NO. 332012

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

ESTATE OF VIOLA WILLIAMS,

Appellant,

v.

LOURDES HEALTH NETWORK, ET AL.

Respondents,

Appeal from the Superior Court of Washington
for Benton County
(Cause No. 14-2-00129-5)

BRIEF OF APPELLANT

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I. INTRODUCTION

This case arises from the brutal murder of 87-year old Viola Williams. Viola was killed by her grandson Adam, a paranoid schizophrenic, on a Less Restricted Alternative (LRA) from Eastern State Hospital where he had been involuntarily committed for severe mental health problems and violent behavior. Respondent Lourdes Health Network ("Lourdes") was charged with monitoring Adam's compliance with his court-ordered release, and Respondents Benton and Franklin Counties' Crisis Unit (the "County" or "Crisis Unit") had the power to detain Adam for violating the conditions of his LRA. Over the course of a ten-month period, Lourdes learned that Adam violated every condition of his LRA – using street drugs, avoiding treatment, declining to take his psychiatric medications. Meanwhile, Adam's condition was deteriorating rapidly. Despite a statutory duty requiring disclosure to the County, Lourdes shared precious little of this information with the Crisis Unit. Still, what the County did know was significant enough to warrant Adam's detention; it had notice of Adam's drug use, his violent history, his sexual aggression toward female clinical staff. Regrettably, neither Lourdes nor the County took reasonable precautions to protect the community from harm despite having the duty to do so; instead

Respondents left Adam to fend for himself and engage in treatment on his terms, rather than the terms of his release.

The court below erred in granting summary judgment to Respondents. First, as to Lourdes, the court applied the wrong standard in defining the duty as one of mere caring and "contact," rather than a duty to take reasonable precautions to prevent foreseeable harm. Next, with respect to both Lourdes and the County, the court decided questions of fact for itself and made implicit credibility determinations that only a jury can resolve. Finally, the court erred in striking the declaration of Plaintiff-Appellant's psychiatrist who supported the causal connection between Respondents' failure to act, and Viola's death. Plaintiff-Appellant respectfully requests that this Court reverse the decision below, and remand this matter for trial.

II. ASSIGNMENT OF ERROR

No. 1 ~ The trial court erred by in granting Defendant-Respondent Lourdes' motion for summary judgment where issues of material fact existed on whether Lourdes breached its duty of care in failing to recommend to the County that Adam's Less Restrictive Alternative (LRA) be revoked once he posed an obvious and substantial risk of harm to others.

No. 2 ~ The trial court erred in granting Defendant-Respondent County's motion for summary judgment when issues of material fact existed on whether the County should have revoked Adam's LRA.

No. 3 ~ The trial court erred in striking the declaration of Plaintiff-Appellant's psychiatric expert, Dr. Matthew Layton.

III. STATEMENT OF THE CASE

A. Lourdes Assumed Care For Adam During His Release From Involuntary Commitment To A Mental Hospital

Adam Williams suffers from paranoid schizophrenia and has a history of methamphetamine and other drug abuse. CP 198-201. He has an extensive criminal history, including felony and domestic violence convictions. *Id.* Following an assault on a health care worker in 2005, Adam was found not guilty by reason of insanity and involuntarily detained at Eastern State Hospital for the maximum time of five years. CP 203-204. Even after the five years of inpatient treatment had elapsed, doctors at Eastern State did not believe that it was safe for Adam to be in the community except in a highly structured environment. CP 206-210. Prior to the expiration of the five-year commitment, ESH doctors petitioned the court to have Adam involuntarily civilly committed. CP 212-219. According to Eastern State doctors, Adam had a history of becoming so ill outside a structured environment that he could hurt people without warning. *Id.* The court agreed and ordered that Adam be detained.

On March 11, 2011, the court agreed to release Adam into the community, but only under the strict supervision of a community mental health care provider. CP 221-225. Lourdes assumed the responsibility for monitoring Adam's compliance with the conditions of his release, and the Court released Adam into the Tri-Cities community under Lourdes' care. *Id.*[1] Even before Lourdes assumed responsibility for Adam's supervision, it was aware of the danger that Adam posed. CP 231. When explaining her decision to take charge of Adam, Lourdes' team leader had to convince her colleagues it was a good idea, stating in an email, "Before you make a huge gasp, hear me out...." *Id.*

The court ordered strict compliance with the conditions of Adam's release (or "LRA"), including that he take his medications as prescribed, abstain from drugs and alcohol, and fully cooperate with Lourdes' recommendations. CP 221-225.

As detailed below, Adam violated every one of the conditions of his LRA multiple times, becoming increasingly ill and spiraling out of control. But rather than report this to the court (and return Adam to Eastern State), Lourdes and the County sat idly by, doing little more than making contact with Adam on Adam's terms, and obtaining extensions of

[1] Lourdes' interdisciplinary Program for Assertive Community Treatment ("PACT") team is designed to provide intensive services in the community to chronically mentally ill people. CP 227. The team is comprised of a case manager, a medication prescriber, nurses, a chemical dependency specialist and a vocational specialist. CP 228-229.

his release.[2] This repeated failure to act had tragic consequences for Adam and his family; ten months into his LRA, Adam brutally murdered his grandmother in a psychotic episode. CP 248-257.

B. Lourdes Was On Notice of Adam's Non-Compliance With His LRA Almost Immediately Upon His Release From The Hospital In March 2011

Adam began violating the court's order shortly after his release from Eastern State Hospital. He regularly failed to take his medications and failed to show up for required lab tests. CP 259-276. Rather than report Adam's violations of the LRA as required by state law,[3] Lourdes' PACT team viewed Adam's compliance with the court-ordered conditions as voluntary:

> Q. With regard to -- well, once you have indicated to someone that he is appropriate for your program, what steps do you take at the beginning of your work with a particular client?
> A. Well, they have to see me first, and then I do the initial intake. And so mine is a psychiatric evaluation for 60 minutes, and then make a plan of if they have money and where their money is going to come from or their medications and order those, get them all set up.
> **And usually the person has to agree, really, to be seen three to four times a week. It's an intensive program and it's a voluntary program.**

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[2] Respondents Lourdes and the County twice petitioned the court for extensions of the LRA in lieu of involuntary commitment. CP 233-246, CP 248-257.

[3] As discussed below, Lourdes had an express duty to notify the County's designated mental health professional when Adam violated the terms of his LRA. RCW 71.05.340(2)(b) (facility "shall" notify the designated mental health professional when a conditionally released person "fails to adhere to terms and conditions of his or her conditional release or experiences substantial deterioration in his or her condition...").

CP 279 at 21:18-22:5.

> Q. If you don't graduate, essentially, successfully and you don't stay on there for life, what are the other kind of chunks of categories of why people are no longer on a PACT?
> A. **Well, it's a voluntary program**. I've had patients not want to be monitored as often or they use, maybe are into something that they don't want us to know about so they say I don't want to be on your team anymore.
> Q. So they voluntarily withdraw themselves?
> A. Yes.

CP 280 at 30:17-31:1.

> Q. Okay, tell us the other people that would have been specific to his team.
> A. And then he's assigned a nurse, who is Teresa Chandler; our peer specialist, James Fisk, he is involved in that; and our chemical dependency person sees anyone who has chemical dependency issues, **if the person is willing to see that person, and if they're willing to see the peer specialist as well. It's voluntary, so they don't have to see that person, I suppose**.

CP 281 at 36:18-25.

> Q. Okay, did you have the ability to ensure that he took his, or that he underwent regular urinalysis?
> A. I could write a standing order.
> Q. Did you ever write a standing order?
> A. No.
> Q. Why not?
> A. **I could only answer that on the fact that this being a voluntary program and my ability to attempt to build rapport with a patient is very important** because if you do not, in my experience, the patient says, I'm not being a part of this program and then he would be on the streets in no program and not have the intensity of the PACT team.

CP 283 at 42:20-43:7.

> A. Meaning, for example, if I get a referral, when somebody has been discharged from this hospital and they go home or go somewhere, I might meet with them initially to make sure they know the intensity of the program and make sure they understand so I don't do an entire intake and then two days later they say, oh, gosh, I don't want to be in there, I don't want somebody coming over every day. **Then I might say it's not going to work out because it's a voluntary program, I want them to be involved.**

CP 284 at 48:22-49:6.

> A. We, during our treatment plan process, we, the clients come in if they want to come in, and we ask if they would like to invite any of their supports, any of their family or friends, so that they're also involved in the treatment plan process. **Again, that's voluntary, that's if the client wants that to happen**.

CP 291 at 34:16-21.

> Q. Okay, and what do you recall were his strengths and his weaknesses in terms of your view of accepting him into the program?
> A. As far as his strengths, with accepting him into the program, we felt that he had had time to be stable in regards to his mental illness and taking medications while he was at Eastern. **He agreed to join the PACT team on a voluntary basis.**

CP 292 at 52:18-25.

Adam also began abusing street drugs in violation of his court-ordered release. On June 14, 2011, Adam was ordered to submit to a urinalysis as part of the community supervision he was under in

connection with a different felony altogether.[4] The test came back positive for opiates, oxycodone and marijuana. CP 294.[5]

In further violation of the LRA, Adam did not participate in required chemical dependency treatment. CP 298-303. Lourdes' chemical dependency case worker, Suzanne Kieffer, explained that Adam avoided her and was not interested in treatment. At deposition, Ms. Kieffer testified:

> . . . that was most of my dealings with him, was trying to engage him in treatment.
> . . . .
> I had a chemical dependency group that I conduct at our office every Thursday, and I tried to engage him in coming and he did maybe two or three times, I think.
>
> He always stated to me that he didn't have a problem with drugs. So that was my first start with him. He was very, he didn't, most people don't want to see me. They just don't, that's the bottom line.
> . . . .
> *So Adam avoided me quite often, and so all I can do is keep engaging, try to engage him, which I did.* There was several times that I was asked to specifically go out to see him because we knew he was using, and of those times that I did engage with him, again, he didn't want to see me, so they weren't very inviting times for me and him.

CP 307-308 at 20:19-20; 20:22-25; 21:1-4; 21:8-14 (emphasis added). Again, Lourdes viewed Adam's engagement in treatment as a voluntary

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[4] Adam was on community supervision by the Department of Corrections as a result of his commission of a felony that occurred prior to his Eastern State Hospital commitment. The community supervision maximum time expired October 2011.

[5] Lourdes' PACT team had access to this information, but did not bother to get it. CP 296

choice, rather than a court-ordered condition of release. CP 306 at 13:18-22. Ms. Keiffer, like other PACT team members, should have and failed to request a revocation of his LRA.

The PACT team attempted to, but could not locate Adam from July 19 to July 31, 2011 (CP 310-313), but still they did not notify the County's Crisis Unit or ask that his LRA be revoked. On July 31, 2011, Adam contacted his father, Steve Williams. CP 315. Adam was actively psychotic, had not taken his medication in a week, and had been using methamphetamine. CP 317-337. Steve Williams took Adam to Kadlec Medical Hospital. CP 315. His potassium levels were dangerously low, the result of methamphetamine use. CP 317-337. The hospital called the County Crisis Unit and explained they were beginning their work-up. CP 339. The hospital staff asked the County to evaluate Adam. CP 342 at 20:24-21:1.

In turn, the County called Lourdes. CP 339. Lourdes' PACT team members reported that they were relieved to find Adam as they did not know where he was. *Id.* Ms. Keiffer, the PACT member on duty, went to the hospital to see Adam. However, she left the hospital explaining in her PACT record, "Due to [Adam's] violent behavior, I would not even attempt to detain him, transport him or be in the same room with him ...." CP 315. She did not, nor did anyone else at Lourdes, contact the County

or recommend that the County revoke Adam's LRA. The nurse practitioner assigned to the case, Michelle Aronow, did not request that Adam's LRA be revoked or that Adam be evaluated for revocation.[6] CP 283 at 43:19-44:7.

If a case manager on Lourdes' PACT team recommends revocation, the the County does not exercise discretion, it automatically detains the individual and awaits a court hearing. CP 349 at 14:24-25; CP 358 at 16:6-15; CP 359 at 17:23-18:5. CRU employees explained in their depositions that if PACT requests revocation, they automatically detain the individual for a five day period pending a court hearing. CP 354 at 48:7-8; CP 362 at 20:16-23. PACT team member Monyay Green confirmed that "there was an understanding" that the County would revoke if the PACT team requested it. CP 365 at 48:5-15. Remarkably and regrettably, no PACT team member made this recommendation.

C. As of August 2011, The County Was On Notice Of Adam's Non-Compliance With The LRA, But Failed To Act

Five months into Adam's LRA, on August 1, 2011, Cameron Fordmeir, the designated mental health professional from the County's Crisis Unit traveled to Kadlec Medical Center to evaluate Adam. CP 367-373. Mr. Fordmeir said that he read the case notes in Adam's file prior to

[6] In litigation, Nurse Aronow suggested that she failed to act because she assumed the court would not have enforced its own order. CP 283.

conducting the evaluation. CP 343 at 21:7-14; 22:25-24:5; CP 344-345 at 52:3-53:21. These consisted of the County's own notes dating back years showing that Adam had a history of non-compliance with medication and repeated drug abuse, and resulting in serious risk of violence to others:

> ... He also has an **extensive history of drug abuse**: alcohol, cocaine, LSD, mescaline, Psilocybin mushrooms, inhalants, marijuana, methamphetamines, nicotine, caffeine, over-the-counter medications and prescription medications (Ritalin). Mr. Williams has been diagnosed as being Schizophrenic, Paranoid type by medical personnel in Monroe (paranoia, grandiose delusions, depression, disorientation, mumbling & laughing to himself, are evident). He is currently on involuntary medications due to a history of non-compliance.... He poses a high risk to victimize his parents and is 'likely to be a threat to others' per the report of Dr. Jewitt, MD, at Monroe. He has poor insight into his mental disorder and his judgement is impaired. When upset, he becomes verbally abusive and threatening to others. **When off his medication, Mr. Williams can become violent.** While incarcerated, he has received a number of infractions.

CP 375 (emphasis in original).

Applying the wrong standard for revoking the release, Mr. Fordmeir did not detain Adam. Instead, Adam was released from Kaldec Hospital back into the community.[7]

[7] Mr. Fordmeir believed that Adam did not meet the initial criteria for detention under the Involuntary Treatment Act. CP 367-373. However, Mr. Fordmeir failed to recognize that Adam need not meet the criteria for involuntary commitment because he had already been conditionally released on an LRA, based on a finding that he met the criteria for involuntary commitment. CP 221-225; CP 233-243; CP 248-257.

D. Lourdes Fails To Act While Adam Repeatedly Violates The Conditions Of His Release

Adam's compliance with medication initially improved after his release from Kadlac Hospital in August 2011. In mid to late September however, he began to miss doses again and had missed several doses by October 3, 2011. CP 377-381.

At Adam's request, on October 6, 2011, Lourdes' Nurse Aronow prescribed Concerta, a stimulant that, like methamphetamine, contains methylphenidate. CP 385-386. On November 23, 2011, Adam admitted that he abused the Concerta, taking a month's supply in the first week. CP 388-390. He also admitted to flushing his other medications down the toilet. CP 392. Nurse Aronow then took Adam off the Concerta.

At the same time, Aronow removed Adam from his anti-psychotic medication, Clozaril. CP 388-390. Clozaril is a major anti-psychotic medication that had stabilized Adam for years.

> Q. Was there anything in his labs that indicated that he needed to be removed from Clozaril?
> A. No.
> Q. So the decision to remove him from Clozaril was that he wasn't taking it routinely?
> A. Yes.

CP 286 at 64:20-25.

Adam's behavior became increasingly erratic and unpredictable. CP 410-417. On October 14, 2011, "he recounted riding the bus and using

his telepathy to determine another passenger wanted him sexually." CP 383. By December 16, 2011, he was sexually preoccupied and delusional, and had made inappropriate sexual advances to a PACT staff member, who he tried to touch several times. CP 419-420.

Lourdes' expert witness, Dr. Vandenbelt, acknowledged that starting in mid-December, Adam was decompensating, and becoming increasingly more sexually preoccupied. ("There was a progressive concern about Adam's behavior and condition.") CP 424 at 48:7-9.

On December 27, 2011, Adam attempted to grope another nurse on the PACT team, Teresa Chandler, RN. CP 426-427. When Nurse Chandler tried to give him his medication dose, he became sexually inappropriate. *Id.* He ran his hands on Nurse Chandler's back and arm. When she told him to stop, he tried to grope her breast. *Id.* Nurse Chandler was so disturbed by Adam's behavior she went back to the PACT office and wrote in their daily log, "Needs revoked." CP 429.

Rather than call the County Crisis Unit and ask for an evaluation or a revocation, Nurse Aronow "talked" to Adam about his behavior. CP 431-432. According to Nurse Aronow, "he initially denied it ..." and then later explained that "he should be able to express his feelings." *Id.* Nurse Aronow explained in her note that if Adam's sexually inappropriate behavior continues, "he may need to be assigned to male staff only." *Id.*

A day later, on December 29, 2011, PACT team members warned female service providers from other agencies not to be alone with Adam. Caseworker Linda Schroeder, "suggested [a female caseworker from another agency] meet with him in a public place with people around and avoid being alone in a car with him." CP 434.

Community members were also concerned about Adam's erratic behavior and reported the behavior to PACT team members. On January 2, 2012, Adam's landlord called Lourdes' PACT offices and explained that Adam was aggressive, was not sleeping and she was concerned that he wasn't taking his medication. CP 436-437.

> The last couple of weeks [Adam] has been getting in guy's faces and being aggressive and throwing his arms out, 'What's up bitch, you want to go at it?' She said he has also been going up to people's doors, knocking on them and running away.

Id. Still, the PACT team did not call the County to report Adam's behavior.

On January 5, 2012, Nurse Aronow noted that Adam continued to be sexually preoccupied, and was looking more disheveled. CP 439-440. She merely told him that, if he continued to make sexual advances to staff, she would call the County. *Id.*

On January 6, 2012, when PACT team member Cynthia Wallace, met with Adam, he spent the session leering at her. CP 442-443. He

explained, "I need a woman, I love methamphetamines and I am an instrument of God." *Id.* He also expressed paranoid delusions about his grandmother, Viola Williams, and his father:

> **CURRENT PROBLEMS/PROGRESS TOWARD TREATMENT OBJECTIVES/INTERVENTIONS:** MHP MET WITH ADAM IN THE OFFICE. HE WAS WELL GROOMED AND DRESSED APPROPRIATELY FOR THE WEATHER. HE SPENT THE ENTIRE SESSION LEERING AT MHP. ADAM REPORTED MEDICATION COMPLIANCE. HE REPORTED ADEQUATE SLEEP AND APPETITE. ADAM STATED I KNOW 3 THINGS ABOUT MYSELF, "I NEED A WOMEN, I LOVE METH AMPHETIMINES AND I AM AN INSTRUMENT OF GOD." MHP ATTEMPTED TO DISCUSS FILTERING HIS THOUGHTS AND BEHAVIORS AS A WAY TO AVOID CONFLICTS. ADAM WOULD NOT DISCUSS THIS. HE REPORTED THAT "MY GRANDMA IS PART OF A PLOT AGAINST ME." ADAM WENT ON TO DESCRIBE HOW SHE IS PART OF A CONSPIRACY TO DO HIM HARM. MHP CHALLENGED HIM ON THIS, ASKING HIM TO PROVIDE EVIDENCE. HE HAD NON BUT REMAINS CONVIENCED. ADAM ALSO REPORTED THAT HE IS NOT GETTING ALONG WITH HIS DAD, "I HATE HIM." MHP REFLECTED THAT HIS DAD HAS BEEN HIS BIGGEST SUPPORT SINCE HE WAS RELEASED FROM ESH. ADAM WAS NOT OPEN TO THIS. ADAM DENIED USING DRUGS. MHP DISCUSSED ADAM SEEING A MALE MHP NEXT WEEK. ADAM WAS NOT OPEN TO THIS. HE DID FINALLY AGREE TO SEE MALE MHP AT LEAST ONE TIME.
>
> **PLANNED INTERVENTIONS/STRATEGIES:** ADAM WILL CONTINUE MEDICATION COMPLIANCE. ADAM WILL SEE MALE MHP NEXT WEEK.

Id.[8]. Despite these alarming indications that Adam was dangerously mentally ill, the PACT team did not contact the County but, instead, decided to transfer Adam from Ms. Wallace's caseload to that of a male staff member. *Id.*

According to plaintiff's expert, Dr. Matthew Layton, the PACT team should have requested revocation no later than January 6, 2012. Adam's "paranoid delusions and his erratic behavior in meeting with Cynthia Wallace" showed that he was "so decompensated, he needed to be in the hospital." CP 400 at 67:18:21.

[8] PACT's expert psychiatrist testified this was the date by which Williams should have been revoked. CP 400 at 67:9-25.

On January 11, 2012, Adam met with PACT vocational specialist Linda Schroeder and James Bischoff from the Department of Vocational Rehabilitation. CP 445-446. At that meeting, Adam was described as paranoid and hostile. *Id.* Indeed, Mr. Bischoff escorted Adam out of the building. CP 448.[9]

On January 16, 2012, Lourdes' Nurse Teresa Chandler sent an email to her team leaders begging that they revoke Adam's LRA, explaining that she was afraid for her own safety. CP 450. She wrote, "How long are we going to let this go on before we revoke him?" *Id.*

> Adam came in this morning to get his check and I was supposed to fill his med box, Adam had the excuse that his med box "dropped on the ground and shattered. 'My Meds went all over the place. I had to throw them away.' I called him this morning to remind him to bring his med. box. He is obviously not taking them. He has been getting odder every day. Today he looked horrible. Disheveled, smelly, and Linda said he smelled like Alcohol. He became very agitated when I pointed out it was obvious he's not taking his medications and hasn't been for quite some time ... **How long are we going to let this go before we revoke him? I thought early detection and intervention was our goal. He's getting so much worse.** I don't see the point of having him come in to fill his med box, and if he's drinking maybe he shouldn't even get an injection. I don't want to be anywhere in a room alone with him. Help ... Teresa.

[9] Inexplicably, Ms. Schroeder gave Adam a ride home from the meeting. CP 445-446. Mr. Bischoff was so concerned for Ms. Schroeder's safety that he asked her to call him after she dropped Adam off to make sure she was safe. *Id.*

On January 18, 2012, Ms. Schroeder drove Adam to an appointment with Nurse Aronow. On the ride, Adam asked Ms. Schroeder if she and her husband "are getting it on." CP 452-453. He admitted that he did not regularly take his medication and said he had not eaten in three days. He was disheveled, dirty and delusional. *Id.*

That same day, Adam met with Nurse Aronow. CP 455-457. In her notes, she documented that he was actively delusional, and admitted to not taking his medications. *Id.* Ms. Aronow once again stated that if his behavior continued, she would call CRU; in her chart notes, she expressed her belief that CRU, "are the ones to make the decision whether to put him back in the hospital." *Id.*

After Adam left on January 18, 2012, Ms. Aronow finally called CRU and spoke to Designated Mental Health Provider (DMHP) Kathleen Laws. What Ms. Aronow said is in dispute. According to Ms. Laws,

> Michelle [Aronow] from PACT Team called about [Adam] who 'reporting isn't taking meds as RX (on LRA). Michelle was supposed to have an appointment with [Adam] today but is home due to snow related closures (D's school). Michelle said there are no known imminent danger issues at this time. PACT will monitor and contact CRU – PRN [i.e., "pro re nata," or "as needed"].

CP89.

According to Nurse Aronow, she called Ms. Laws and related her concerns that Adam was making "sexualized comments," not taking his

medication, and taking methamphetamines as evidenced by his "tweeking." CP 459. Still, Nurse Aronow decided that because Adam had been given his medications, the weather was bad and the County's Crisis Unit was short staffed, she would delay the evaluation. *Id.*

Ms. Schroeder then drove Adam to the grocery store where he showed signs of being "internally preoccupied." CP 461. She also documented in her chart that, when she carried the groceries into his home, she saw 50 black capsules in a pile in the center of the room. *Id.*

Plaintiff's expert witness, William Heusler, Psy.D., a psychologist who has years of experience with multidisciplinary treatment teams, testified in deposition that Lourdes' PACT team should have requested revocation because Adam had failed to participate in substance abuse treatment, failed to take his prescribed medications, was taking street drugs including methamphetamine, and was decompensating. Dr. Heusler testified that Adam posed an increased risk of serious harm to others as demonstrated by his attempts to sexually assault staff members. CP 464-465. Dr. Heusler explained that, while it may be difficult to predict violence, it was not difficult to predict risk of violence in this case and Adam had many risk factors for violence. CP 464 at 29:10-11. Dr. Heusler concluded, "I think Lourdes Medical Center's PACT team was negligent in their treatment of Adam. In fact, they were grossly negligent when you

take it all into consideration in terms of the concerns and difficulties that they had, and the failures that they made in terms of following through on his treatment and staying current to the guidelines that the State provided for PACT programs." CP 467. According to Dr. Heusler, PACT had an obligation to report all violations of the LRA and to request revocation if the violations amounted to an increased risk of harm. CP 468 at 72-73.

E. The County Mental Health Professional Sees Adam Again And Again Takes No Action

On January 25, 2012, Adam met again with Nurse Aronow. CP 470-472. He admitted to using methamphetamines, made tangential statements, continued to be dirty and disheveled, and "forgot" to bring his medication box. *Id.* Finally, Nurse Aronow contacted the County to see Adam that day. *Id.* The purpose and substance of the meeting/evaluation is disputed with the defendants presenting starkly different and irreconcilable versions of the event, with each Defendant-Respondent casting blame against the other.

According to the County's designated mental health professional, Ms. Laws, she was at the PACT offices evaluating another client and was asked to simply "remind" Adam to follow his LRA. CP 350 at 19:2-6; 19:15-17. Ms. Laws testified that this meeting took five minutes. CP 351 at 24:23-25. By her own admission, Ms. Laws failed to read the County's

casefile. CP 352 at 25:13-15. As a result, she did not know Adam's diagnosis, his history of non-compliance, or his violent history. CP 352 at 25:8-12. She did not interview Nurse Aronow or anyone else on Lourdes' PACT team. CP 352 at 25:16-17. Adam was not detained, but was instead referred to "voluntary" outpatient services. CP 475. When she got back to the office, Ms. Laws filled out the paperwork indicating she had evaluated Adam. CP 352 at 27:10-13. It was only then that she learned his diagnosis. CP 352 at 26:4-10.

Nurse Aronow's version of events differs markedly from that of Ms. Laws. According to Nurse Aronow, the visit took 30 minutes. CP 287 at 93:18-19. Nurse Aronow reported that she asked Ms. Laws to evaluate Adam for revocation of his LRA. CP 288 at 100:9-10.

What happened the next day is also in dispute. Defendants agree that Nurse Aronow called Ms. Laws. According to Nurse Aronow, she explained to Ms. Laws that female staff were afraid of Adam. CP 482. She conveyed that only male staff should treat Adam. *Id.* Nurse Aronow also reported that Ms. Laws indicated that the County would revoke Adam's LRA in the future if Lourdes requested it. *Id.*

According to Ms. Laws, the substance of the phone call was Ms. Aronow thanking her for reminding Adam to follow the conditions of his LRA. CP 352 at 28:13-18.

F. Lourdes' And The County's Repeated Failure To Act To Protect Adam And Others From Harm Results In Tragedy

The following day, Adam murdered his grandmother, Viola Williams. Adam believed that he was "Lucifer Grand Am Dynasty" and God had directed him to kill Viola. CP 484-487. That morning, Viola, acting with characteristic kindness, opened her home to Adam. Adam punched Viola in the face and head, causing her to fall to the floor. *Id.* He placed his boot on her neck then put a belt around her neck and tried to decapitate her. *Id.* He pulled the belt around her neck so hard that the belt broke. *Id.* Viola kept repeating, "Adam, what are you doing?" *Id.* Adam placed tin foil in her mouth and tried to suffocate her. *Id.* Viola continued to breathe. Adam held a plastic bag around Viola's mouth. *Id.* Adam poured lighter fluid on Viola's face and lit her on fire. *Id.* Adam took a knife from the kitchen and stabbed Viola multiple times in the chest and in the throat. *Id.* He only stopped the attack and left "when God told him that was enough." *Id.* At some point Adam pulled open Viola's shirt and put his hand on her. He also pulled her pants down to reveal the pubic hair around her vagina. *Id.* Adam took a picture of Viola's body, which he intended to post on the internet. He showed the picture to a woman he met on the bus. *Id.*

Averly Nelson, MD, a psychiatrist at Eastern State Hospital who treated and evaluated Adam after the murder (CP 403-408), noted:

> The medications he was taking at the time of the murder represented a total failure in treatment. Haldol D might slow him down and decrease overt agitation, but the Haldol D didn't stop the murder. Abilify was a bust. Seroquel was too low to matter.

CP 408.

The Court found that Adam was not competent to stand trial, and he was hospitalized for 10 months while staff at Eastern State tried to restore his competency. CP 489-494. Upon regaining competency, Adam was found not guilty by reason of insanity based on a joint stipulation by the prosecution and defense. CP 496-498. An evaluating psychiatrist from Eastern State found that Adam "was so acutely ill and entrenched in his delusional system" that he was insane at the time of the murder. CP 500-502.

G. Procedural History

Sherrie Lennox, as personal representative of the Estate of Viola Williams, brought this suit against Lourdes Health Network and Benton and Franklin Counties alleging gross negligence in treating, supervising, monitoring and evaluating Adam Williams. Following oral argument of counsel, the trial court delivered its ruling from the bench, granting Defendants' motions for summary judgment:

> In this case, I believe that the evidence that I've seen through the affidavits establishes that – that the defendants in this case exercised more than a slight level of care.
>
> I think – I'm going to rule – I'm going to grant the summary judgment to both defendants. The defendants were in contact with Mr. Williams. The contact increased. The contact was frequent. The PACT workers were frequent. They were attempting to work with him. You know, it's not a negligence standard; it's a gross negligence. And I don't think plaintiffs have established gross negligence. I suspect – and I'm not offended by this – but I suspect Judge Fearing will again be asked to make a humbling and daunting decision, and I'm not offended by it if that happens at all. But I'm going to grant both defendants' Motions for Summary Judgment.

Verbatim Report of Proceedings at 50.

The trial court also granted, in part, a motion to strike The declaration of Plaintiff's expert psychiatrist, Dr. Layton. This appeal follows.

IV. ARGUMENT

A. Standard Of Review

An appellate court reviews summary judgment de novo. *Hisle v. Todd Pac. Shipyards Corp.,* 151 Wn.2d 853, 860, 93 P.3d 108 (2004). Summary judgment is appropriate if, in view of all of the evidence, reasonable persons could reach only one conclusion. *Johnson v. Spokane to Sandpoint, LLC*, 176 Wn. App. 453, 457, 309 P.3d 528, 532 (2013). Summary judgment is only proper when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of

law. *Hertog ex rel., S.A.H. v. City of Seattle*, 138 Wn.2d 265, 275, 979 P.2d 400 (1999). If there is "substantial evidence of seriously negligent acts or omissions... then the issue of gross negligence should be resolved by the jury under proper instructions." *Nist v. Tudor*, 67 Wn.2d 322, 332, 407 P.2d 798, 804 (1965). In reviewing a motion for summary judgment, this Court must view all facts and reasonable inferences in the light most favorable to the nonmoving party. *Elcon Const., Inc. v. E. Washington Univ.*, 174 Wn.2d 157, 164, 273 P.3d 965, 969 (2012). An appellate court reviewing a summary judgment places itself in the position of the trial court and considers the facts in a light most favorable to the nonmoving party. *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 226, 770 P.2d 182, 188 (1989). In this case, where there are two defendants seeking summary judgment and they disagree about the facts, the facts must be construed against each defendant as it relates to their motion for summary judgment.

B. The Trial Court Erred in Granting Lourdes' Motion For Summary Judgment

1. The Trial Court Applied The Wrong Legal Standard In Defining Lourdes' Duty To Protect Others From Harm

The court below applied the wrong legal standard in granting Lourdes' motion for summary judgment when it confused the notion of Lourdes staff's general care for the mentally ill and its frequent "contact"

with Adam, with the actual standard of care a facility undertakes when it is designated to provide court-ordered outpatient treatment

> . . . there was comments in one of the briefs, but tragedy, also, to the social workers. They don't get involved in this kind of work unless – unless they are caring people.

Verbatim Report of Proceedings at 49.

This was error. The question is not whether Lourdes' social workers and nurses cared for Adam and had contact with him (they did); rather, the question is whether Lourdes exercised reasonable care in discharging its legal duties, including the duties expressly embodied in statute:

> The hospital or facility designated to provide outpatient treatment **shall notify** the secretary or designated mental health professional when a conditionally released person fails to adhere to terms and conditions of his or her conditional release or experiences substantial deterioration in his or her condition and, as a result, presents an increased likelihood of serious harm. The designated mental health professional or secretary **shall order** the person apprehended and temporarily detained in an evaluation and treatment facility in or near the county in which he or she is receiving outpatient treatment.

RCW 71.05.340(2)(b) (emphasis added). Under this provision, Lourdes was required to, at minimum, notify the County when Adam repeatedly failed to "adhere to the terms and conditions of his release or experienced a substantial deterioration in his condition and as a result presents an increased risk of serious harm." *Id.*

The court's misconception of Lourdes' duty of care cannot be squared with binding Washington precedent. In the seminal case of *Petersen v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983), the Supreme Court held that an attending psychiatrist at Western State Hospital had a duty to take reasonable precautions to protect third-parties – even strangers – from the harm of his patient who had been involuntarily committed. *Id.* at 49. Under strikingly similar facts to those here, the psychiatrist in *Petersen* released his patient despite notice of his ongoing probation violations, extensive history of drug abuse, and non-compliance with his psychiatric medication. While on release from the hospital, Knox stopped taking his medication and drove his car into another car, causing serious injuries to the other driver, plaintiff Cynthia Petersen. The Court reversed the lower court's entry of judgment on the verdict, holding that the psychiatrist incurred a duty to take reasonable precautions to protect others from harm, including but not limited to petitioning the court for additional confinement. *Id.*

Although an actor ordinarily has no duty to prevent harm committed by another, this is not the rule where a "special relationship" exists, as between Lourdes and its patient, Adam. *Petersen*, 100 Wn.2d at 426; *Estate of Jones v. State*, 107 Wn. App 510, 518, 15 P.3d 180 (2000).

Section 315 of the Restatement (Second) of Torts carves out the "special relationship" exception to this rule.

> (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
> (b) a special relation exists between the actor and the other which gives to the other a right to protection.

The "take charge" relationship, as set forth in the Restatement (Second) of Torts § 319, is one subset of special relationships contemplated in § 315. Accordingly,

> One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.

Restatement (Second) of Torts § 319.

Once the "take charge" relationship is established, the actor "has a duty to take reasonable precautions to protect against reasonably foreseeable dangers posed by the dangerous propensities of [the third party]." *Joyce v. State Dep't of Corr.*, 155 Wn.2d 306, 310, 119 P.3d 825 (2005) (emphasis omitted) (quoting *Taggart*, 118 Wn.2d at 217). Thus, the relevant threshold questions for purposes of §§ 315 and 319 are (a) whether the actor has taken charge of the third party and (b) whether the actor knows or should know of the danger posed by the third party. *Bishop v. Miche*, 137 Wn.2d 518, 527, 973 P.2d 465 (1999).

When the actor has a definite, established, and continuing relationship with a third person, the actor has a duty to control the third person's conduct. *Taggart v. State*, 118 Wn.2d 195, 822 P.2d 243 (1992). The cases arise most commonly in the context of Department of Corrections supervision. However, as noted in *Volk v. Demeerleer,* 184 Wn .App. 389, 337 P.3d 372 (2014), the "special relationship" line of cases in the mental health field derived from *Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 398 P.2d 14 (1965). In *Volk*, the Court found it was a question of *fact* whether a psychiatrist sporadically treating a voluntary outpatient psychiatrist had such a "take charge" relationship.

Here, the trial court erred when it decided, as a matter of law, that Lourdes satisfied its duty by simply caring for Adam and having contact with him. Under *Petersen* and its progeny, Lourdes had a duty to do take reasonable precautions to protect others from harm, including its statutory duty to report violations of the LRA to the County. Lourdes' relationship with Adam was definite, established and continuing. Lourdes' PACT team was providing intensive outpatient services. He was not seen on a "hit or miss" basis. *See Volk,* 337 P.3d 372. Rather, Lourdes "took charge" of Adam when they agreed to accept him into their mental health program and monitor the conditions of the LRA.

Because of the special take charge relationship the PACT had with Adam, Viola Williams was in the realm of victims who could foreseeably be injured as a result of his volatile behavior. It is not the "unusualness of the act that resulted in injury to plaintiff that is the test of foreseeability, but whether the result of the act is within the ambit of the hazards covered by the duty imposed upon defendant." *Jones v. Leon*, 3 Wn. App. 916, 924, 478 P.2d 778 (1970); *Koker v. Armstrong Cork, Inc.*, 60 Wn. App. 466, 480, 478 P.2d 778 (1991) (reasoning that liability is present where the conduct is "within the general field of danger that the defendant should have been anticipated"). A mental health treatment provider owes a duty to anyone who might be foreseeably endangered by a patient's unpredictable behavior. *Petersen*, 100 Wn.2d at 427-428.

Here, as in *Petersen*, PACT knew that Adam was unpredictable and potentially violent. When explaining her decision to take charge of Adam, team leader Dana Otis said, "Before you make a huge gasp, hear me out...." CP 231. Lourdes agreed to monitor Adam's LRA knowing that he suffered from paranoid schizophrenia, had a history extensive drug use, medication non-compliance, violent behavior, and that he had been involuntarily committed to a psychiatric hospital for a period of five years, the maximum allowable time. CP 375. As such, it was foreseeable that his unpredictable behavior could injure a third party.

Lourdes' PACT team admits that, in abdication of its duty, its stated goal was to keep Adam *out of jail* and *out of the hospital.* CP 259; 279-280; see also CP 279 (Nurse Aronow understood it was Lourdes' job to "do everything that we can to keep him out of jail and out of the hospital, and continue them to be a member of society.") As his condition deteriorated, at least some members of the team recognized steps needed to be taken, including hospitalizing to stabilize him so he could remain in the community (CP 437; 456), yet Lourdes failed to act. The Court should remand the matter to the trial court for correct application of the standard of care, which goes beyond mere caring and contact.

2. The Trial Court Erred in Granting Summary Judgment On A Record of Significant, Disputed Facts

Next, the trial court erred in ignoring the plethora of factual disputes on the question of whether Lourdes breached its duty of care to innocent third persons, which is ordinarily a question for the jury. *Bader v. State*, 43 Wn. App. 223716 P.2d 925, (1986) ("Ordinarily, the question of negligence is one of fact for the jury to determine from all the evidence presented.). In *Bader v. State*, for example, Division Three reversed summary judgment granted to a county mental health center for its supervision of a mentally ill man, reasoning:

> Here, the center's own records contain a copy of the court's order of acquittal on the ground of insanity and conditional

> release. The order stated Mr. Roseberry was a substantial danger to others and likely to commit felonious acts jeopardizing public safety. It also listed the conditions of his release, which included taking his medication, contacting the center and following its staff's instructions regarding treatment. The center's records show it was aware Mr. Roseberry missed several of his appointments, was not taking his medication, and was exhibiting paranoid behavior, e.g., talking of seeing the devil in people and how he must kill the devil. Thus, questions of fact exist as to the foreseeability of Mr. Roseberry doing what he did and the action the center should have taken once it became aware Mr. Roseberry was violating the conditions of his court-ordered release.

Id. at 229.

Here, as in *Bader*, the trial court erred in deciding for itself the fact question of whether Lourdes breached its duty of care. Plaintiff-Appellant submitted substantial evidence from which a jury could reasonably conclude that Lourdes failed to take reasonable precautions once it was on notice of Adam's violations of the LRA, and his declining mental condition and erratic, violent behavior. Viewing all of the evidence in the light most favorable to Plaintiff-Appellant, including evidence submitted by the County, Lourdes contacted the County just *two* times regarding Adam's noncompliance, a full *nine* months into his release. First, on January 18, 2012, Nurse Aronow called the County and told them that Adam was not taking his medications as prescribed, but did little else; instead, she decided to watch and wait to see if his condition improved.

A week later, Lourdes reached out to the County one more time, but only to have the County "remind" Adam to follow his LRA. CP 350. During one of these contacts, Nurse Aronow also informed the County that Adam had been sexually inappropriate with female staff, had thoughts of a sexual nature, and disclosed recent drug use. CP 474-476.

A jury could reasonably conclude that this scant communication did not begin to satisfy Lourdes' duty to monitor Adam's compliance with the LRA. Lourdes' communications with the County were so limited that the County could have misinterpreted them to mean that Adam had merely a brief relapse on drugs, leading to inappropriate sexual language with staff. When in fact, for the past seven months, Adam had violated *every* condition of his LRA repeatedly, he was dangerous and growing more so. The fact-finder could reasonably conclude that Lourdes should have, at a minimum, told the County Crisis Unit the following:

- The PACT team already reminded Adam to follow his LRA numerous times over the proceeding weeks and months. CP 367-373; 450.

- Adam has lied about his drug use and his medication noncompliance. He had engaged in a series of deceptive acts to hide his non-compliance including forgetting his medication box and flushing his medication down the toilet. CP 310-312; 329; 378; 388-389; 392; 450.

- Adam refused to participate in chemical dependency treatment (CP 298-303; CP 307-308 at 20:19-20; 20:22-25; 21:1-4; 21:8-14) and had been abusing street drugs for months. CP 294. In the two previous months Adam's substance use had escalated and included regular use of methamphetamine. CP 317-337; 442.

- Adam was decompensating rapidly. His appearance was growing more disheveled. CP 400 at 67:9-21; 410; 415; 439-440; 448; 450.

- His paranoia and delusions were increasingly becoming more intense over the period of several months. CP 383; 388-389; 413-414; 416-417; 439-440; 442-443; 445-446.

- Adam's landlord reported that he was demonstrating bizarre and erratic behavior. CP 436-437.

- Adam had attempted to sexually grope two female staff members. CP 419-420; 426-427; 442-443.

- Female staff were afraid of Adam and refused to be alone with him. CP 315; 436-437; 450; 482.

- Staff warned those outside the agency not to be alone with Adam. CP 434.

Nurse Aronow's post-homicide version of events that she requested an evaluation for revocation on January 25 and 26, while CRU adamantly maintains PACT never requested an evaluation for revocation, suggest she immediately recognized her error. The care the PACT

demonstrated was directed to keeping Adam Williams out of the hospital – not reasonably supervising compliance with the court order. The trial court erred when it deprived Appellant from presenting its evidence to the jury on the question of breach.

3. A Reasonable Jury Could Find That Lourde's Failure to Act Was A Proximate Cause Of Viola William's Death

A cause is proximate if it is both a cause in fact and a legal cause. *Petersen v. State*, 100 Wn.2d, 671 P.2d 230 (1983); *Gall v. McDonald Indus.*, 84 Wn. App 194, 207, 916 P.2d 934 (1966).

a. Legal Causation

"The focus in the legal causation analysis is whether, as a matter of policy, the connection between the ultimate result and the act of the defendant is too remote or insubstantial to impose a liability." *Schooley v. Pinch's Deli Market*, 134 Wn.2d 468, 478-79, 951 P.2d 749 (1998). This determination depends upon "mixed considerations of logic, common sense, justice, policy, and precedent." *Id.* at 479 (citation omitted); *Tyner v. State*, 92 Wn. App. 504, 515, 963 P.2d 215 (1998), *review granted*, 137 Wn.2d 1020, 980 P.2d 1282 (1999) (citing *Taggart*, 118 Wn.2d at 226). Legal causation "rests on considerations of policy and common sense as to how far the defendant's responsibility for the legal consequences of its actions should extend." *Id.*; *Hartley v. State*, 103 Wn.2d 768, 779, 698

P.2d 77 (1985)). Legal causation is intertwined with the question of duty. *Taggart*, 118 Wn.2d at 226; *Hartley*, 103 Wn.2d at 779-80, (*quoting* William L. Prosser, Handbook of the Law of Torts 244-45 (4th ed. 1971)).

b. Cause In Fact

To establish cause in fact in a negligence suit there must be substantial evidence that some act or omission of the defendant produced injury to the plaintiff in a direct, unbroken sequence under circumstances where the injury would not have occurred but for the defendant's act or omission. *Tyner*, 92 Wn. App. at 514. This factual aspect of proximate cause is generally a matter for the jury, unless only one reasonable conclusion is possible. *Id.*

The trial court below did not mention causation in its ruling, and it is unclear whether its decision turns on this element of Plaintiff-Appellant's claims. In the event this Court reaches the issue, it should determine that a reasonable jury could find that Lourdes' failure to request revocation or communicate with the County were the proximate cause of Viola Williams' death. Below, Lourdes argued that "Plaintiff must show that at the time Viola Williams was murdered, Adam Williams would have been involuntarily committed – in a hospital or treatment facility – were it not for the negligence of Lourdes …." CP 139.

Plaintiff-Appellant established that, in fact, the County would have detained Adam had *any* PACT team member requested revocation and further, that the PACT team instructed Nurse Aronow to make such a request. There is also ample evidence that had Lourdes provided the information that they were required to provide under the statute, the County would have detained Adam. Plaintiff-Appellant's expert, Dr. Layton, testified at deposition that by January 6, 2012, Adam met the criteria of 71.05.340(b) and should have been detained. CP 400 at 67:9-68:5. Likewise, Lourdes' own expert, Dr. Vandenbelt agreed that by January 16, 2012, Adam met the criteria for detention. CP 423 at 38:5-40:22. Assuredly, reasonable jurors could find that the PACT team's failure to properly monitor Adam's LRA was a proximate cause of Ms. Williams' death.

Further, if detained, Adam would have been held pending a hearing. Under RCW 71.05.340(3)(c) , a person is detained for up to five days pending a court hearing to determine if the person should be returned to the hospital. In this case, such a detention would have saved Viola William's life.

4. A Reasonable Jury Could Find That the County's Failure To Revoke Adam William's LRA Was Not A Superseding Cause

A superseding cause can break the causal chain in an analysis of cause-in-fact. *Campbell v. ITE Imperial Corp.,* 107 Wn.2d 807, 813, 733, P.2d 969 (1987). A superseding cause is "an act of a third person ... which by its intervention prevents the actor from being liable for harm to another which his antecedent negligence is a substantial factor in bringing about." *Restatement (Second) of Torts* § 442 (1965). In determining whether an intervening act constitutes a superseding cause, the relevant considerations under § 442 are, *inter alia,* whether (l) the intervening act created a *different type of harm* than otherwise would have resulted from the actor's negligence; (2) the intervening act was *extraordinary* or resulted in extraordinary consequences; (3) the intervening act *operated independently* of any situation created by the actor's negligence. *Campbell,* 107 Wn.2d at 812-13 (emphasis in original).

Whether an act may be considered a superseding cause sufficient to relieve a defendant of liability depends on whether the intervening act can reasonably be foreseen by the defendant; only intervening acts which are *not* reasonably foreseeable are deemed superseding causes. *Campbell,* 107 Wn.2d at 817; *Anderson v. Dreis* & *Krump Mfg. Corp.,* 48 Wn. App. 432,442, 739 P.2d 1177, *review denied,* 109 Wn.2d 1006 (1987).

Below, Lourdes argued that the County's failure to revoke Adam's LRA on January 25 and then again on January 26 are superseding causes. However, the facts of what transpired on both of those dates are hotly disputed and involve credibility determinations that can only be made by the jury. According to the County, the PACT team did not request an evaluation, nor did it request or even recommend that the County revoke Adam's release; rather the PACT only asked the County to "remind" Adam to follow the conditions of his release. Viewing the facts against Lourdes and in Plaintiff-Appellant's favor, it was foreseeable that the County would not revoke Adam's LRA.

Under RCW 71.05.340, the outpatient treatment provider (here, Lourdes) and the designated mental health care provider (the County Crisis Unit), work in tandem. Lourdes' PACT team was required to report violations of the LRA that resulted in an increased likelihood of serious harm, and in turn, the County was required to detain the individual. When the PACT team does not meet its obligation to report all material facts to the County, it is foreseeable that the County would not revoke the LRA. *See Tyner*, 141 Wn.2d at 83 (reasoning that a court order does not break the causal chain if the court is not aware of all of the material information).

Further, an intervening cause is a force that operates to produce harm after the defendant has committed the act or omission. *State v. Roggenkamp*, 115 Wn. App. 927, 945, 64 P.3d 92 (2003), *affirmed* 153 Wn.2d 614 (2005). In this case, the acts and omissions of the County were concurrent with that of the PACT team.

Below, Lourdes argued the causal chain was broken by the unforeseeable gross negligence of the County. In support of its argument that gross negligence is not foreseeable, Lourdes cited cases from Michigan and Colorado. *People v. Schaefer*, 473 Mich. 418, 703 N.W.2d 774 (2005); *People v. Saavedra-Rodriguez*, 971 P.2d 223, 98 CJ C.A.R. 6083 (1998). Even if this court were to adopt this legal principle, the motion is premature. No fact finder has yet decided that the County was grossly negligent. These factual disputes on a factual question only underscore that this case is not ripe for adjudication on summary judgment. At bottom, this question of causation arises because the Defendants-Respondents dispute the material facts, each blaming the other.

C. The Trial Court Improperly Granted the County's Motion For Summary Judgment

In considering the County's motion for summary judgment, the disputed facts must be construed against it. Here, like the mental health

care providers in *Bader* and *Petersen*, the County's own notes show that Adam was a danger to others when off his medications. Prior to Viola's murder, the County Crisis Unit knew that Adam was off his medications and using street drugs. In addition, the County knew that Adam was sexually preoccupied. These facts were sufficient evidence of gross negligence in *Petersen* and *Bader*, as they are here. Although, as discussed above, Lourdes should have provided the County *more* information about Adam's LRA violations and declining condition, a reasonable jury could conclude that the County had more than enough evidence to act and that it breached its duty when it failed to do so. Summary judgment in favor of the County was in error.

Below, the County relied on *Estate of Davis v. State, Dep't of Corr.*, 127 Wn. App. 833, 113 P.3d 487 (2005), as amended (June 2, 2005), publication ordered (June 2, 2005); however, those facts are inapposite. In *Davis,* a mental health counselor was directed to see if a probationer would benefit from mental health counseling. *Id.* at 837-838. The mental health counselor found that the probationer was upset from the breakup with his girlfriend, suffered from depression and would benefit from counseling. *Id.* The court reasoned that the counselor was not liable when the probationer later killed someone. *Id.*

In contrast, here, the court overseeing Adam's LRA had already determined that Adam was so ill that he could not be in the community without being in a rigorous mental health program and following strict conditions. Further, unlike the case here, the counselor in *Davis* was not asked to evaluate the probationer for an increased likelihood of serious harm. *Id.* The legislature, through RCW 71.05.340(b) has directed the County to conduct such evaluations.

In *Davis*, plaintiff's expert opined that the mental health assessment was deficient because the mental health counselor should have contacted the probation officer after the evaluation. The expert provided only conclusory statements that the counselor's evaluation was incomplete and unreasonable. *Davis*, 127 Wn. App. at 491. The court held that this conduct did "not rise to the level of gross negligence." *Id.* Again, by contrast to this case, Plaintiff-Appellant has presented ample evidence that the County had at least three opportunities to act and failed to do, in violation of its duty to protect innocent third parties from harm. .

1. The County's Failure To Act In August 1, 2011 Following Its Contact with Adam Williams Was Grossly Negligent

Below, the County admitted that Mr. Fordmeir performed an evaluation for Adam's initial detention using the wrong standard. That is, Mr. Fordmeir evaluated Adam pursuant to RCW 71.05.150 and .153 rather

than 71.05.340(b). Unlike the latter provision (which pertains to involuntary commitment), the criteria to revoke an LRA does not require a showing of imminent danger.[10] *Id.* Because an individual who has been committed under the ITA has *already been found* to pose a risk to himself or others, a revocation under the LRA only requires a showing the conditions have been violated and there is ***an increased likelihood*** of serious harm.[11] RCW 71.05.340 (b). According to Dr. Layton, an LRA is designed to "put a safety net around a person, [so that] when they are not doing well they can be brought back to a higher level of care." CP 396 at 44:10-2.

Below, the County also relied on dicta in *Kelley v. Dep't of Corr.*, 104 Wn. App. 328, 336, 17 P.3d 1189 (2000), citing dicta that had the probation counselor done nothing to investigate a probation violation, this would constitute gross negligence. The County argues that any evaluation of Adam, no matter how negligently conducted, negates a finding of gross negligence. Not only is this a fact question for the jury, it is not a correct

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[10] "Imminence" means "the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote." RCW 71.05.020(20).

[11] "Likelihood of serious harm" means: (a) A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others ..." CP 512.

reading of the law. Even accepting for sake of argument, the "form over substance" analysis of the County, Fordmeir conducted *no* evaluation for revocation, but instead performed an evaluation for initial detention.

The August 1, 2011 evaluation by Cameron Fordmeir was grossly deficient in other respects as well. Washington State's designated mental health professional (DMHP) protocols provide the standards for implementing the civil commitment laws. CP 504-541 (hereafter "Protocols"). The Protocols require that a DMHP, for example, search reasonably available history [12] and databases in order to obtain the individual's background. CP 527. Here, Mr. Fordmeir failed to adequately review the County's own records. If he had, he would have seen that Adam had a history of non-compliance with his medication, significant substance abuse, and violence, particularly when off his medication. CP 375. In the County's own records was the June 9, 2011 petition extending Adam's LRA for 180 days, reporting:

> When his medications are not regulated, the characteristics of his decompensation include paranoia, a religious

[12] This term is defined in the Protocols. **"Reasonably Available History"** means history made available to the DMHP by: referral sources, risk assessments, and/or discharge summaries from the Department of Corrections (DOC), law enforcement, treatment providers and family at the time of referral and investigation, and/or other information that is immediately accessible, other information which may be available and include an individual's crisis plan or other available treatment record, evaluations of incompetency or insanity under RCW 10.77, criminal history records, risk assessments, and discharge summaries from DOC, historical behavior including a history of one or more violent acts, and records from prior civil commitments. CP 513.

> preoccupation, agitation/violence, and audio and visual hallucination. CP 242.

Mr. Fordmeir failed to adequately evaluate Adam's increased risk of harm to others. The only effort that Mr. Fordmeir made to assess Adam Williams' risk of harm to others was to ask if he was homicidal. CP 367-373.

Finally, even with the inadequate information that Mr. Fordmeir had, he should have revoked Adam's LRA, because he met the criteria of RCW 71.05.340(b). Adam had violated the terms and conditions of his LRA, and posed an increased risk of serious harm. Lourdes' expert witness, Dr. Vandenbelt, agrees that for schizophrenic patients, risk factors for violence include: being male, a history of violence, noncompliance with antipsychotic medication, and excessive substance use. CP 423 at 40:3-11. All of those factors were present in this case. Each of those criteria was present at the time of Mr. Fordmeir's evaluation. According to Dr. Layton:

> He should have been revoked. He almost killed himself with drugs. And he blew through an amazing amount of money in a very short time. His judgment was impaired.

CP 397 at 46:17-20. Had Adam been revoked, hospitalized and stabilized, his entire course of deterioration would have been altered. CP 544 at ¶8(e).

2. The County's Failure To Act Following its January 25, 2012 Contact With Adam Was Grossly Negligent

A jury could reasonably find that the January 25, 2012 evaluation by CRU employee Kathleen Laws was grossly inadequate. As explained above, the facts of this encounter are hotly disputed between the defendants. Ms. Laws asserts she took only five minutes to remind Adam to follow the conditions of his LRA:

> Q. What questions did you ask?
> A. I really don't remember specific questions. It was a brief encounter, and I reminded him to follow the conditions of his LRA.
> Q. How much time do you think the interview took, or the reminder?
> A. Five minutes.

CP 351 at 24:19-25. According to Dr. Layton, a competent mental health evaluation cannot possibly be completed in five minutes. CP 542-547 at ¶9(b). Ms. Laws failed to review the PACT team chart notes showing how poorly Adam was doing in the previous weeks despite the fact that they were readily available in the PACT team offices. *Id.* at ¶9(e). Except for this brief five minute meeting with Adam and Nurse Aronow, Ms. Laws did not interview PACT team members, despite the fact that she was in their offices and Nurse Aronow was present. CP 352 at 25:16-17.

Ms. Laws failed even to review CRU's own notes. CP 352 at 25:13-15. Ms. Laws did not know Adam's diagnosis, his history of non-

compliance, or his history of violence. CP 352 at 25:11-12; 26:4-14; CP 353 at 32:19-25. She had not read the CRU notes which indicated: "He poses a high risk to victimize his parents and is 'likely to be a threat to others ..." CP 375. She did not know his diagnosis until she returned to the office and filled out the paperwork. CP 352 at 26:4-14. Ms. Laws failed to interview family members or caseworkers. CP 355 at 70:3-9. A reasonable jury could find that the five minute encounter which was the entirety of her contact with Adam Williams did not constitute an evaluation at all, and was grossly negligent and an abdication of her responsibilities as a DMHP.

3. The County Again Failed to Act The Day Before Viola's Murder

There is also a material issue of fact as to what happened the following day. The testimony of Ms. Aronow is that she contacted Ms. Laws on January 26, 2012 by phone and told her that Adam's condition continued to deteriorate and that female staff were afraid of Adam. Ms. Laws had an obligation, for the second time in two days, to detain Adam at that time as required by RCW 71.05.340 (b). Had Ms. Laws detained Adam on January 25th or January 26th, he would have been in the hospital instead of in his grandmother's home, brutally murdering her on January 27, 2012.

D. The Trial Court Improperly Granted Defendants Motion To Strike Portions Of Dr. Layton's Declaration

The trial court erred in striking portions of Dr. Mathew Layton's declaration. ER 702 permits testimony by a qualified expert where "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Courts generally "interpret possible helpfulness to the trier of fact broadly and will favor admissibility in doubtful cases." *Miller v. Likins*, 109 Wn. App. 140, 147-48, 34 P.3d 835, 839 (2001) (internal citations omitted).

The Court struck the portion of Dr. Layton's declaration containing the following language in Paragraph 12 of his declaration:

> CRU had the legal authority to detain Mr. Williams on January 25 and January 26, 2012. They could have detained him for up to five days at an inpatient facility pending a hearing. Had CRU detained Adam Williams, [he] would have been in the hospital on January 27, 2012, the date Viola Williams was murdered. Further, when the case came before a judge, it is my experience that judges usually order detention and continued detention when requested by the DMHP. Given Mr. Williams' violation of the LRA, it is likely that he would have been detained beyond the initial 5 day detention.

CP 547 at ¶12. The judge did not provide written findings. His oral findings consisted of a colloquy between the court and counsel:

> **The Court:** I note in his conclusion down there in Paragraph No. 12, he says, "further, when the case came before a judge, it is my experience that judges usually order detention and continued detention when requested by the

> designated mental health professional." Has Dr. Layton ever appeared down here?
>
> **Ms. Roe:** I don't know that he's appeared in this court, Your Honor, but similar language has been cited in declarations and specifically approved in *Tyner v. State*, where a social worker was allowed to opine that – with regard to CPS cases that the Court in her experience usually followed the recommendation of the social worker. So I think there is authority for that kind of opinion.
>
> **Mr. Aiken:** I would argue there's no foundation in Benton County, though. They haven't established a foundation that he's appeared in Benton County and knows anything about Benton County, so there's no foundation for it. Plus, it's speculation.
>
> **The Court:** Yeah. So I'm going to strike that too. And I periodically appear at mental hearings, whether I want to or not. I've never – never seen them [presumably DMHPs] there. So okay. So, I'm striking ...

Verbatim Report of Proceedings at p. 12-13.[13]

The trial judge's assertion that he has not seen a DMHP appear in a Benton County mental health proceeding does not make Dr. Layton's statement that "when the case [comes] before a judge, it is my experience that judges usually order detention and continued detention when requested by the DMHP any less likely. There is nothing to suggest that the Court in Benton County administers the law in a way that is markedly different from other counties in the State. The provisions of the Involuntary Treatment Act at issue in this case, RCW 71.05.340, apply

[13] Defendants did not argue or brief this rationale for striking the motion in the briefing below.

throughout Washington State and are not dependent on the County in which one lives.

Courts routinely allow such expert opinion. In *Tyner v. State v.*, a father sued DSHS for separating him from his children during a negligent investigation of child abuse. *Tyner v. State Dep't of Soc. & Health Servs., Child Protective Servs.,* 141 Wn.2d 68, 87, 1 P.3d 1148, 1158 (2000). DSHS argued that the court's issuance of no-contact orders was a superseding intervening cause of the separation. *Id.* The Washington Supreme Court ruled that there was no superseding or intervening cause because DSHS failed to provide the court with the relevant information "that might have been relied upon by the court in its decision making." *Id.* The Court noted that "There is little question that courts rely heavily on the judgment of CPS caseworkers in making dependency determinations." *Id.* In footnote 7, the court also explained,

> There was expert testimony given at trial that courts "always follow" the recommendations of social workers in dependency proceedings. Verbatim Report of Proceedings (RP) (Oct. 10, 1996) at 148. This testimony was objected to and the objection was overruled. The jury was free to reach the conclusion that in many cases a social worker's determination will be material to a judge's decision, which was the issue in this case.

Id. at n. 7; *see also Estate of Bordon ex rel. Anderson v. State, Dep't of Corr.*, 122 Wn. App. 227, 244, 95 P.3d 764, 773 (2004) (reasoning that in

order to establish causation on summary judgment, courts routinely allow evidence from experts about how judges typically rule in particular proceedings); *Joyce v. State, Dep't of Corr.*, 155 Wn.2d 306, 322-23, 119 P.3d 825, 834 (2005)(upholding admission of expert testimony on question of whether judge would have detained probationer).

Plaintiff-Appellant is not required to prove with certainty that the court would have revoked Adam's LRA before January 26. By its gross negligence, Lourdes and the County prevented the court from ever making such a determination. In any event, on summary judgment, Plaintiff-Appellant need only present a triable issue on the matter, which Plaintiff has done.

V. CONCLUSION

The Superior Court erred in adjudicating this complex, and tragic case on the papers. The trial court substituted its own view of the evidence for findings of fact that only a jury can make. The Court also erred in striking portions of Dr. Layton's declaration. Plaintiff respectfully asks the Court to reverse the grant of summary judgment and remand this case for trial.

DATED this 18th day of August, 2015.

SCHROETER GOLDMARK & BENDER

REBECCA J. ROE, WSBA #7560
ANNE M. KYSAR, WSBA #28351
Counsel for Appellant

CERTIFICATE OF SERVICE

On the 18th day of August, 2015, I caused to be served upon the following, at the address stated below, via the method of service indicated, a true and correct copy of the foregoing document.

West H. Campbell, WSBA #9049 Thorner Kenedy & Gano 101 S. 12th Ave. P.O. Box 1410 Yakima, WA 98907 *Attorney for Defendant Benton & Franklin County*	☐ Via Hand Delivery – ABC Legal ☒ Via U.S. Mail, 1st Class, Postage Prepaid ☐ Via CM/ECF System ☐ Via Overnight Delivery ☐ Via Facsimile ☒ Via Email
Jerome R. Aiken, WSBA #14647 Erin E. Moore, WSBA #44779 Meyer Fluegge & Tenney 230 S. Second St. P.O. Box 22680 Yakima, WA 98907 *Attorney for Defendant Lourdes Health Network*	☐ Via Hand Delivery – ABC Legal ☒ Via U.S. Mail, 1st Class, Postage Prepaid ☐ Via CM/ECF System ☐ Via Overnight Delivery ☐ Via Facsimile ☒ Via Email

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED at Seattle, Washington, this 18th day of August, 2015.

Darla Moran, Legal Assistant