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NO. 98958-3

SUPREME COURT OF THE STATE OF WASHINGTON

LINDA J. ACOSTA,

Petitioner,

v.

STATE OF WASHINGTON, DEPARTMENT OF CORRECTIONS,

Respondent.

RESPONDENT'S ANSWER TO PETITION FOR REVIEW

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

I. INTRODUCTION

Medical malpractice cases generally require expert testimony to prove negligence and causation. This case, in which Plaintiff Linda J. Acosta brought a medical malpractice action against the State of Washington Department of Corrections, is no different, as the Court of Appeals correctly determined. *See Acosta v. Dep't of Corrections*, No. 52953-0-II, 13 Wn. App. 2d 1141 (July 28, 2020) (unpublished).

Acosta, who has been incarcerated at the Washington Corrections Center for Women (WCCW) since 2012, sued the Department alleging malpractice related to the treatment of her 2014 back injury. After she had injured her back, WCCW medical staff repeatedly evaluated and treated her subsequent pain complaints, revising their recommendations as her reported pain waxed and waned. Over time, they obtained multiple imaging studies and specialist consults, culminating in back surgery in 2016. At summary judgment, Acosta failed to present any expert testimony to support her malpractice claims, and the trial court dismissed her suit.

In affirming summary judgment, the Court of Appeals properly followed precedent and engaged in a fact-specific analysis when concluding that the doctrine of res ipsa loquitur did not apply in this case so as to relieve Acosta from having to present expert testimony. The Department's medical treatment of Acosta's injured back was not of a kind that ordinarily does not

happen absent negligence. In addition, the Department did not exclusively control Acosta's treatment when that treatment involved outside providers the Department did not control. Further, by pursuing MRI imaging under the Department's offender-paid health care process, Acosta participated in the process of arranging for her treatment. Because the Court of Appeals' unpublished opinion in this fact-intensive case does not involve an issue of substantial public interest, review should be denied. *See* RAP 13.4(b)(4).

II. COUNTERSTATEMENT OF THE ISSUE

Did the Court of Appeals properly determine that the doctrine of res ipsa loquitur did not apply to Acosta's medical malpractice claims and that she needed to present expert testimony on standard of care and causation to survive summary judgment?

III. COUNTERSTATEMENT OF THE CASE

A. After Acosta Fell in 2014, WCCW Medical Staff Began Conservatively Treating Her Injury

Acosta has been in the Department's custody since March 2012. CP 95. Her medical history upon arrival at WCCW included a total right hip replacement and diagnoses of osteoarthritis and multilevel degenerative disc disease. CP 58, 69. Between July 2012 and September 2014, Acosta sought and received treatment at the WCCW medical clinic for back, hip, knee, and lower extremity pain. CP 96-97, 179-86, 213-14, 216, 288.

In October 2014, Acosta tripped on a floor mat and fell on her buttocks and back. CP 178, 353. A week later, she presented to the clinic, complained of increasing lumbar pain, and denied any bowel or bladder dysfunction. CP 97, 177-78. ARNP Pamelyn Saari requested X-rays, prescribed medications, and ordered a wheelchair. CP 97, 176-77, 212. The X-rays showed an "age indeterminate compression fracture" of the L1 vertebra with over 50 percent loss of vertebral height, multilevel degenerative disc disease, osteoarthritis, and atherosclerosis. CP 97, 211.

After reviewing the X-rays, Saari requested a sit-down walker for Acosta, allowed continued use of the wheelchair, and referred Acosta for physical therapy. CP 97, 175. Acosta then requested to see an orthopedic surgeon. CP 358. Saari explained she was conservatively treating Acosta's fracture and that an orthopedist would not do anything different. CP 358.

In mid-December, Acosta returned to the clinic in a sit-down walker; she had not been to physical therapy. CP 173. Saari encouraged her to walk as much as possible. CP 173. Acosta later reported that her right upper posterior hip area was at 10/10 pain. CP 97-98, 170-71. She advised she was "regaining mobility" after her fall, was using a walker, and her back pain had resolved, but she had begun having aching pain with activity, which was "different." CP 98, 170. On exam, Dr. Lisa Anderson found Acosta's hip very painful and questioned where the pain was localized. CP

98, 170. She ordered X-rays and prescribed pain medication. CP 98, 170.

B. WCCW Staff Obtained New X-Rays and an Orthopedic Consult

The January 2015 X-rays taken of Acosta's hips and pelvis indicated mild sacroiliac joint osteoarthritis. CP 98, 210. Acosta soon returned to the clinic complaining of radiating right hip pain, as well as constipation from medication. CP 98, 167-68. Saari admitted Acosta for pain control and bowel regulation. CP 98, 167-68. Dr. Mary Colter, WCCW's Facility Medical Director and an internal medicine physician, followed up with Acosta and again referred her to physical therapy. CP 95, 98, 167, 264.

Acosta next returned to the clinic with right face swelling, for which she was ultimately sent to St. Anthony's Hospital for treatment. CP 165-66, 268-69. After returning to WCCW, Acosta reported pain in her right back flank and buttocks; she denied numbness or tingling in her right leg. CP 98, 163. Saari was unclear if Acosta's lower back pain was due to the compression fracture or a new muscle strain. CP 162. She prescribed medications and encouraged self-care. CP 98-99, 162.

On January 20, Acosta requested an MRI. CP 359. Saari set an appointment for Acosta to see Dr. Colter. CP 99, 157, 359. Dr. Colter assessed Acosta with severe low back pain without any "red flags." CP 156. She continued Acosta's prescriptions, ordered lumbar X-rays, requested a consult by the Department's orthopedic surgeon, Dr. Kenneth Sawyer, and

consulted with the Department's Chief Medical Officer about a nodule that had been discovered on Acosta's thyroid. CP 99, 156, 158, 266.

Dr. Sawyer reviewed Acosta's X-rays and noted that, in the absence of any red flags or neurologic deficit, he would assume she had mechanical low back pain; he recommended additional imaging. CP 99, 154-55. New X-rays showed further interval collapse of the L1 vertebral body, from about 50 percent to 60-70 percent. CP 99, 151, 208. Dr. Sawyer explained that, if Acosta was neurologically intact, WCCW could continue observation. CP 151. It was unclear to Dr. Sawyer if her pain was due to pathology at L1 or a lower level. CP 99, 151. Meanwhile, staff ordered diagnostics related to Acosta's thyroid. CP 152, 159, 263.

C. WCCW Staff Continued Conservatively Treating Acosta's Pain and Ordered an MRI

In February 2015, Acosta returned to Dr. Colter and denied any pain or tenderness over the L1 fracture site and stated her hip pain was much better, but that her right lower back pain was no better. CP 99, 150. Acosta was neurologically intact. CP 150. Dr. Colter reviewed Dr. Sawyer's recommendations with Acosta, continued her medications, ordered physical therapy, and planned for a thyroid nodule biopsy. CP 99, 150.

In mid-February, Acosta began physical therapy. CP 261. Later, Acosta requested a new wheelchair and underwent the thyroid nodule

biopsy. CP 206-07, 258, 362. Dr. Colter told Acosta that she should be out of the wheelchair and moving as much as possible. CP 362. In March 2015, Acosta followed up about her back and hip pain. CP 100, 146. Saari asked about injecting Acosta's iliac crest. CP 100, 146. She also noted that she had called TRA Medical Imaging with Acosta's request for an MRI. CP 146. The Department's policy regarding offender-paid health care outlined the necessary approval process for self-paid medical services. CP 346-52. Acosta would decide on the MRI after learning its cost. CP 146.

During March 2015, Acosta asked about her thyroid biopsy and her self-paid MRI. CP 283-86, 363-67. Dr. Colter wanted more imaging of her thyroid nodule. CP 146. As for the MRI, Saari had told TRA about the areas to be imaged, but had not heard back; she instructed Acosta to contact Health Services Manager Jeff Perry. CP 284-86, 363-65. In April 2015, after hospitalization for a gastrointestinal bleed, Acosta asked Saari and Perry about her MRI. CP 140-44, 282, 368-70. Perry responded that he had not received her cost estimate, and Saari instructed Acosta to contact TRA about the cost and then contact Perry when ready to make payment. CP 282, 368-70. In May 2015, Saari provided Acosta with initial cost estimates. CP 281, 371. She later provided additional estimates. CP 280, 373.

Meanwhile, Acosta returned to Dr. Colter and reported walking around her unit and only using a wheelchair for long distances. CP 191. In

August 2015, Acosta presented to Saari with left knee pain, and Saari spoke with Acosta and Perry about the self-paid MRI. CP 138. In September 2015, Acosta completed her portion of the self-paid MRI paperwork. CP 289, 292. In October 2015, the rest of her MRI paperwork was completed, and Saari sent the request to TRA. CP 100, 137, 256, 291-92.

D. After MRI and CT Imaging and Consults with Two Outside Surgeons, Acosta Had Surgery in June 2016

In November 2015, Acosta underwent an MRI of her right hip and lumbar spine. CP 100, 194-96. Dr. Colter then approved a request for an outside surgical consult and payment of the MRI by the Department. CP 100, 231, 446, 449. In December 2015, Acosta saw Dr. Marc Goldman, an outside neurosurgeon. CP 100, 249-54. Dr. Goldman noted that the MRI showed a greater than 90 percent height loss burst fracture of L1 with severe canal stenosis due to retropulsed bone fragments. CP 250. He believed "there [was] no urgency in treatment" and ordered a CT scan. CP 253. Dr. Goldman also noted that, while it "may" be beneficial to perform surgery, he was "not entirely certain this will help her back pain." CP 253.

In January 2016, Acosta underwent the CT scan and, in February 2016, she followed up with Dr. Goldman. CP 100, 192-93, 246-47. He similarly noted he was "not entirely sure" that surgery would be beneficial to Acosta in the long run and considered just treating her pain

symptomatically. CP 247. Ultimately, Dr. Goldman wanted a second opinion from Dr. Michael Martin, an outside orthopedic surgeon. CP 247.

In March 2016, Saari reported that Dr. Martin's office had put Acosta's paperwork in the wrong doctor's box for a time, they were waiting for his office to answer, and Acosta would be scheduled soon. CP 392. Later that month, Acosta presented to Dr. Martin and Nicholas Harrison, PA-C, for a second surgical opinion. CP 101, 244-45. Dr. Martin recommended a laminectomy at T12-L3 and a fusion at T11-L3. CP 245. Thereafter, Saari contacted Dr. Martin's office to schedule Acosta's surgery; she also ordered wheelchair use without limitations. CP 101, 135.

In April 2016, Acosta asked if she had been scheduled for surgery. CP 393-99. WCCW staff initially responded that she had been scheduled and would be sent for another MRI, then clarified that they were awaiting a return call from Dr. Martin's office. CP 393-96. Staff worked on expediting Acosta's surgery and continued contacting Dr. Martin's office. CP 132, 397. Meanwhile, Acosta presented to the medical clinic with continuing pain complaints. CP 101, 130-34. Medical staff noted she was due to have surgery soon, and prescribed her medications. CP 101, 130-34. On June 7, 2016, Drs. Martin and Goldman performed Acosta's surgery. CP 228-30.

E. WCCW Staff Treated Acosta's Continued Pain After Surgery

In July 2016, Acosta followed up with PA-C Harrison about her

surgery and indicated significant improvement. CP 225-27. In September 2016, Acosta complained of bilateral posterior thigh and calf pain. CP 222-24. Dr. Martin ordered testing of her lower extremities to evaluate for lumbar radiculopathy. CP 187-90, 223. Those test results showed evidence of left acute S1 radiculopathy and left chronic L5 radiculopathy. CP 102, 187-90. In November 2016, Acosta complained of radiating nerve pain in her right thigh. CP 125. Dr. Colter prescribed medications. CP 125.

In February 2017, Acosta saw Dr. Martin, reported her symptoms had improved but complained of pain in the left buttock and right thigh. CP 102, 113-15. Dr. Martin recommended she stay active and stop using a walker when ready. CP 102, 114. In June and July 2017, Acosta and Dr. Colter discussed Acosta's use of a walker. CP 311. Acosta also reported she had twisted her back, causing mild back pain. CP 311. In October 2017, Acosta reported leg numbness and weakness. CP 308-09. In November 2017, she saw Dr. Martin and reported that her back was fine, but that her legs were giving her problems. CP 323-25. Dr. Martin believed most of her symptoms came from her hip and a leg length discrepancy. CP 325. He noted that she should have her hip evaluated by a specialist. CP 325.

In January and February 2018, Acosta underwent diagnostic testing because of left leg pain complaints. CP 313-17. In April 2018, she followed up with Dr. Colter about her back surgery. CP 304-05. She reported doing

well but still used a walker because of low back pain and leg weakness. CP 304. In May and June 2018, Acosta returned to the clinic complaining of left hip pain. CP 302-03. X-rays showed mild hip joint space narrowing and small osteophyte formation. CP 312. In July 2018, Acosta followed up with Dr. Martin for the last time. CP 318-22. She complained of pain in her legs and was using a walker. CP 318. Dr. Martin assessed Acosta with neurogenic claudication associated with aging. CP 321.

F. Procedural History

Acosta filed suit against the Department alleging medical malpractice claims related to the treatment of her October 2014 back injury. CP 1-7. The Department moved for summary judgment arguing Acosta could not establish its medical staff violated the applicable standard of care or that their treatment caused her injury. CP 16-17, 35-39, 416-23. It submitted testimony of Drs. Colter and W. Brandt Bede, an orthopedic surgeon, in support of its motion. CP 57-63, 95-103, 444-47.

Dr. Colter opined that all treatment Acosta obtained at WCCW, including conservative treatment of her pain complaints and surgical consults, met the applicable standards of care. CP 102-03. Dr. Colter also testified that the cause of Acosta's lower back, hip, and lower extremity pain appeared related to an S1 nerve root issue. CP 103. Dr. Bede similarly opined that Saari's treatment of Acosta met the standard of care, that the

treatment plan followed by Drs. Colter and Sawyer met the standard of care, and that the Department's personnel followed standard medical procedures for diagnosis and treatment of Acosta's fracture. CP 59-60, 62. Dr. Bede also opined that the timing of Acosta's surgery did not cause or worsen her lumbar condition, that her leg radiculopathy stems from her S1 nerve root, and that the significant arthritic and degenerative condition of her lumbar spine was not caused or worsened by the Department. CP 62-63.

Acosta opposed the Department's motion. CP 326-415. She did not submit any expert testimony and instead argued the doctrine of res ipsa loquitur applied. CP 327, 331-38. The Department contended the doctrine was inapplicable and submitted additional testimony of Dr. Colter related to the offender-paid health care process. CP 420, 445-46. The trial court agreed with the Department and, because Acosta did not have supportive expert testimony, granted summary judgment. CP 13-15, 452-53; VRP 15.

The Court of Appeals affirmed that decision. *See Acosta v. Dep't of Corrections*, No. 52953-0-II, 13 Wn. App. 2d 1141 (July 28, 2020) (unpublished) (hereinafter Pet., Ex. A). It held that res ipsa loquitur was not applicable to this case because the evidence does not show that the Department's course of medical treatment was not one that "ordinarily does not happen in the absence of someone's negligence." Pet., Ex. A at 9, 12. The court also concluded that, even if it accepted Acosta's narrow definition

of the "occurrence" as the Department's delay in obtaining her MRI, "the evidence does not show that a delay in obtaining a medical test is the type of occurrence that does not ordinarily occur in the absence of negligence." *Id.* at 10-11. Finally, the court also agreed with the Department that "summary judgment dismissal was proper because Acosta did not provide expert testimony on the standard of care or causation." *Id.* at 12.

IV. ARGUMENT WHY REVIEW SHOULD BE DENIED

The Court of Appeals, in its unpublished opinion, comprehensively analyzed the evidence in the record in the light most favorable to Acosta, applied this Court's precedent, and correctly concluded that she had failed to produce sufficient evidence to survive summary judgment on her medical malpractice claims. As the court properly determined, the doctrine of res ipsa loquitur does not apply in this case, where the record demonstrates that the Department's treatment of Acosta's back injury was not of a kind that ordinarily does not happen absent negligence. *See* Pet., Ex. A at 9-12. Further, the doctrine is also inapplicable because the Department did not exclusively control Acosta's treatment and Acosta participated in the process of arranging for her treatment. *See Pacheco v. Ames*, 149 Wn.2d 431, 436, 69 P.3d 324 (2003) (discussing the elements of res ipsa loquitur). Thus, to survive summary judgment, Acosta needed to present expert testimony on negligence and causation, which she did not do. *See*, *e.g.*,

Frausto v. Yakima HMA, LLC, 188 Wn.2d 227, 232, 393 P.3d 776 (2017).

In seeking review by this Court, Acosta argues that "this case raises an issue of substantial public interest that the Supreme Court should address." Pet. at 7. To the extent Acosta intends to invoke RAP 13.4(b)(4), her argument should be rejected. The unpublished opinion, which is not precedent and is not binding on any court under GR 14.1(a), does not raise any reviewable issue of substantial public interest. Here, the Court of Appeals correctly applied settled law to the unique facts of this case. It did not "unnecessarily limit[ ] the res ipsa loquitur doctrine" as Acosta argues. *See* Pet. at 7. Review by this Court is not warranted under RAP 13.4.

A. Because the Unpublished Opinion Rests on Unique Facts and Settled Law, the Petition Does Not Present an Issue of Substantial Public Interest

In this medical malpractice case, Acosta bears the burden of proving both negligence and causation. *See* RCW 7.70.040 (requiring proof of a violation of the accepted standard of care and proximate cause). Where medical facts are involved, jurors generally lack the knowledge and experience to determine whether there has been a violation of the standard of care and causation. Thus, expert testimony on both elements is almost always required. *Frausto*, 188 Wn.2d at 231-32. Exceptions include where a physician amputates the wrong limb or pokes a patient in the eye while stitching a wound on the face. *Id.* at 232.

In this case, the Court of Appeals appropriately rejected Acosta's attempt to rely on the doctrine of res ipsa loquitur to avoid having to present expert testimony on the standard of care and causation. *See* Pet., Ex. A at 8-12. In order to apply res ipsa loquitur, the following criteria must be met:

> (1) the accident or occurrence producing the injury is of a kind which ordinarily does not happen in the absence of someone's negligence, (2) the injuries are caused by an agency or instrumentality within the exclusive control of the defendant, and (3) the injury-causing accident or occurrence is not due to any voluntary action or contribution on the part of the plaintiff.

Reyes v. Yakima Health Dist., 191 Wn.2d 79, 89-90, 419 P.3d 819 (2018) (quoting *Pacheco*, 149 Wn.2d at 436). As Acosta notes, the Court of Appeals recognized that those criteria controlled its analysis here. *See* Pet. at 10, Ex. A at 9. Because the evidence fails to meet the first criterion, the court correctly concluded that res ipsa loquitur did not apply. Ex. A at 12.

While Acosta disagrees with the result reached by the Court of Appeals, she does not explain how the court erred in its analysis. *See* Pet. at 11-12. Nor can she provide such an explanation, as the court did not err. Further, because neither of the remaining two criteria are met here, the doctrine is inapplicable for those alternative reasons.

1. The Court of Appeals properly followed controlling precedent and determined that the Department's treatment was not of a kind which ordinarily does not happen absent negligence

A plaintiff has three ways in which to show that the "occurrence producing the injury" is of a kind which ordinarily does not happen in the absence of negligence:

> (1) [w]hen the act causing the injury is so palpably negligent that it may be inferred as a matter of law, i.e., leaving foreign objects, sponges, scissors, etc., in the body, or amputation of a wrong member; (2) when the general experience and observation of mankind teaches that the result would not be expected without negligence; and (3) when proof by experts in an esoteric field creates an inference that negligence caused the injuries.

Reyes, 191 Wn.2d at 90 (quoting *Pacheco*, 149 Wn.2d at 438-9).

In *Reyes,* the Court concluded that prescribing the decedent isoniazid, which sometimes can lead to fatal liver toxicity, was not so "palpably negligent" as leaving foreign objects in a body or amputating the wrong limb. 191 Wn.2d at 90. Nor could a layperson's "general experience and observation" show that it was negligent. Thus, res ipsa loquitur was inapplicable and could not be substituted for expert testimony. *Id.* Similarly, in *Miller v. Jacoby*, the Court concluded that, "[w]ithout knowing the professional standard of care for a health care provider placing a Penrose drain during surgery, a layperson would not be able to determine that [the plaintiff's] injury would not have occurred absent negligence by [the defendant surgeon]." 145 Wn.2d 65, 75, 33 P.3d 68 (2001).

By contrast, in *Pacheco*, 149 Wn.2d at 439, the Court noted that the

surgeon's act of drilling on the wrong side of the patient's mouth was akin to a surgeon's amputation of the wrong limb and concluded that "it is within the general experience of mankind that the act of drilling on the wrong side of a patient's jaw would not ordinarily take place without negligence." Similarly, in *Ripley v. Lanzer*, the court noted that the defendant "does not and could not argue that a surgeon who leaves a scalpel blade in a patient without noticing the blade is there and closes the surgical portals is doing something that ordinarily happens in the absence of negligence." 152 Wn. App. 296, 313, 215 P.3d 1020 (2009).

This case is analogous to *Reyes* and *Miller* and distinguishable from *Pacheco* and *Ripley*. Acosta identifies her injury as "prolonged pain and disability" and the occurrence producing that injury as "delay[ ] in obtaining the MRI." Pet. at 11. Yet, the Court of Appeals not only rejected that identification of the "occurrence" as too narrow, but also determined that it would not make a difference if her argument was accepted:

> But even if we accept this argument at face value, the evidence does not show that a delay in obtaining a medical test is the type of occurrence that does not ordinarily occur in the absence of negligence. To the contrary, there can be a multitude of reasons for the DOC's delay in obtaining a self-paid MRI.
>
> For example, the evidence here shows that the MRI request required a DOC medical care staff member to deem it "medically appropriate" before it could be approved. Acosta argues that the delay here was caused by ineptitude

> and lies, but the particular facts regarding this delay are not determinative. Our focus in analyzing this element of res ipsa loquitur is whether *a delay* in obtaining a medical test is the type of occurrence that does not *normally occur* in the absence of negligence. It is not, and Acosta's argument fails on this point.

Ex. A at 10-11 (emphases in original). The court was correct in its analysis.

Acosta does not address the court's reasoning on this issue and, instead, argues that "the negligent activity of DOC staff precluded a timely MRI from being conducted and, therefore it extended the period of time in which Ms. Acosta was in pain." *See* Pet. at 11. She is mistaken. It is the judgment of medical professionals to decide when diagnostic imaging is appropriate and when a patient is a candidate for surgery. Here, there is no evidence of what an MRI likely would have shown had it been taken any earlier, let alone that it would have revealed findings supporting surgical consultation as were present in November 2015. There is also no evidence of whether Acosta's surgeons would have recommended surgery had she consulted with them sooner; rather, her surgery, when it occurred, was not urgent. CP 446. Without expert testimony on either point, it is speculation to suggest that an earlier MRI would have changed anything in this case.

In addition, conservatively treating Acosta's pain and obtaining additional imaging, specialist consults, and eventually surgery as time progressed was not so "palpably negligent" or within "the general

experience and observation of mankind" that it can be compared to leaving foreign objects in a body or amputating the wrong limb. *See Reyes*, 191 Wn.2d at 90. As Acosta's reported symptoms changed overtime, Saari and Drs. Anderson, Colter, Sawyer, and Goldman each questioned the cause of her pain or the benefit of surgery. *See supra* Part III. The Court of Appeals explained in its opinion:

> During the entire time in question, Acosta was receiving medical care for the fall she suffered in October 2014, and the record contains declarations from experts that describe that care as meeting the requisite standard of care for medical professionals. *Her medical providers, the same people to review and possibly approve her MRI request, were unsure of the cause of her pain or the benefit of surgery. These facts take this case out of the realm of "palpable negligence" where this doctrine would normally apply*, i.e., drilling in the wrong side of a patient's jaw, leaving foreign objects in the body, or amputation of a wrong member.

Pet., Ex. A at 11-12 (emphasis added).

Without knowing the standard of care for treating an age indeterminate vertebral compression fracture and lower back, hip, knee, and lower extremity pain in a patient with pre-existing pain complaints, osteoarthritis, and degenerative disc disease, "a layperson would not be able to determine that [Acosta's] injury would not have occurred absent negligence by [the Department]." *See Miller*, 145 Wn.2d at 75. Thus, the first criterion of res ipsa loquitur is not present in this case.

2. Alternatively, res ipsa loquitur does not apply because the Department did not exclusively control Acosta's treatment and she participated in the process for arranging for her treatment

Acosta also cannot establish that she meets the remaining two criteria for res ipsa loquitur, either one of which would be an alternative basis to affirm the Court of Appeals' decision.

As to the criterion of the defendant's exclusive control,

> [t]he reason for the prerequisite of exclusive control of the offending instrumentality is that the purpose of the rule is to require the defendant to produce evidence explanatory of the physical cause of an injury which cannot be explained by the plaintiff. If the defendant does not have exclusive control of the instrumentality producing the injury, he cannot offer a complete explanation, and it would work an injustice upon him to presume negligence on his part and thus in practice demand of him an explanation when the facts indicate such is beyond his ability.

Pacheco, 149 Wn.2d at 437 (quoting *Morner v. Union Pac. R.R. Co*., 31 Wn.2d 282, 296, 196 P.2d 744 (1948)). Thus, in *Miller*, because the surgeon did not exclusively control the Penrose drain after surgery, res ipsa loquitur was not available to impose liability on the surgeon. 145 Wn.2d at 75.

Here, Acosta's treatment was not in the exclusive control of the Department. Akin to *Miller*, her treatment also depended on the actions of other medical providers outside the Department – TRA Medical Imaging and Drs. Goldman and Martin. The Department cannot control the length of time it takes to hear back from an outside provider related to an offender-

paid health care procedure, and the Department cannot control if there is a delay in scheduling an appointment with an outside provider because the provider's schedule is full for weeks or months. CP 445-46. Applying res ipsa loquitur in these circumstances would work an injustice by demanding of the Department an explanation for the delay of others.

Res ipsa loquitur also does not apply in this case because Acosta participated in the process of arranging her treatment. The doctrine requires that "the injury-causing accident or occurrence is not due to any voluntary action or contribution on the part of the plaintiff." *Reyes*, 191 Wn.2d at 90. Here, there is evidence that Acosta participated in arranging for the MRI. The process of setting up an offender-paid health care procedure requires the offender to complete certain steps, including locating a provider in the community willing to see the offender, filling out a request, paying a processing fee, obtaining a cost estimate, and submitting money to cover that cost. CP 445. Because Acosta participated in the process of arranging for the MRI, the third criterion of res ipsa loquitur is not met.

V. CONCLUSION

Given Acosta's complicated medical history and presentation, she needed expert testimony on the standard of care and causation to survive summary judgment. The Court of Appeals correctly affirmed the dismissal of her claims under settled law. This Court should deny review.

RESPECTFULLY SUBMITTED this 2nd day of November, 2020.

s/ Sara A. Cassidey

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DECLARATION OF SERVICE

I declare under penalty of perjury, pursuant to the laws of the State of Washington, that on the date below, the preceding "RESPONDENT'S ANSWER TO PETITION FOR REVIEW" was electronically filed in the Washington State Court of Appeals, Division II, and electronically served on the following parties, according to the Court's protocols for electronic filing and service.

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DATED this 2nd day of November, 2020, at Lacey, Washington.

s/ Tina M. Sroor
TINA M. SROOR, Legal Assistant

ATTORNEY GENERAL'S OFFICE, TORTS DIVISION

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