. CP 712. Ms. Samuels tried to yell for help, but her throat closed up on her right side. CP 712. Ms. Samuels was also having trouble swallowing. CP 713. Ms. Samuels got out of the shower, went to her room, and laid down. CP 713 and 724.

As Ms. Samuels lay on her bed, her squeezing headache turned into a piercing pain in her right temple. CP 713. A few minutes later, numbness started in her face and spread to her right arm. CP 713.

Ms. Samuels got the attention of Mr. Williams who found her in the bedroom. CP 713. Mr. Williams asked if she was all right. CP 713. Ms. Samuels said her head hurt. CP 713. Mr. Williams asked Ms. Samuels if he should call 911. CP 713. Ms. Samuels responded "no" because she thought the pain would subside. CP 713.

After about 15 minutes, Ms. Samuels got up and went to the bathroom to look in the mirror. CP 713. By that time, her piercing headache had subsided to a squeezing headache, but numbness persisted on the right side of her face and in her right arm. CP 714.

When Ms. Samuels looked in the mirror, her face looked droopy, with her mouth and eye being turned down. CP 714. Ms. Samuels exited and asked Mr. Williams to call 911, telling him, "I think I'm having a stroke."

CP 714. Mr. Williams called 911 and told the 911 operator he thought Ms. Samuels was having a stroke. CP 714 and 747.

Ms. Samuels moved into the living room to wait for the Tacoma Fire Department, ("TFD"), to arrive. CP 726. While she was waiting, Ms. Samuels attempted to call her son on the telephone, reaching only his girlfriend, who could not understand what Ms. Samuels was saying and hung up. CP 715.

Within minutes of 911 being called, TFD responders arrived at Williams' and Samuels' apartment. CP 537 and 713. The TFD's event history lists EMT Lt. William Jones, EMTs Nate Kaiel and Benjamin Baker, and paramedics Kristopher Johnson and Anthony Brakebush as the responders.[1] CP 537, 603, and 614.

One of the responders knelt down on the floor on the other side of couch arm from where Samuels was sitting and took Samuels' vital signs, blood pressure, and glucose. CP 726-28.

Ms. Samuels' blood pressure was 176/98, CP 535, just under the 180 systolic blood pressure level for which the 2012 Pierce County EMS Protocols, (the "Protocols"), mandate an advanced life support transport to a hospital. CP 544.

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[1] A paramedic is one level above an EMT and obtains an additional certification. CP 644.

While one responder took Samuels' vital signs, blood pressure, and glucose, another responder asked Ms. Samuels questions and examined her. CP 726-27.

The examining responder looked in Ms. Samuels' eyes, looked in her throat and did resistance testing, but did not ask Ms. Samuels to smile or make a face. CP 728.

Asking the patient to smile or make a face is part of the "F" or "face" portion of something known as a FAST exam where the Protocols direct responders in assessing stroke risk to "ask the patient to show his or her teeth or smile to see if each side of the face moves as well as the other." CP 542-43, esp CP 543.

One of the responders asked Ms. Samuels her name and what county she lived in, and if she knew why the responders were there. CP 729. Ms. Samuels responded by telling him her name, that she lived in Pierce County, and that: "I think I'm having a stroke." CP 729.

The responder did not ask Ms. Samuels why she thought she was having a stroke. CP 729.

Lt. Jones testified that he asked Ms. Samuels the questions and took notes during the exam but did nto do the exam itself. CP 569-71.

Lt. Jones testified that Ms. Samuels told him she had a headache and her face was numb and pointed to a specific spot on one of her cheeks. CP 535, 571, 582, 683, and 730.

The responders had no explanation as to what was causing the facial numbness. CP 683 and 686. In the words of the highest-ranking paramedic on-scene: "We couldn't explain it." CP 571 and 683.[2] During that same paramedic's deposition, he conceded that facial numbness was known to him to be a potential stroke symptom. CP 686.

Lt. Jones testified that he asked Samuels about what symptoms she was experiencing before the responders showed up, but his computer-generated patient report, while indicating the answers or denials to other questions, does not indicate that he asked any questions concerning whether Samuels had experienced FAST indicators like numbness or weakness of an arm, or leg, trouble speaking or understanding, trouble seeing in one or both eyes, trouble walking, dizziness, loss of balance or coordination, or a severe headache with no known cause or the last time she had been clear of any of those symptoms. CP 535 and 572.

Responders' Knowledge of Stroke Symptoms – Lt. Jones testified that he has been trained that high blood pressure correlates with a segment

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[2] Both paramedic Kristopher Johnson and Fire Lietenant Jones acknowledged that Johnson had seniority and final decision-making authority for any treatment or transport questions. CP 594, 683 and 686.

of the population that has a higher incidence of strokes and he knows that strokes involve oxygen and blood to the brain being blocked or inhibited. CP 573-74 and 582. The other responders testified, in slightly different terms, that this was also their understanding. CP 607, 613, 622, 652, 660, and 698.

Paramedic Anthony Brakebush testified that slurred speech and numbness in the face were potential stroke symptoms as are numbness in one or more extremities or dizziness. CP 652 and 662-63.

EMT Nathaniel Kaiel testified that he understood that facial numbness was a potential stroke symptom and if oxygen is inhibited or blocked from reaching a part of the brain a person can potentially suffer brain damage or die. CP 607, 610, and 613.

Unauthorized Communication of the Misdiagnosis - At the end of the examination of Samuels, the examining responder turned to another of the responders, (Lt. Jones), and said "she's not having a stroke." CP 732-33.

Ms. Samuels then asked: "Well, what's wrong with my face then?" and the responder to which the diagnosis had been directed (Lt. Jones) said: "Your face looks a little off, but you're not having a stroke." CP 732-33.

Lt. Jones then told Ms. Samuels "We could take you to the hospital to ease your mind or (pointing to Mr. Williams) … he could take [you]." CP 733.

Samuels declined this offer and the responders left. CP 535 and 733.

Ms. Samuels and Mr. Williams both testified that, although the "we could take you to the hospital" statement was made, Mr. Williams did not reply to it and neither Ms. Samuels, nor Mr. Williams, at any point, indicated that Ms. Samuels would be going to the hospital in anyone's private vehicle. CP 732-33.

Ms. Samuels testified she turned down the Fire Department's offer to transport her to the hospital because the responders told her she was not having a stroke and she "…trusted that these guys knew what they were looking at." CP 733-34, (esp. CP 733, Samuels Dep, 116:5-12 and CP 734, Samuels Dep, 118:4-8).

She also denied that the responders recommended that she go get checked out at an ER. CP 734.

Fire Department Parameters – The responders are not authorized under the Protocols to make diagnoses and are bound to the Protocols in terms of the treatment they can offer. CP 644-45 and 676-78.[3] The Protocols do not allow responders to diagnose, rule in, or rule out strokes.

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[3] The 2012 Protocols were still in effect as of 12/24/15. CP 676-77.

CP 575, 577, 580, 653, 680, 685-86, 694, and 697. The responders must, instead, follow state approved triage procedures, regional patient care procedures, and the Protocols, WAC 246-976-182(3), but it is part of the responders' training that trouble speaking, numbness or weakness of the face, body, leg or arm, trouble seeing, trouble with balance, dizziness, coordination, or headaches with no known cause are potential stroke symptoms. CP 627.

The Protocols, themselves, and the testifying responders, refer to a "FAST exam" as their stroke risk assessment tool. CP 541-44, 682, and 686. The FAST exam is the Protocols' screening tool for assessing stroke risk. *Id.*, and CP 643.

Asking the patient to smile or make a face is part of the "F" or "face" portion of the FAST exam where the Protocols direct responders to "ask the patient to show his or her teeth or smile to see if each side of the face moves as well as the other." This step is described at Appendices D-1 and D-2 to the 2012 Protocols. CP 542-43, esp CP 543.

Appendix D-1 to the 2012 Protocols states that the initial step in completing a FAST exam, however, is to get a "[r]eport from patient or bystander of one or more sudden: numbness or weakness of the face, arm, or leg, especially on one side of the body, confusion, trouble speaking or understanding, trouble seeing in one or both eyes, trouble walking,

dizziness, loss of balance or coordination, [or] severe headache with no known cause" and that the "T" in FAST refers to inquiring about the "[t]ime last normal (determine time patient last known normal)." CP 542, 654, 677, and 701.

Appendix D-2 to the 2012 Protocols again emphasizes that the "T" in FAST stands for "time" and indicates that the person performing the FAST exam must "[a]sk the patient, family or bystanders the last time the patient was seen normal." CP 543. See also CP 626, 654, 677, and 701-02.

Transport and Release Procedures – Handwritten and computer-generated reports for the Samuels response were created by Fire Lieutenant William Jones. CP 570, 581, and 683-84.

On the back-side side of the handwritten report is a place for the patient to sign an "ROR" section. CP 576. "ROR" means "release of responsibility." *Id.* and CP 680. A patient is asked to sign the ROR if the responders are terminating care and the patient is intending to follow the responders' advice in terms of getting additional treatment from another source. *Id.* If transportation has been offered but has been turned down, the responders must attempt to have an ROR signed by the patient. CP 619.

The back-side of the handwritten report also contains a place for a patient to sign an "AMA." CP 576 and 680. "AMA" means the patient is acknowledging that his/her refusal of additional services is "against medical advice." *Id.* and CP 573 – 74.

Lt. Jones testified that, upon returning to the fire station following the treatment of Samuels, he shredded this report and, therefore, the only documentary evidence that would possibly have been kept of any advice given to Samuels to follow up at, or be driven to, an emergency room. CP 570 and 577.

Base Station Physicians – The availability of a supervising or "base-station" physician for paramedics and EMTs is mandated by statute. See citations in "Argument" section, *infra.*

The base-station physician's duty under the Protocols is to supervise and confer with responders to provide treatment direction. CP 624, 650, and 678-79. The base-station physician can, if necessary, overrule responders' decisions. CP 624 and 678 - 79.

A base-station physician is available, via telephone or radio on a 24-hour a day basis, 365 days a year, to all paramedics and EMTs employed by, or acting for, the TFD. CP 617, 650, 678-79, and 681.[4] If a base-

[4] The emergency responder statutes refer to this doctor as the "supervising physician," but the paramedic testimony in this case refers to that doctor as the "base-station

station physician is contacted by responders, that communication must be documented in the patient report. CP 577 and 685. There is no documentation of any communication with a base station physician in the Fire Department's patient report. CP 535.

Disputed Testimony Regarding Standard of Care - Ms. Samuels' experts, (medical doctors Brown and Lombardi), concluded that no pre-arrival FAST exam history of Samuels was taken by the responders and, therefore, the FAST exam attempted by the responders was incomplete. CP 146-47 and 171-75.

Samuels' expert testimony, in sum, is that by failing to obtain a history of what occurred prior to their arrival and to perform the "face" portion of the FAST exam by asking the patient to attempt to smile, the responders skipped steps in the FAST exam and this constituted a breach of the 2012 Protocols. *Id.*

In addition, Samuels' experts testified that the responders' failure to perform these steps rendered the FAST exam incomplete and minimally useful as a stroke risk assessment tool. *Id.* They, therefore, dispute whether the results of the FAST exam could be viewed as "negative" when the FAST exam was incompletely, and therefore incorrectly, performed. CP 144, 146-47 and 171-75.

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physician" when describing the person who is available to Tacoma Fire Department paramedics and EMTs. CP 678-81

Ms. Samuels' experts testified that the responders also seriously departed from the Protocols by:

1. failing to take a patient history for the items that the FAST exam, (Protocol Appendices D-1 and D-2), explicitly told them to ask about before conducting the physical portion of the FAST exam because, had the responders inquired into what had happened before they arrived and communicated that history to a base-station physician, they would have been told by any competent doctor that there was a high risk of stroke and to transport Ms. Samuels to a hospital immediately. CP 144, 147, 169, and 171-75.

2. failing to contact a supervising, aka "base-station," physician when the Protocols did not provide a treatment regimen for Samuels' unresolved stroke symptom, e.g., facial numbness and high blood pressure, CP 143-47 and 171-75,

   and

3. that these errors were harmful because termination of care is especially injurious for stroke victims, as is making an unqualified off-the-cuff diagnosis like "you're not having a stroke," because it makes it less likely that the patient will follow up with a qualified medical professional. CP 143-47, 169, and 171-75.

ARGUMENT

A. The decision of the Court of Appeals should be reviewed because it is in conflict with the Supreme Court's *Brainerd*, *Nist*, and *Harper* opinions on gross negligence.

The statute on the qualified immunity otherwise potentially applicable to EMTs and paramedics states it:

> … shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct. RCW 18.71.210(5).

In *Brainerd v. Stearns,* 155 Wash. 364, 367, 284 P. 348 (1930), the Supreme Court ruled that:

> [Where] [t]he appellant knew, or to him is imputed the knowledge, that the probable consequence of [his/her] conduct would be to cause an accident **[s]uch disregard of consequences** warrant[s] the jury in finding the appellant guilty of gross negligence. (Emphasis added).

The *Nist* court then found the definition of gross negligence irreducible to any one pat formula but that it should almost always be a jury question:

> A review of the commentaries, scholarly treatises and case law on gross negligence shows the term to have universally escaped definition, and [that] despite the most assiduous efforts ... it retains its amorphous quality. What constitutes gross negligence is almost always a jury question. *Nist v. Tudor* 67 Wn.2d 322, 324-25, 407 P.2d 798 (1965).

The standard for gross negligence must nearly always be left to the jury because:

> [c]ircumstances surrounding the actors largely determine the quantum of care required in any rule referring to or prescribing standards of care ... *Nist* at 331, cited by *Harper v. State*, 192 Wn2d 328, 341, 429 P3d 1071 (2018).

Likewise, in *Kelley v. State,* 104 Wn. App. 328, 334-35, 17 P.3d 1189 (Div. 2, 2000), it was ruled that a violation of policy directives can be evidence of gross negligence. *Id.* As such, and in light of the fact that evidence of departures from the Protocols was admitted at summary judgment, reasonable minds could differ on whether the paramedics /

EMTs conduct constituted gross negligence. Therefore, under *Brainerd's, Nist's, Harper's, and Kelley's* standards, Ms. Samuels was entitled to have the issue of the EMTs and paramedics' gross negligence decided by a jury and termination of her case was in conflict with Supreme Court precedent because Ms. Samuels' experts testified that the paramedics and EMTs seriously departed from the Protocols by failing to take the patient history mandated by the "T" section of the FAST exam before conducting the rest of it, failing to communicate with a base-station physician when Samuels had unresolved stroke symptoms, and falsely and without being qualified to do so, giving a diagnosis that "you're not having a stroke," CP 731.

The EMTs and paramedics concede that a diagnosis by one of them is not permitted under the Protocols or something any of them are qualified to do, so a jury should have, under the above-mentioned Supreme Court precedents, been allowed to decide whether the EMTs' and paramedics' conduct amounted to gross negligence.

B. The Court of Appeals decision should be reviewed because it will legally define the parameters of care permitted under County Protocols, thus affecting the health, safety and welfare of all citizens.

RCW 18.71.210(2) states that qualified immunity for EMTs and paramedics:

> … shall only apply to an act or omission committed or omitted in the performance of … actual emergency

> medical procedures and not in the commission or omission of an act which is **not within the field of medical expertise of the ... emergency medical technician and paramedic**, emergency medical technician, or first responder ... (Emphasis added).

A County Medical Program Director, ("MPD"), is responsible for establishing what medical treatment EMTs and paramedics can perform. RCW 18.71.200, RCW 18.73.030 (12), and WAC 246-976-010 (46). None of these medical procedures are listed in statutes. The only authorized medical procedures for paramedics and EMTs are listed in WAC 246-976-182.

Under WAC 246-976-182, Emergency Medical Services personnel are only authorized to provide patient care which is within:

- approved guidelines/curriculum for the individual's level of certification or included in approved specialized training; **<u>AND</u>**
- State-approved county MPD protocols. WAC 246-976-182 (1) (c).

This directive is repeated at WAC 246-976-182(3). "All prehospital providers must follow state approved triage procedures, regional patient care procedures, and county MPD patient care protocols." *Id.*

"If protocols and regional patient care procedures do not provide off-line direction for [a] situation, the certified person in charge of the patient must consult with their online medical control as soon as possible." WAC 246-976-182 (2). In that situation, "[t]he ... directions for medical control

are provided by the MPD or MPD delegate." WAC 246-976-010(44). (The MPD delegate is referred to by the EMTs and paramedics in their depositions as their "base-station physician" and that term shall be used below).

The EMTs and paramedics should have consulted with their online medical control, i.e., base-station physician, because, according to the EMTs and paramedics themselves, there are no direction in the Protocols for what to do when a patient has unresolved potential stroke symptoms, like numbness in the face, high blood pressure, facial droop, and a self-diagnosis of stroke, but all of the paramedics and EMTs knew that strokes presented a risk of paralysis, brain damage, or death and that they were beyond their field of medical expertise in determining Ms. Samuels' actual condition. CP 147, 167, 169, and 171-72. Therefore, they should have contacted their base-station physician because "[i]f protocols and regional patient care procedures do not provide off-line direction for [a medical] situation, the certified person in charge of the patient must consult with their online medical control as soon as possible." WAC 246-976-010 (47).

The above failures were violations of the Protocols, as was the paramedics' and EMTs' communication of their diagnosis that "*you're not having a stroke*," CP 731, and the skipping of the first step required by

Appendices D-1 and D-2 to the Protocols, i.e., getting a "[r]eport from patient or bystander of one or more sudden: numbness or weakness of the face, arm, or leg, especially on one side of the body, confusion, trouble speaking or understanding, trouble seeing in one or both eyes, trouble walking, dizziness, loss of balance or coordination, [or] severe headache with no known cause." CP 542.

When the paramedics and EMTs failed to contact a base-station physician, issued a false and unqualified diagnosis, and skipped a step in performing the FAST exam, they stripped themselves of the qualified immunity otherwise provided under RCW 18.71.210 and were grossly negligent. As such, the Supreme Court should review whether trial should occur on these issues.

CONCLUSION

There is evidence that the paramedics and EMTs ignored the WACs and 2012 Protocols. Whether doing so stripped them of qualified immunity and constituted gross negligence are questions for the trier-of-fact. Therefore, the termination of this case by summary judgment is an issue that should be reviewed by the Supreme Court.

Respectfully submitted this 4th day of Novemnber, 2019,

/s/ F. Hunter MacDonald
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Attorney for Appellant/Petitioner Lesa Samuels

APPENDIX A

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Washington State
Court of Appeals
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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

LESA M. SAMUELS, Appellant, v. MULTICARE HEALTH SYSTEM and GLORIA N. LEM, ARNP, DOES 1-10, and CITY OF TACOMA, Respondents.	No. 51827-9-II UNPUBLISHED OPINION

SUTTON, J. — Lesa Samuels appeals the superior court's order determining that the City of Tacoma was entitled to qualified immunity, dismissing her negligence claim, and awarding statutory costs to the City. Samuels argues that (1) the applicable standard of fault is simple negligence, (2) the qualified immunity statute, RCW 18.71.210(1), does not apply, and (3) there are genuine issues of material fact as to gross negligence, and thus, the City is not entitled to qualified immunity and the superior court erred. We hold that RCW 18.71.210(1) applies, there are no genuine issues of material fact under the applicable gross negligence standard, the City is entitled to qualified immunity as a matter of law, and thus, the superior court did not err. We affirm the superior court's order and award of statutory costs.

FACTS

On December 24, 2015, Tacoma Fire Department emergency medical technicians (EMTs) and paramedics (collectively first responders) responded to a 911 call at Samuels's home. Samuels asked her significant other, Arnold Williams, to call 911 because she was experiencing dizziness,

a headache, and numbness in her face and right arm. When the first responders arrived at Samuels's home, they asked why they had been called to assist her and she said, "I think I'm having a stroke." Clerk's Papers (CP) at 426. She also told them that she started experiencing facial numbness about an hour earlier.

Pierce County has adopted prehospital stroke triage procedures for first responders to identify stroke patients in the field and take those patients to the most appropriate hospital. According to the stroke protocols, the first responders are to assess the applicability for triage by getting a

> [r]eport from [the] patient or [a] bystander of one or more sudden:
>
> - Numbness or weakness of the face, arm, or leg, especially on one side of the body
> - Confusion, trouble speaking or understanding
> - Trouble seeing in one or both eyes
> - Trouble walking, dizziness, loss of balance or coordination
> - Severe headache with no known cause

CP at 69.

When evaluating a patient for symptoms of a possible stroke, first responders administer a FAST examination to assess whether a patient might be having a stroke. A FAST examination requires a first responder to check the patient for the following symptoms:

> Face: unilateral face droop?
>
> Arms: unilateral drift or weakness?
>
> Speech: abnormal or slurred?
>
> Time last normal (determine [the] time patient [was] last known [as] normal)[.]

CP at 69 (underscore omitted). If the patient demonstrates any one of these symptoms (face, arms, or speech), it is likely the patient is having a stroke, and the first responders are directed to transport

the patient to the nearest stroke center, limit the time at the scene, and alert the destination hospital as soon as possible.

The "F" of the FAST examination refers to asking the patient to smile, make a face, or "show his or her teeth," to see if each side of the face moves as well as the other. CP at 70. A normal response occurs when both sides of the face move equally. An abnormal response is when one side of the face does not move as well as the other side.

The "A" in the FAST examination refers to arm drift, where the first responders ask the patient to close her eyes and extend both arms straight out for 10 seconds. The palms should be facing up with thumbs pointing out. A normal response is for both arms to move in the same manner. An abnormal response is when one arm drifts down or one arm does not move at all.

The "S" in the FAST examination refers to speech, where the first responders ask the patient to repeat a simple phrase such as, "Firefighters are my friends." CP at 70. A normal response is for the patient to say the requested phrase correctly without slurring. An abnormal response occurs if the patient slurs, says the wrong words, or is unable to speak.

The "T" in the FAST examination refers to asking the patient, family, or bystanders about the "[t]ime last normal (determine [the] time patient [was] last known [as] normal)." CP at 69.

In her deposition, Samuels described what the first responders did during the FAST examination of her:

> A: He [referring to one of the first responders] looked in my eyes, and he looked in my throat, and then he also did the – the resistant (sic) test.
>
> . . . .
>
> Q: Did – when you say "the resistance test," you're – you held your hands out – we have to get this for the record – you held your hands out in front of you?

A: Yes.

Q: And you put your palms up and down?

A: Yes.

Q: Did he actually press on your hands to see whether –

A: Yes.

Q: – you could hold them up?

A: Yes. He pushed down a little bit; so I had to push and pull.

Q: Okay.

A. I mean push and – and – and lift.

Q: Okay.

A. Right.

Q: And did you have any trouble resisting the pressure that he put on your hands?

A: No.

CP at 50.

The first responders took Samuels's vitals, including her pulse, respiratory rate, blood pressure, glucose, and pulse oximetry. The FAST examination revealed that Samuels's grip on each side was equal, her pupils were normal, her facial grimace was equal, she was able to lift both palms equally and steadily, she had control over her upper extremities, and she was oriented and able to communicate orally. Samuels claims that the first responders did not fully complete the FAST examination because they did not ask her to smile or grimace as required by the protocols. The first responders spoke with her for a period of time and were able to observe her speech. When

asked, she denied experiencing any loss of consciousness, chest pain, shortness of breath, nausea, vomiting, or diarrhea. They observed that her skin was pink, warm, and dry, and her lungs were clear. She reported that she did not have any significant medical history and was not taking medication although she had recently taken an over-the counter cold medicine, which she had used before without incident.

The first responders determined that the FAST examination was negative for a stroke because they (1) did not observe a unilateral face droop, (2) noted that there was no unilateral drift or weakness in her arms, and (3) observed that her speech was normal. According to the Pierce County protocols, a negative FAST examination meant that the patient qualified for basic life support transport if she wanted it. Following the protocols, the first responders recommended that Samuels either take a private ambulance to Tacoma General Hospital's emergency room, or have her significant other drive her there. Samuels testified that one of the first responders told her, "[Y]ou're not having a stroke." CP at 53, 733.

After about 10 minutes, the first responders left Samuels's home believing that Samuels's significant other was going to transport her to Tacoma General Hospital's emergency room. The patient contact report for Samuels states that "the spouse of [the patient] was going to [transport] the [patient] [via privately owned vehicle] to [Tacoma General Hospital's emergency room]." CP at 64. After the first responders left, Samuels continued to experience dizziness and suffer from a "squeezing" headache, but decided not to go to the emergency room. CP at 43. She went to work the next morning and worked a full shift and also worked her full shift for the next three days.

On December 30, Samuels went to the MultiCare Westgate Urgent Care Center. At MultiCare, Gloria Lem, Advanced Registered Nurse Practitioner (ARNP), treated her for a headache and sent her home. On January 5, 2016, Samuels went to Tacoma General Hospital's Emergency Room where a doctor examined her and determined that she was exhibiting symptoms that indicated she had recently suffered from a stroke.

Samuels then sued the City of Tacoma. In her complaint, Samuels alleged that the City was liable for the first responders' negligent conduct in misdiagnosing her medical condition and failing to properly treat her stroke. The City filed a motion for summary judgment arguing that there were no genuine issues of material fact and that it was entitled to qualified immunity as a matter of law under RCW 18.71.210(1) because the first responders were acting in good faith and without gross negligence. In support of its motion, the City filed the Pierce County protocols that the first responders were required to follow, the patient contact report from the incident, and portions of Samuels's deposition testimony where she described what the first responders did in administering the FAST examination. In opposition to the summary judgment motion, Samuels provided the expert opinions of Dr. David Lombardi, a licensed medical doctor in California who specializes in treating stroke patients, and Dr. Kevin Brown, a licensed medical doctor in New York who specializes in emergency medicine.

The superior court ruled that there was no genuine issue of material fact as to gross negligence and that the City was entitled to qualified immunity as a matter of law under RCW

18.17.210. The court then granted the motion, dismissed Samuels's negligence claim, and awarded statutory costs to the City under RCW 4.84.010. Samuels appeals.[1]

ANALYSIS

Samuels argues that (1) simple negligence, not gross negligence, is the applicable fault standard, (2) any alleged failure of the first responders to follow the Pierce County protocols precludes qualified immunity, and thus, RCW 18.71.210(1) does not apply, and (3) there are genuine issues of material fact as to gross negligence and the City was not entitled to qualified immunity. We hold that RCW 18.71.210(1) applies, there are no genuine issues of material fact under the applicable gross negligence standard, the City is entitled to qualified immunity as a matter of law, and thus, the superior court did not err.

I. LEGAL PRINCIPLES

We review a superior court's order granting summary judgment de novo. *Larson Motors, Inc. v. Snypp*, 3 Wn. App. 2d 127, 135, 413 P.3d 632, *review denied*, 191 Wn.2d 1013 (2018). We review the evidence and all reasonable inferences from the evidence in the light most favorable to the nonmoving party. *Snypp*, 3 Wn. App. 2d at 135. Summary judgment is appropriate where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c); *Snypp*, 3 Wn. App. 2d at 135. "If reasonable minds can reach only one

[1] Samuels initially sued MultiCare Health System and Gloria Lem, ARNP, for medical malpractice under chapter 7.70 RCW, but settled with these defendants and amended her complaint to add the City as a defendant. Samuels sought discretionary review, which a commissioner of this court denied. Ruling Denying Review, 501413-8-II (Sept. 21, 2017). In January 2018, Samuels settled and dismissed her remaining claims against MultiCare and Lem.

conclusion on an issue of fact, that issue may be determined on summary judgment." *Sutton v. Tacoma Sch. Dist. No. 10*, 180 Wn. App. 859, 865, 324 P.3d 763 (2014).

II. Qualified Immunity

A. Applicable Fault Standard

Samuels initially argues that RCW 18.71.210 does not apply and that simple negligence, not gross negligence, is the correct fault standard. She also argues that any deviation from the treatment protocols defeats qualified immunity. We hold that gross negligence is the applicable fault standard and that Samuels's interpretation of RCW 18.17.210 is not consistent with the plain language of the statute. Thus, her arguments on this basis fail.

We review interpretations of a statute de novo. *Jametsky v. Olsen*, 179 Wn.2d 756, 761, 317 P.3d 1003 (2014). When engaging in statutory interpretation, we endeavor to determine and give effect to the legislature's intent. *Jametsky*, 179 Wn.2d at 762. In determining the legislature's intent, we must first examine the statute's plain language and ordinary meaning. *Jametsky*, 179 Wn.2d at 762. Legislative definitions included in the statute are controlling, but in the absence of a statutory definition, we give the term its plain and ordinary meaning as defined in the dictionary. *American Cont'l Ins. Co. v. Steen*, 151 Wn.2d 512, 518, 91 P.3d 864 (2004). In addition, we consider the specific text of the relevant provision, the context of the entire statute, related provisions, and the statutory scheme as a whole when analyzing a statute's plain language. *Lowy v. PeaceHealth*, 174 Wn.2d 769, 779, 280 P.3d 1078 (2012).

If there is more than one reasonable interpretation of the plain language, the statute is ambiguous. *Jametsky*, 179 Wn.2d at 762. When a statute is ambiguous, we resolve ambiguity by engaging in statutory construction and considering other indications of legislative intent.

Jametsky, 179 Wn.2d at 762. However, if the statute is unambiguous, we apply the statute's plain meaning as an expression of legislative intent without considering other sources. *Jametsky*, 179 Wn.2d at 762.

The qualified immunity statute, RCW 18.71.210(1) states:

> No act or omission of any physician's trained advanced emergency medical technician and paramedic, as defined in RCW 18.71.200, or any emergency medical technician or first responder, as defined in RCW 18.73.030, *done or omitted in good faith while rendering emergency medical service under the responsible supervision and control of a licensed physician or an approved medical program director* or delegate(s) to a person who has suffered illness or bodily injury shall impose any liability upon:
>
> . . . .
>
> (g) *Any* federal, state, county, *city*, or other local governmental unit or employees of such a governmental unit.

(Emphasis added.)

RCW 18.71.210 applies to emergency medical service personnel, allowing them immunity from liability for actions or omission done in good faith while rendering emergency medical service. *Marthaller v. King County Hosp. Dist. No. 2*, 94 Wn. App. 911, 915-16, 973 P.2d 1098 (1999). The statute's purpose is "to protect [first responders] from 'the unduly inhibiting effect the fear of personal liability would have on the performance of [their] professional obligations.'" *Marthaller*, 94 Wn. App. at 916 (quoting *Savage v. State*, 127 Wn.2d 434, 441-42, 899 P.2d 1270 (1995)). Under RCW 18.71.210, "Qualified immunity is immunity from suit, not simply from liability." *Marthaller*, 94 Wn. App. at 916.

The immunity from suit does not extend to "any act or omission which constitutes either gross negligence or willful or wanton misconduct." RCW 18.71.210(5). "Gross negligence" is "negligence substantially and appreciably greater than ordinary negligence." *Nist v. Tudor*, 67 Wn.2d 322, 331, 407 P.2d 798 (1965). "Gross negligence" also means the "failure to exercise slight care." *Nist*, 67 Wn.2d at 331. "Gross negligence" does not mean the total absence of care, but care substantially or appreciably less than the quantum of care inhering in ordinary negligence. *Nist*, 67 Wn.2d at 331; *Johnson v. Spokane to Sandpoint, LLC*, 176 Wn. App. 453, 460, 309 P.3d 528 (2013).

Our Supreme Court recently clarified the definition of gross negligence:

> To survive summary judgment in a gross negligence case, a plaintiff must provide substantial evidence of serious negligence. In determining whether the plaintiff has provided substantial evidence, the court must look at all the evidence before it, evidence that includes both what the defendant failed to do *and* what the defendant did. If a review of all the evidence suggests that reasonable minds could differ on whether the defendant may have failed to exercise slight care, then the court must deny the motion for summary judgment. But if a review of all the evidence reveals that the defendant exercised slight care, and reasonable minds could not differ on this point, then the court must grant the motion.

Harper v. State, 192 Wn.2d 328, 345-46, 429 P.3d 1071 (2018).

Thus, we hold that the applicable fault standard is gross negligence here, not simple negligence as Samuel claims. To defeat summary judgment, under *Harper*, Samuels must provide substantial evidence of serious negligence.

Samuels further argues that RCW 18.71.210 simply provides a standard of fault greater than simple negligence when the protocols are followed. According to Samuels, RCW 18.71.210 does not provide qualified immunity to first responders even if they follow all of the applicable protocols. Samuels's argument is inconsistent with the plain language of the statute that explicitly

provides qualified immunity to first responders for their actions when "done or omitted in good faith while rendering emergency medical service under the responsible supervision and control of a licensed physician or an approved medical program director." RCW 18.71.210(1). Further, Samuels's argument is inconsistent with the policy underlying the statute—that RCW 18.71.210 is intended, "to protect [first responders] from 'the unduly inhibiting effect the fear of personal liability would have on the performance of [their] professional obligations.'" *Marthaller*, 94 Wn. App. at 916 (quoting *Savage*, 127 Wn.2d at 441-42). Because the statute's language and the underlying policy provide immunity from suit, we hold that Samuels's argument on this basis fails. We address Samuels's additional arguments related to gross negligence below.

B. VIOLATION OF PROTOCOLS

Samuels argues that there are genuine issues of material fact because the first responders failed to complete the FAST examination and did not operate under the direction of an approved medical program director as required by the Washington Administrative Code. Thus, Samuels claims that the superior court erred by granting summary judgment dismissal of her claim. We disagree.

1. FAST Examination

Samuels argues that a FAST examination was not administered to her and that she presented symptoms of high blood pressure, facial numbness, facial droop, and self-reported indications of a stroke. Even assuming these facts in the light most favorable to Samuels, they do not create any genuine issues of material fact of gross negligence based on this record.

Under *Harper*, Samuels must provide substantial evidence of serious negligence to survive summary judgment. *Harper*, 192 Wn.2d at 342. Here, the first responders exercised at least slight care in their FAST examination of Samuels. They took actions that allowed them to evaluate each aspect of the FAST examination (face, arms, speech) and, based on that evaluation, determined that there were no positive stroke symptoms. Under the protocols, because Samuels's symptoms did not meet the requirements under the FAST examination for immediate transport, they did not immediately transport her to the nearest stroke center at Tacoma General Hospital. They advised her to go to the emergency room either by private ambulance or personal vehicle and after they were done, they left believing that her significant other would be taking her to the hospital, although Samuels disputes this fact.

Viewing the evidence in the light most favorable to Samuels, reasonable minds could not differ on whether the first responders exercised at least slight care. Because the first responders exercised at least slight care, Samuels fails to raise a genuine issue of material fact as to gross negligence.

2. Supervision by an Approved Medical Director and Scope of Authority

Samuels next argues that "[o]nly EMTs and paramedics trained under the supervision of an approved medical director, among other things, are subject to, and the beneficiaries of, RCW 18.71's rules and privileges" Appellant's Opening Br. at 30. That statement is incorrect.

RCW 18.71.210(1)(g) specifically provides in relevant part that qualified immunity to "[a]ny . . . city, or other local governmental unit or employees of such a governmental unit." This language includes the first responders here. The first responders also meet the requirements set out in RCW 18.71.210(1). There is no dispute that the first responders were acting as first

responders or EMTs as defined in the statute. Further, Samuels has not presented any evidence showing that the first responders were not acting in good faith. *See Marthaller*, 94 Wn. App. at 917 ("[R]easonable minds could not differ on the question here because there is absolutely no evidence in the record to suggest that the paramedics acted without good faith.").

"Emergency medical service" means "medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities." RCW 18.73.030(10). The first responders rendered emergency medical services because they were assessing Samuels for what she thought was a stroke. The first responders acted under the responsible supervision and control of an approved medical program director. The first responders rendered emergency medical service to a person who suffered illness or bodily injury because they took Samuels's vitals and assessed her for stroke symptoms in her home when she thought she was having a stroke. Accordingly, her argument on this basis fails because the first responders meet the requirements of both RCW 18.71.210(1) and RCW 18.71.210(1)(g).

Samuels also argues the first responders were required to contact their medical program director "when unresolved potential stroke symptoms, including . . . a self-diagnosis of stroke by the patient," are known to them, and by not doing so, they acted outside their scope of authority and violated WAC 246-976-182(2). Appellant's Opening Br. at 32. Even viewing the evidence in the light most favorable to Samuels, she fails to create a genuine issue of material fact as to gross negligence.

Under WAC 246-976-182(2),

> If protocols and regional patient care procedures do not provide off-line direction for the situation, the certified person in charge of the patient must consult with their online medical control as soon as possible. Medical control can only authorize a certified person to perform within their scope of practice.

Under WAC 246-976-182, first responders are required to contact the medical program director only when the protocols did not provide appropriate direction for the circumstance. Here, the protocols governed the first responders' interaction with Samuels and they acted within those protocols by performing the FAST examination.

As discussed above, "gross negligence means the failure to exercise slight care." *Nist*, 67 Wn.2d at 324. Under *Harper*, Samuels must provide substantial evidence of serious negligence. 192 Wn.2d at 342. Samuels fails to provide substantial evidence of departure from the protocols. Further, her interpretation of RCW 18.71.210 would lead to absurd results that would defeat qualified immunity and permit liability even where the first responders acted in good faith and without gross negligence. Such an interpretation is not consistent with the plain language of the statute or the legislature's purpose as discussed above. And we avoid construing a statute to lead to absurd results. *Jespersen v. Clark County*, 199 Wn. App. 568, 578, 399 P.3d 1209 (2017). Thus, Samuels's argument on this basis fails.

3. Medical Diagnosis

Samuels also argues that the first responders gave her a medical diagnosis when one of them told her that "you're not having a stroke," and that neither the applicable regulation nor the protocols allow first responders to diagnose or rule out a medical condition. We disagree.

The first responders are required, as part of their job and within the scope of their practice, to assess and communicate to the patient at the time.[2] Viewing the evidence in the light most favorable to Samuels, even if this statement was made to her by a first responder, Samuels fails to present substantial evidence of serious negligence. In sum, reasonable minds could not differ on whether the first responders acted with gross negligence and that the City is entitled to qualified immunity as a matter of law. Thus, we hold that the superior court did not err by granting summary judgment and dismissing her claim.[3]

IV. COSTS

Samuels argues that the superior court erred in awarding statutory costs to the City. We hold that the award of costs to the City was appropriate, and thus, the court did not err.

RCW 4.84.010 provides that "[t]he measure and mode of compensation of attorneys and counselors, shall be left to the agreement, expressed or implied, of the parties, but there shall be allowed to the prevailing party upon the judgment certain sums for the prevailing party's expenses in the action, which allowances are termed costs." In other words, the prevailing party is entitled to costs under RCW 4.84.010.

Here, the City prevailed on its motion for summary judgment. The superior court then awarded $200 in costs to the City pursuant to RCW 4.84.010. Because the statute permits the award of costs to the prevailing party and the City prevailed, we affirm the superior court's award of statutory costs.

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[2] *See* Wash. Court of Appeals oral argument, *Samuels v. City of Tacoma*, No. 51827-9-II (June 25, 2019) at 23 mi., 30 sec. to 24 min., 13 sec. (on file with court.)

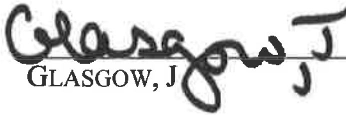
[3] Because we affirm, we do not reach the issue of whether expert opinion testimony is required.

We affirm the superior court's order granting summary judgement and award of statutory costs.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

SUTTON, J.

I concur:



GLASGOW, J.

MELNICK, P.J. (concur in part, dissent in part) — Because material issues of fact are in dispute, I respectfully disagree with the majority's decision to affirm the trial court's grant of summary judgment. Even if we resolve all of the disputed material facts in favor of Lesa Samuels, I believe that reasonable minds can differ as to whether the City of Tacoma's acts constituted negligence or gross negligence. If a finder of fact determined that the City's acts constituted mere negligence, I agree with the majority that the City would have statutory immunity.

We engage in the same inquiry as the trial court and review a summary judgment order de novo. *Woodward v. Lopez*, 174 Wn. App. 460, 467, 300 P.3d 417 (2013). We consider all evidence and all reasonable inferences that arise therefrom in the light most favorable to the nonmoving party. *Woodward*, 174 Wn. App. at 468.

Summary judgment is appropriate "if the pleadings, affidavits, and depositions before the trial court establish that there is no genuine issue of material fact and that as a matter of law the moving party is entitled to judgment." *Ruff v. King County*, 125 Wn.2d 697, 703, 887 P.2d 886 (1995). The burden is on the moving party to demonstrate there is no genuine issue of material fact. *Woodward*, 174 Wn. App. at 468. On summary judgment, questions of fact may be determined as a matter of law "'when reasonable minds could reach but one conclusion.'" *Ruff*, 125 Wn.2d at 704 (quoting *Hartley v. State*, 103 Wn.2d 768, 775, 698 P.2d 77 (1985)).

"'After the moving party submits adequate affidavits, the nonmoving party must set forth specific facts which sufficiently rebut the moving party's contentions and disclose the existence of a genuine issue as to a material fact.'" *Woodward*, 174 Wn. App. at 468 (internal quotation marks omitted) (quoting *Visser v. Craig*, 139 Wn. App. 152, 158, 159 P.3d 453 (2007)). However, "a nonmoving party 'may not rely on speculation [or on] argumentative assertions that unresolved

factual issues remain.'" *Woodward*, 174 Wn. App. at 468 (internal quotation marks omitted) (quoting *Visser*, 139 Wn. App. at 158). "An expert opinion on an ultimate issue of fact is sufficient to preclude summary judgment." *Woodward*, 174 Wn. App. at 468; *see Lamon v. McDonnell Douglas Corp.*, 91 Wn.2d 345, 353, 588 P.2d 1346 (1979). When a material fact is in dispute, a court must deny summary judgment. *Smith v. Safeco Ins. Co.*, 150 Wn.2d 478, 485-86, 78 P.3d 1274 (2003).

In the present case, Samuels identifies a number of material facts, both acts and omissions, she claims are in dispute. I agree with her. Samuels first asserts that the Tacoma Fire Department emergency medical technicians and paramedics (collectively first responders) did not perform the FAST test properly and did not follow established protocols. There is a dispute of a material fact as to whether the first responders performed all parts of the FAST test. Next, Samuels asserts there is a dispute as to whether the first responders rendered a medical opinion that Samuels was not having a stroke. Because of this opinion, Samuels asserts she did not have the first responders transport her to the hospital. Lastly, Samuels asserts that there is a factual dispute as to whether the first responders recommended she take a private ambulance to the hospital or have her significant other drive her.[4] Because these factual disputes are material, I believe the court erred in granting summary judgment.

[4] In addition, Samuels alleges that the first responders went outside of their field of expertise by not contacting a base-station (on call) physician, in violation of administrative rules. She alleges they failed to follow protocol. Samuels agrees that this issue does not involve a factual dispute.

The majority seems to imply that even if all of these factual disputes are settled in Samuels's favor, that she would only prove negligence, not gross negligence. The majority asserts that reasonable minds could not differ on this issue. I disagree.

First, however, I agree with the majority that if all of the facts show nothing more than mere negligence, that RCW 18.71.210 provides the City with immunity. However, I disagree with the majority's view that reasonable minds could not differ on whether these acts and omissions constitute negligence or gross negligence. I believe that this determination is for a trier of fact.

Ordinary negligence "is the act or omission which a person of ordinary prudence would do or fail to do under like circumstances or conditions; it is that degree of care which the reasonable prudent person would exercise in the same or similar circumstances." *Nist v. Tudor*, 67 Wn.2d 322, 331, 407 P.2d 798 (1965) (automobile accident). Gross negligence is "negligence substantially and appreciably greater than ordinary negligence. . . . In determining the degree of negligence, the law must necessarily look to the hazards of the situation confronting the actor." *Nist*, 67 Wn.2d at 331. *Nist* recognized that the application of the terms negligence and gross negligence has not been uniform. "In some instances, negligence, which has been declared insufficient to constitute gross negligence as a matter of law, has been held in similar cases to create an issue of gross negligence" for the trier of fact. *Nist*, 67 Wn.2d at 329.

Additionally, in *Harper v. State*, 192 Wn.2d 328, 341, 429 P.3d 1071 (2018), where the plaintiff sued the Department of Corrections (DOC) for failing to supervise a probationer who killed his girlfriend, the court recognized that normally the issue confronting us is one for the trier of fact, unless reasonable minds could not differ. It affirmed *Nist*'s principles and affirmed that

courts must specifically identify the relevant failure(s) identified by the plaintiff. *Harper*, 192 Wn.2d at 344.

> Following guidance from *Nist*, in ruling on a motion for summary judgment, trial courts must specifically identify the relevant failure alleged by the plaintiff. If the evidence shows that the defendant may have failed to exercise slight care in the specific area that is relevant to the case (e.g., turning into oncoming traffic), then the trial court should not grant summary judgment—even if a defendant exercised great care in other respects (e.g., allowing a car to pass).

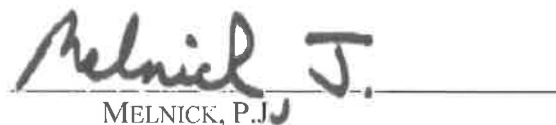
Harper, 192 Wn.2d at 344.

In so ruling, the court said that a plaintiff must provide substantial evidence of serious negligence. The court must look at what the defendant did as well as what it failed to do.

> If a review of all the evidence suggests that reasonable minds could differ on whether the defendant may have failed to exercise slight care, then the court must deny the motion for summary judgment. But if a review of all the evidence reveals that the defendant exercised slight care, and reasonable minds could not differ on this point, then the court must grant the motion.

Harper, 192 Wn.2d at 346.

In the present case I believe the superior court erred by granting summary judgment. First, it failed to specifically identify the relevant failure(s) alleged by Samuels. Second, there are material facts in dispute. Third, even if all the material facts are resolved in the light most favorable to the City, as the majority seems to say it is doing, I believe reasonable minds could differ on whether this case involves negligence or gross negligence. This case is qualitatively different from a car accident case and a DOC failure to supervise case. I would reverse the trial court's granting of summary judgment.



MELNICK, P.J.

APPENDIX B

RCW 18.71.200

Physician's trained advanced emergency medical technician and paramedic—Definition.

As used in this chapter, a "physician's trained advanced emergency medical technician and paramedic" means a person who:

(1) Has successfully completed an emergency medical technician course as described in chapter **18.73** RCW;

(2) Is trained under the supervision of an approved medical program director according to training standards prescribed in rule to perform specific phases of advanced cardiac and trauma life support under written or oral authorization of an approved licensed physician; and

(3) Has been examined and certified as a physician's trained advanced emergency medical technician and paramedic, by level, by the University of Washington's school of medicine or the department of health.

[2015 c 93 § 2; 1995 c 65 § 2; 1991 c 3 § 165; 1986 c 259 § 111; 1983 c 112 § 1; 1977 c 55 § 2; 1973 1st ex.s. c 52 § 1; 1971 ex.s. c 305 § 2.]

NOTES:

Severability—1986 c 259: See note following RCW **18.130.010**.

Effective date—1973 1st ex.s. c 52: See note following RCW **43.22.010**.

APPENDIX C

RCW 18.71.210

Physician's trained advanced emergency medical technician and paramedic—Liability.

(1) No act or omission of any physician's trained advanced emergency medical technician and paramedic, as defined in RCW **18.71.200**, or any emergency medical technician or first responder, as defined in RCW **18.73.030**, done or omitted in good faith while rendering emergency medical service under the responsible supervision and control of a licensed physician or an approved medical program director or delegate(s) to a person who has suffered illness or bodily injury shall impose any liability upon:

(a) The physician's trained advanced emergency medical technician and paramedic, emergency medical technician, or first responder;

(b) The medical program director;

(c) The supervising physician(s);

(d) Any hospital, the officers, members of the staff, nurses, or other employees of a hospital;

(e) Any training agency or training physician(s);

(f) Any licensed ambulance service; or

(g) Any federal, state, county, city, or other local governmental unit or employees of such a governmental unit.

(2) This section shall apply to an act or omission committed or omitted in the performance of the actual emergency medical procedures and not in the commission or omission of an act which is not within the field of medical expertise of the physician's trained advanced emergency medical technician and paramedic, emergency medical technician, or first responder, as the case may be.

This section shall apply also to emergency medical technicians, advanced emergency medical technicians, paramedics, and medical program directors participating in a community assistance referral and education services program established under RCW **35.21.930**.

(3) This section shall apply also, as to the entities and personnel described in subsection (1) of this section, to any act or omission committed or omitted in good faith by such entities or personnel in rendering services at the request of an approved medical program director in the training of emergency medical service personnel for certification or recertification pursuant to this chapter.

(4) This section shall apply also, as to the entities and personnel described in subsection (1) of this section, to any act or omission committed or omitted in good faith by such entities or personnel involved in the transport of patients to mental health facilities or chemical dependency programs, in accordance with applicable alternative facility procedures adopted under RCW **70.168.100**.

(5) This section shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct.

[**2015 c 157 § 5; 2015 c 93 § 4; 1997 c 275 § 1; 1997 c 245 § 1.** Prior: **1995 c 103 § 1; 1995 c 65 § 4; 1989 c 260 § 4; 1987 c 212 § 502; 1986 c 68 § 4; 1983 c 112 § 3; 1977 c 55 § 4; 1971 ex.s. c 305 § 3.**]

NOTES:

Reviser's note: This section was amended by 2015 c 93 § 4 and by 2015 c 157 § 5, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW **1.12.025**(2). For rule of construction, see RCW **1.12.025**(1).

Effective date—1995 c 103: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [April 19, 1995]." [**1995 c 103 § 3.**]

APPENDIX D

RCW 18.73.030

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Advanced life support" means invasive emergency medical services requiring advanced medical treatment skills as defined by chapter **18.71** RCW.

(2) "Aid service" means an organization that operates one or more aid vehicles.

(3) "Aid vehicle" means a vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedure.

(4) "Ambulance" means a ground or air vehicle designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

(5) "Ambulance service" means an organization that operates one or more ambulances.

(6) "Basic life support" means noninvasive emergency medical services requiring basic medical treatment skills as defined in chapter **18.73** RCW.

(7) "Communications system" means a radio and landline network which provides rapid public access, coordinated central dispatching of services, and coordination of personnel, equipment, and facilities in an emergency medical services and trauma care system.

(8) "Council" means the local or regional emergency medical services and trauma care council as authorized under chapter **70.168** RCW.

(9) "Department" means the department of health.

(10) "Emergency medical service" means medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

(11) "Emergency medical services medical program director" means a person who is an approved medical program director as defined by RCW **18.71.205**(4).

(12) "Emergency medical technician" means a person who is authorized by the secretary to render emergency medical care pursuant to RCW **18.73.081** or, under the responsible supervision and direction of an approved medical program director, to participate in a community assistance referral and education services program established under RCW **35.21.930** if the participation does not exceed the participant's training and certification.

(13) "First responder" means a person who is authorized by the secretary to render emergency medical care as defined by RCW **18.73.081**.

(14) "Patient care procedures" means written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures in chapter **70.170** RCW.

(15) "Prehospital patient care protocols" means the written procedure adopted by the emergency medical services medical program director which direct the out-of-hospital emergency care of the emergency patient which includes the trauma care patient. These procedures shall be based upon the assessment of the patient's medical needs and what treatment will be provided for emergency conditions. The protocols shall meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter **70.168** RCW.

(16) "Secretary" means the secretary of the department of health.

(17) "Stretcher" means a cart designed to serve as a litter for the transportation of a patient in a prone or supine position as is commonly used in the ambulance industry, such as wheeled stretchers, portable stretchers, stair chairs, solid backboards, scoop stretchers, basket stretchers, or flexible stretchers. The term does not include personal mobility aids that recline at an angle or remain at a flat position, that are owned or leased for a period of at least one week by the individual using the equipment or the individual's guardian or representative, such as wheelchairs, personal gurneys, or banana carts.

[**2015 c 93 § 5.** Prior: **2010 1st sp.s. c 7 § 25; 2005 c 193 § 2; 2000 c 93 § 16; 1990 c 269 § 23; 1988 c 104 § 3; 1987 c 214 § 2; 1983 c 112 § 5; 1979 ex.s. c 261 § 1; 1973 1st ex.s. c 208 § 3.**]

NOTES:

Effective date—2010 1st sp.s. c 26; 2010 1st sp.s. c 7: See note following RCW **43.03.027**.

Finding—2005 c 193: "The legislature finds that requiring all patients who need to travel in a prone or supine position but are medically stable, to be transported by ambulance can be overly restrictive to individuals with disabilities. These individuals frequently travel by means of reclining wheelchairs or devices commonly referred to as banana carts. Expanding travel options for these individuals will give them greater opportunities for mobility and reduce their costs of travel." [**2005 c 193 § 1.**]

APPENDIX E

NOTE: HTML has links - PDF has Authentication

PDF WAC 246-976-010

Definitions.

Definitions in RCW **18.71.200**, **18.71.205**, **18.73.030**, and **70.168.015** and the definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Activation of the trauma system" means mobilizing resources to care for a trauma patient in accordance with regional patient care procedures.

(2) "Adolescence" means the period of physical and psychological development from the onset of puberty to maturity, approximately twelve to eighteen years of age.

(3) "Advanced cardiac life support (ACLS)" means a course that includes the education and clinical interventions used to treat cardiac arrest and other acute cardiac related problems.

(4) "Advanced emergency medical technician (AEMT)" means a person who has been examined and certified by the secretary as an intermediate life support technician as defined in RCW **18.71.200** and **18.71.205**.

(5) "Advanced first aid" means an advanced first-aid course prescribed by the American Red Cross or its equivalent.

(6) "Advanced life support (ALS)" means invasive emergency medical services requiring the advanced medical treatment skills of a paramedic.

(7) "Agency" means an aid or ambulance service licensed by the secretary to provide prehospital care or interfacility ambulance transport.

(8) "Agency response time" means the interval from dispatch to arrival on the scene.

(9) "Aid service" means an agency licensed by the secretary to operate one or more aid vehicles, consistent with regional and state plans.

(10) "Ambulance service" means an agency licensed by the secretary to operate one or more ground or air ambulances.

(11) "Approved" means approved by the department of health.

(12) "ATLS" means advanced trauma life support, a course developed by the American College of Surgeons.

(13) "Attending surgeon" means a physician who is board-certified or board-qualified in general surgery, and who has surgical privileges delineated by the facility's medical staff. The attending surgeon is responsible for care of the trauma patient, participates in all major therapeutic decisions, and is present during operative procedures.

(14) "Available" for designated trauma services described in WAC **246-976-485** through **246-976-890** means physically present in the facility and able to deliver care to the patient within the time specified. If no time is specified, the equipment or personnel must be available as reasonable and appropriate for the needs of the patient.

(15) "Basic life support (BLS)" means emergency medical services requiring basic medical treatment skills as defined in chapter **18.73** RCW.

(16) "Board certified" or "board-certified" means that a physician has been certified by the appropriate specialty board recognized by the American Board of Medical Specialties. For the purposes of this chapter, references to "board certified" include physicians who are board-qualified.

(17) "Board-qualified" means physicians who have graduated less than five years previously from a residency program accredited for the appropriate specialty by the accreditation council for graduate medical education.

(18) "BP" means blood pressure.

(19) "Certification" means the secretary recognizes that an individual has proof of meeting predetermined qualifications, and authorizes the individual to perform certain procedures.

(20) "Consumer" means an individual who is not associated with the EMS/TC system, either for pay or as a volunteer, except for service on the steering committee, or regional or local EMS/TC councils.

(21) "Continuing medical education method" or (CME method) means prehospital EMS recertification education required after initial EMS certification to maintain and enhance skill and knowledge. The CME method requires the successful completion of department-approved knowledge and practical skill certification examinations to recertify.

(22) "County operating procedures" or "COPS" means the written operational procedures adopted by the county MPD and the local EMS council specific to county needs.

(23) "CPR" means cardiopulmonary resuscitation.

(24) "Critical care transport" means the interfacility transport of a patient whose condition requires care by a physician, RN or a paramedic who has received special training and approval by the MPD.

(25) "Department" means the Washington state department of health.

(26) "Dispatch" means to identify and direct an emergency response unit to an incident location.

(27) "Diversion" means the EMS transport of a patient past the usual receiving facility to another facility due to temporary unavailability of care resources at the usual receiving facility.

(28) "E-code" means external cause code, an etiology included in the International Classification of Diseases (ICD).

(29) "ED" means emergency department.

(30) "Emergency medical procedures" means the skills that are performed within the scope of practice of EMS personnel certified by the secretary under chapters **18.71** and **18.73** RCW.

(31) "Emergency medical services and trauma care (EMS/TC) system" means an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability. The emergency medical services and trauma care system includes prevention activities, prehospital care, hospital care, and rehabilitation.

(32) "Emergency medical responder (EMR)" means a person who has been examined and certified by the secretary as a first responder to render prehospital EMS care as defined in RCW **18.73.081**.

(33) "Emergency medical technician (EMT)" means a person who has been examined and certified by the secretary as an EMT to render prehospital EMS care as defined in RCW **18.73.081**.

(34) "EMS" means emergency medical services.

(35) "EMS provider" means an individual certified by the secretary or the University of Washington School of Medicine under chapters **18.71** and **18.73** RCW to provide prehospital emergency response, patient care, and transport.

(36) "EMS/TC" means emergency medical services and trauma care.

(37) "General surgeon" means a licensed physician who has completed a residency program in surgery and who has surgical privileges delineated by the facility.

(38) "ICD" means the international classification of diseases, a coding system developed by the World Health Organization.

(39) "Injury prevention" means any combination of educational, legislative, enforcement, engineering and emergency response initiatives used to reduce the number and severity of injuries.

(40) "Interfacility transport" means medical transport of a patient between recognized medical treatment facilities requested by a licensed health care provider.

(41) "Intermediate life support (ILS)" means invasive emergency medical services requiring the advanced medical treatment skills of an advanced EMT (AEMT).

(42) "IV" means a fluid or medication administered directly into the venous system.

(43) "Local council" means a local EMS/TC council authorized by RCW **70.168.120**(1).

(44) "Medical control" means oral or written direction of medical care that certified prehospital EMS personnel provide to patients of all age groups. The oral or written direction is provided by the MPD or MPD delegate.

(45) "Medical control agreement" means a written agreement between two or more MPDs, using similar protocols that are consistent with regional plans, to assure continuity of patient care between counties, and to facilitate assistance.

(46) "Medical program director (MPD)" means a person who meets the requirements of chapters **18.71** and **18.73** RCW and is certified by the secretary. The MPD is responsible for both the supervision of training and medical control of EMS providers.

(47) "MPD delegate" means a physician appointed by the MPD and recognized and approved by the department. An MPD delegate may be:

(a) A prehospital training physician who supervises specified aspects of training EMS personnel; or

(b) A prehospital supervising physician who provides online medical control of EMS personnel.

(48) "Ongoing training and evaluation program (OTEP)" means a continuous program of prehospital EMS education for EMS personnel after completion of initial training. An OTEP is approved by the MPD and the department. An OTEP must meet the EMS education requirements and core topic content required for recertification. The OTEP method includes evaluations of the knowledge and skills covered in the topic content following each topic presentation.

(49) "PALS" means a pediatric advanced life support course.

(50) "Paramedic" or "physician's trained emergency medical service paramedic" means a person who has been trained in an approved program to perform all phases of prehospital emergency medical care, including advanced life support, under written or oral authorization of an MPD or approved physician delegate, examined and certified by the secretary under chapter **18.71** RCW.

(51) "Pediatric education requirement (PER)" means the pediatric education and training standards required for certain specialty physicians and nurses who care for pediatric patients in designated trauma services as identified in WAC **246-976-886** and **246-976-887**.

(52) "PEPP" means pediatric education for prehospital professionals.

(53) "PHTLS" means a prehospital trauma life support course.

(54) "Physician" means an individual licensed under the provisions of chapters **18.71** or **18.57** RCW.

(55) "Physician with specific delineation of surgical privileges" means a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

(56) "Postgraduate year" means the classification system for residents who are undergoing postgraduate training. The number indicates the year the resident is in during his/her postmedical school residency program.

(57) "Practical skills examination" means a test conducted in an initial course, or a test conducted during a recertification period, to determine competence in each of the practical skills or group of skills specified by the department.

(58) "Prehospital index (PHI)" means a scoring system used to trigger activation of a hospital trauma resuscitation team.

(59) "Prehospital patient care protocols" means the department-approved, written orders adopted by the MPD under RCW **18.73.030**(15) and **70.168.015**(27) which direct the out-of-hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment. The protocols meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter **70.168** RCW.

(60) "Prehospital provider" means EMS provider.

(61) "Prehospital trauma care service" means an agency that is verified by the secretary to provide prehospital trauma care.

(62) "Prehospital trauma triage procedure" means the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC **246-976-930**(2).

(63) "Public education" means education of the population at large, targeted groups, or individuals, in preventive measures and efforts to alter specific injury, trauma, and medical-related behaviors.

(64) "Quality improvement (QI)" or "quality assurance (QA)" means a process/program to monitor and evaluate care provided in the EMS/TC system.

(65) "Regional council" means the regional EMS/TC council established by RCW **70.168.100.**

(66) "Regional patient care procedures" means department-approved written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter **70.170** RCW. Patient care procedures do not relate to direct patient care.

(67) "Regional plan" means the plan defined in WAC **246-976-960** (1)(b) that has been approved by the department.

(68) "Registered nurse" means an individual licensed under the provisions of chapter **18.79** RCW.

(69) "Rural" means an unincorporated or incorporated area with a total population of less than ten thousand people, or with a population density of less than one thousand people per square mile.

(70) "Secretary" means the secretary of the department of health.

(71) "Senior EMS instructor (SEI)" means an individual approved by the department to be responsible for the administration, quality of instruction and the conduct of initial emergency medical responder (EMR) and emergency medical technician (EMT) training courses.

(72) "Special competence" means that an individual has been deemed competent and committed to a medical specialty area with documented training, board certification and/or experience, which has been reviewed and accepted as evidence of a practitioner's expertise:

(a) For physicians, by the facility's medical staff;

(b) For registered nurses, by the facility's department of nursing;

(c) For physician assistants and advanced registered nurse practitioners, as defined in the facility's bylaws.

(73) "State plan" means the emergency medical services and trauma care system plan described in RCW **70.168.015**(7), adopted by the department under RCW **70.168.060**(10).

(74) "Steering committee" means the EMS/TC steering committee created by RCW **70.168.020.**

(75) "Suburban" means an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety-nine or any area with a population density of between one thousand and two thousand people per square mile.

(76) "System response time" for trauma means the interval from discovery of an injury until the patient arrives at a designated trauma facility.

(77) "Training program" means an organization that is approved by the department to be responsible for specified aspects of training EMS personnel.

(78) "Trauma rehabilitation coordinator" means a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

(79) "Trauma response area" means a service coverage zone identified in an approved regional plan.

(80) "Trauma service" means the clinical service within a hospital or clinic that is designated by the department to provide care to trauma patients.

(81) "Urban" means:

(a) An incorporated area over thirty thousand; or

(b) An incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.

(82) "Verification" means a prehospital agency is capable of providing verified trauma care services and is credentialed under chapters **18.73** and **70.168** RCW.

(83) "Wilderness" means any rural area not readily accessible by public or private maintained road.

[Statutory Authority: Chapters **18.71**, 18.73, and **70.168** RCW. WSR 11-07-078, § 246-976-010, filed 3/22/11, effective 5/15/11; WSR 05-01-221, § 246-976-010, filed 12/22/04, effective 1/22/05; WSR 00-08-102, § 246-976-010, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter **18.71** RCW. WSR 96-03-052, § 246-976-010, filed 1/12/96, effective 2/12/96. Statutory Authority: RCW **43.70.040** and chapters **18.71**, 18.73 and **70.168** RCW. WSR 93-01-148 (Order 323), § 246-976-010, filed 12/23/92, effective 1/23/93.]

APPENDIX F

NOTE: HTML has links - PDF has Authentication

PDF **WAC 246-976-182**

Authorized care—Scope of practice.

(1) Certified EMS personnel are only authorized to provide patient care:

(a) When performing in a prehospital emergency setting or during interfacility ambulance transport; and

(b) When performing for a licensed EMS agency or an organization recognized by the secretary; and

(c) Within the scope of care that is:

(i) Included in the approved instructional guidelines/curriculum for the individual's level of certification; or

(ii) Included in approved specialized training; and

(iii) Included in state approved county MPD protocols.

(2) If protocols and regional patient care procedures do not provide off-line direction for the situation, the certified person in charge of the patient must consult with their online medical control as soon as possible. Medical control can only authorize a certified person to perform within their scope of practice.

(3) All prehospital providers must follow state approved triage procedures, regional patient care procedures and county MPD patient care protocols.

[Statutory Authority: Chapters **18.71**, 18.73, and **70.168** RCW. WSR 11-07-078, § 246-976-182, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-182, filed 4/5/00, effective 5/6/00.]

FIFE LAW, P.S.

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Appellate Court Case Title:	Lesa Samuels, Appellant v. City of Tacoma, Respondent
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