

FILED
November 7, 2016
Court of Appeals
Division I
State of Washington
NO. 74654-5-1

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

**MILTON LONG, individually and as the Personal
Representative of the ESTATE OF DONALD RODENBECK,**

Respondents,

VS.

**PEACEHEALTH dba PEACEHEALTH ST. JOSEPH MEDICAL
CENTER, a Washington Non-profit Corporation,**

Appellant.

BRIEF OF RESPONDENT

Douglas R. Shepherd, WSBA #9514
Bethany C. Allen, WSBA #41180
SHEPHERD and ALLEN
2011 Young Street, Suite 202
Bellingham, WA 98225
(360) 733-3773 or 647-4567

November 7, 2016

TABLE OF CONTENTS

I. INTRODUCTION	1
II. RESTATEMENT OF THE CASE	3
A. Death.....	3
B. PeaceHealth "Investigation"	4
C. Judicial Examination of Dr. Quigley	6
D. Additional Comments on the Evidence	7
E. Trial Testimony	9
1. Long's Expert Dr. Coleman.....	9
2. PeaceHealth's Expert Dr. Quigley	9
3. PeaceHealth's Expert Dr. Lacey	10
4. Long's Proposed Rebuttal Witness Dr. Owings	11
5. Long's Proposed Rebuttal of Dr. Coleman	14
F. Post-Surgical Internal Bleeding	16
G. Pre-Trial and Post-Trial	15
III. ARGUMENT	16
1. Standard of Review.....	17
2. Fair Statement of the Case	18

3. Statutory and Regulatory Responsibility	19
4. Constitutional Prohibition.....	22
5. Other Facts and Circumstances of the Case	23
A. An expert's foundation cannot be based upon Guess work	24
B. Substantial Evidence	25
VI. CONCLUSION	27

TABLE OF AUTHORITIES

Washington Supreme Court

<i>Moore v. Smith</i> , 89 Wn.2d 932, 578 P.2d 26 (1978)	17
<i>Port of Seattle v. Pollution Ctrl Hrg. Bd.</i> , 151 Wn.2d, 568, 90 P.3d 659 (2004)	18
<i>Risely, v. Moberg</i> , 69 Wn.2d 560, 419 P.2d 151 (1966).....	22
<i>Schmidt v. Cornerstone, Invs., Inc.</i> , 181 Wn.2d 102, 330 P.2d 182 (2014)	18
<i>State v. Becker</i> , 132 Wn.2d 54, 935 P.2d 1321 (1997).....	22
<i>State v. Bogner</i> , 62 Wn.2d 247, 382 P.2d 254 (1963)	17, 18
<i>State v. Lampshire</i> , 74 Wn.2d 888, 447 P.2d 727 (1968).....	22, 23
<i>State v. Levy</i> , 156 Wn.2d 709, 132 P.3d 1076 (2006)	18, 22

Washington State Court of Appeals

<i>City of Seattle v. Swanson</i> , 193 Wn.App 795, 373 P.2d 342 (Div. 2, 2016).....	18
<i>Dybdahl v. Genesco, Inc.</i> , 42 Wn.App 486, 713 P.2d 113 (Div. 2, 1986).....	17

**Washington State Court of Appeals
(continued)**

Pham v. Corbett, 187 Wn.App 816, 351 P.2d 241
(Div. 1, 2015)18

Reese v. Stroh, 74 Wn.App 550, 874 P.2d 200
(Div. 1, 1994)24, 25

Safeco Ins. Co. v. McGrath, 63 Wn.App 170,
817 P.2d 861 (Div. 1, 1991).....24

Schneider v. City of Seattle, 24 Wn.App 251,
600 P.2d 666 (Div. 1, 1979).....17

Seybold v. Neu, 105 Wn.App 666, 19 P.3d 1068
(Div. 1, 2001)25

States v. Stearns, 61 Wn.App. 224,
810 P.2d 41 (Div. 1, 1991)17

Court Rules

RAP 10.3(a)(5)18

Statutes

RCW 68.50.010.....19

RCW 68.50.020.....19, 20

RCW 68.50.050.....20

RCW 70.56.020.....5

Appendices

RCW 68.50.010.....	Appendix A
RCW 68.50.020.....	Appendix B
RCW 68.50.050.....	Appendix C
RCW 70.56.020.....	Appendix D
Exhibit 3 (Progress Note).....	Appendix E
Exhibit 9 (Death Certificate).....	Appendix F
Plaintiffs' Jury Instruction No. 29 (not given)	Appendix G
Plaintiffs' Jury Instruction No. 30 (not given)	Appendix H
Plaintiffs' Jury Instruction No. 25 (not given)	Appendix I

I – INTRODUCTION

On August 12, 2012, at ten (10) minutes to midnight, Donald Rodenbeck (Rodenbeck), age 72, was found dead in his hospital room, cold, on the floor, in a pool of blood. PeaceHealth cleaned up the blood, tidied the room, washed Rodenbeck, and put him back in bed. PeaceHealth then called Rodenbeck's treating physician, Dr. Zastrow, and his registered domestic partner, Milton Long (Long).

PeaceHealth, over the phone, told Long that Rodenbeck fell out of bed. While on the phone, Long heard a commotion. The caller then told Long, Rodenbeck was dead. Long asked the caller for more information, but none was provided. Long phoned a friend to take him to the hospital. Upon arrival, Long was advised the nurses were devastated by Rodenbeck's death. Dr. Zastrow told Long nothing like Rodenbeck's death had ever happened before. Dr. Zastrow told Long that Rodenbeck's central line became dislodged from his neck and Rodenbeck bled to death.

Between 10:42 p.m. on August 12, 2012, and 6:00 a.m. on August 13, 2012, more than twenty (20) employees of PeaceHealth logged into Rodenbeck's electronic medical records. When and by

whom the Whatcom County Coroner was contacted is not clear, but it was not for at least six (6) hours.

PeaceHealth investigated Rodenbeck's death. On August 15, 2012, PeaceHealth reported to the Washington State Department of Health (DOH) that Rodenbeck's fall was an "Adverse (Hospital) Event," resulting in his death. On September 4, 2012, after the completed investigation, PeaceHealth again determined and reported that Rodenbeck's fall was an "Adverse (Hospital) Event," resulting in his death.

PeaceHealth's contemporaneous records describe Rodenbeck's external blood loss, which was immediately cleaned up, as a "pool of blood." Later, PeaceHealth's records describe the pool as "moderate." In 2015, Dr. Zastrow, who was not present, described the pool as a "small amount of blood." One month before trial, PeaceHealth disclosed a witness who described the pool as a "very small amount of blood." At trial, PeaceHealth's expert, Dr. Quigley, described the pool of blood as "trivial."

Dr. Zastrow prepared a Death Certificate. The Certificate first listed Rodenbeck's manner of death as "accidental". It later was changed to "natural". Dr. Zastrow certified that Rodenbeck's

death was not referred to the Coroner, and she changed the immediate cause of death. Ex 9.

The jury, in its Special Verdict Form, determined that PeaceHealth was negligent in its care of Rodenbeck, but that its negligence was not the proximate cause of Rodenbeck's death. CP 71-2.

II – RESTATEMENT OF THE CASE

A. Death.

On August 12, 2012, at 11:50 p.m., Rodenbeck was found dead on the floor, in a pool of blood, in his hospital room. Ex. 3; Ex. 4¹. When he was found, his hospital door was closed, the lights were off and he was cold to the touch. RP 2422; RP 1601-02. PeaceHealth's employee, Kaitlyn Ekema, CNA, was told when she took over Rodenbeck's care at 10:52 p.m. that Rodenbeck was alert and oriented. RP 2411. However, PeaceHealth's retained expert, Dr. Quigley, admitted that Rodenbeck was most likely dead on the floor at 11:00 p.m. RP 1662.

////

B. PeaceHealth "Investigation."

¹ Not in original designation.

On August 15, 2012, after an initial investigation, PeaceHealth notified the DOH, that it believed Rodenbeck's death was an adverse event and described the event as a "fall" resulting in Rodenbeck's death. Ex. 35. In September, after completing its investigation, PeaceHealth again reported to the DOH that Rodenbeck's death was an adverse event and described the event as a "fall" resulting in his death. RP 2401. Jan Anderson (Anderson), PeaceHealth's safety consultant, made the reports to the DOH.

At trial, Anderson, by way of Deposition, testified that Rodenbeck's death was a sentinel event. RP 2399-2406.² It was also described as a "never event" which is a serious hospital error required to be reported by PeaceHealth. RP 714. The written DOH report was marked by Long as Exhibit 67, rejected by Judge Garrett, and sealed. Ex. 67 (sealed). Judge Garrett conducted the initial examination regarding Ex. 67. RP 1454-57.

² During the trial, the terms serious events, sentinel event, and adverse event were used interchangeably. The National quality Forum defined Serious Reportable Event as "an incident involving death or serious harm to a patient resulting from a lapse or error in a health care facility." Plaintiff's Proposed Jury Instruction 30, rejected by Judge Garrett. Appendix H.

Twice, PeaceHealth reported Rodenbeck's death to the DOH as a sentinel event, caused by a fall. RP 2405. Anderson believed her reports on Rodenbeck's death were correct. RP 2403. Anderson, on behalf of PeaceHealth, described the death as a sentinel event because after her investigation, it "met the criteria of the definition of National Quality Forum." RP 2404. PeaceHealth determined Rodenbeck's death met the statutory requirements of RCW 70.56.020, as a reportable adverse event.³ CP 1477.

Q. And would it be fair to say by August 15th PeaceHealth had determined that an adverse event had occurred?

A. Yes.

. . .

Q. And your conclusion from the initial conclusion on the 15th through the investigation didn't change, right?

A. No.

Q. I didn't do it very good. Did your conclusion change between the initial submission and the actual end of the investigation?

A. No.

RP 2405.

Q. How do you get to the conclusion as to what happened without talking to people that were involved in the treatment or care?

³ See Long's proposed jury instruction No. 29, which was rejected by Judge Garrett. Appendix G. "(1) . . . [A]dverse Health events . . . notification and reporting . . . is designed to facilitate quality improvements in the health care system, improve patient safety, . . . decrease medical errors . . . (2) When a medical facility confirms that an adverse event has occurred, it shall submit to the department of health:" RCW 70.56.020, in part.

A. I talk to people. You asked if I got written statements from people. I don't get written statements.

Q. So you trust that your memory from talking to them is accurate?

A. Yes.

RP 2405-2406.

Q. So you're comfortable when you finally file a report with the Department of Health that what you're saying is correct; is that fair?

A. Yes.

Id.

C. Judicial Examination of Dr. Quigley.

Judge Elich granted a new trial. CP 582. Judge Elich granted a new trial because of the following judicial examination of Dr. Quigley, conducted by Judge Garrett, after PeaceHealth had completed its direct examination but before allowing Long to ask any questions of Dr. Quigley.

MR. FOX: Thank you. Those are all my questions.

THE COURT: **I have one question, Doctor, and that is, I don't know the technical jargon, you indicated that you're understanding, you indicated that amount of blood that was noted at the scene was not extensive in your view.**

DR. QUIGLEY: Yes.

THE COURT: **What's your understanding, obviously you weren't there so you're relying on information from other sources on what the amount of blood was, and what I want to know is that's your information about what the amount of blood was?**

DR. QUIGLEY: Well, someone described, I forget, I really apologize, two inches around the head, which is frankly a trivial amount of blood and fluid. And someone else said it was less than a can of soda, which would be less than two of these put together and that's not enough blood to cause death, it just isn't.

THE COURT: **Uh-huh, okay. So the information that you've got comes from your reading of the chart notes?**

DR. QUIGLEY: Depositions.

THE COURT: **And from the depositions.**

DR. QUIGLEY: Actually from the depositions. I don't remember recall reading anything in the chart that said anything about blood loss. These were from eye-witnesses who were there and saw the patient and the amount of blood around his head.

THE COURT: **Okay.**

MR. FOX: Your Honor, that triggers a couple follow ups for me on this subject.

RP 1639-1640 (Emphasis added).

After the judicial examination, PeaceHealth was allowed to return to its direct examination. Dr. Quigley, when asked by PeaceHealth whose deposition provided the foundation for his opinion regarding the amount of blood on the floor, answered as follows: "But I can't remember, I really apologize, I don't remember who said what." RP 1640-41.

D. Additional Comments on the Evidence.

During Long's cross examination of PeaceHealth's expert Nurse Hobson, Hobson testified that nurses can rely upon fall risk

patients to follow instructions. Long marked Exhibit 69, and the following exchange took place in front of the jury:

THE CLERK: Plaintiff's Exhibit 69 is marked.

Q. (BY MR. SHEPHERD) I'm going to hand you what's been marked as Exhibit No. 69. Have you seen this article before?

A. Yeah, my name is on it.

Q. Is it a learned publication?

A. Is this in publication?

Q. Yes.

A. Yes.

Q. Did you write in 2004 the following: "What is" --

A. I was one of the authors, is that what you're asking?

Q. Yeah.

MR. SHEPHERD: May I approach, Your Honor, and show her where I'm going to begin?

THE COURT: You may approach.

MS. HOBSON: This is over ten years old.

Q. (BY MR. SHEPHERD) Why don't you read it to yourself to begin with starting right there "one of the institute of medicine's ten rules for health care system redesign", you see that?

A. So is there a question.

MR. FOX: Your Honor, we're way beyond the scope.

THE COURT: Where are we going with this?

MS. HOBSON: This is medication reconciliation.

THE COURT: Is there a concern in the case about medication that was given to Mr. Rodenbeck when he arrives.

MR. SHEPHERD: There is concern about poor communication between care teams and --

THE COURT: But, no, you're reading from the document. Why is this relevant?

MR. SHEPHERD: Because she testified that all nurses have to do is tell the patient not to get out of bed and they have complied with the standard of care.

THE COURT: I have read this article yesterday, it seem to be about medication.

MR. SHEPHERD: Your Honor, I'd like the jury out of here before I argue with the Court.

THE COURT: I'm going to ask you to move on and so that you can utilize the time that we have. This line of questioning we'll discuss in private and may resume it with Ms. Hobson telephonically if that's necessary.

RP 1531-33. (Emphasis added.)

E. Trial Testimony.

1. Long's Expert Dr. Coleman.

Dr. Coleman, Long's retained expert, testified that Rodenbeck's immediate cause of death was that he bled to death. RP 309. The contributing cause was Rodenbeck's fall to the floor, likely fainting, because of his undiagnosed, unrecognized internal bleeding. The risk to Rodenbeck, on the evening of August 12 and morning of August 13, was that even if he did not fall and bleed out from the neck, he was still at risk for death, if the cause of the blood loss anemia continued to go undiagnosed. RP 309-10.

2. PeaceHealth's Expert Dr. Quigley.

On cross examination, Dr. Quigley, PeaceHealth's retained expert, testified as follows:

Q. (BY MR. SHEPHERD) I'm going to hand you what's been marked and admitted as Exhibit No. 8.

A. Thank you.

Q. I'd ask you to look at the last paragraph. Dr. Owing has written in his autopsy report "it's felt that most likely death resulted from a dysrhythmia. The dysrhythmia originating in moderate to severe coronary artery

disease **complicated by** the surgical and **postsurgical blood loss**". Do you see that?

A. "And other stresses", I do see that.

Q. Do you disagree with that statement?

A. I totally agree with it.

RP 1666 (Emphasis added).

3. PeaceHealth's Expert Dr. Lacy.

On cross examination, Dr. Lacy, PeaceHealth's retained expert, testified he did not know how much external blood was lost because it was cleaned up. Dr. Lacy knew that before Rodenbeck fell, he had received two blood transfusions. RP 1958. Dr. Lacy did not know how much blood a person in Rodebeck's condition would need to lose externally to die. *Id.* Dr. Lacy testified "[c]ertainly any blood loss . . . in a person with heart disease can be considered a contributing factor" in his death. RP 1958-59.

Q. If it was at 6.8 when he fell and the central line became disconnected how much blood would he have to lose before he died?

A. Again, the amounts of blood loss are quite large, but we're talking in the order of around two liters, and for somebody with heart disease it could be less.

Q. It could be a lot less?

A. I don't know.

Q. I could be a lot less?

A. It could be less, yeah.

RP 1958.

**4. Long's Proposed Rebuttal Witness Dr.
Owings.**

Dr. Owings Pathology Report, in part, reads:

[I]t is felt that most likely death resulted from a dysrhythmia, the dysrhythmia originating in moderate to severe coronary artery disease complicated by the perisurgical and postsurgical blood loss and other stresses. It is not possible to accurately assign significance to the blood loss through the disconnected central line, though that may have contributed to the development of, or possible sustaining of, a fatal dysrhythmia.

Ex. 8.⁴ When PeaceHealth provided the testimony of Dr. Quigley, and after the trial judge's examination of Dr. Quigley, Long attempted to present the testimony of Dr. Owings, who performed Rodenbeck's autopsy, in rebuttal. Judge Garrett did not allow Dr. Owings to testify in rebuttal. RP 1919.

After Judge Garrett ruled that Dr. Owings could not testify in rebuttal, PeaceHealth provided the jury with the following testimony from Dr. Lacy:

Q. Okay. So who is more objective here, Dr. Owings or yourself, when it says "the exact amount of blood that was lost due to the disconnected central line was not available to consider as a factor in this case"?

⁴ See Plaintiff's/Appellant's Second Supplemental Designation of Clerk's Papers.

A. Well, actually both are true because Dr. Owings I'm sure did not have the information I have at this later date.

RP 1957.

Even after the above testimony by Dr. Lacy, Judge Garrett did not allow Dr. Owings to testify on behalf of Long in rebuttal. Dr. Owings' testimony was presented as an offer of proof.⁵ RP 2049-51; Ex. 79. The offered testimony included the following:

Q. So from reading your autopsy report if I were to conclude that likely you relied upon information you had from Dr. Zastrow as the foundation before you went into the autopsy, would that be a reasonable conclusion?

A. Yes. Yes. That's fair and reasonable.

Q. And if there was something of significance that you reviewed in the record you would have put it in the autopsy report and said you got that from the record; is that correct?

A. That's correct. That's fair and correct.

Ex. 79, 35: 12-22.

Q. Then it says, "Found in room in a pool of blood." Do you see that?

A. Yes.

Q. Was it your understanding that, in fact, Donald Rodenbeck had been found lying in a pool of blood?

A. I don't remember, but -- again, that makes sense with what I put in my summary, yes.

Q. So you believe his heart stopped beating for some reason?

A. Yes.

⁵ The highlighted portions of Trial Exhibit 79, contains Long's offer of proof.

Q. And you say that with the disease he had, he had an increased risk of his heart stopping, correct?

A. Yes.

Q. With the surgery he had, he had an increased risk of his heart stopping; is that correct?

A. Yes.

Q. And with the internal bleeding that he had, he had an increased risk of his heart stopping, correct?

A. Yes.

Q. And with a pool of blood from external bleeding, that would increase risk of his heart stopping, would it not?

A. I think so, yes.

Id. 39:17-40:16.

Q. Yes. So in the third full paragraph you say, "The exact amount of blood that was lost through the disconnected central line was not available to consider as a factor in this case?"

A. Right.

Q. Did you have a conversation with anyone as to why the blood was cleaned up and made to disappear before

--

A. I don't remember any conversation, no.

Id. 44:5-13.

Q. In the last full paragraph on the second page in the end of the first sentence you say, "and an unknown quantity of blood loss through a disconnected central line." Do you see that?

A. Yes.

Q. Now, I want to go back and make sure I've got this correct. Because of this disease he was an increased risk of his heart stopping; is that correct?

A. Yes.

Id. 45:16-25.

Q. And if he had been slowly, on the 12th or 11th, leaking blood internally he was at increased risk of his heart stopping, correct?

A. I'm not sure that's exactly fair to say. I'm not sure that's exactly fair to say. I'm assuming, and I don't have access to the clinical records, but I'm assuming that fluids were being replaced, perhaps even blood, I don't know. So slow loss of a unit of blood may or may not have had a major impact on his risk if it had been replaced. So that question has to be actually answered with a bit of a question.

Q. I'll show you how it was replaced twice and then how he continued to have tachycardia all through the 12th.

A. Okay.

Q. And then losing blood externally after you fall with the health that he was in and having just come out of major surgery increases the risk of his heart stopping?

A. I agree with that statement. It depends on how much, but, yes, as a general concept, I agree.

Id. 46:7-47:2.

Q. And then you say, it's not possible to exclude contribution of an episode of fainting?

A. Yes.

Q. And the fainting would be caused because he might not be getting enough blood to the brain --

A. Sure. Stand up quickly and, yes, become orthostatic.

Id. 47.

5. Long's Proposed Rebuttal of Dr. Coleman

After refusing to allow Long to bring Dr. Owings in rebuttal, Long called Dr. Coleman to rebut the testimony of Dr. Quigley and Dr. Lacy with regard to the amount of blood loss. The Court ruled that Dr. Coleman could not offer any rebuttal testimony with regard to the amount of blood on the floor.

THE COURT: But can't go into detail about how that would affect the size of the pool of blood. That's, he's already testified about that and when you talked about the blood rushing to the head that's what I was thinking about. You can talk about the function of the body nourishing the core, but not in terms of how that would effect the blood loss onto the floor.

. . . .

If he goes into a discussion of the size of the pool of blood I'll entertain an objection because that's outside the scope.

RP 2059-60.

F. Post-Surgical Internal Bleeding.

On August 10, 2012, Rodenbeck was admitted to PeaceHealth for aortobifemoral bypass surgery. Prior to surgery his blood hemoglobin was 13. Following surgery, his hemoglobin was 7.6. Dr. Zastrow diagnosed Rodenbeck with blood loss anemia. Ex. 57. He was given a blood transfusion. The next day, Rodenbeck's hemoglobin had dropped to 6.8. Ex. 59; RP 656. He was given another transfusion of blood. Ex. 61; Ex. 65.

After his second transfusion, at 10:45 a.m., on the day of his death, Rodenbeck was determined to be tachycardic, with an abnormally fast resting heart rate of 140. At 6:25 p.m., Rodenbeck was again determined to be tachycardic. Ex. 55. At 8:52 p.m., the

night of his death, a chart note disclosed that Rodenbeck remained tachycardic. Ex. 30 at 6, 8; RP 318-19; RP 343; RP 397.

These repeated tachycardic readings are a sign or symptom of hemodynamic instability. RP 395. Internal bleeding is a known cause of hemodynamic instability. RP 402.

G. Pre and Post-trial.

Pre-trial, Long filed Plaintiff's Motion for Summary Judgment re: Cause and Manner of Death (CP 1181), Plaintiff's Motion re: Spoliation (CP 1244), and Plaintiff's Motion for Partial Summary Judgment re: Negligence (CP 1877), asking Judge Garrett to address the destruction of the blood evidence on the floor. Judge Garrett denied all three motions. Long filed and requested a spoliation instruction. CP 2266; Plaintiff's Proposed Jury Instruction No. 25, Appendix I. Judge Garrett refused to instruct on spoliation stating the Court believed there was a very good explanation for the removal of the blood. RP 2156, 2160.

III – ARGUMENT

The amount of blood loss, and its role in Rodenbeck's death, was at the heart of Long's case throughout depositions, written discovery, motions and trial. PeaceHealth incorrectly argues that

the amount of blood was not significant to Long's case or that Long failed to appropriately address the blood loss. Many of Long's pleadings, motions, declarations and papers revolved around the evidentiary issue of Rodenbeck's blood loss.

1. Standard of Review.

PeaceHealth appeals Judge Elich's Supplemental Order Granting Plaintiffs' Motion for New Trial. CP 562. The standard of review of an order granting a new trial is usually abuse of discretion. *Moore v. Smith*, 89 Wn.2d 932, 942, 578 P.2d 26 (1978); *Schneider v. City of Seattle*, 24 Wn.App. 251, 255, 600 P.2d 666 (Div. 1, 1979). Judge Elich provided reasons for his decision, and reasons predicated upon an issue of law are reviewed de novo. *Id.*; *Dybdahl v. Genesco, Inc.*, 42 Wn.App. 486, 489, 713 P.2d 113 (Div. 2, 1986). Whether the comments by the Court were in violation of the constitution is an issue of law. "[I]f the reasons cited in the order are based upon issues of law, the appellate court reviews for error of law only." *Id.*

Whether judicial comments on the evidence were prejudicial is an issue of fact, reviewed for an abuse of discretion. The court is required to review the comments in light of the facts and

circumstances of the case. *State v. Stearns*, 61 Wn.App. 224, 231, 810 P.2d 41 (Div. 1, 1991). "All remarks and observations *as to the facts* before the jury are positively prohibited. . . ." *State v. Bogner*, 62 Wn.2d 247, 252, 382 P.2d 254 (1963) (emphasis added). Comments by judges "are presumed to be prejudicial." *State v. Levy*, 156 Wn.2d 709, 723, 132 P.3d 1076 (2006).

Factual findings are reviewed for substantial evidence. *City of Seattle v. Swanson*, 193 Wn.App. 795, 815, 373 P.3d 342 (Div. 1, 2016); *Port of Seattle v. Pollution Control Hearing Board*, 151 Wn.2d 568, 588, 90 P.3d 659 (2004). "Substantial evidence exists when there is a sufficient quantity of evidence to persuade a fair minded, rational person that a finding is true." *Pham v. Corbett*, 187 Wn.App. 816, 825, 351 P.2d 214 (Div. 1, 2015).

Unchallenged findings of fact are accepted as verities in this appeal. RAP 10.3(g); *Pham v. Corbett*, 187 Wn.App. at 825.

2. Fair Statement of the Case.

PeaceHealth is required to provide a fair statement of the case, without argument. RAP 10.3(a)(5). PeaceHealth's statement of the case is quarrelsome in almost every particular, especially

when it comes to the issue of blood loss. PeaceHealth argues that Rodenbeck's post surgical blood loss, while significant, was not unexpected. Brief of Appellant (BA) 6. PeaceHealth argues Rodenbeck's response to two post-surgery blood transfusions was a normal response. BA 7. PeaceHealth argues its employees created memories regarding the amount of blood loss resolves the conflict between their records and their recollection. BA 12. PeaceHealth argues its "theory" of the case. BA 16-20. PeaceHealth concludes its argument by stating that Judge Garrett referred the examination of her conduct to the presiding judge, who appointed Judge Elich, at "Mr. Long's counsel's insistence." BA 24.

PeaceHealth concludes its "factual" presentation, with the following language: Mr. Long's counsel also complained; Judge Garrett was merely explaining her ruling; Judge Garrett's questioning benefitted the plaintiff; and Judge Garrett merely asked foundational questions. BA 25-6.

3. Statutory and Regulatory Responsibility.

PeaceHealth violated clear Washington law when it moved Rodenbeck's body, placed him back in bed, cleaned up the blood, and did not call the coroner for more than six (6) hours.

PeaceHealth was not allowed to move Rodenbeck's body or clean up his blood until the Whatcom County Coroner was notified. RCW 68.50.010. "Any person knowing of the existence of such dead body and not having good reason to believe that the coroner has notice thereof and who shall fail to give notice to the coroner as aforesaid, shall be guilty of a misdemeanor." RCW 68.50.020. Any person not authorized by the coroner to move the body or who in any way conceals the body or evidence is guilty of a gross misdemeanor. RCW 68.50.050.

It is not disputed in this case that Rodenbeck was, as a matter of law, under the jurisdiction of the Whatcom County Coroner from the time of his death until a determination was made by the coroner to waive jurisdiction. The night he died, Dr. Zastrow told Long, Rodenbeck bled to death. RP 230. Dr. Zastrow, wrote in Rodenbeck's chart:

Pt (patient) had an unwitnessed fall. Found in room in a pool of blood. . . I have spoken (with) Milton Long, the pt's significant other, who arrived to the hospital. All questions were answered but obviously etiology of the fall, duration, etc. are not known. Coroner expected to evaluate.

Ex. 3. Dr. Zastrow believed that other hospital PeaceHealth employees would contact the coroner. RP 1364. PeaceHealth's house manager was instructed by Dr. Zastrow to contact the coroner. RP 1365.

Dr. Zastrow admitted Rodenbeck did not die from a heart attack and he did not die from a stroke. RP 1381. She filled out Rodenbeck's Death Certificate. Ex. 9. It was the first death certificate Dr. Zastrow filled out. RP 1343. On the death certificate, Dr. Zastrow checked "accident" as the manner of death. Ex. 9. She did not remember why the manner of death was changed to natural. RP 1446. Dr. Zastrow did not know why she had put whiteout on the section (a) of immediate cause of death and changed it to "unspecified natural causes." RP 1444.

At her pretrial deposition Dr. Zastrow testified that she relied upon someone's information to fill out the death certificate. RP 1450. At trial, Dr. Zastrow testified that no other person assisted her in filling out the death certificate and that she was confused at her deposition. RP 1450. She simply filled out the death certificate, on August 16, 2012, "with the information (she) . . . had at the time." RP 1450. In Section 56 of the Death Certificate, Dr.

Zastrow, certified that the death of Rodenbeck was not referred to the Coroner. Ex. 9.

4. Constitutional Prohibition.

“Art. IV, § 16 prohibits a judge from conveying to the jury his or her personal attitudes toward the merits of the case.” *State v. Becker*, 132 Wn.2d 54, 64, 935 P.2d 1321 (1997). Judge Garrett’s personal feelings on an issue need not be stated clearly. “[I]t is sufficient if they are merely implied.” *State v. Levy*, 156 Wn.2d 709, 721, 132 P.3d 1076 (2006). Judge Garrett’s examination of PeaceHealth’s retained expert, Dr. Quigley, on the amount of blood, clearly addressed an essential and vital part of Long’s case. When a judge’s questions appears to assume the existence of evidence which is disputed, or appears “personally to corroborate and seemingly to indorse the credibility” of a party or its expert witness, the judge improperly comments on the evidence. *Risely v. Moberg*, 69 Wn.2d 560, 565, 419 P.2d 151 (1966).

In *State v. Lampshire*, 74 Wn.2d 888, 447 P.2d 727 (1968), the Court examined one comment by the trial court, which was:

Counsel's objection is well taken. We have been from bowel obstruction to sister Betsy, and I don't see the materiality, counsel.

Id. at 891. The Washington Supreme Court held the statement made in ruling on an objection was prejudicial and entitled the defendant to a new trial. In so ruling, the *Lampshire* Court reasoned, "We are satisfied that the remark of the trial judge was made inadvertently in ruling on the motion. Nevertheless, the remark implicitly conveyed to the jury his personal opinion concerning the worth of the defendant's testimony. . . ." *Id.* at 892.

5. Other Facts and Circumstances of the Case.

During cross examination, Dr. Zastrow asked if she might look at some documents she brought with her before answering. RP 1394. Dr. Zastrow testified that the documents were informal notes made in preparation for her examination. RP 1395. They were made the night before while talking to counsel for PeaceHealth. *Id.* At that time the jury was excused at the request of Long. *Id.* Long was concerned that PeaceHealth's sharing of the testimony of Long's retained expert with Dr. Zastrow in preparation for her examination was a violation of an order in

limine and the order excluding witnesses until they testified. RP 1396. A difficult exchange took place regarding Order in Limine 9. RP 1396-1404.

When Dr. Zastrow returned to the stand, she identified three cards she had with her during her direct examination. RP 1404. She testified she wrote the information down because she believed she might be asked about the information. *Id.* While counsel for Long was examining Dr. Zastrow, Judge Garrett objected to further questions of Dr. Zastrow. RP 1405. When counsel for Long asked to see the cards, Judge Garrett examined Dr. Zastrow. RP 1405-1407. Long took exception to the procedure and asked again to see the cards. RP 1408. Judge Garrett reviewed the cards and one card, simply identified as a note card regarding the Death Certificate, was not provided to Long and was marked as Exhibit 64 and sealed. RP 1423-1424. Judge Garrett was going to give the Exhibit back to Dr. Zastrow until Long advised Judge Garrett that returning the document to Dr. Zastrow would be a clear mistrial. RP 1420. It was never provided to Long and remains sealed.

A. An expert's foundation cannot be based upon guess work.

Conclusory or speculative expert opinions lacking an adequate foundation cannot be admitted at trial. *Safeco Ins. Co. v. McGrath*, 63 Wn.App. 170, 177, 817 P.2d 861 (Div. 1, 1991).

In performing this gatekeeping responsibility, the judge should focus primarily on ER 702, which allows admission of “scientific ... knowledge” which will “assist” the trier of fact. The term “scientific” implies a grounding in the methods and procedures of science, and **“knowledge” connotes more than a subjective belief or unsupported speculation.**

Reese v. Stroh, 74 Wn.App. 550, 559-60, 874 P.2d 200 (Div. 1, 1994). (Emphasis added.) Expert testimony must be based upon the facts of the case and not on guessing or speculation. *Seybold v. Neu*, 105 Wn.App. 666, 677, 19 P.3d 1068 (Div. 1, 2001).

MR. FOX: In your opinion were the amounts described sufficient to be an actual cause of death for Mr. Rodenbeck?

DR. QUIGLEY: Absolutely not.

MR. FOX: Why not?

DR. QUIGLEY: Well, it takes an awful lot of blood loss to result in someone’s death, an otherwise normal person could lose half their blood volume and survive that. Half your blood volumes would be a tremendous amount of bleeding. In addition to that this is an IV fluids that are mixed with it probably on a 50-50 basis so half of what you see if just IV fluid, **I’m guessing but –**

MR. SHEPHERD: Your Honor, it’s not appropriate for the witness to guess for this jury. I move to strike his last answer.

THE COURT: I'll overruled. I think the witness was using vernacular as opposed to speculation.

RP 1636. (Emphasis added.)

B. Substantial Evidence.

PeaceHealth appeals several findings of fact entered by Judge Elich, which findings are not predicated on the law. Judge Elich found that the quantity of blood on the hospital floor where Rodenbeck died was a crucial fact in the trial. FF 1.19; CP 568. Judge Elich found Judge Garrett's questions of PeaceHealth's expert addressed a significant issue, the amount of blood lost by Rodenbeck. FF 1.22; CP 568. Judge Elich found that the judicial questions of Dr. Quigley were on facts that were the heart of Long's case. FF 1.23; CP 569. Judge Garrett conveyed her opinion to the jury about the credibility of PeaceHealth witnesses on the quantity of blood. FF 1.25; CP 569.

PeaceHealth does not assign error, does not argue and has not appealed the following findings of fact entered by Judge Elich. Judge Elich had both the duty and authority to make the findings and reach the conclusions he made. FF 1.7; CP 565. Article IV § 16 of the Constitution of the State of Washington prohibited Judge

Garrett from conveying her personal attitudes or from commenting on the evidence. FF 1.12; CP 565. Judge Garrett inappropriately commented on the evidence when she prohibited the cross-examination of Nurse Hobson on an Exhibit before any question was asked. FF 1.15, 1.16; CP 566-67.

V – CONCLUSION

For the reasons stated above, the Court should affirm and award Long fees and costs on appeal.

DATED this 7th day of November 2016.

SHEPHERD and ALLEN



Douglas R. Shepherd, WSBA 9514
Bethany C. Allen, WSBA 41180

DECLARATION OF SERVICE

I, Jen Petersen, declare that on November 7, 2016, I caused to be served a copy of the following document: **Respondents' Brief**; and, this **Declaration of Service**, in the above matter, on the following persons, at the following addresses, in the manner described:

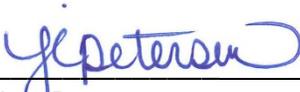
Mary Spillane, Esq. (X) U.S. Mail
Jennifer Koh, Esq. () Fax
Fain Anderson Vanderhoef () Messenger Service
Rosendahl O'Halloran Spillane, PLLC () Personal Service
701 Fifth Avenue, Suite 4650 (X) Email
Seattle, WA 98104
mary@favros.com; carrie@favros.com; jennifer@favros.com

Heath Fox, Esq. () U.S. Mail
Brian Waters, Esq. () Certified Mail
Johnson, Graffe, Keay, Moniz & Wick () Fax
925 Fourth Avenue () Personal Service
Suite 2300 (X) E-Mail*
Seattle, WA 98104
heath@jgkmw.com; sandra@jgkmw.com; brian@jgkmw.com

* Pursuant to the parties' CR 5(b)(7) Agreement dated July 23, 2014, regarding electronic service.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 7th day of November, 2016.



Jen Petersen

APPENDIX A

RCW 68.50.010

Coroner's jurisdiction over remains.

The jurisdiction of bodies of all deceased persons who come to their death suddenly when in apparent good health without medical attendance within the thirty-six hours preceding death; or where the circumstances of death indicate death was caused by unnatural or unlawful means; or where death occurs under suspicious circumstances; or where a coroner's autopsy or postmortem or coroner's inquest is to be held; or where death results from unknown or obscure causes, or where death occurs within one year following an accident; or where the death is caused by any violence whatsoever, or where death results from a known or suspected abortion; whether self-induced or otherwise; where death apparently results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulations, suffocation or smothering; or where death is due to premature birth or still birth; or where death is due to a violent contagious disease or suspected contagious disease which may be a public health hazard; or where death results from alleged rape, carnal knowledge or sodomy, where death occurs in a jail or prison; where a body is found dead or is not claimed by relatives or friends, is hereby vested in the county coroner, which bodies may be removed and placed in the morgue under such rules as are adopted by the coroner with the approval of the county commissioners, having jurisdiction, providing therein how the bodies shall be brought to and cared for at the morgue and held for the proper identification where necessary.

APPENDIX B

RCW 68.50.020

Notice to coroner or medical examiner—Penalty.

It shall be the duty of every person who knows of the existence and location of human remains coming under the jurisdiction of the coroner or medical examiner as set forth in RCW 68.50.010 or 27.44.055, to notify the coroner, medical examiner, or law enforcement thereof in the most expeditious manner possible, unless such person shall have good reason to believe that such notice has already been given. Any person knowing of the existence of such human remains and not having good reason to believe that the coroner has notice thereof and who shall fail to give notice to the coroner as aforesaid, shall be guilty of a misdemeanor. For purposes of this section and unless the context clearly requires otherwise, "human remains" has the same meaning as defined in RCW 68.04.020. Human remains also includes, but is not limited to, skeletal remains.

APPENDIX C

RCW 68.50.050

Removal or concealment of body—Penalty.

(1) Any person, not authorized or directed by the coroner or medical examiner or their deputies, who removes the body of a deceased person not claimed by a relative or friend, or moves, disturbs, molests, or interferes with the human remains coming within the jurisdiction of the coroner or medical examiner as set forth in RCW 68.50.010, to any undertaking rooms or elsewhere, or any person who knowingly directs, aids, or abets such unauthorized moving, disturbing, molesting, or taking, and any person who knowingly conceals the human remains, shall in each of said cases be guilty of a gross misdemeanor.

(2) In evaluating whether it is necessary to retain jurisdiction and custody of human remains under RCW 68.50.010, 68.50.645, and 27.44.055, the coroner or medical examiner shall consider the deceased's religious beliefs, if known, including the tenets, customs, or rites related to death and burial.

(3) For purposes of this section and unless the context clearly requires otherwise, "human remains" has the same meaning as defined in RCW 68.04.020. Human remains also includes, but is not limited to, skeletal remains.

APPENDIX D

RCW 70.56.020

Notification of adverse health events—Notification and report required—Rules.

(1) The legislature intends to establish an adverse health events and incident notification and reporting system that is designed to facilitate quality improvement in the health care system, improve patient safety, assist the public in making informed health care choices, and decrease medical errors in a nonpunitive manner. The notification and reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(2) When a medical facility confirms that an adverse event has occurred, it shall submit to the department of health:

(a) Notification of the event, with the date, type of adverse event, and any additional contextual information the facility chooses to provide, within forty-eight hours; and

(b) A report regarding the event within forty-five days.

The notification and report shall be submitted to the department using the internet-based system established under RCW 70.56.040(2) if the system is operational.

(c) A medical facility may amend the notification or report within sixty days of the submission.

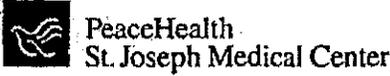
(3) The notification and report shall be filed in a format specified by the department after consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1). The format shall identify the facility, but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

(4) As part of the report filed under subsection (2)(b) of this section, the medical facility must conduct a root cause analysis of the event, describe the corrective action plan that will be implemented consistent with the findings of the analysis, or provide an explanation of any reasons for not taking corrective action. The department shall adopt rules, in consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1), related to the form and content of the root cause analysis and corrective action plan. In developing the rules, consideration shall be given to existing standards for root cause analysis or corrective action plans adopted by the joint commission on accreditation of health facilities and other national or governmental entities.

(5) If, in the course of investigating a complaint received from an employee of a medical facility, the department determines that the facility has not provided notification of an adverse event or undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to provide notification or to undertake an investigation of the event.

(6) The protections of RCW 43.70.075 apply to notifications of adverse events that are submitted in good faith by employees of medical facilities.

APPENDIX E



Prog & Orders

DATE	NOTE: PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT.
8-12-12	<p><i>Prog - above noted</i></p> <p><i>T in 37.8</i></p> <p><i>abd soft, NT.</i></p> <p><i>Drainage dry</i></p> <p><i>WBC 6.1</i></p> <p><i>All: Doing well, nothing to add.</i></p>
8/12/12 1800	<p><i>epidural Progress note - Anesthesia - Pietro</i></p> <p><i>Pod #2 sp. Anest. Doing well. Pain adequately controlled. Diet:</i></p> <p><i>Clears, Ambulating. Independent throughout pain requirements.</i></p> <p><i>Epidural #42 @ 7 ml/hr. p.s.c.</i></p> <p><i>O. AVSS, Afibrate. BP's > 180. Catheter shows some old dry</i></p> <p><i>hem. Below bandage, o/w catheter site intact, NT.</i></p> <p><i>AP. Continue epidural -> consider transition to</i></p> <p><i>po pain meds on Monday.</i></p> <p style="text-align: right;"><i>[Signature]</i> PITSCH 55862 527-7651</p>
8/13/12 0110	<p><i>Vase Sup</i></p> <p><i>Pt had an unwitnessed fall. Found in room in a</i></p> <p><i>pool of blood. Code blue called. No pulse obtained</i></p> <p><i>so pt pronounced by Dr Rantisky. I have spoken to</i></p> <p><i>Milton Long, the pt's significant other, who</i></p> <p><i>arrived to the hospital. All questions answered</i></p> <p><i>but obviously, etiology of the fall, duration, etc</i></p> <p><i>are not known. Coroner expected to evaluate.</i></p> <p style="text-align: right;"><i>[Signature]</i></p>

DOS: 11 JUL 2012
 ACCT#: 031266622

 RODENBECK, Donald K.
 6Aug1940 72 II SUR ZASTROW, COIN

 MRN: 02177240

PROGRESS NOTES

WR116-013 (10/13/10)

APPENDIX F

STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number: 1013 Washington State Certificate of Death State File Number: Edubert 9

1. Legal Name (Include AKAs if any) First Middle LAST Donald Kenneth Rodenbeck			2. Death Date 08/13/2012		
3. Sex (M/F) Male	4a. Age - Last Birth Day 72	4b. Under 1 Year Months Days 08/06/1940	4c. Under 1 Day Hours Minutes 092-30-9574	5. Social Security Number 092-30-9574	
7. Birthdate 08/06/1940		8a. Birthplace (City, Town, or County) Rochester	8b. (State or Foreign Country) NY	9. Decedent's Education Some College, No Degree	
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. No			11. Decedent's Race(s) Caucasian		12. Was Decedent ever in U.S. Armed Forces? Yes
13a. Residence: Number and Street (e.g., 624 SE 5th St.) (Include Apt. No.) 425 Chuckanut Dr N #22			13b. City or Town Bellingham		13c. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.
13c. Residence: County Whatcom		13d. Tribal Reservation Name (if applicable)	13e. State or Foreign Country WA	13f. Zip Code + 4 98229	13g. Zip Code + 4 98229
14. Estimated length of time at residence. 12 Years		15. Marital Status at Time of Death Never Married		16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage)	
17. Usual Occupation (Indicate type of work done during most of working life. Do not use retired.) Documentation Specialist			18. Kind of Business/Industry (Do not use Company Name) Import/Export		
19. Father's Name (First, Middle, Last, Suffix) Kenneth Rodenbeck			20. Mother's Name Before First Marriage (First, Middle, Last) Bernice Doyle		
21. Informant's Name Milton Long		22. Relationship to Decedent Partner		23. Mailing Address: Number and Street or RFD No., City or Town, State, Zip 425 Chuckanut Dr N #22, Bellingham, WA 98229	
24. Place of Death, if Death Occurred in a Hospital Inpatient			24. Place of Death, if Death Occurred Somewhere Other than a Hospital		
25. Facility Name (If not a facility, give number & street or location) St. Joseph Hospital			26a. City, Town, or Location of Death Bellingham	26b. State WA	27. Zip Code 98225
28. Method of Disposition Cremation		29. Place of Final Disposition (Name of cemetery, crematory, other place) Seattle Service Group Crematory		30. Location: City/Town, and State. Seattle, WA	
31. Name and Complete Address of Funeral Facility Neptune Society, 19324 40th Ave W, Ste A, Lynnwood, WA 98036			32. Date of Disposition 08/21/2012		
33. Funeral Director Signature X Les Lippitt					

34. Enter the chain of events - diseases, injuries or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or

IMMEDIATE CAUSE (Final disease or condition resulting in death): → Unspecified natural causes	Interval between Onset & Death: unknown
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST b. Vascular disease 9p aorto-bifemoral bypass Due to (or as a consequence of): c. Coronary artery disease Due to (or as a consequence of):	Interval between Onset & Death: unk
d.	Interval between Onset & Death:

35. Other significant conditions contributing to death but not resulting in the underlying cause given above:

36. Autopsy? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		37. Were autopsy findings available to complete the Cause of Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
38. Manner of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		39. If female: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	

40. Did tobacco use contribute to death?
 Yes Probably No Unknown

41. Date of Injury (MM/DD/YYYY) 42. Hour of Injury (24hrs) 43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) 44. Injury at Work?
 Yes No Unk

45. Location of injury: Number & Street, City or Town, County, State, Zip Code + 4

46. Describe how injury occurred 47. If transportation injury, specify:
 Driver/Operator Pedestrian
 Passenger Other (Specify)

48a. Certifying Physician: In the best of my knowledge, death occurred at the time, date, and place and due to the causes and manner stated.
WASH

48b. Medical Examiner/Coroner: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the causes and manner stated.

49. Name and Address of Certifier: Physician, Medical Examiner or Coroner (Type of Print)
COMM. ZASTROW MD 2450 Squallicum Pkwy Bellingham WA 98225

50. Hour of Death (24hrs)
0005

51. Name and Title of Attending Physician (if other than Certifier) (Type of Print)
MD

52. Date Signed (MM/DD/YYYY)
08/13/12

53. Title of Certifier
MD

54. License Number
20150843

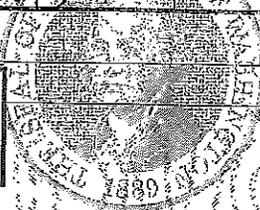
55. ME/Coroner File Number

56. Was case referred to ME/Coroner?
 Yes No

57. Registrar Signature
Guy Stone MD

58. Date Received (MM/DD/YYYY)
AUG 21 2012

TRIAL EXHIBIT 9



APPENDIX G

INSTRUCTION NO. 29

A Washington Statute defines the adverse health events and incident notification and reporting system as follows:

(1) The legislature intends to establish an adverse health events and incident notification and reporting system that is designed to facilitate quality improvement in the health care system, improve patient safety, assist the public in making informed health care choices, and decrease medical errors in a nonpunitive manner. The notification and reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(2) When a medical facility confirms that an adverse event has occurred, it shall submit to the department of health:

(a) Notification of the event, with the date, type of adverse event, and any additional contextual information the facility chooses to provide, within forty-eight hours; and

(b) A report regarding the event within forty-five days.

The notification and report shall be submitted to the department using the internet-based system established under RCW 70.56.040(2) if the system is operational.

(c) A medical facility may amend the notification or report within sixty days of the submission.

(3) The notification and report shall be filed in a format specified by the department after consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1). The format shall identify the facility, but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

WPI 60.01 (as modified);

WPI 60.03 (as modified);

RCW 70.56.020

Plaintiff's Proposed Instruction No. ____

(4) As part of the report filed under subsection (2)(b) of this section, the medical facility must conduct a root cause analysis of the event, describe the corrective action plan that will be implemented consistent with the findings of the analysis, or provide an explanation of any reasons for not taking corrective action. The department shall adopt rules, in consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1), related to the form and content of the root cause analysis and corrective action plan. In developing the rules, consideration shall be given to existing standards for root cause analysis or corrective action plans adopted by the joint commission on accreditation of health facilities and other national or governmental entities.

(5) If, in the course of investigating a complaint received from an employee of a medical facility, the department determines that the facility has not provided notification of an adverse event or undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to provide notification or to undertake an investigation of the event.

(6) The protections of RCW 43.70.075 apply to notifications of adverse events that are submitted in good faith by employees of medical facilities

The violation, if any, of a Washington Statute is not necessarily negligence, but may be considered by you as evidence in determining negligence.

WPI 60.01 (as modified);
WPI 60.03 (as modified);
RCW 70.56.020

Plaintiff's Proposed Instruction No. ____

APPENDIX H

INSTRUCTION NO. 30

The National Quality Forum defines a Serious Reportable Event as follows:

"A serious reportable event (SRE) is an incident involving death or serious harm to a patient resulting from a lapse or error in a health care facility."

APPENDIX I

INSTRUCTION NO. 25

You have heard evidence regarding the destruction of or failure to produce certain evidence. If you find that the plaintiffs have shown that PeaceHealth has failed to produce evidence within its control, and it has not provided a satisfactory explanation for doing so, the only inference you may draw is that evidence of the amount of blood, if produced, would have been unfavorable to defendant.

In determining whether a party's explanation for failing to produce evidence is satisfactory, you may consider the relevance of the missing evidence to the issues in the case, whether the failure to produce the evidence has resulted in an advantage for one party over another, and whether plaintiff was afforded an adequate opportunity to examine the evidence. You may also consider whether the party failing to produce the evidence acted in conscious disregard of the importance of the evidence, or whether there is some innocent explanation for the failure to produce.

Lynott v. National Union Fire Ins. Co.,
123 Wn.2d 678, 689, 871 P.2d 146 (1994);
Pier 67, Inc., v. King County, 89 Wn.2d 379,
385-386, 573 P.2d 2 (1977).

Plaintiff's Proposed Instruction No. _____