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COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
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IN THE COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

NO. 318141

BEVERLY VOLK, et al.,
Appellants,

v.

JAMES B. DERMEERLEER, et al.,
Respondents

BRIEF OF RESPONDENT ASHBY – RAP 18.8

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

I. Introduction

On June 21, 2013, the Trial Court granted summary dismissal of all of Appellants' claims against Respondents' Dr. Howard Ashby and the Spokane Psychiatric Clinic. CP 274-277 (modified from a previous Order, CP 260-263). Appellants insist the Trial Court erred by ordering dismissal in the face of "competent medical testimony." As set forth herein, Appellants' position would require the extension of Washington law to impose a duty to warn upon a treating psychiatrist to anyone who might potentially be the target of undefined thoughts of violence by a patient, even in the absence of specific threats of harm against a reasonably identifiable victim.

Horrible events occurred months after Jan DeMeerleer last saw Dr. Ashby, but there is no evidence in this record that Mr. DeMeerleer ever made any specific threat of harm against any reasonably identifiable victim, including any threats of harm against Rebecca Schiering and/or her children. Appellants offered a declaration from an expert witness containing generalities, factually unsupported conclusions and speculation, advocating for a boundless and expansive duty to warn. Appellants ask the courts to ignore statutes intended to both protect the rights of mental health patients and foster the essential purposes of psychotherapy. Specifically, Appellants seek to impose upon mental health care providers

the requirements and duties imposed upon persons in a "take charge" position over parolees, probationers or other persons under the control of the state correctional system or the courts. Appellants' position would result in a significant impairment on the statutory protections afforded mental health care providers and their patients in favor of a general, far-reaching duty found only in custodial or court ordered monitoring situations. If such a position is adopted, then an overactive and in many cases unfounded alert system would result, at the expense of the underpinnings of psychotherapy, which encourages patients to express even fleeting thoughts and emotions without fear that those thoughts and feelings will be disclosed to third parties. In order to encourage those who need mental health care to candidly and fully disclose information to their psychotherapist, and in order to allow psychotherapists to build trust with their patients necessary to gain such complete disclosures, patients and psychotherapists both need to know that communications between them, absent a specific threat of harm to a reasonably identifiable victim, will remain confidential. Appellants' advocated position jeopardizes the foundation of what makes psychotherapy successful and violates the protections provided to mental health care providers by RCW 71.05 provided to mental health care patients pursuant to RCW 70.02.

Dr. Ashby respectfully submits that the Trial Court correctly dismissed Appellants' claims against both himself and the Spokane Psychiatric Clinic. As set forth herein, there is simply no basis for Appellants' claims under Washington law, and Appellants' invitation for this Court to extend Washington law to impose a general duty on psychotherapists to warn third parties of generalized or potential harm posed by patients, absent specific threats of imminent harm against a reasonably identifiable victim, must be rejected.

II. Counter Statement of Facts

On July 18, 2010, Mr. DeMeerleer assaulted Jack Schiering, Philip Schiering, Rebecca Schiering and Brian Winkler. *Amended Complaint,* ¶2.3; CP 29. Rebecca Schiering and Philip Schiering died as a result of the assaults. *Amended Complaint,* ¶2.5; CP 30. For nine years preceding the assaults, Mr. DeMeerleer received periodic psychiatric treatment from Dr. Ashby. *Amended Complaint,* ¶2.7; CP 30.

Appellants brought this lawsuit against Dr. Ashby and the Spokane Psychiatric Clinic alleging that Dr. Ashby did not follow the accepted standard of care for providing psychiatric services to Mr. DeMeerleer. *Amended Complaint,* ¶3.6; CP 31. The standard of care violation is asserted to be the proximate cause of Mr. DeMeerleer's July 18, 2010 assaults. *Amended Complaint,* ¶3.7; CP 31. Specifically, Appellants

theorize that if Dr. Ashby had not allegedly breached the applicable standard of care, then Mr. DeMeerleer may have disclosed to Dr. Ashby an intent to commit the intentional assaults of July 18, 2010. Alternatively, Appellants seek to impose upon mental health care providers the same legal duty owed by persons in "take charge" custodial roles to protect third parties from the potential harm that patients may present.

Respondents moved for dismissal of those claims, and the Trial Court granted that motion by Order entered on May 31, 2013 (CP 260-263) and as amended on June 21, 2013. CP 274-277.

III. Statement Regarding Appellants' Assignment of Error and Issues Pertaining To Assignment Of Error

Appellants' Assignments of Errors Nos. 1 and 2 are both incorrectly premised upon the position that liability can and should be imposed on a mental health care provider based upon a standard that the provider "knew or should have known" that a patient presented a "foreseeable risk of harm" to a third party. That standard is not the law in Washington, or any other jurisdiction that has squarely addressed the issue. Rather, as is set forth herein, to impose a duty to warn on a mental health care provider, the patient must disclose an actual threat of harm toward a reasonably identifiable victim. In this case, there is no evidence that Mr. DeMeerleer, at any time or to any person, including Dr. Ashby,

ever disclosed an actual threat of harm against Ms. Schiering and/or her children. That fact is dispositive of Appellants' claims against Dr. Ashby and the Clinic.

Faced with the absence of such evidence, Appellants rely on the Declaration of Dr. James Knoll to suggest that had Dr. Ashby not allegedly violated the applicable standard of care, it is *possible* that Mr. DeMeerleer *may have* disclosed to Dr. Ashby homicidal thoughts Mr. DeMeerleer *may have* had about Ms. Schiering and/or her children. Dr. Knoll's opinion as to what Mr. DeMeerleer may have potentially reported to Dr. Ashby is nothing more than speculation premised upon speculation, as it assumes, without any factual support, that Mr. DeMeerleer was having homicidal thoughts about Ms. Schiering and/or her children at some point prior to the evening of July 18, 2010, and that Mr. DeMeerleer would have shared these thoughts with Dr. Ashby.

Dr. Knoll's speculation and assumptions are irreconcilable with all of the testimony in the record from those who spent time with and talked to Mr. DeMeerleer in the weeks, days and hours leading up to the July 18, 2010 assaults. As set forth in all of those declarations, Mr. DeMeerleer said nothing to anyone indicating any intention of committing the assaults, which only emphasizes the complete speculative nature of Dr. Knoll's

opinions. The victims' family could not and did not foresee Mr. DeMeerleer having any intent to kill or harm Ms. Schiering or her children.

Finally, and perhaps more importantly, Dr. Knoll's declaration does not, and cannot, establish that Mr. DeMeerleer did in fact disclose any actual threats of harm against Ms. Schiering and/or her children, which is the standard required to impose a duty to warn in Washington on a mental health providers.

Appellants' Assignment of Error No. 3 argues that the requirements of the Mental Health Act, and specifically RCW 71.05.120(2), are applicable only to state institutions and to involuntary commitment proceedings. No such limitations exist in the statute. Nonetheless, Appellants try to distance themselves from the requirements of RCW 71.05.120(2) in favor of abstract notions of the common law despite the statute specifically providing protection to a mental health professional when considering treatments, including involuntary commitment, for a patient.

IV. Argument In Response.

Appellants have not and cannot demonstrate that the Trial Court erred when it granted summary judgment. A motion for summary judgment presents a question of law that is reviewed de novo. *Denaxas v.*

Sandstone Court of Bellevue, LLC, 148 Wn.2d 654, 662, 63 P.3d 125 (2003). Even though the evidence presented at the time of the motion is to be viewed in a light most favorable to the non-moving party (*Osborn v. Mason County,* 157 Wn.2d 18, 22, 134 P.3d 197 (2006)), when there is no genuine issue as to any material fact, summary judgment is proper. *Id.* In this case, Appellants failed to present any admissible, credible evidence of any alleged breach of the standard of care for a psychiatrist in Washington state under the facts alleged and they cannot create a genuine issue based on admissible evidence on the proximate cause element.

A. The Declaration Of James Knoll Does Not Create A Question Of Fact Precluding Dismissal Of Appellants' Claims.

Appellants argue that "competent medical testimony" (the Declaration of James Knoll) establishes that Dr. Ashby violated the applicable standard of care by allegedly not performing an "adequate suicide risk assessment" and not having "regularly scheduled" follow-up appointments over the Summer, 2010. *Appellants' Brief, pgs. 14-15.* Had Dr. Ashby seen Mr. DeMeerleer during the summer of 2010, Appellants argue Dr. Ashby "would have been able to inquire about his [DeMeerleer] thoughts and emotions about his current relationship with Ms. Schiering and her children, and any ideas of suicide and/or homicide." *Appellants'*

Brief, pg. 16. There are three fatal flaws with Appellants' arguments. Each is discussed below.

1. Dr. Knoll's Testimony Is Not "Competent" Evidence, As His Opinions Are Purely Speculative.

Dr. Knoll's assertions and assumptions essentially conclude that but for Dr. Ashby's negligence, Mr. DeMeerleer would have disclosed to Dr. Ashby homicidal thoughts about Ms. Schiering and/or her children. This, of course, assumes that Mr. DeMeerleer entertained homicidal thoughts about Ms. Schiering and/or her children prior to the evening of July 18, 2010, and that he would have disclosed those thoughts to Dr. Ashby. This type of speculation is inadmissible and insufficient to preclude summary judgment.

In opposition to summary judgment, Appellants submitted no evidence showing Mr. DeMeerleer ever had any homicidal thoughts about Ms. Schiering and/or her children at any point prior to the evening of July 18, 2010. Instead, Appellants point to expressions of suicidal and homicidal ideation that Mr. DeMeerleer expressed to Dr. Ashby years earlier (and that were not directed toward Ms. Schiering or her children). Appellants never deposed Dr. Ashby and did not move under CR 56(f) for time to do so. As a result, Appellants asked the Court to extrapolate from earlier office records that Mr. DeMeerleer must have been having suicidal

and homicidal ideations in the summer of 2010. There is no evidence that past, unrelated, fleeting thoughts and emotions (which were not acted upon) translated into specific threats of harm against Ms. Schiering or her boys before July 18, 2010. In fact, the evidence in the record from those persons who spent time with and talked to Mr. DeMeerleer during the summer of 2010 establishes just the opposite. Specific testimony relating Mr. DeMeerleer's conduct and demeanor leading up to July 18, 2010 – from friends, his ex-wife, family and his mother – all demonstrate that Mr. DeMeerleer gave no indication to anyone that he was in distress, was despondent or depressed, or that he had either thought or intended to do any harm to Ms. Schiering or her family, or anyone else for that matter. CP 167-170, 152-158, 159-162, 171-194, 163-166, 198-201 and 195-197.

The victims' own family did not foresee Mr. DeMeerleer doing harm to the victims. Notwithstanding the same, Dr. Knoll opines that if Mr. DeMeerleer treated with Dr. Ashby after April 16, 2010, then Mr. DeMeerleer may have disclosed to Dr. Ashby an intention to commit the assaults in question. Contrary to the unfounded supposition of Dr. Knoll, there was no evidence of a "worsening condition" (*Appellants' Brief,* p. 14) or "apparent psychological distress leading up to July 18, 2010" *Id.,* p. 15. Appellants' argument that Mr. DeMeerleer was "unstable"

during the summer of 2010 (*Id.*) is unsupported, argumentative speculation.

CR 56 requires the dismissal of claims if the defendant can demonstrate that the plaintiffs are unable to establish a critical element of their claim. *Celotex v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986), cert. denied, 484 U.S. 1066, 108 S.Ct. 1028, 98 L.Ed.2d 992 (1988). To support their case, the nonmoving party may not rely on speculation or argumentative assertions. *Pelton v. Tri-State Memorial Hosp.*, 66 Wn. App. 350, 355, 831 P.2d 1147 (1992). When reasonable minds can reach but one conclusion on a question of fact, such questions may be determined as a matter of law. *Ruffer v. St. Frances Cabrini Hosp.*, 56 Wn. App. 625, 628, 784 P.2d 1288, review denied, 114 Wn.2d 1023, 792 P.2d 535 (1990).

Appellants' reliance upon the speculative and factually unsupported declaration by Dr. Knoll is insufficient to defeat summary judgment. In his declaration, Dr. Knoll established that he has excellent credentials (CP 83-84) and that he consulted with some unknown person in Washington state to form his opinion regarding the Washington standard of care. CP 84. Dr. Knoll also stated that he "reviewed" the "clinical records of Jan B. DeMeerleer from Spokane Psychiatric Clinic" (CP 83), but he neither attached nor referenced specific records to his

Declaration. Dr. Knoll's conclusions are vague as to time and place in what appears to be a purposeful attempt to avoid the reality that the few foundational facts recited in his declaration were all of events occurring no later than 2005. CP 84-87. From there, Dr. Knoll speculates that Mr. DeMeerleer may have been experiencing homicidal ideation during the summer of 2010, and that he may have expressed the same to Dr. Ashby had Mr. DeMeerleer seen Dr. Ashby that summer. This type of speculation is inadmissible and insufficient to defeat summary judgment.

Dr. Knoll's opinions are not based upon identifiable facts but instead are based upon conclusory allegations and pure speculation.[1] To preclude summary judgment, an expert's affidavit must amount to more than speculation and conjecture. *Guile v. Ballard Community Hospital*, 70 Wn.App. 18, 25, 851 P.2d 689, *review denied sub nom*, *Guile v. Crealock*, 122 Wn.2d 1010, 863 P.2d 72 (1993). *See also Griswold v. Kilpatrick*, 107 Wn.App. 757, 762, 27 P.3d 246 (2001). The issue that is the subject of an expert's affidavit or declaration must be of such a nature that an expert can express an opinion based on "a reasonable probability rather than mere conjecture of speculation." *Davidson v. Municipality of Metropolitan Seattle*, 43 Wn.App. 569, 719 P.2d 569 (1986).

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[1] At the time of summary judgment Dr. Ashby filed a separate Motion to Strike the declaration of Dr. Knoll; CP 202-204.

[2] While Dr. Knoll opines that Dr. Ashby should have more thoroughly

"Presumptions may not be pyramided upon presumptions nor inference upon inference." *Davidson, supra*, at 575, quoting *Prentiss Packing and Storage Company v. United Pacific Insurance Company*, 5 Wn.2d 144, 164, 106 P.2d 314 (1940).

Dr. Knoll's speculative and unsupported opinions are simply insufficient to defeat summary judgment.

2. Dr. Knoll's Opinions Fail To Address Causation.

To prove medical negligence, a plaintiff must establish that a health care provider failed to use reasonable care and the failure was a proximate cause of the plaintiff's injury. RCW 7.70.040. Proximate cause in a medical negligence case requires evidence establishing that "but for" the failure to observe the standard of care, the injury would not have occurred. *Harbeson v. Parke-Davis, Inc.,* 98 Wn.2d 460, 475-76, 656 P.2d 483 (1983); and *Tyner v. DSHS,* 141 Wn.2d 68, 82, 1 P.3d 1148 (2000). The evidence establishing cause in fact must "rise above speculation, conjecture, or mere possibility." *Reese v. Stroh,* 128 Wn.2d 300, 309, 907 P.2d 282 (1995).

In his declaration, Dr. Knoll opines that Dr. Ashby violated the applicable standard of care by allegedly failing to "perform an adequate assessment" and failing to "adequately monitor DeMeerleer's psychiatric condition." CP 90-91, ¶11. While that testimony might be sufficient to

establish an issue of fact on the element of "breach," Dr. Knoll's conclusions fall far short on the requisite causation element. Recognizing that shortcoming, Appellants make the unique, but improper, argument that Dr. Ashby's alleged negligence resulted in a "loss of chance" for Appellants. That argument is addressed below.

In his declaration, Dr. Knoll states that had Dr. Ashby performed an "adequate assessment" and "adequately monitored" Mr. DeMeerleer, Dr. Ashby "may have substantiated that Ms. Schiering and her children were foreseeably at risk of harm from DeMeerleer." CP 90, ¶10. (emphasis added). Expert testimony must rise to the level of probability and is insufficient if it allows a jury to speculate. *O'Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823, 830 (1968). Dr. Knoll's testimony simply does not meet the testimonial requirement necessary to establish medical negligence. *Id.* Instead, Dr. Knoll could only say that if the alleged breaches had not occurred, Dr. Ashby *may have* discovered that Mr. DeMeerleer *might have* been having suicidal/homicidal ideations, and with that information *may have* been able to take measures to prevent the assaults. Dr. Knoll's testimony is that had the alleged breaches not occurred, the "risk and occurrence of the Incident would have been mitigated, and probably would not have occurred." CP 90, ¶9. Dr. Knoll's conclusion requires an incredible leap of faith devoid of admissible,

factual evidence. Dr. Knoll must assume that there would be a direct, unbroken sequence of events between Mr. DeMeerleer's April 16, 2010 visit with Dr. Ashby and the July 18, 2010 event, yet neither Appellants nor Dr. Knoll have presented any documentation, witness testimony or even anecdotal evidence that connect Mr. DeMeerleer's April 16, 2010 or prior sessions with the assaults upon Ms. Schiering and her boys on July 18, 2010.

Dr. Knoll's declaration was insufficient because he was simply unable to testify that "but for" the alleged breaches, the assaults in question would not have occurred. The Trial Court agreed and found that summary judgment of dismissal was proper.

3. Evidence Of Suicidal Or Homicidal Ideation Is Insufficient To Defeat Summary Judgment.

Appellants argue that had Dr. Ashby not allegedly violated the applicable standard of care, Dr. Ashby may have discovered Mr. DeMeerleer was experiencing "ideas of suicide and/or homicide" in the months preceding July 18, 2010. *Appellants' Brief, pg. 16.* Even if Appellants could have shown Mr. DeMeerleer was having "ideas of suicide and/or homicide" over the summer of 2010, those unexpressed thoughts are insufficient for Appellants to survive summary judgment. Rather, in order to impose liability on a mental health care provider based

upon the intentional, criminal acts of a patient, a plaintiff must show that the patient communicated to the provider an actual threat of harm against a reasonably identifiable victim. Dr. Knoll did not and obviously cannot opine that absent the alleged standard of care violations, Mr. DeMeerleer would have communicated to Dr. Ashby an actual threat of harm toward Ms. Schiering and/or her children.

It is not sufficient for Appellants to establish that absent the alleged breaches of the standard of care, "the risk and occurrence of the Incident would have been mitigated." *Appellants' Brief, pg. 16.* Instead, under applicable Washington law, liability can be imposed on Dr. Ashby and the Clinic only if Dr. Ashby failed to warn/protect Ms. Schiering and her children after receipt of an actual threat harm against them. The absence of such evidence made summary judgment proper.

B. Mental Health Providers Have No Duty To Protect Third Persons Absent An Actual Threat Of Harm Against A Reasonably Identifiable Victim.

The victims of Mr. DeMeerleer's crimes were not patients of Dr. Ashby, and as third parties to the doctor-patient relationship between Dr. Ashby and Mr. DeMeerleer they were owed no legal duty by Dr. Ashby.

> Actors have a duty to exercise reasonable care to avoid the foreseeable consequences of their acts. Restatement (Second) of Torts § 281 cmts. c, d (1965). This duty

> requires actors to avoid exposing another to harm from the foreseeable conduct of a third party. Restatement § 302. Criminal conduct is generally unforeseeable. *Nivens v. 7–11 Hoagy's Corner,* 133 Wash.2d 192, 205 n. 3, 943 P.2d 286 (1997). Consequently, there is generally no duty to prevent third parties from causing criminal harm to others. *Robb v. City of Seattle,* 176 Wash.2d 427, 429–30, 295 P.3d 212 (2013).

Washburn v. City of Fed. Way, 87906-1, 2013 WL 5652733 (Wash. Oct. 17, 2013).

In arguing that Dr. Ashby and the Clinic had a "duty to warn" the eventual victims of Mr. DeMeerleer's criminal actions, Appellants seek to extend the duty recognized in custodial control cases to health care providers, an extension that would be in direct contradiction to Washington statutes that specifically provide protections to both health care providers and their patients. Appellants' extension would also run contrary to the very purposes and goals of psychotherapy.

1. RCW 70.02.050 Precludes The General Duty To Warn Advocated By Appellants.

Relying upon *Peterson v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983) and its progeny, Appellants ask this Court to adopt a general duty to protect/duty to warn upon psychotherapists. The duty proposed generalized is in direct contradiction to RCW 71.02 (Public Health - Uniform Health Care Act), which was enacted in 1991, eight years after *Peterson v. State*. *See*, 1991 Wash. Legis. Serv. Ch. 335 (S.H.B. 1828).

RCW 71.02 defines when a health care provider is even *authorized* to "warn" third persons about a patient.

The mandatory language of RCW 70.02.050 precludes a health care provider from disclosing "health care information about a patient to any other person without the patient's written authorization." There is no discretion in this mandatory language. Instead, the legislature defined specific situations when a physician can disclose health care information. Relevant to this case is subsection (1)(d), which authorizes the disclosure of such information when the health care provider reasonably believes that the patient poses an "imminent danger" to the health and safety of an "individual." The subsection obviously calls for actual or real threats of harm to a specific "individual" and not fleeting thoughts or comments lacking direction or focus upon a specific person.

There is simply no evidence in this record to suggest that Dr. Ashby ever reasonably believed that Mr. DeMeerleer posed an "imminent danger" to Ms. Schiering and/or her children. This limited exception to the rule of non-disclosure squarely rejects a general duty to protect or warn as advocated by Appellants herein. A general duty to protect anyone who might foreseeably be endangered by a patient simply cannot be reconciled with the prohibition from disclosing health care

information absent a belief of an *imminent* danger to the health and safety of an *individual*.

Further, it is of no small significance that this limited exception includes the following language: "...however, there is no obligation under this chapter on the part of the provider or facility to so disclose." Thus, even when a health care provider knows that a patient presents an "imminent danger" to the health or safety of an individual, the provider has discretion on whether to disclose that information. Again, this language simply cannot be reconciled with the general duty proposed by Appellants to warn or protect third parties whenever a patient "might" foreseeably endanger unidentified and non-specific members of the public.

The standard/duty advocated by Appellants jeopardizes the very nature, purpose and goals of psychotherapy. In order to fully understand the chilling effect of the Appellants' position in that regard, the Court should examine the reasons for the psychotherapist-patient privilege in the first place. The confidentiality of communications made by a patient to his or her health care provider has long been recognized as a critical component of treatment:

> . . . it is generally recognized and accepted that the privilege is essentially one intended for the benefit of the patient, and is one personal to the patient. State v. McCoy, [70 Wash.Dec.2d 935, 425 P.2d 874 (1967)] supra. This approach is in keeping with the underlying purpose of the

> privilege, that is, to facilitate and safeguard a free exchange of information in the course of treatment. A further purpose has also been occasionally noted-that of protecting the patient from embarrassment, scandal, or incrimination which might flow from the revelation of intimate details connected with the medical treatment of physical ills. These purposes are benevolent and wholesome. They fully warrant and justify the privilege in appropriate cases.

State v. Boehme, 71 Wn.2d 621, 636, 430 P.2d 537 (1962).

Requiring mental health care providers to breach this privilege and disclose confidential information based solely on the most general of statements (i.e., "ideas of suicide and/or homicide") by a mental health patient not only presents an unmanageable, undefined duty, but it also discourages the very principles of psychotherapy (open and frank disclosure of information).

Pursuant to Appellants' position, a mental health provider would be left to wonder whether a general or vague statement by a patient would require warnings to an unknown or ill-described person or group, with the professional encouraged to err on the side of disclosure to protect his or her own professional liability. Patients, knowing this, will likely withhold or forego treatment with the professional because candid conversation could lead to disclosure of the emotions or thoughts which precipitate the therapy. Functionally, the mental health professional would need to render what would amount to a "Miranda warning" to the patient at the beginning

of each session. It is quite conceivable that many patients who desperately need treatment would avoid it simply because of the potential for interrogation by authorities, such as the police, who are not primarily concerned with that patient's mental health. A duty imposed on health care providers that results in the discouragement of psychotherapy should not be adopted by this Court.

Additionally, the practitioner facing such a broad and undefined standard would be left to wonder to whom any disclosure should be made if the patient's thoughts and comments are not directed at a reasonably identifiable third person.

While RCW 70.02.050(1)(d) does not create a duty ("obligation") to report a reasonable concern about imminent danger presented by a patient, it does define the *minimum* that must be known to a health care provider before the provider can share any patient health care information. In this case, Appellants have not produced any evidence that Dr. Ashby had reason to believe that Ms. Schiering and/or her children were in "imminent danger" from Mr. DeMeerleer. In fact, no one in any facet of Mr. DeMeerleer's life perceived an imminent danger to the Appellants. Instead, Appellants rely upon the declaration of Dr. Knoll for the proposition that more thorough assessments or closer monitoring "may have substantiated" that "Ms. Schiering and her children were foreseeably

at risk." CP 90. As a matter of law, this supposition does not establish a reasonable belief of "imminent danger" allowing for a breach of the confidentiality between provider and patient.

2. Washington Law Does Not Impose A Duty On Mental Health Providers To Warn/Protect Third Persons From Generalized Dangers Presented By Patients.

In support of their argument that this Court should impose on mental health providers a general duty to protect/warn third persons from the general and/or potential danger presented by their patients, Appellants cite at length to *Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 398 P.2d 14 (1965) (abrogated on other grounds by *Pederson v. Dumouchel,* 72 Wn.2d 73, 431 P.2d 973 (1967)) and *Peterson v. State, supra.* (*Appellants' Brief,* pp. 16-21). Neither case supports Appellants' position.

Kaiser v. Suburban Transp. Sys. is readily distinguishable from the present case. As explained by Appellants, *Kaiser* involved the duty of a doctor to warn his own patient of possible side effects of a prescribed drug and the finding that a third party might foreseeably be injured if that warning is not given. The patient, a bus driver, became drowsy and drove a municipal bus into a pole, and the plaintiff passenger was injured. That case was cited in *Peterson v. State* as an example of the reach of foreseeability which is also central to Appellants' argument (*Appellants' Brief,* pp. 19-21) herein.

The *Kaiser* case did not result in a rule requiring general warnings to third parties, which is what the Appellants seek here. In *Kaiser*, the physician *knew* the prescribed drug had the side effect of drowsiness and he *knew* that his patient was a municipal bus driver. *Id.,* at p. 464.

In contrast, the Washington Supreme Court held in *Hartley v. State,* 103 Wn.2d 768, 698 P.2d 77 (1985), that Grant County and the State could not be held liable for failure to revoke the driver's license of a habitual drunk driver, reasoning:

> . . . but here the failure of the government to revoke Johnson's license is too remote and insubstantial to impose liability for Johnson's drunk driving.
>
> Johnson clearly was subject to license revocation under the HTOA. Nothing, however, sets Johnson apart from the thousands of other offenders subject to license revocation under the act. No special relationship or privity existed between the government agents and either Johnson or the victim of his negligence which would impose liability. Johnson was not under the control of government agents who should have known of his dangerous proclivities, as was the case in *Peterson v. State, supra.*

Hartley v. State, 103 Wn.2d at 784-785. Early in that decision the *Hartley* Court explained the difference of a "direct relationship" between the defendant and the plaintiff and an attenuated relationship, as we have here.

> This court has also imposed liability on a government agent for the negligent acts of a third person. *Peterson v. State,* 100 Wash.2d 421, 671 P.2d 230 (1983). In *Peterson,* we found liability in the release by a psychiatrist of a mentally ill patient and that patient's negligent driving, which injured

another. The court recognized the State's duty "to take reasonable precautions to protect anyone who might foreseeably be endangered ..." *Peterson,* at 428, 671 P.2d 230. Since the State had full control over the patient at Western State Hospital and wrongly released him, it can be said the State was in a special relationship with the patient which justified imposition of liability.

Peterson was premised on our earlier holding in *Kaiser v. Suburban Transp. Sys.,* 65 Wash.2d 461, 398 P.2d 14, 401 P.2d 350 (1965). There, we recognized liability may be imposed on an original actor despite an intervening negligent event. The original actor in *Kaiser* was a doctor who prescribed a sleep inducing drug, allegedly without warning, to a bus driver. The intervening event was the bus driver's failure to take action despite his drowsiness. We held that liability would be dependent upon the foreseeability of the intervening event—a question we remanded for jury determination.

The holdings in *Peterson* and *Kaiser* are distinguishable from our holding of nonliability for a third party's subsequent negligent acts in *Pratt v. Thomas,* 80 Wash.2d 117, 491 P.2d 1285 (1971). A cause in fact connection could be made in *Pratt;* "but for" leaving keys in a car, the car may not have been stolen. It was not reasonable, however, to assign responsibility to the car owner for the subsequent theft, reckless driving, and resultant accident. The car owner's duty/relationship to the person injured in the accident was simply too attenuated.

In summary, we have premised legal causation (liability) on the existence of some direct contact or special relationship between the defendant and the injured party. *See, e.g., J & B Dev. Co. v. King Cy., supra; Chambers-Castanes v. King Cy., supra; Campbell v. Bellevue, supra.* In the case of an injury caused directly by a third party, we have attributed legal causation on the basis of the relationship between the defendant and the third party. *Peterson v. State, supra; Kaiser v. Suburban Transp. Sys., supra.* In addition, we have recognized legal causation

> when legislation mandates protection of a "particular and circumscribed class of persons." *Halvorson v. Dahl, supra,* 89 Wash.2d at 676, 574 P.2d 1190.

Hartley v. State, 103 Wn.2d at 783-784.

The Supreme Court explained the very limited reach of *Peterson* and *Kaiser* long ago, noting that it only applies to situations where:

> . . . a public entity has a 'take charge' duty to control parolees [citing *Taggart v. State*, 118 Wn.2d 195, 822 P.2d 243 (1992)], mental patients, *Peterson v. State,* 100 Wn.2d 421, 428-29, 671 P.2d 230 (1983), and others it has authority to control, to the extent it has authority to control them. *See, e.g., Couch v. Dep't of Corrs.,* 113 Wn.App. 556, 571, 54 P.3d 197 (2002). And a public entity has a duty to protect foreseeable victims of criminals, mental patients, and others leaving its custody. *See Peterson,* 100 Wash.2d at 428-29, 671 P.2d 230. (other citations omitted)

Osborn v. Mason County, 157 Wn.2d 18, 24, 134 P.3d 197 (2006).

These cases are simply not applicable to a private psychiatrist or mental health provider and the potential dangers presented by his or her patient.

Peterson v. State likewise does not support imposition of a generalized duty to warn or protect third persons upon mental health providers. First, *Peterson v. State* is distinguishable on its facts from the instant case. Second, the duty of care announced in *Peterson v. State* (duty to "protect anyone who might foreseeably be endangered" by a patient) is no longer the applicable duty in Washington. Rather, just as in California

and numerous other states, the Washington legislature recognized the impossibly broad and ambiguous duty placed upon mental health care providers to "protect anyone who might foreseeably be endangered" by a patient, and therefore adopted a standard requiring a duty to protect only when "the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims." RCW 71.05.120.

Peterson v. State is distinguishable on its facts, and contrary to Appellants' position, does not stand for the proposition that a psychiatrist has a general duty to warn third parties if the psychiatrist believes that a patient poses a risk of danger to others. In *Peterson*, the plaintiff was injured by a patient of a state psychiatric hospital who had been released five days earlier. On these facts, the Court answered two questions:

> First, does a state hospital psychiatrist have a duty to seek additional confinement of a patient who remains potentially dangerous after initial hospitalization? Second, under the specific circumstances of this case, was Dr. Miller required, or even allowed, to disclose information about the violation by Knox of the conditions of his parole to the Superior Court or to Knox's probation officer?

Peterson v. State, 100 Wash. 2d at 425.

While the Court answered the first question affirmatively, that holding was "abrogated" with the adoption of RCW 71.05.120 (see below). As it relates to the second question, the Court rejected the

argument that the psychiatrist had a duty to warn others of the patient's potential dangerous propensities.

> "We agree with defendant that Dr. Miller was prohibited from disclosing information about the violation by Knox of the conditions of his parole to the Superior Court or to Knox's probation officer."

Peterson v. State, 100 Wash. 2d at 431-32.

According to the *Peterson* Court and consistent with the confidentiality statute examiner earlier herein, the psychiatrist was precluded by patient confidentiality provisions from warning others about the patient's dangerous propensities. *Id.* Similarly, Dr. Ashby is precluded by statute (RCW 71.02.050) from disclosing patient confidences absent more than a general concern that a patient may present a risk of danger to undefined third parties.

Peterson v. State simply does not stand for the broad proposition that a psychiatrist has a duty to warn anyone who might be foreseeably endangered by a patient. Rather, the Court merely held that a psychiatrist can be held liable for not protecting third parties from a dangerous patient by not seeking additional involuntary commitment. As set forth below, RCW 71.05.120 was enacted in response to *Peterson v. State* and provides Dr. Ashby with immunity from any claim that he should have involuntarily committed Mr. DeMeerleer. With respect to any assertion

that Dr. Ashby should have warned Ms. Schiering that Mr. DeMeerleer presented a risk of harm, Dr. Ashby, just like the psychiatrist in the *Peterson* case, was statutorily precluded from sharing any of Mr. DeMeerleer's health care information absent a reasonable belief that Ms. Schiering and her children were in "imminent danger." Appellants have not produced any evidence suggesting that Dr. Ashby had a reasonable belief that Ms. Schiering or her children were in "imminent danger."

In addition to being factually distinguishable, *Peterson v. State* is simply not the law in Washington regarding the disclosure of information by mental health providers. The practice of "Mental Health" is governed in part by RCW 71. The intent of that legislation is, in relevant part:

> (1) To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;
>
> (2) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders;
>
> (3) To safeguard individual rights;
>
> . . .
>
> (7) To protect the public safety.

RCW 71.05.010.

In a case involving professional mental health evaluation and the "duty to warn," the legislature has defined when a mental health provider can warn a third party:

> (1) No officer of a . . . private agency, nor the . . professional person in charge . . . or attending staff of such agency . . . shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, . . . administer antipsychotic medication, or detain a person for evaluation; PROVIDED, That such duties were performed in good faith and without gross negligence.
>
> (2) This section does not relieve a person from . . . the duty to warn or to take reasonable precautions to provide protection from violent behavior <u>where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims</u>.

RCW 71.05.120 *(emphasis added)*.

This statute has abrogated the holding of *Peterson v. State*. Former Justice Phillip Talmadge specifically noted this in his concurring opinion in *Hertog v. City of Seattle,* 138 Wn.2d 265, 293 n.7, 979 P.2d 400 (1999), stating: "the Legislature statutorily abrogated our holding in *Peterson* in Laws of 1987, ch. 212, § 301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State."

To fully understand the intent behind the legislature's adoption of RCW 71.05.120, and that statute's applicability to this case, it is important to look at the history of *Peterson v. State* and the duty the Court adopted

therein. The duty announced in *Peterson* was adopted from *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal.3d 425, 551 P.2d 334 (1976) which has since been abrogated by cases and statute. Subsequent to *Tarasoff*, California courts "limited the scope of the therapist's duty to readily identifiable victims." *Peterson*, 100 Wash.2d at 427-28. Then, in 1985, California adopted Assembly Bill 1133 (1985–1986 Reg. Sess.) in response to the concerns expressed in the *Tarasoff* dissent.

> The resulting statutory provision, section 43.92, was expressly not intended to overrule *Tarasoff* and its progeny, "but rather to limit the psychotherapists' liability for failure to warn to those circumstances where the patient has communicated an 'actual threat of violence against an identified victim [,]' " and to "'abolish the expansive rulings of *Tarasoff* and *Hedlund* ... that a therapist can be held liable for the mere failure to predict and warn of potential violence by his patient.'" (Assem. Com. on Judiciary, Analysis of Assem. Bill No. 1133 (1985 Reg. Sess.) May 14, 1985, p. 2.)

Ewing v. Northridge Hosp. Med. Ctr., 120 Cal. App. 4th 1289, 1300-01, 16 Cal. Rptr. 3d 591, 599 (2004). "Civil Code section 43.92 (section 43.92) immunizes psychotherapists from liability for failing to predict, warn of, or protect from a patient's violent behavior, unless the patient communicated to the psychotherapist a threat against an identifiable victim." *Greenberg v. Superior Court*, 172 Cal. App. 4th 1339, 1344, 92 Cal. Rptr. 3d 96, 99 (2009).

Similar to what occurred in California and after the Court's decision in *Peterson v. State*, the Washington Legislature amended RCW 71.05.120 ("Exemptions from Liability"), which provides immunity to mental health providers for intentional acts of their patients absent situations "where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims." The statute was amended in 1987 to include subsection (2), which as Justice Talmadge noted, has the practical effect of abrogating *Peterson v. State*. This Court previously held that under this statute mental health professionals are immune from tort liability in the performance of their duties unless they act in bad faith or with gross negligence. *Estate of Davis v. State Dept. of Corrections,* 127 Wash.App. 833, 840, 113 P.3d 487 (2005), citing *Spencer v. King County,* 39 Wash.App. 201, 205, 692 P.2d 874 (1984), *review denied,* 103 Wash.2d 1035 (1985), *overruled on other grounds by Frost v. City of Walla Walla,* 106 Wash.2d 669, 724 P.2d 1017 (1986).

California and Washington are not the only states to have adopted limitations on the third party liability of mental health care providers to those occasions when a patient makes an actual threat against a reasonably identifiable person. A review of how other states have responded to *Tarasoff* only clarifies the intent and purpose of RCW 71.05.120 to

abrogate *Peterson v. State*. The following is a sampling of how other states have statutorily limited the duty of mental health providers.

> There shall be no cause of action against a mental health provider nor shall legal liability be imposed for breaching a duty to prevent harm to a person caused by a patient, unless...: (1) The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

Ariz. Rev. Stat. Ann. §36-517.02 (emphasis added)

> (a) Except as provided in subsection (d) of this section, no cause of action shall lie against a mental health services provider, nor shall legal liability be imposed, for inability to prevent harm to person or property caused by a patient unless: (1) The patient has communicated to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly identified victim or victims, or to commit a specific violent act or to destroy property under circumstances which could easily lead to serious personal injury or death, and the patient has an apparent intent and ability to carry out the threat;

Del. Code Ann. tit. 16, §5402 (emphasis added)

> A mental health professional has a duty to warn a victim if a patient has communicated to the mental health professional an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat.

Idaho Code Ann. §6-1902 (emphasis added)

> (b) There shall be no liability on the part of, and no cause of action shall arise against, any person who is a physician, clinical psychologist, or qualified examiner based upon that

person's failure to warn of and protect from a recipient's threatened or actual violent behavior except where the recipient has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victiMs. Nothing in this Section shall relieve any employee or director of any residential mental health or developmental disabilities facility from any duty he may have to protect the residents of such a facility from any other resident.

IL ST CH 405 §5/6-103 (emphasis added)

(1) No monetary liability and no cause of action shall arise against any mental health professional for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior, unless the patient has communicated to the mental health professional an actual threat of physical violence against a clearly identified or reasonably identifiable victim, or unless the patient has communicated to the mental health professional an actual threat of some specific violent act.

Ky. Rev. Stat. Ann. §202A.400 (emphasis added)

(b) A cause of action or disciplinary action may not arise against any mental health care provider or administrator for failing to predict, warn of, or take precautions to provide protection from a patient's violent behavior unless the mental health care provider or administrator knew of the patient's propensity for violence and the patient indicated to the mental health care provider or administrator, by speech, conduct, or writing, of the patient's intention to inflict imminent physical injury upon a specified victim or group of victims.

Md. Code Ann., Cts. & Jud. Proc. §5-609 (emphasis added)

If a patient communicates to a mental health professional who is treating the patient a threat of physical violence against a reasonably identifiable third person and the recipient has the apparent intent and ability to carry out that

> threat in the foreseeable future, the mental health professional has a duty to take action as prescribed in subsection (2). Except as provided in this section, a mental health professional does not have a duty to warn a third person of a threat as described in this subsection or to protect the third person.

Mich. Comp. Laws Ann. §330.1946 (emphasis added)

> A mental health professional has a duty to warn of or take reasonable precautions to provide protection from violent behavior only if the patient has communicated to the mental health professional an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim.

Mont. Code Ann. §27-1-1102 (emphasis added)

> A physician licensed under this chapter has a duty to warn of, or to take reasonable precautions to provide protection from, a client's violent behavior when the client has communicated to such physician a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property.

N.H. Rev. Stat. Ann. §329:31 (emphasis added)

> A therapist has no duty to warn or take precautions to provide protection from any violent behavior of his client or patient, except when that client or patient communicated to the therapist an actual threat of physical violence against a clearly identified or reasonably identifiable victim. That duty shall be discharged if the therapist makes reasonable efforts to communicate the threat to the victim, and notifies a law enforcement officer or agency of the threat.

Utah Code Ann. §78B-3-502 (emphasis added)

Statutes from other states containing nearly identical language are identified at CP 145-151. As can be seen, the majority of states have adopted statutes limiting the duty of a mental health professional to protect others to situations when the patient communicates a specific threat of actual harm to a reasonably identifiable person. In states where no such statute exists, case law has almost universally either rejected *Tarasoff* and adopted the same standard contained in the above-identified statutes, or the cases have held that patient-therapist confidentiality statutes preclude a duty to warn absent a threat to a reasonably identifiable victim. *See, e.g., Emerich v. Philadelphia Ctr. for Human Dev.,* 554 Pa. 209, 720 A.2d 1032, 1035 (1998) (a duty to warn in this context exists "only where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a specifically identified or readily identifiable victim"); *Peck v. Counseling Serv. of Addison Cnty., Inc.*, 146 Vt. 61, 499 A.2d 422, 426 (1985) ("A mental patient's threat of serious harm to an identified victim is an appropriate circumstance under which the physician-patient privilege may be waived"); *Nasser v. Parker*, 249 Va. 172, 455 S.E.2d 502, 504 (1995) (rejecting *Tarasoff*); *Cole v. Taylor*, 301 N.W.2d 766, 768 (Iowa 1981) ("We have not adopted the rationale in *Tarasoff.*"); *Gregory v. Kilbride*, 150 N.C. App. 601, 565 S.E.2d 685, 692 (2002) ("Thus, unlike the holding in *Tarasoff,* North

Carolina does not recognize a psychiatrist's *duty to warn* third persons"); *Santana v. Rainbow Cleaners*, 969 A.2d 653, 666 (R.I. 2009) (finding the imposition of "a *Tarasoff*-type duty" unjust, and could "result in the overcommitment of patients as mental health professionals operated under the increased fear of potential liability"); *Bishop v. S. Carolina Dep't of Mental Health*, 331 S.C. 79, 502 S.E.2d 78, 82 (1998) ("if the Department [Mental Health] knew or should have known a specific threat was made by mother, the Department had a duty to warn the threatened third party of mother's release"); *Jacobs v. Taylor*, 190 Ga. App. 520, 379 S.E.2d 563 (1989) (Psychiatrists who treated mental patient cannot be held liable for failing to warn members of public of generalized threats made by patient during his treatment, and could not be held liable when patient killed two victims who were not acquainted with him); *Doe v. Marion*, 373 S.C. 390, 645 S.E.2d 245, 251 (2007) (summary dismissal affirmed because "[p]etitioner's claim fails to allege a specific threat against James Doe necessary to create a duty to warn").

Courts and legislatures have recognized the necessity of protecting physician-patient confidences, as well as the inability of providers to predict the future. The ambiguous nature of the duty announced in *Tarasoff* and adopted in *Peterson v. State* puts providers in the impossible position of trying to forecast when a patient may pose a risk of danger to

others such that the provider can and should violate the patient's confidences. This is especially true for mental health providers, who deal on a regular basis with patients whose mental conditions could potentially make them a risk to themselves or others. It is precisely because of this dilemma that so many states, including Washington, have abandoned the *Tarasoff* duty in favor of a bright line rule imposing a duty only when a specific threat of harm against an identifiable victim is made.

3. RCW 71.05.120 Defines The "Duty To Warn" Applicable To Mental Health Care Providers.

When a patient seeks mental health treatment, there is an expectation of privacy and confidentiality. It is both implicit and well understood that treatment cannot be fully developed and be successful unless the patient believes that his or her statements will remain confidential. Without the expectation of privacy and confidentiality, patients may well avoid confiding to their providers the full extent of their emotions, thoughts and impulses. The Washington legislature recognized this important public interest in enacting RCW 71.05.120 (and RCW 70.02.050), which protects the expectations of privacy and confidentiality. At the same time the statute provides protections to third persons should a patient express an actual threat of harm against a reasonably identifiable victim.

Here, Appellants seek to judicially abolish the provisions of RCW 71.05.120(2) by a hyper-technical argument that pigeon-holes the application of the statute to situations where the mental health treatment is provided *only through government providers and only in civil commitment hearings*. Appellants' arguments in this regard is unpersuasive.

The legislative intent supporting Chapter 71.05 RCW is in part "to protect the public safety." RCW 71.05.010(7). Nothing within that chapter limits application to state agencies. In fact, the language of RCW 71.05.120 makes it applicable to "private" agencies and staff of private agencies. Further, Appellants' argument in this regard is contrary to *Poletti v. Overlake Hosp. Med. Ctr.*, 175 Wash. App. 828, 303 P.3d 1079 (2013), in which Division 1 held that RCW 71.05.120 applied to Overlake Hospital's decision to discharge a patient without first obtaining an evaluation by a county mental health professional. In that case, Overlake Hospital discharged a bi-polar patient (Sherri Poletti) who had earlier been voluntarily admitted to the psychiatric unit. After Ms. Poletti was discharged, she died in a single-car accident. Her estate brought suit against Overlake Hospital, alleging negligence based upon the hospital's failure to get an in-person evaluation by a county designated mental health professional prior to discharge. The Court of Appeals held that "Overlake's decision to discharge the patient implicated the involuntary treatment act,

chapter 71.05 RCW, and the hospital cannot be liable if the decision was made in good faith and without gross negligence." *Poletti*, 175 Wash. App. at 830-831. Pursuant to the language of RCW 71.05 and *Poletti*, RCW 71.05.120 applies to non-state actors.

Similarly, Appellants' argument that RCW 71.05.120 is limited to "the civil mental health commitment process" is unpersuasive because, as evidenced by the present case, Appellants' interpretation of RCW 71.05.120 is too narrow. Appellants' contention Dr. Ashby did not perform an adequate risk assessment and did not properly "monitor" Mr. DeMeerleer just begs the question of what actions Dr. Ashby could have taken if, as Dr. Knoll speculates, a "more proper and/or formal risk assessment" had revealed that Mr. DeMeerleer was experiencing homicidal ideations. Dr. Ashby's only options in such a situation, as it relates to any duty owed to a third person, would be to (1) have Mr. DeMeerleer involuntarily committed; or (2) warn anyone who may be the identifiable victim of Mr. DeMeerleer's homicidal ideations.[2] Any decision Dr. Ashby would have made as it relates to whether or not to

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[2] While Dr. Knoll opines that Dr. Ashby should have more thoroughly "assessed" and "monitored" Mr. DeMeerleer, he ultimately concludes that had Dr. Ashby performed these tasks then he would have discovered Mr. DeMeerleer's alleged homicidal ideations and either had Mr. DeMeerleer committed or taken action to warn Ms. Schiering. CP 90.

have Mr. DeMeerleer involuntarily committed makes RCW 71.05.120 directly applicable.

Appellants' argument that RCW 71.05.120 is not applicable to this case was rejected by this Court in *Estate of Davis v. State Dep't of Corr., supra.* In that case, a Stevens County mental health provider (Jones) evaluated an individual (Erickson) on community supervision to determine whether Erickson would benefit from counseling. After the initial assessment, Erickson brutally murdered a third party (Davis). Davis' estate sued Stevens County, alleging that the Jones's assessment of Erickson was negligent. Stevens County moved for summary judgment based upon RCW 71.05.120. The estate argued that RCW 71.05.120 did "not apply because Mr. Jones was not making an assessment under this chapter." *Estate of Davis*, 127 Wash.App. at 840. The Court of Appeals disagreed:

> Mr. Jones testified he was not making an assessment under this chapter. The estate's amended complaint, however, alleges Mr. Jones evaluated Mr. Erickson for the purpose of providing mental health assistance and supervision. The complaint then alleges Mr. Jones failed to provide assistance or take any action, despite the need to do so. To the extent the estate alleged Mr. Jones was liable because he failed to detain Mr. Erickson, the immunity provision of RCW 71.05.120 applies because the only authority for him to detain Mr. Erickson was under chapter 71.05 RCW.

Estate of Davis, 127 Wash.App. at 840-841.

To the extent Appellants allege that Dr. Ashby should have had Mr. DeMeerleer involuntarily committed,[3] the case falls squarely within RCW 71.05 and provides Dr. Ashby with immunity from Appellants' claims.[4]

The second section of RCW 71.05.120 goes on to state that the statute does not relieve a health care provider from the duty to "warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims." There is no language contained in this provision limiting its application to health care provided in connection with civil commitment proceedings. Rather, it simply clarifies Washington's "duty to warn" and that RCW 71.05.120 should not be interpreted as limiting that duty.

In an effort to avoid the application of RCW 71.05.120, Appellants misread other precedent. At pp. 22-23 of their *Appeal Brief,* Appellants insist that the case *Tobis v. State of Washington,* 52 Wn.App. 150, 758 P.2d 534 (1988) somehow isolates RCW 71.05.120 only to mental health

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[3] Dr. Knoll suggests that absent the "breaches," Mr. DeMeerleer could have been admitted for "intensive clinical or institutional psychiatric treatment." CP 90.

[4] Immunity is lost under RCW 71.05.120 only upon a showing of bad faith or gross negligence. Appellants have alleged neither.

commitment procedures under Chapter 71.05 RCW. Yet the *Tobis* language quoted by Appellants merely shows that Division I of the Court of Appeals would not extend RCW 71.05.120 to overrule or otherwise control a statutory immunity that is provided to mental health professionals appointed directly by the court under Chapter 10.77 RCW, reasoning that under RCW 10.77 the court ultimately makes its own decision concerning the detained defendant after taking the evaluation from the mental health professional under advisement. Therefore, statutory/judicial immunity is provided to that professional. *Tobis v. State of Washington,* 52 Wn.App. at 158-159. The *Tobis* case did not limit RCW 71.05.120 to mental health commitment procedures only.

Likewise, Appellants rely upon *dicta* from a concurring opinion by Justice Talmadge in *Hertog v. City of Seattle,* 138 Wn.2d 265, 293 n. 7, 979 P.2d 400 (1999). This *dicta* has never been cited. Fleshing out Justice Talmadge's concerns, the concurring opinion concludes:

> The majority correctly applies the law, but the Legislature should take this opportunity to examine issues of pre-trial release, probation and post-conviction community supervision to strike the appropriate balance among public safety, liability, and the public policy behind such programs if it wishes those programs to continue at all.

Hertog v. City of Seattle, 138 Wn.2d at 294.

Hertog involved a claim that a probation officer had negligently supervised a violent probationer who attacked a child. In that case the Court found that the City and its probation counselors had a duty to control municipal court probationers to protect others from reasonably foreseeable harm, including a duty to report violations of conditions of probation to the court. *Hertog* had nothing to do with the relationship between a private psychiatric patient and his doctor or the policy reasons supporting immunity for the subsequent actions of the patient in the absence of clear, specific warnings to the doctor of imminent threat to identifiable persons. The distinct line of cases to which *Hertog*, *Taggart* and their progeny apply was recognized in *Sheikh v. Choe,* 156 Wn.2d 441, 449-51, 128 P.3d 574 (2006). *Sheikh* involved a "take charge special relationship" between the defendant and the actor, whether a prisoner, probationer or parolee, and the statutory duty of the officer to ensure that the actor complied with pre-release, parole or probation conditions. Appellants cannot cite any statute or other authority which would require Dr. Ashby to "take charge" of Mr. DeMeerleer in the same vein as the *Hertog* and *Taggart* line of cases. Under *Hartley v. State, supra,* the path to liability in *Peterson* and *Kaiser* is inapplicable in a case such as this.

C. The Loss of Chance Doctrine Is Inapplicable To This Case And Does Not Replace The "But For" Causation Requirement.

Unable to establish that "but for" the alleged breaches of the standard of care by Dr. Ashby the murders would not have occurred, Appellants argued the case presented an "avenue of recovery" pursuant to the "loss of chance" doctrine. In support of that idea Appellants relied upon Dr. Knoll's conclusion that the alleged breaches were a "causal and substantial factor" in contributing to and in bringing about loss of chance "that the Incident and resulting harm wouldn't have occurred." CP 91, ¶14. Where plaintiff asserts the injury is death due to negligence and life without negligence, there is no avoiding traditional tort law principles, including "but for" causation. *Estate of Dormaier ex rel. Dormaier v. Columbia Basin Anesthesia, P.L.L.C.*, 30864-2-III, 2013 WL 6037098, 6 (Wash. Ct. App. Nov. 14, 2013).

In *Herskovits v. Group Health Coop. of Puget Sound,* 99 Wn.2d 609, 664 P.2d 474 (1983), a doctor negligently failed to diagnose the plaintiff's lung cancer, depriving the patient of a chance to pursue therapy that might have extended his life; however, even with timely diagnosis the patient was likely to die from his cancer. *Herskovits*, 99 Wn.2d at 612. A Supreme Court plurality allowed recovery on an injury based on *statistical* evidence that the negligence caused a reduction in the possibility of a 5–

year survival from 39 percent to 25 percent. *Id.* Here, Appellants presented the all or nothing claim of life versus death due to violation of the Standard of Care and no statistics are offered, likely because the claimed injury is not amenable to quantifiable loss of chances.

Similarly, in *Mohr v. Grantham,* 172 Wn.2d 844, 262 P.3d 490 (2011) (also cited by Appellants) the plaintiffs presented *statistical* evidence that "but for" the alleged negligence of the defendant, the plaintiff would have had a 50% to 60% chance of a better outcome. *Mohr,* 172 Wn.2d at 860. In this case Dr. Knoll presented only speculation on what might have been revealed had Mr. DeMeerleer been institutionalized, drugged or both; not a "statistically demonstrable loss." See *Herskovits v. Group Health Cooperative,* 99 Wn.2d at 634 (Pearson, J., concurring). Where *Herskovits* and *Mohr* involved testimony of "probable" diminution in the patient's chances, Dr. Knoll's testimony never offers the "more probable than not testimony" of a different outcome.

The loss of a chance of a better outcome is a compensable injury, but the requirement of establishing "but for" causation is not abrogated. *Herskovits v. Group Health Coop.*, 99 Wn.2d 609, 632-32, 634-35, 262 P.2d 474 (1983); *Mohr v. Grantham*, 172 Wn.2d 844, 857, 262 P.3d 490 (2011); *Estate of Dormaier ex rel. Dormaier v. Columbia Basin Anesthesia, P.L.L.C.*, at 6. "Under this formulation, a plaintiff bears the

burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome." *Mohr v. Grantham*, 172 Wash. 2d 844, 857, 262 P.3d 490, 496 (2011); *See also*, *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wash. App. 155, 166, 194 P.3d 274, 279 (2008) ("Because Ms. Rounds fails to make out a prima facie case on causation, we do not need to discuss if her loss of chance theory applies on the issue of damages"). In *Mohr v. Grantham* the plaintiffs were allowed to pursue a claim for "loss of a chance" at a better statistical outcome with expert testimony that hospitalizing Mrs. Mohr would have significantly lessened the severity of her stroke because of the availability of immediate care as symptoms manifested. Here, there were no facts established between April 16, 2010 and July 18, 2010 that Mr. DeMeerleer had any intention of committing the assaults in question. Appellants fail to present evidence – statistical or otherwise – that there was an opportunity lost given the facts presented in the record.

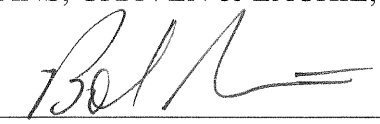
Appellants' logic in applying the "loss of chance" theory to this case is that Ms. Schiering and her children would have sustained the injuries in question (death and bodily harm) even in the absence of any alleged negligence, and that compliance with the standard of care would have prevented harm secondary to a warning of DeMeerleer's commitment.

V. Conclusion

Based upon the foregoing arguments and authorities, and the record presented to the Trial Court, Respondent Dr. Howard Ashby respectfully submits that the Trial Court was correct in granting Dr. Ashby's motion for summary judgment to dismiss all of the Plaintiffs'/ Appellants' claims against him in this case. Therefore, Dr. Ashby submits that the Trial Court Order dated June 21, 2013, should be affirmed.

DATED this 11th day of December, 2013.

EVANS, CRAVEN & LACKIE, P.S.



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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that on December 12th, 2013, I caused to be delivered to the address below a true and correct copy of Brief of Respondent Dr. Howard Ashby:

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DATED this 12th day of December, 2013.

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