

No. 36805-6-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

H. CRAIG SCHWEIKART, individually, and as Personal Representative
of the ESTATE of HELENA M. SCHWEIKART; and DARCI M.
SCHWEIKART, individually, and as the Attorney-in-fact for H. CRAIG
SCHWEIKART,

Plaintiffs/Respondents,

v.

FRANCISCAN HEALTH SYSTEM-WEST, d/b/a ST. JOSEPH
MEDICAL CENTER, a Washington non-profit corporation,

Defendant/Petitioner,

NORTHWEST EMERGENCY PHYSICIANS OF TEAMHEALTH, a
Washington corporation; RANDALL KAHNG, M.D., a Washington
licensed physician, and JOHN DOES 1-10,

Defendants.

BRIEF OF RESPONDENTS

Darrell L. Cochran, WSBA No. 22851
Thomas B. Vertetis, WSBA No. 29805
James W. Beck, WSBA No. 34208
Attorneys for Plaintiffs/Respondents

GORDON, THOMAS, HONEYWELL,
MALANCA, PETERSON & DAHEIM LLP
1201 Pacific Avenue, Suite 2100
P.O. Box 1157
Tacoma, WA 98401-1157
(253) 620-6500

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I. INTRODUCTION

At issue before this Court is a premises liability case involving significant injuries sustained by an 83-year-old business invitee that subsequently caused her death. Appellant, Franciscan Health System-West (“Franciscan”), asks this Court to improperly ignore the significant evidence showing that the hospital knew its flooring was unreasonably dangerous and reverse the decision of the Superior Court denying summary judgment. This Court should affirm because Respondents (the “Schweikarts”) presented evidence that: (1) Franciscan was placed on notice of the unacceptably slippery nature of its flooring as a woman named Avis Cartier was injured approximately two years before Helena Schweikart due to the hospital’s failure to install flooring with “non-slip materials that will prevent slipping hazards” CP 141-143; (2) Franciscan was placed on notice of the unacceptably slippery nature of its flooring because its own safety committee notes from approximately two and a half years before Mrs. Schweikart’s injury detail that there was a “trend” of employee injures due to “wet floors” CP 80; (3) Franciscan failed to comply with its common law duty to inspect for dangerous conditions as the hospital had no inspection procedures CP 134; and (4) Franciscan destroyed evidence compiled during its investigation into the incident after the Schweikarts requested this evidence. CP 161-170, 302. In the

procedural posture before the Court, all reasonable inferences are drawn in the Schweikarts' favor.

Franciscan devotes much of its opening brief to incorrectly framing the issue as whether the hospital knew that there was a liquid on the floor for an extended period of time. This attempt to inaccurately frame the question was ultimately ineffective before the trial court and should be equally ineffective before this Court. The question regarding notice is simply whether the hospital knew that its flooring was posing a danger to its business invitees because it was unreasonably slick. The Schweikarts are not required to show that water was on the floor for an extended period of time because it is the choice of flooring materials, not the presence of a liquid, which presented the hazard.

This Court can take judicial notice of the fact that different materials have various coefficients of friction, or slipperiness, when wet. For instance, asphalt does not become slippery even when wet. However, a surface made of glass, for example, will become extremely slippery with even the smallest addition of a liquid. Through this premises liability case, Respondents make the straight-forward case that the hospital knew its flooring was far too slippery – it was more like glass than asphalt.

Franciscan's notice is shown by the prior injuries and its own safety committee notes. Despite this information, the hospital also failed to reasonably inspect for hazards. This proof, coupled with Franciscan's

intentional destruction of evidence, is more than sufficient to affirm the decision below. Because the Superior Court did not err in denying summary judgment on this premises liability claim, Respondents respectfully request that this Court affirm and remand this matter for trial.

II. ASSIGNMENTS OF ERROR

The Schweikarts acknowledge Franciscan's assignments of error set forth in its brief at 2, but believe the issues pertaining to the assignments of error are more appropriately formulated as follows:

1. Whether the trial court correctly concluded that evidence offered by the Schweikarts showed that Franciscan had knowledge that that its flooring was dangerous, and/or that Franciscan had unreasonable safety protocols in place to inspect for dangerous conditions such that summary judgment was inappropriate; and

2. Whether the trial court abused its discretion in ordering that Franciscan was responsible for the spoliation of evidence such that summary judgment was not appropriate.

III. STATEMENT OF THE CASE

On April 28, 2005, Helena Schweikart arrived at Franciscan's St. Joseph Medical Center to visit her husband who was admitted for surgery.

CP 86, Appendix at A-2 (CP 431).¹ Mrs. Schweikart was 83 years old. CP 256.

After entering the hospital, Mrs. Schweikart approached an elevator, and while walking to enter the elevator her foot slipped in a liquid causing her to fall hard on her right side and also hit her head. CP 88, 431. In the moments after the fall, her clothes were observed wet and covered in a liquid substance. CP 263. Mrs. Schweikart explained to Security Officer Matthew Dunne, who was assigned to investigate, that she “slipped on some liquid on the floor.” CP 165. As explained in more detail below, a bystander observed the accident. CP 86-88, 165.

Directly after the injury, Mrs. Schweikart was taken to the emergency room. CP 88, 431. When she arrived at the emergency room, she was complaining of head pain and nausea. CP 431. The emergency room doctor examined her head injury, but was more concerned with her shoulder, which he determined was dislocated. *Id.*

Mrs. Schweikart’s sons, Grant and Craig Schweikart, arrived at the hospital shortly after the accident. CP 431. During her admission, the

¹ Respondents filed a supplemental designation of Clerks Papers in accordance with RAP 9.6(a). The only document added in the supplementation is the full declaration of Grant Schweikart. This document is partially in the previously designated clerks papers at CP 259-60. However, the second page of his declaration was inadvertently not included in that portion of the record. A complete copy of this declaration was filed on October 10, 2006, and it is that copy, which is added. A copy of the complete declaration as filed October 10, 2006 is attached with the Appendix. Because Respondents believe that the Superior Court’s Clerks’ Office will label this three page document as CP 430-432, it is referenced in this manner in Respondents’ brief. If the document receives some other numbering, Respondents apologize for any confusion.

hospital staff and her doctor were advised that Mrs. Schweikart was currently prescribed a number of medications including Warfarin, an anticoagulant used to inhibit blood clotting. CP 56.² Despite being 83 years old, the hospital discharged Mrs. Schweikart that evening with no formal neurological examination or imaging study to evaluate her head trauma. *Id.*

Less than 24 hours after her discharge, Mrs. Schweikart's family found her unresponsive in bed and called for an ambulance. CP 256-57. She was immediately rushed to Good Samaritan Hospital where an examination and CT scan revealed a right intracranial hemorrhage and subarachnoid hemorrhage with an intracranial bleed. CP 56. Mrs. Schweikart never regained consciousness and passed away on May 3, 2005. *Id.*

Immediately after her injury, both of Mrs. Schweikart's sons tried to find out more information about her injury. CP 432, 276. The Schweikarts were informed that they could pick up the hospital's report by 5:00 p.m. on April 28th. CP 269. Franciscan provided the family with a document stating, in relevant part, as follows:

Franciscan Health System

....

² As this appeal only relates to the premises liability claim, and not the professional negligence claim, this citation is merely to Respondents' underlying brief and is only for the purpose of providing background information regarding the claims pending before the trial court.

For a copy of the report contact Mike Hill
Please refer to this report number when contacting Security
Services about your incident
Security Report # 05-04-2055
Date 4/28/05
426-6032 Patty Reinkensmeyer Patient Advocate Risk
Management.

CP 273.

Grant Schweikart went to Franciscan's security desk the same day as her injury and said that he "wanted a copy of the Security Report." CP 432. However, when he arrived at the security desk, he was told it was not available, allegedly because Franciscan had not yet completed the report. CP 169. After this encounter, Grant Schweikart "stopped in every day" requesting a copy of the report. CP 432. Finally, on May 2, 2005, Grant Schweikart was able to speak with Franciscan's agent, Mike Hill. *Id.* Instead of providing a copy of the report as previously promised, Mr. Hill explained that "he no longer had the report because it went to Risk Management." *Id.* Grant Schweikart then contacted Franciscan's Risk Management department, but "was told that [he] could not obtain a copy [of the report]." *Id.* Mrs. Schweikart's other son, Craig Schweikart, also tried to acquire a copy of the incident report. CP 276. However, Franciscan told him that if he wanted the incident report, he would need to retain an attorney. CP 276 ("[i]f I wanted to see the accident report, they told me I needed to talk to a lawyer.").

After initiating this action, the Schweikarts learned through discovery that Franciscan's representatives: (1) omitted the name and contact information of the only known eye-witness to the accident; (2) destroyed the statement taken from the only known eye-witness to the accident from the incident report; and (3) destroyed the handwritten investigative field notes which contained information received from Mrs. Schweikart, and the only eyewitness to the accident. CP 161-70, 302.

As noted above, Security Officer Matthew Dunne received the assignment to investigate Mrs. Schweikart's injury at the time of the fall. CP 160, 165. Upon arriving at the scene, he investigated and learned that an eye-witness was present for the accident. CP 162, 165. He spoke to the eye-witness and obtained a statement from her detailing the nature of the accident. CP 162, 165. Mr. Dunne, however, testified that his supervisor, Curtis Robinson, instructed him to delete the eye-witness's statement from the report. CP 162, 171-72. He testified on this issue as follows:

Q: Did Curtis Robinson tell you to leave out information that you had just taken from the bystander?

A: Just her statement.

Q: The bystander's statement, correct?

A: Yes.

CP 162.

Mr. Dunne also testified that he took down in his notebook the statement of the witness. CP 165. He testified as follows in his deposition regarding the statement taken by the witness:

Q: You took down a statement from the bystander who was there when Helena Schweikart died, correct?

A: Correct.

CP 162.

A: I then spoke to the bystander and recorded what she had told me.

Q: And you recorded that on your notepad?

A: Yes.

CP 165.

Mr. Dunne also took a written statement of Mrs. Schweikart. He testified in his deposition regarding this statement as follows:

Q: Then what did you do?

A: I then asked Mrs. Schweikart what her – what basically happened, which is what I entered into the report, which went in under her statement in the report. It was recorded in my notebook.

CP 165 (emphasis added).

When Mr. Dunne later produced his notes, he produced essentially blank pages. CP 302. The notes he produced provide no information and they completely contradict his sworn testimony that a detailed investigation was taken and statements from both Helena Schweikart and the eye-witness bystander were recorded. CP 161-172.

During the Schweikarts' investigation into Mrs. Schweikart's death, expert Gary D. Sloan, Ph.D. conducted a site investigation to determine why she fell. CP 95. Dr. Sloan conducted a battery of tests on the flooring, including a co-efficient of friction analysis. CP 94-102. Dr. Sloan explained that the floor had to be wet when Mrs. Schweikart fell and that the hospital should have installed flooring that was safe and slip resistant even when wet. CP 100. These flooring materials have been available for approximately 15 years and have been used to replace less safe flooring in grocery stores, furniture stores, and other public places. CP 334-35.

Franciscan acknowledged that although the hospital is a high traffic area with routine liquid spills on its flooring, there are no procedures in place to proactively check the floor for hazards. CP 100, 134. Further, Franciscan admitted that despite the inherently dangerous nature of the flooring, the hospital has failed to institute any personal checks or regular observations of the flooring to ensure its patrons' safety. CP 134. In fact, the hospital failed to have hourly or even daily floor maintenance checks. CP 134.

Through their investigation, the Schweikarts were also able to establish that Franciscan had notice of the dangerous state of its flooring materials. In Franciscan's September 19, 2002 safety committee minutes, the hospital noted that there was a problem with employees falling on the

hospital's floors. CP 80. Specifically, these minutes, recorded approximately two and a half years before Mrs. Schweikart's injury, noted that "[t]here has been a trend of employee's actions being the cause of other employee's injuries, such as wet floors . . ." *Id.*

Franciscan also knew of the dangerous condition of its flooring because it had recorded 52 prior falls by employees³ and even experienced the serious fall of a woman named Avis Cartier, which resulted in litigation against Franciscan. CP 77, 329-35. On July 3, 2003, Ms. Cartier fell "when she unexpectedly encountered a slippery floor." CP 142. Ms. Cartier filed a lawsuit against Franciscan for its dangerous flooring. CP 140-47. In this lawsuit, Ms. Cartier explained that Franciscan had a dangerous condition in that the hospital failed to install flooring made from "non-slip materials that will prevent slipping hazards." CP 143. This is the same allegation made by the Schweikarts. In support of her lawsuit, filed June 28, 2006, Ms. Cartier submitted the expert testimony of Dr. Daniel Johnson. Dr. Johnson testified that his site inspection and testing revealed that the hospital's flooring was inherently dangerous with an unacceptably low level of slip resistance. CP 332-35.

³ While the Department of Labor and Industry report does not provide details regarding the specific circumstances of these 52 injuries, at a minimum, these falls should have prompted Franciscan to conduct an investigation into its flooring to see if there was a problem or develop an inspection protocol.

On March 9, 2006, Respondents filed suit for negligence against Franciscan citing that the flooring was unreasonably dangerous and the medical care provided fell below the standard of care. CP 1-8. The complaint was amended on April 27, 2008, adding defendants regarding the medical negligence claim. CP 9-16. Thereafter, on June 29, 2007, Franciscan moved for summary judgment dismissal of Respondents' claims. CP 37-52. On August 10, 2007, the trial court entered an order granting summary judgment on the premises liability claims against Franciscan. CP 210-11. The Schweikarts promptly moved for reconsideration, and the trial court did so denying the motion for summary judgment on August 31, 2007. CP 357-59.

Franciscan moved for discretionary review, which this Court granted. Franciscan's interlocutory appeal of the denial of summary judgment is now before this Court.

IV. ARGUMENT

A. Standard Of Review.

When considering an appeal from an order of summary judgment, this Court engages in the same inquiry as the trial court. *City of Spokane v. Spokane County*, 158 Wn.2d 661, 671, 146 P.3d 893 (2006). This Court views all facts, and all reasonable inferences from those facts, in a light most favorable to the non-moving party. *Id.* Summary judgment is

appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Id.*

Further, a discovery sanction is an order reviewable only for an abuse of discretion. *John Doe v. Puget Sound Blood Ctr.*, 117 Wn.2d 772, 778, 819 P.2d 370 (1991); *Henderson v. Tyrrell*, 80 Wn. App. 592, 604, 910 P.2d 522 (1996). Judicial discretion, such as was exercised in this case, “[m]eans a sound judgment which is not exercised arbitrarily, but with regard to what is right and equitable under the circumstances and the law, and which is directed by the reasoning conscience of the judge to a just result.” *State ex rel. Clark v. Hogan*, 49 Wn.2d 457, 462, 303 P.2d 390 (1956). An appellate court will find an abuse of discretion only “on a clear showing” that the court’s exercise of discretion was “manifestly unreasonable, or exercised on untenable grounds, or for untenable reasons.” *State ex rel. Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971). A trial court’s discretionary decision “is based ‘on untenable grounds’ or made ‘for untenable reasons’ if it rests on facts unsupported in the record or was reached by applying the wrong legal standard.” *State v. Rohrich*, 149 Wn.2d 647, 654, 71 P.3d 368 (2003). A court’s exercise of discretion is “manifestly unreasonable” if “the court, despite applying the correct legal standard to the supported facts, adopts a view ‘that no reasonable person would take.’” *Id.* Although Franciscan claims that the standard of review on spoliation should be *de novo*, it cites no legal

authority for this assertion. Brief at 15. The review is for abuse of discretion.

Here, there is ample evidence to support the trial court's denial of Franciscan's motion for summary judgment. The evidence offered shows that Franciscan was negligent. Moreover, the trial court did not act in a manifestly unreasonable manner by finding that Franciscan was responsible for the spoliation of evidence. Therefore, this Court should affirm the decision below and remand this matter for trial.

B. The Trial Court Appropriately Denied Summary Judgment Because Franciscan Had Notice Of Its Dangerous Flooring.

The question of notice is one for the jury. *Schmidt v. Coogan*, 162 Wn.2d 488, 492, 173 P.3d 273 (2007). Viewing the evidence in the light most favorable to the Schweikarts, there is sufficient evidence to create a question of fact, particularly on the issue of notice, which is almost always a question for the fact finder, not the court. *Id.* (holding that “[w]hether a defective condition existed long enough so that it should have reasonably been discovered is ordinarily a question of fact for the jury.”).

To establish the elements of an action for negligence, the plaintiff must show “(1) the existence of a duty owed, (2) breach of that duty, (3) a resulting injury, and (4) a proximate cause between the breach and the injury.” *Iwai v. State*, 129 Wn.2d 84, 96 915 P.2d 1089 (1996) (citing *Tincani v. Inland Empire Zoological Society*, 124 Wn.2d 121, 128, 875

P.2d 621 (1994)). In this negligence action, Franciscan's duty is derived from its status as a landowner with its duties to Mrs. Schweikart as a business invitee. "The legal duty owed by a landowner to a person entering the premises depends on whether the entrant falls under the common law category of a trespasser, licensee, or invitee." *Iwai*, 129 Wn.2d at 90-91. "The highest duty of the three levels toward persons entering the premises of the owner or occupier of land attaches to invitees." Here, Mrs. Schweikart's status as a business invitee is not in dispute.

The Court of Appeals, in *Swanson v. McKain*, 59 Wn. App. 303, 309-10, 796 P.2d 1291 (1990), *review denied*, 116 Wn.2d 1007 (1991) explained the difference between duties owed to a licensee and those owed to an invitee: "[u]nder the Restatement standards, there exists a duty to exercise reasonable care toward licensees where there is a known dangerous condition on the property which the possessor can reasonably anticipate the licensee will not discover or will fail to realize the risks involved." *Id.* "In contrast, a possessor of land owes invitees *an affirmative duty to discover dangerous conditions.*" *Id.* at 310 n.4 (emphasis added).

Washington courts have addressed "the duty owed by business owners to their invitees to protect them from harm on the business premises." *Nivens v. 7-11 Hoagy's Corner*, 133 Wn.2d 192, 198, 943

P.2d 286 (1997). “In the case of physical danger on the business premises, Washington courts have held a business owner owes a duty to invitees to protect them from dangerous conditions on the premises.” *Id.* Many premises liability cases confirm this well established rule of law. *See, e.g., Mucsi v. Graoch Assocs. Ltd. P’ship No. 12*, 144 Wn.2d 847, 856, 31 P.3d 684 (2001) (“Reasonable care requires the landowner to inspect for dangerous conditions, ‘followed by such repair, safeguards, or warning as may be reasonably necessary for [a tenant’s] protection under the circumstances.’”) (quoting *Tincani*, 124 Wn.2d at 139); *Ford v. Red Lion Inns*, 67 Wn. App. 766, 769, 840 P.2d 198 (1992), *review denied*, 102 Wn.2d 1029 (1993)) (“A possessor of land owes a duty of reasonable care to invitees with respect to dangerous conditions on the land.”).

Despite the cases cited above, and the high duty of care owed to Mrs. Schweikart as a business invitee, Franciscan argues that the trial court erred in denying its motion for summary judgment. Franciscan’s argument is critically flawed for several reasons: (1) Franciscan had notice of the dangerous nature of its flooring because there were a number of previous falls, which were sufficient to place the hospital on notice, at least sufficient to warrant further investigation, including a fall resulting in litigation over the same issues presented here; (2) Franciscan had notice of the dangerous nature of its flooring as shown through its own committee notes; (3) Franciscan failed to fulfill its affirmative duty to discover

dangerous conditions on its property because it failed to have any program for evaluating and curing hazards, despite the notice discussed above; and (4) even assuming, *arguendo*, that there was not actual or constructive notice, the *Pimentel v. Roundup Corp.*, 100 Wn.2d 39, 666 P.2d 888 (1983), exception to providing notice should apply. Each of these issues is discussed in turn below.

1. The Schweikarts proffered sufficient evidence of notice through other injuries, including that of Avis Cartier.

One method for establishing that a landowner had notice of a dangerous condition is through the use of other incidents. Here, the trial court considered the evidence offered by the Schweikarts, and Franciscan has not assigned error to the trial court's consideration of this evidence. Appellant's Brief at 2. Therefore, this evidence was properly before the Court and the trial court's consideration of the evidence is not at issue in this appeal. RAP 10.3(a)(4); *ITT Rayonier, Inc. v. Dalman*, 122 Wn.2d 801, 803 863 P.2d 64 (1993).

Since as early as *Slaton v. Chicago, Minneapolis & St. Paul Railroad Co.*, 97 Wash. 441, 166 P. 644 (1917), Washington courts have acknowledged that reports of prior accidents similar to the one at issue are one way to establish notice. In *Slaton*, the plaintiff offered evidence of prior fires along a railroad to show the defendant's knowledge of the

danger and the defendant's negligent toleration of the danger. Our Supreme Court affirmed, reasoning:

Evidence of other fires along the right of way at other times, and, as it is alleged, under other conditions, was admitted. . . . *we think it was proper to admit the testimony as tending to show knowledge of a condition and a negligent toleration of it.* We find no error.

Id. at 443-44 (emphasis added).

Following the *Slaton* decision, many Washington decisions reaffirm that evidence of prior accidents is sufficient to show a dangerous or defective condition on the defendant's premises and the defendant's notice of such condition. In *Miller v. Staton*, 58 Wn.2d 879, 884-85, 365 P.2d 333 (1961), our Supreme Court affirmed the trial court's decision to admit evidence of previous fights in a tavern because the prior events were similar and the evidence of prior fights was relevant to the question of whether the tavern used reasonable care in protecting its patrons from the criminal acts of third parties. The Court in *Toftoy v. Ocean Shores Properties, Inc.*, 71 Wn.2d 833, 836-37, 431 P.2d 212 (1967) upheld the use of evidence that some weeks prior to the event at issue involving a dance hall slip and fall, another person had broken his leg when his heel caught on the same floor crack. *See also, O'Dell v. Chicago, Milwaukee, St. Paul & Pac. R. Co.*, 6 Wn. App. 817, 496 P.2d 519 (1972) (using other accidents and "near accidents" at grade crossing); *Evans v. Miller*, 8 Wn. App. 364, 366, 507 P.2d 887, *review denied*, 82 Wn.2d 1005 (1973)

(reversing trial court's grant of defendant's motion *in limine* excluding evidence of prior accidents); *Seay v. Chrysler Corp.*, 93 Wn.2d 319, 609 P.2d 1382 (1980) (considering prior accidents involving similar vehicles); *Davis v. Globe Machine Manufacturing Co.*, 102 Wn.2d 68, 684 P.2d 692 (1984) (use of similar spreading machine accident in Alabama).

Furthermore, where other incidents are admitted to demonstrate that a defendant had notice of a hazardous condition, the requirement of incident similarity is significantly relaxed. "When evidence is offered to show only that defendant had notice of a dangerous condition, the requirement of similarity of circumstances is relaxed: 'all that is required . . . is that the previous injury should be such as to attract the defendant's attention to the dangerous situation . . .'" *Hasson v. Ford Motor Co.*, 32 Cal.3d 388, 404, 185 Cal. Rptr. 654 (Cal. 1982). "The requisite similarity and proximity will vary depending on what the evidence of the other accident is offered to prove. If dangerousness is the issue, a high degree of similarity will be essential, and the courts usually require the prior accident to be substantially similar to the one at issue. The substantially similar standard is relaxed when the unrelated incidents are introduced for a purpose other than to prove that a product was unreasonably dangerous. If the accident is offered to prove notice, a lack of exact similarity of conditions will not preclude admission provided the accident was of a kind which should have served to warn the defendant." 2-401 *Weinstein's*

Federal Evidence § 401.08 (footnote omitted). Under the law cited above, prior accidents are sufficient to establish that an owner had notice of a dangerous condition and was unreasonably tolerant of that condition.

In *Fredrickson v. Bertolino's Tacoma Inc.*, 131 Wn. App. 183, 127 P.2d 5 (2005), a case relied on by Franciscan, the plaintiff sued a coffee shop after one of its antique chairs broke, injuring the plaintiff. There, the court deliberately observed, in holding that there was insufficient notice, that “no customer before Fredrickson [the plaintiff] had ever complained of being injured by a chair.” 131 Wn. App. at 186-187. The *Fredrickson* court also reasoned that “Fredrickson presented no evidence that antique or ‘used’ chairs pose an unreasonable risk of harm to the customers; nor did he present evidence that other chairs had broken and injured customers at Bertolino’s in the past.” *Id.* at 190. In stark contrast to *Fredrickson*, the Schweikarts have presented evidence of past injuries that put Franciscan on notice that its flooring was dangerous. A careful reading of *Fredrickson* shows that it supports the Schweikarts’ case.

In this set of circumstances, Franciscan knew people would be seriously hurt, yet it kept its same flooring in place. CP 77, 142. Specifically, the hospital was on notice of the serious injury to Ms. Cartier, which occurred on July 3, 2003. CP 142. Ms. Cartier’s 2003 injury alone is sufficient to raise a question of fact, which a jury must decide. Just as the plaintiff in *Slaton* was able to use the prior fires along

the railroad to establish notice and the railroad's unreasonable toleration of a dangerous condition, so should this Court allow the Schweikarts to use the prior injuries to show that the hospital knew or should have known that its floor was unreasonably slippery and that the hospital was negligent for tolerating that condition for such an extended period of time. For this reason, the Court should affirm the decision below and remand the case for trial.

2. Franciscan's own committee notes from 2002 are sufficient to show notice.

Franciscan's September 19, 2002 safety committee minutes show that the hospital was aware that its employees were having problems falling on the hospital's floors. CP 80. The minutes were recorded approximately two and a half years before Mrs. Schweikart's injury and state that "[t]here has been a trend of employee's actions being the cause of other employee's injuries, such as wet floors . . ." *Id.*

Franciscan clearly had notice regarding the dangerous nature of its flooring. At a minimum, these injuries were sufficient to "attract the defendant's attention to the dangerous situation[,]" and prompt an investigation into the flooring. *Hasson*, 32 Cal.3d at 404. Viewing the evidence in the light most favorable to the Schweikarts, summary judgment would not be appropriate.

3. The Schweikarts offered sufficient evidence to show that Franciscan was negligent for failing to implement safety protocols.

Franciscan, as the landowner, had a duty to both prevent hazardous conditions and affirmatively inspect for dangerous conditions. *Swanson*, 59 Wn. App. at 310. In *Egede-Nissen v. Crystal Mountain, Inc.*, 93 Wn.2d 127, 132, 606 P.2d 1214 (1980), the Supreme Court recognized that “[i]n addition to the duty owed to licensees, landowners owe invitees an affirmative duty to discover dangerous conditions. See section 343, comment b.” *Egede-Nissen*, 93 Wn.2d at 132. Comment b to the *Restatement (Second) of Torts* § 343 states, in pertinent part, that:

One who holds his land open for the reception of invitees is under a greater duty in respect to its physical condition than one who permits the visit of a mere licensee. The licensee enters with the understanding that he will take the land as the possessor himself uses it. Therefore such a licensee is entitled to expect only that he will be placed upon an equal footing with the possessor himself by an adequate disclosure of any dangerous conditions that are known to the possessor. On the other hand an invitee enters upon an implied representation or assurance that the land has been prepared and made ready and safe for his reception. He is therefore entitled to expect that the possessor will exercise reasonable care to make the land safe for his entry, or for his use for the purposes of the invitation. He is entitled to expect such care not only in the original construction of the premises, and any activities of the possessor or his employees, which may affect their condition, but also in inspection to discover their actual condition and any latent defects, followed by such repair, safeguards, or warning as may be reasonably necessary for his protection under the circumstances. As stated in § 342, the possessor owes to a licensee only the duty to exercise reasonable care to disclose to

him dangerous conditions which are known to the possessor, and are likely not to be discovered by the licensee. To the invitee the possessor owes not only this duty, but also the additional duty to exercise reasonable affirmative care to see that the premises are safe for the reception of the visitor, or at least to ascertain the condition of the land, and to give such warning that the visitor may decide intelligently whether or not to accept the invitation, or may protect himself against the danger if he does accept it. . .

(emphasis added). *See also, Swanson*, 59 Wn. App. at 310 n.4 (citing comment b for the source of duty to disclose dangerous conditions).

Washington Practice also explains the duty as follows:

A possessor of land owes business and public invitees the duty to use reasonable care, which includes an affirmative duty to discover dangerous conditions. Unlike the duty owed to a licensee, a possessor of land has a duty to protect an invitee against even known or obvious dangers where the possessor should anticipate harm to the invitee, notwithstanding such knowledge or obviousness.

David DeWolf and Keller W. Allen, 16 *Wash. Practice* § 17.5 at 552 (emphasis added).

Again, in *Fredrickson*, the case cited by Franciscan, the court acknowledged that a landowner's failure to use reasonable care in fulfilling the obligation to inspect for dangerous conditions is a sufficient basis for the matter to go to the jury. 131 Wn. App. at 190. There, the court affirmed summary judgment because the plaintiff "offered no evidence that [the owner] failed to inspect the chairs or that his inspection routine did not meet industry standards." *Id.*

In contrast to *Fredrickson*, the hospital here failed to exercise reasonable care in preventing harm because the hospital did not have inspection protocols in place to (1) determine when and where there was liquid on the floor, and (2) to act promptly to remedy liquid on the floor when this occurs. CP 134. If this Court were to accept the hospital's position on appeal, the Court would be encouraging businesses to be willfully blind by intentionally failing to implement proper safety protocols, and then claim "no notice" when injury occurs on their premises. This would be contrary to Washington law. As explained in *Egede-Nissen*, the landowner has a duty to use reasonable care to inspect. A landowner cannot ignore this duty and then escape liability based on a lack of notice.

Respondents have supplied evidence that is sufficient to raise an issue of material fact as to the hospital's notice of the inherently dangerous condition of its flooring. Specifically considering the hospital's long-term failure to exercise reasonable care in avoiding harm through regular inspections, this evidence would allow a jury to conclude that if the hospital did have regular inspections, then the injury would not have occurred. Because this is a question of fact, the trial court was correct for denying summary judgment.

4. Assuming *arguendo* that there was insufficient evidence of notice, the *Pimentel* exception for notice should apply.

As this Court has held, “[a]n injured business invitee may be excused from proving notice if the unsafe condition causing the injury is ‘continuous or foreseeably inherent in the nature of the business or mode of operation.’” *Fredrickson*, 131 Wn. App. at 191 (quoting *Ingersoll v. DeBartolo, Inc.*, 123 Wn.2d 649, 869 P.2d 1014 (1994)). In *Iwai*, 129 Wn.2d 84, four justices concurring in the majority opinion sought to expressly extend the *Pimentel* exception beyond self-service establishments, as they determined that “‘self-service’ is not the key to the exception.” *Iwai*, 129 Wn.2d at 100 (quoting *Ingersoll*, 123 Wn.2d at 654). There, these four justices reasoned that when determining if the exception applied, the issue is simply whether “the nature of the proprietors business and his methods of operation are such that the existence of unsafe conditions on the premises is reasonably foreseeable.” *Id.* This Court in *Fredrickson* declined to follow the four justices concurring in the majority opinion finding that it was not binding precedent, and determined that under the particular facts of the *Fredrickson* case, the *Pimentel* exception should not apply. 131 Wn. App. at 193.

Under the facts present here, the reasoning set forth by the four justices in *Iwai* is persuasive. There is no substantive basis to limit this exception to only self-service situations. While this Court may feel bound

by its prior decision in *Fredrickson*, the Schweikarts request that this Court reconsider that decision to the extent it limits the *Pimentel* exception to self-service situations. If necessary, the *Pimentel* exception should apply here.

C. The Trial Court Did Not Abuse Its Discretion In Finding Franciscan Responsible For The Spoliation Of Evidence.

The trial court's spoliation decision was well grounded and not an abuse of discretion. The trial court concluded, "[t]aking everything into consideration, including the spoliation issue, I'm concerned that the information of the bystander was not taken. I'm very concerned about that . . . [t]hat's bad business. I'm going to change my mind, and I'm going to deny the summary judgment." RP (8/31/07) at 41:2-8.

Before the trial court were four examples in which Franciscan spoliated critical evidence: (1) the failure to preserve the contact information for the only eye-witness; (2) the destruction of the statement taken regarding the eye-witness's observations; (3) the destruction of Helena Schweikart's statement; and (4) the destruction of the investigating officer's field notes. CP 161-170, 302. While the security guard testified that his notes were preserved at the time of his initial deposition, they were not produced upon further request and the issuance of a subpoena.

CP 162-165, 287-302. The trial court was reasonably troubled by the chronic omission and destruction of critical evidence.⁴

Washington law on spoliation is clear. As this Court previously recognized, spoliation is an evidentiary conclusion: “when a party fails to produce relevant evidence, without satisfactory explanation, ‘the only inference which the finder of fact may draw is that such evidence would be unfavorable to him.’” *Homeworks Construction, Inc., v. Wells*, 133 Wn. App. 892, 898-899, 138 P.3d 654 (2006) (quoting *Henderson*, 80 Wn. App. at 606). This Court applies the two-part *Henderson* test to determine when spoliation requires a sanction, in which the court weighs (1) the potential importance or relevance of the missing evidence; and (2) the culpability or fault of the adverse party. *Marshall v. Bally’s Pacwest, Inc.*, 94 Wn. App. 372, 381-82, 972 P.2d 475 (1999). After weighing these two general factors, the trial court uses its discretion to craft an appropriate sanction. *Id.*

Washington law and the trial court’s discretion were properly applied in this case, both as to the legal test for determining when spoliation requires a sanction, and as to the proper sanction once spoliation is found. The trial court’s sanction ensured the Schweikarts an

⁴ RP (8/31/07) at 15:23-16:19; 41:2-8; 43:21-44:2.

opportunity to have their claim presented to a jury despite the hospital's destruction of critical evidence.

1. The trial court's decision that Franciscan failed to produce important and relevant evidence was not manifestly unreasonable.

Franciscan concedes, as it must, that the missing information is relevant. The loss of evidence has resulted in an unfair investigative advantage for the hospital and the deprivation of any opportunity for the Schweikarts to examine the missing evidence. These points are significant in guiding the court's discretion where spoliation is alleged. *Henderson*, 80 Wn. App. at 607-608 (positively citing spoliation cases where one party lost or destroyed evidence before the other party had an opportunity to examine it as a factor in the court's relevance analysis).

By failing to record the name and contact information for the only eye-witness and then intentionally deleting her statement from both the report and the security officer's notes, Franciscan destroyed the Schweikarts' access to the only available eye-witness. CP 161-170. The bystander was present before, during and after the accident and reasonably would have testified to nature, duration and circumstances surrounding the liquid on the flooring and how the injury occurred. CP 165.⁵ Mr. Dunne

⁵ Franciscan argues that the only permissible inference from the spoliation would be that Mrs. Schweikart fell when there was a liquid on the floor. Brief at 33. Franciscan cites no case law in support of this contention. To the contrary, there is already evidence that Mrs. Schweikart fell while there was liquid on the floor. CP 165, 263. Franciscan's argument is also unpersuasive because it is contradicted by the recent Supreme Court decision in *Schmidt* where the court, in a per curiam opinion, held that a employee who

stated in his deposition that he took a written statement from that witness. CP 162, 165. Again, this information was not produced. CP 302. Mr. Dunne also stated in his deposition that his supervisor, Curtis Robinson, directed him to delete the statement of the independent bystander who witnessed the accident. CP 162.

The third piece of spoliated evidence is the written statement of Mrs. Schweikart. CP 165. Mr. Dunne's incident report reads, "Security Officer Matthew Dunne recorded a verbal statement from Mrs. Schweikart onto a report sheet." CP 88. Nevertheless, Franciscan has not produced the statement. Finally, the field notes of Mr. Dunne are also missing. CP 164, 302.

This evidence is more than sufficient to support the trial court's denial of summary judgment.

2. The trial court's sanction was appropriately applied and was not an abuse of discretion.

Franciscan makes two arguments based on the second culpability prong: (1) that it cannot be held responsible for spoliation by Mr. Dunne, a contract employee, and, (2) even if it can be held responsible, the spoliation was not intentional and thus does not warrant the sanction

could have seen the liquid, if the employee had looked, was sufficient to establish notice. 162 Wn.2d at 490 (reasoning that sufficient evidence was submitted when plaintiff "noticed from her position at the checkout stand that the shampoo she had slipped on was visible. The employee did not call anyone to clean the spill, and Schmidt did not see anyone checking the aisles.").

applied. Neither of these arguments is sufficient nor supports a finding of abuse of discretion.

a. Franciscan had control over the investigation.

The trial court properly determined that an inference for Respondents was appropriate due to the acts of Franciscan's agent because it retained control over both the investigation protocol and over the spoliated incident reports themselves. First, though self-evident, Franciscan concedes it is standard protocol and necessary for security officers to obtain the name and contact information for witnesses to accidents occurring within the hospital. CP 156. Second, in *Homeworks*, this court recognized that “for a direct sanction to apply the spoliation must in some way be connected to the party against whom the sanction is directed.” 133 Wn. App at 900 (quoting *Henderson*, 80 Wn. App 609-610). This court applies a “control” standard to determine when third party conduct is attributable to a party in spoliation cases. In *Homeworks*, the court analyzed whether the defendant insurer exercised “control” over a third party homeowner's decision to repair their house that resulted in spoliation of evidence in a construction defect claim. In holding that there was no control over the homeowner's actions, the court emphasized there was no legal method to force the homeowners to allow the plaintiff to inspect the house, and there was no evidence that the homeowners notified the insurer that they were going to repair the home. 133 Wn. App at 901.

In contrast, the record in this case contains evidence of the hospital's control over how its security officers responded to and recorded safety-related incidents, and directly over how the documents produced from those incidents were disclosed once they were within Franciscan's possession. First, Article 7 of Franciscan's Security Services Agreement with its independent contractors expressly requires security guards to respond to incidents "in compliance with FRANCISCAN HEALTH SYSTEM policies and procedures." CP 370. Mr. Dunne's business card is a Franciscan business card, showing he is an ostensible agent of the hospital. CP 273. Second, the record shows that all incident reports are managed by the hospital's risk management and legal department. CP 169, 273, 276, 349. When Grant Schweikart attempted to obtain a copy of the report using Mr. Dunne's business card, he was directed to Franciscan's risk management office. CP 273, 432. The risk management office informed Grant Schweikart that he "could not obtain a copy[.]" and told Craig Schweikart that if he wanted to see the accident report, he needed to "talk to a lawyer." CP 276, 432. Indeed, the declaration of Rick Nelson, a Franciscan employee, states that Franciscan controls disclosure of security reports and, if a report is requested as part of litigation, that request is reviewed by Franciscan risk management and its legal department before disclosure. CP 349.

Further, according to Mr. Dunne's deposition, the incident report contained three pieces of information before it entered Franciscan's possession: he took a written statement of the eyewitness, took a written statement of the victim, and typed field investigation notes all as part of his investigation. CP 162-65. Again, the recorded eye-witness statement and Mrs. Schweikart's statement were not produced, and once Mr. Dunne's field notes were produced, they were materially different from his testimony. CP 302.

In sum, the hospital's assertion that it is somehow unfair to hold it accountable for the acts of its security officer is simply contrary to common sense, the record, and Washington law. This argument was properly and reasonably rejected by the trial court.

b. Franciscan had a duty to preserve the incident report.

Under Washington law, a party may be responsible for spoliation without a finding of bad faith. A party's actions are improper and constitute spoliation where the party has a duty to preserve the evidence in the first place. *Homeworks*, 133 Wn. App. at 900 (citing *Henderson*, 80 Wn. App. at 610). As already stated, it is undisputed that it is standard protocol and necessary for Franciscan security officers to preserve the information gathered from investigations of accidents occurring within the hospital. CP 156. The hospital's security guards have a contractual duty

in their service agreement to provide accurate complete information. CP 369. Further, as a potential litigant, the hospital has a duty to preserve security incident reports from accidents occurring within the hospital, particularly where, as in this case, the family has come forward and requested the report. CP 349, 432. At a minimum, once a copy of the report was requested by Grant Schweikart, the hospital had an obligation to preserve the documents.

Here, the hospital failed to record and preserve the name, contact information, and statement of the only witness who observed the accident. Due to the hospital's election to exclude the Schweikarts from interviewing and obtaining the information, Respondents were severely prejudiced in discovering the truth preceding Mrs. Schweikart's fall. The trial court was correct in its decision to deny summary judgment on this independent basis.

An appropriate treatment for spoliation should include *a favorable inference treated as substantive evidence* to prove the essential fact not otherwise proved, *Pier 67, Inc. v. King County*, 89 Wn.2d 379, 385-86 573 P.2d 2 (1977) (the county's failure to preserve records relating to property valuation techniques created an inference that the county had employed discriminatory practices as alleged by the plaintiff, and that inference was sufficient to prove discrimination on the dates in question), or a *rebuttable presumption* shifting the burden to the party against whom the

presumption operates to prove the non-existence of the fact presumed. *Henderson*, 80 Wn. App. at 605 (citing *Sweet v. Sisters of Providence*, 895 P.2d 484, 491 (Alaska 1995)). On the question of spoliation, the trial court did not err in denying Franciscan's motion for summary judgment.

V. CONCLUSION

The trial court properly denied Franciscan's motion for summary judgment. The issue of notice is one for the jury and there was ample evidence that Franciscan knew or should have known that a dangerous condition was present in that its flooring was unreasonably slippery. Furthermore, the trial court did not abuse its discretion in finding that Franciscan was responsible for the spoliation of evidence.

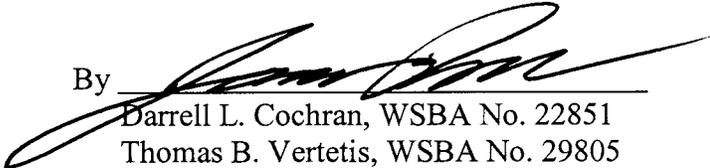
This Court should affirm the decision of the trial court. Costs on appeal should be award to the Respondents.

Dated this 22nd day of April, 2008.

Respectfully submitted,

GORDON, THOMAS, HONEYWELL,
MALANCA, PETERSON & DAHEIM LLP

By



Darrell L. Cochran, WSBA No. 22851
Thomas B. Vertetis, WSBA No. 29805
James W. Beck, WSBA No. 34208
Attorneys for Plaintiffs/Respondents

APPENDIX

Selected Record Materials

Declaration of Grant Schweikart (CP 430-432).....	A-1
Deposition of Nancy Chester (excerpt) (CP 134).....	A-4
Complaint filed by Avis Cartier (CP 140-147).....	A-5
Deposition of Matthew Dunne (excerpts) (CP 160-170).....	A-13
Notes produced by Matthew Dunne (CP 302).....	A-24
September 19, 2002 Safety Committee Minutes (excerpt) (CP 80)	A-15
Deposition of John Gastelum (excerpt) (CP 91).....	A-26

October 10 2006 8:30 AM

KEVIN STOCK
COUNTY CLERK

SERK October 20, 2006 9:00 AM

SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR PIERCE COUNTY

H. CRAIG SCHWEIKART, individually, and
as Personal Representative of the ESTATE OF
HELENA M. SCHWEIKART, and DARIC M.
SCHWEIKART, individually, and as the
Attorney-in-Fact for H. CLINE
SCHWEIKART,

Plaintiffs,

vs.

FRANCISCAN HEALTH SYSTEM-WEST
d/b/a ST. JOSEPH MEDICAL CENTER, a
Washington non-profit corporation;
NORTHWEST EMERGENCY PHYSICIANS
OF TEAMHEALTH, a Washington
corporation; RANDALL KAHNG, M.D., a
Washington licensed physician; and JOHN
DOES 1-10,

Defendants.

NO. 06-2-05927-7

DECLARATION OF GRANT
SCHWEIKART IN OPPOSITION TO
DEFENDANT'S MOTION FOR
SUMMARY JUDGMENT

ASSIGNED TO THE HONORABLE
VICKI L. HOGAN

HEARING DATE: October 20, 2006

I, GRANT SCHEIKART, declare and state as follows:

1. I am the son of decedent, Helena M. Schweikart, and have personal knowledge
of the facts set forth in this declaration and am competent to testify as to such facts. I am over
the age of eighteen (18) years.

DECL. OF GRANT SCHWEIKART - 1 of 3
(05-2-09429-506-2-05927-7)
[1362829 v1]25755

LAW OFFICES
GORDON, THOMAS, HONEYWELL, MALANCA,
PETERSON & DAHEIM LLP
1201 PACIFIC AVENUE, SUITE 2100
POST OFFICE BOX 1157
TACOMA, WASHINGTON 98401-1157
(253) 820-8500 - FACSIMILE (253) 820-8585

1 2. I was the first family member to arrive at the Emergency Room at St. Joseph
2 Hospital on the day of my mom's fall.

3 3. In the Emergency Room, my mother explained that she slipped on something
4 on the floor while waiting for the elevator to go up and visit my dad. She told me to look over
5 at her pants because they were wet.

6 4. I looked at my mother's pants and could see that there was a wet spot the size
7 of baseball – maybe a little larger.

8 5. When I arrived at the ER, my mother was already in a hospital gown with her
9 clothing removed. I remember asking my mother how she was. My mother explained that
10 she hurt her hip and it appears that she dislocated her shoulder. My mother also said she
11 bumped her head. I felt the back of her head and felt a bump.

12 6. I specifically recall my mother on multiple occasions advising the ER
13 physician and staff that she had "bumped her head", but her shoulder was really hurting her.
14 My mother was also complaining of nausea. The doctor felt the back of her head and said it
15 was a small bump and told her that the major thing we need to do is fix your shoulder.

16 7. I am aware that my brother, Craig Schweikart, provided to St. Joseph Hospital
17 staff a list of my mother's medications. The hospital made a copy of the current medication
18 list that Craig provided them.

19 8. The doctor came in after he examined her because he wrote an order for pain
20 medication to help tug and pull on her shoulder to repair the dislocation. Approximately 20-
21 30 minutes passed and the doctor returned to start manipulating the shoulder; however, no one
22
23
24
25
26

DECL. OF GRANT SCHWEIKART - 2 of 3
(05-2-09429-506-2-05927-7)
[1362829 v1]25755

LAW OFFICES
GORDON, THOMAS, HONEYWELL, MALANCA,
PETERSON & DAHEIM LLP
1201 PACIFIC AVENUE, SUITE 2100
POST OFFICE BOX 1157
TACOMA, WASHINGTON 98401-1157
(253) 820-8500 - FACSIMILE (253) 820-8565

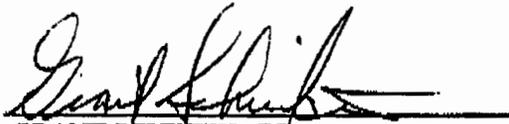
1 had yet administered the pain medication and my mom was screaming in pain. The doctor
2 left the room and then the nurse came in and gave her a shot for the pain.

3 9. Shortly after I arrived at the hospital, my father handed me a business card
4 that said "Matt Dunne, Security Officer and one side. On the back side, it said for a copy of
5 the report contact Mike Hill".
6

7 10. While my mom was in the ER, I went to the security desk and I said I wanted a
8 copy of the Security Report. They were unable to reach Mike Hill. I stopped in every day
9 and finally I started keeping notes because I was calling Mike Hill and I wasn't receiving any
10 return calls. Finally, on May 2, 2006, Mike Hill answered his phone and advised me that he
11 no longer had the report because it went to Risk Management. I attempted to reach Patty in
12 Risk Management and was told by her that I could not obtain a copy.
13

14 I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE
15 STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

16 SIGNED THIS 10th day of October, 2006, in Tacoma, Washington.

17 
18 _____
19 GRANT SCHWEIKART

20
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25
26
DECL. OF GRANT SCHWEIKART - 3 of 3
(05-2-09429-506-2-05927-7)
[1362829 v1]25755

LAW OFFICES
GORDON, THOMAS, HONEYWELL, MALANCA,
PETERSON & DAHEIM LLP
1801 PACIFIC AVENUE, SUITE 8100
POST OFFICE BOX 1137
TACOMA, WASHINGTON 98401-1137
(253) 820-8000 • FACSIMILE (253) 820-8888

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Page 18

1 A That's correct.
2 Q Okay. Were there any personal checks or observations
3 from anyone from St. Joseph's Medical Center to
4 determine if the area had any safety hazards during
5 the day, back at that time period?
6 A Not that I'm aware of.
7 Q At that time was there a policy in place that would
8 have required anyone from St. Joseph's Medical Center
9 to do hourly or every couple hour checks to make sure
10 that hallways were free of any safety hazards?
11 A Not that I'm aware of.
12 Q Okay.
13 A Not from environmental services.
14 Q Okay. Are there currently any policies and
15 procedures in place now that have those safety checks
16 in place?
17 A Not for environmental services.
18 Q Okay. When you say "not for environmental services,"
19 is there any other part of the hospital that may be
20 doing these safety checks?
21 A I can't speak for other departments.
22 Q But based on your experience at St. Joseph's Medical
23 Center, what other facility, that you can think of,
24 would possibly be inspecting the floor to determine
25 for safety hazards?

Page 19

1 A Possibly facilities or security.
2 Q You have no evidence of that?
3 A No, I have not.
4 Q You mentioned that the cleaning on the first floor
5 and also in the area of the accident is done at night
6 due to foot traffic, correct?
7 A That's correct.
8 Q How much foot traffic do you estimate that you
9 receive in the area of this accident in a day?
10 MR. ASHCRAFT: Object to the form;
11 outside the scope.
12 Go ahead.
13 THE WITNESS: I have no idea. I would
14 say hundreds of people.
15 Q (By Mr. Vertetis) Do you have a cafeteria in that
16 area?
17 A Not in that immediate area, no.
18 Q How far?
19 A Cafeteria is on the ground floor. There is a deli on
20 that floor.
21 Q Ms. Chester, it is a big hospital, I know. In the
22 area of the accident, are you familiar with that
23 area? Do you walk around that area occasionally?
24 A Yes.
25 Q So you are aware of the surroundings in that elevator

Page 20

1 vestibule?
2 A Yes.
3 Q Are you aware of a trash disposal area right around
4 the corner from the elevators?
5 A I believe there is a chute around the corner.
6 Q Do you know where the trash that feeds into that area
7 comes from?
8 Would it come from the emergency department?
9 A No.
10 Q Where would it come from?
11 A From up above there's a chute room there, possibly
12 across the corridor but not from the emergency
13 department.
14 Q Is trash or refuse from the floors that-- strike
15 that.
16 In the elevator vestibule area on the first
17 floor, is trash or waste brought down from the upper
18 floors using those elevators?
19 A No.
20 Q Wasn't there a freight elevator that's in that
21 elevator vestibule?
22 A Those are not the elevators-- the service elevators
23 that we use.
24 Q Okay. How would trash from those upper floors come
25 down?

Page 21

1 A Most of it comes down the chutes.
2 Q And that's the door that we're talking about that's
3 around the elevator?
4 A Yes, sir.
5 Q Is there any type of policy in place anywhere within
6 the hospital to be doing either hourly or semi-daily
7 inspections to make sure that the floors are free of
8 safety hazards?
9 MR. ASHCRAFT: Object to form and
10 outside the scope.
11 Go ahead.
12 THE WITNESS: We would do that only at
13 main entrances to the facility.
14 Q (By Mr. Vertetis) Is it done at main entrances to
15 the facility?
16 A Yes.
17 Q Why?
18 A We have a great deal of rain in this area, and we
19 post "wet floor" signs, and we go around and make
20 sure that those signs are in place.
21 Q Who is responsible for doing those checks?
22 A Environmental service employees.
23 Q People under your purview?
24 A Yes.
25 Q And who decides when those inspections are going to

6 (Pages 18 to 21)

Nancy A. Chester
December 6, 2006



06-2-09014-0 25718130 CMP 06-28-06

FILED
IN COUNTY CLERK'S OFFICE

A.M. JUN 28 2006 P.M.

PIERCE COUNTY, WASHINGTON
KEVIN STOCK, County Clerk
BY *[Signature]* DEPUTY

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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF PIERCE

AVIS J. CARTIER, a single woman,

Plaintiffs,

vs.

FRANCISCAN HEALTH SYSTEM, a
Washington corporation, d/b/a ST.
JOSEPH HOSPITAL,

Defendants.

NO.: 06 2 09014 0

COMPLAINT FOR DAMAGES

COMES NOW, the Plaintiff, Avis Cartier, by and through her undersigned attorney, Rodney B. Ray of Margullis, Luedtke & Ray, PLLC, and for her cause of action against Defendants above-named states and alleges as follows

I. JURISDICTION

1.1 That Pierce County Superior Court of the State of Washington has jurisdiction over this matter and that venue is proper for this claim.

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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-6264
TEL. (253) 752-2251
FAX (253) 752-1071

ORIGINAL

II. STATUS OF PLAINTIFF

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2.1 That Plaintiff Avis Cartier is a single woman and has resided in the City of Lakewood, County of Pierce, State of Washington at all times material to this Complaint for Damages.

III. STATUS OF DEFENDANTS

3.1 That at all times relevant to this Complaint for Damages, Defendant Franciscan Health System is a Washington corporation, licensed to do business in the State of Washington on August 19, 1981, and holds a current license to do business in the State of Washington through August 31, 2006.

3.2 That the registered agent for Defendant Franciscan Health System is CT Corporation System, located at 520 Pike Street in Seattle, Washington 98101.

3.3 That at all times relevant hereto Defendant Franciscan Health System is doing business as St. Joseph Hospital, with a primary place of business located at 1717 South J Street in Tacoma, Pierce County, State of Washington 98405.

3.4 That upon belief and knowledge, Plaintiff alleges that at all times material hereto, the employees, janitors, doctors, nurses, nurses assistants, agents and other staff members were employees and/or agents of Defendant Franciscan Health System d/b/a St. Joseph Hospital, and these employees and/or agents were acting within the course and scope of their employment with Defendants, and Defendant Franciscan Health System is responsible for the actions of Defendant's employees/agents under the doctrine of respondeat superior.

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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-6264
TEL. (253) 752-2251
FAX (253) 752-1071

1 3.5 That Defendant Franciscan Health System d/b/a St. Joseph Hospital is
2 jointly and severally liable for Plaintiffs' damages directly and proximately caused
3 by the actions of Defendants at the time complaint of herein.

4 IV. STATEMENT OF FACTS

5 4.1 That Plaintiff hereby incorporates by reference all allegations set forth in
6 paragraphs I, II and III above as though fully set forth herein.

7 4.2 That on or about July 3, 2003, Plaintiff Avis Cartier was at St. Joseph
8 Hospital located at 1717 South J Street in Tacoma, Pierce County, Washington.
9 Plaintiff was walking in a normal fashion in a hospital corridor when she
10 unexpectedly encountered a slippery floor. When Plaintiff took a step, her shoe
11 shot out from under her and she fell against the wall in an awkward fashion.

12 4.3 That as a direct and proximate result of the incident, Plaintiff sustained
13 bodily injury, including but not limited to injuries to her right shoulder, right ankle
14 and left leg.

15 4.4 That as a result of the injuries suffered, Plaintiff Avis Cartier has been and
16 will be compelled to seek treatment in the future for her injuries, resulting in
17 expenses and time away from work and out-of-pocket expenses.

18 4.5 That Defendant should be held financially accountable for all of Plaintiff's
19 damages, including but not limited to medical bills, disability, pain and suffering
20 and lost wages.
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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-6264
TEL. (253) 752-2251

FAX (253) 752-1071

4.6 That as a result of the Defendant's negligent acts or omissions, the Plaintiff sustained injuries and damages, such injuries and damages to be described below.

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V. CAUSE OF ACTION

5.1 That Plaintiff hereby incorporates by reference all allegations set forth in paragraphs I, II, III and IV above as though fully set forth herein.

5.2 That Defendant has the duty to properly design and maintain its floors and premises and to choose polishing materials that will not become a slipping hazard and/or choose non-slip materials that will prevent slipping hazards.

5.3 That Defendant had a duty to maintain the floors, walkways and stairs at their premises in a safe condition and to make reasonable inspections on the floors, walkways and stairs in their buildings, and to take reasonable steps to protect Plaintiff from dangerous conditions.

5.4 That on the Defendant's premises there existed a dangerous condition that was created by and/or not maintained properly by Defendant, namely that the floors were waxed and were slick, creating a dangerous condition. This dangerous condition was known or should have been known to Defendant. Defendant acted or failed to act, and by so doing, or failing to do, were reckless and/or negligent in their actions/lack of actions, and breached their duty to the Plaintiff.

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5.5 Defendant was negligent in that they failed to exercise due care for Plaintiff's safety by not utilizing slip-resistant flooring materials or substances on their floors thereby creating a hazard.

5.6 As a direct and proximate result of the negligent acts and/or omissions of the Defendant and Defendant's employees/agents, Plaintiff suffered injuries.

5.7 Defendant had a duty under the common law to exercise reasonable care to protect Plaintiff from injury on its premises, which duty included ensuring that the walkways and floors were slip-resistant, and to take reasonable steps to protect Plaintiff from such dangerous conditions.

5.8 That Defendant is liable for the acts and/or omissions of its employees and/or agents by way respondeat superior.

5.9 Plaintiff Avis Cartier was unaware of the dangerous condition and was exercising due care for her own safety at the time of the incident.

5.10 As a direct and proximate result of the Defendant's negligence, Plaintiff Avis Cartier suffered the following damages:

- a. Physical injuries and physical disabilities to her body, the full extent and nature of which will be shown at the time of trial;
- b. Emotional distress, pain and suffering, past, present and future, the full extent of which will be shown at the time of trial;
- c. Wage loss and/or diminished earning capacity, the full extent of which will be fully shown at the time of trial;
- d. Loss of enjoyment of life;

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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-6264
TEL. (253) 752-2251
FAX (253) 752-1071

1 e. Medical and related expenses incurred to date and to be incurred in
2 the future, the full extent of which at present are unknown to Plaintiff and
3 will be fully shown at the time of trial

4 f. Out-of-pocket expenses. Plaintiff is entitled to prejudgment interest
5 on out-of-pocket expenses directly and proximately caused by the
6 negligence of Defendant alleged herein;

7 g. General damages in the amount which will fully and fairly
8 compensate Plaintiff for the nature and extent of her injuries in an amount
9 which will be shown at the time of trial.
10

11 **VI. ABSENCE OF NON-PARTY "AT FAULT" ENTITIES**

12 6.1 Defendants named herein are the only "at fault" entities for this incident.
13 There are no non-party "at fault" entities who are in any way or percentage "at
14 fault" for this collision and/or for Plaintiff's injuries and damages herein.
15

16 **VII. PHYSICIAN-PATIENT WAIVER**

17 7.1 That Plaintiff Avis Cartier asserts the physician-patient privilege for 88 days
18 following the filing of this Complaint. On the 89th day following the filing of this
19 Complaint, the Plaintiff hereby waives the physician-patient privilege. That waiver
20 is conditioned and limited as follows:
21

22 a. That the Plaintiff does not waive the Plaintiff's constitutional right of
23 privacy;
24
25

- 1 b. That the Plaintiff does not authorize contact with the Plaintiff's health
2 care providers of any kind except by judicial proceeding authorized
3 by the Rules of Civil Procedure;
- 4 c. That representatives of the Defendant are specifically instructed not
5 to attempt ex parte contacts with health care providers of the
6 Plaintiff; and
- 7 d. That representatives of the Defendant are specifically instructed not
8 to write letters to Plaintiff's health care providers telling them that
9 they may mail copies of records to the Defendants.
10

11 **VIII. DEMAND FOR RELIEF REQUESTED**

12 WHEREFORE, Plaintiff Avis Cartier prays for judgment against Defendant
13 Franciscan Health System d/b/a St. Joseph Hospital jointly and severally on the
14 Complaint for Damages by way of monetary damages for all causes of action
15 pled, and for all injuries and damages allowed, provided for and permitted by the
16 common law and statutory law of the State of Washington, in such an amount as
17 shall be determined by the finder of fact under the evidence presented at trial,
18 together with such other damages, to include Plaintiff's costs, including any
19 arbitration fees, and attorney's fees, pre and post judgment interest on all fixed
20 and liquidated damages, to include Plaintiff Avis Cartier's past medical expense
21 and as follows:
22

- 23 a. For Plaintiff, Avis Cartier, special damages for medical, wage
24 loss and/or diminished earning capacity, and other related losses
25

COMPLAINT FOR DAMAGES
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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-6264
TEL. (253) 752-2251
FAX (253) 752-1071

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incurred to date and reasonably probable to be incurred in the future, caused by Defendant in the matter complained of herein for the full extent of any liability imposed on Defendant on the Plaintiff's claims.

- b. For Plaintiff Avis Cartier's costs and disbursements incurred herein, and for prejudgment interest on all special damages, and her reasonable attorney fees.
- c. For Plaintiff, Avis Cartier, general damages in an amount which will be fully shown at the time of trial, which will fully and fairly compensate her for the nature and extent of her injuries and damages caused by Defendant , and for the pain and suffering and mental anguish experienced to date and in the future.
- d. For such other and further relief as the Court deems just and equitable in the premises.

DATED this 2nd day of June, 2006,

MARGULLIS, LUEDTKE & RAY, PLLC

BY: 
RODNEY B. RAY, WSB# 7440
Of Attorneys for Plaintiff

COMPLAINT FOR DAMAGES
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MARGULLIS, LUEDTKE & RAY, PLLC
ATTORNEYS AT LAW
2601 NORTH ALDER ST.
TACOMA, WA 98407-8264
TEL. (253) 752-2251
FAX (253) 752-1071

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1 entrances of the hospital, which were sectioned off
2 into patrol of the tower area, the south pavilion
3 area, ground floor, SJMC, SJC, which are the-- "SJMC"
4 is the St. Joseph's Medical Center. "SJC" is the
5 St. Joseph's pavilion or an exterior patrol.
6 Q So you had one of six potential patrolling
7 assignments?
8 A They also would be able to assign us to relieve a
9 permanently posted officer because there were actual
10 permanent posts at the parking lot at certain times
11 of the day.
12 Q Any other assignment you could have gotten as a line
13 officer?
14 Those are the basic ones?
15 A Yeah. The only other assignment would be a pipe,
16 which is a specific type of patrol where we use an
17 electronic time-keeping device that records from a
18 marker the time and location of where we're at during
19 patrol.
20 Q And what's the purpose of that?
21 A To show that we're actually doing our patrols and
22 doing our job.
23 Q So you might be assigned the pipe, and that would
24 track what you were doing during the course of the--
25 A Correct.

Page 35

1 Q On April 28th, 2005, can we tell what your assignment
2 was that day?
3 A It's possible I may have been inbetween assignments
4 at the time or I may have been just completing a
5 patrol or I could have been on patrol at the time and
6 I was called back to the SOC to respond to the fall.
7 Q At this point you don't know which of those
8 assignments you had?
9 A No.
10 Q Can you tell what Brianna Miller's assignment was?
11 A According to this, she was the SOC officer of the
12 day.
13 Q What does that mean about whether any assistant
14 supervisor or supervisors were there?
15 Were they on shift is what I'm asking.
16 A Yeah, there would have been an assistant supervisor
17 on a shift, and if I remember correctly, the
18 assistant supervisor that was on shift at that time
19 would have been, I believe, Curtis Robinson.
20 The supervisor that would have been on shift at
21 that time would have been John Roche, I believe, if
22 it was the day shift. If it was swing shift, it
23 would have been Lisa Crider-Williams, if this was a
24 weekend.
25 Q So if it was a swing shift, who would the assistant

Page 36

1 supervisor have been?
2 A It could have been Curtis Robinson or-- I can't
3 remember the other person that would have been the
4 assistant supervisor at the time.
5 Q If it comes back to you, let me know.
6 What did the assistant supervisor typically do
7 during the course of a day? What was their
8 responsibility?
9 MR. ASHCRAFT: Object to form.
10 Go ahead.
11 Q (By Mr. Cochran) You can go ahead and answer.
12 A The assistant supervisor would have been there to
13 assist the SOC if the SOC needed any assistance, give
14 any guidance to the officers during the day if they
15 needed it, to handle any special projects they may
16 have been assigned.
17 They also, at times, do patrols as well.
18 Q Do you have any knowledge of what a supervisor
19 typically did during the day?
20 A They sometimes performed rounding, which was to see
21 how the officers were performing by asking the staff
22 at the hospital, and they would be at the SOC helping
23 coordinate and reviewing reports to see if any
24 corrections need to be made, whether there were
25 misspellings or something needed to be clarified.

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1 Q Do you remember an assistant supervisor or supervisor
2 reviewing the report that you did for Helena
3 Schweikart's fall?
4 MR. ASHCRAFT: Object to the form.
5 Q (By Mr. Cochran) Go ahead.
6 A It would have been reviewed, but the only initials
7 that are on the report are Mike Hill's.
8 Q Did Mike Hill have an office at St. Joe's back in
9 April of 2005?
10 A Yes. He had an office in the regional security
11 office.
12 Q Where is that located in the hospital?
13 A On the ground floor.
14 Q When you say "regional security," does that mean for
15 more hospitals than just St. Joe's?
16 A Yes. It manages all of the security departments
17 within the Franciscan Health System.
18 Q And that would include St. Francis where you work at
19 now?
20 A Yes.
21 Q Does Mike Hill typically review reports that you do
22 in an accident situation like Helena Schweikart's?
23 A I would assume so, yes.
24 Q Have you ever talked to him about a report that
25 you've done?

10 (Pages 34 to 37)

Matthew W. Dunne
November 2, 2006

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1 A No.
2 Q Did you talk to him about the report that you did for
3 Helena Schweikart, aside from the last couple of
4 weeks? I am talking about on April 28th, 2005 or any
5 day after it.
6 A No.
7 Q When did you find out that Mike Hill had reviewed
8 your report for Helena Schweikart?
9 A When I saw his initials on this when I first reviewed
10 the report.
11 Q And when was that?
12 A Last week when I got it.
13 Q And the initials you're indicating are Mike Hill's
14 are on Page 2?
15 A Correct.
16 Q Can we tell whether a lead officer or assistant
17 supervisor or supervisor reviewed this report of
18 yours for Helena Schweikart?
19 A No, we can't tell that because there is no initials
20 for a lead officer or assistant supervisor or a
21 supervisor that was on duty at the time.
22 Q Again, you're looking at Page 2 of 3?
23 A Yes.
24 Q "Ops supervisor review" is where we find Mike Hill's
25 initials.

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1 Is that usually the spot where an assistant
2 supervisor or supervisor for the security division at
3 St. Joe's signs it?
4 MR. ASHCRAFT: Object to form.
5 THE WITNESS: No, the lead officer or
6 assistant supervisor or supervisor would initial it
7 where the "lead officer review" initials are.
8 Q (By Mr. Cochran) Over on the left-hand blank where
9 it's an empty blank, right?
10 A Correct.
11 Q Then is it usual, from your experience, that Mike
12 Hill would do his signatures over here in the ops
13 supervisor review part?
14 A Correct.
15 Q And did Mike Hill give you any feedback about Helena
16 Schweikart's report?
17 A No.
18 Q Did any other supervisor or superior of yours give
19 you any feedback about the Helena Schweikart report?
20 A Assistant Supervisor Robinson gave me no feedback
21 other than the fact that he was looking it over.
22 Q So you remember Curtis Robinson reviewing this Helena
23 Schweikart report?
24 A I believe, yes.
25 Q Did you have Brianna Miller review the report on

Page 40

1 April 28th, 2005?
2 A No.
3 Q Do you remember John Roche reviewing it at all?
4 A No. The only person I remember actually looking at
5 the report would have been Curtis Robinson.
6 Q Did Curtis Robinson remove the bystander's name from
7 the report?
8 A Remove the bystander's name from the report?
9 Q Correct.
10 A No.
11 Q Did he ask you to remove any portion of the report
12 that you drafted?
13 A No, not that I recollect.
14 Q Did he play any part in altering the report that you
15 initially filled out?
16 A Did he play any part in altering the report?
17 Q Right.
18 MR. ASHCRAFT: Object to the form.
19 Q (By Mr. Cochran) Go ahead.
20 Matt, do you feel comfortable telling the truth
21 here today?
22 A Yes.
23 Q Did Curtis Robinson alter your report?
24 A I do not believe he did, no.
25 Q Did he go into the Word document that you created

Page 41

1 with this report and change it in any fashion?
2 A Not to my knowledge.
3 Q I assume at some point in your security career, you
4 learn what to look for when someone is not telling
5 the truth, right?
6 A Yes.
7 Q What types of things did you learn about?
8 A If they're not looking at you directly, body
9 language.
10 Q Changing words to say "not that I recollect" if
11 you're uncomfortable with it, right?
12 MR. ASHCRAFT: Object to the form.
13 Q (By Mr. Cochran) Did you learn that?
14 A No.
15 Q To use evasive words--
16 A Well, using evasive words, yes.
17 Q Shaking, right?
18 A I am nervous.
19 Q Okay. And you're nervous in particular about
20 answering this question about whether Curtis Robinson
21 changed the report, right?
22 MS. ALVAREZ: Objection.
23 Q (By Mr. Cochran) Go ahead.
24 A I'm trying to remember whether he had said anything
25 that would have guided the way the report was

11 (Pages 38 to 41)

Matthew W. Dunne
November 2, 2006

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1 written, but I cannot remember him doing that.
2 Q Okay. Tell me what you do remember about Curtis
3 Robinson's role in reviewing your report because to
4 me it appears obvious that you're upset about it.
5 MR. ASHCRAFT: Object to the form.
6 Q (By Mr. Cochran) Go ahead.
7 A Okay. The thing was I was told that the report had
8 to be done as quick as possible and it had to be
9 written before the end of my shift, and they told me
10 I had to write down everything I was able to record,
11 and the only thing he told me to leave out was the
12 bystander as far as the-- leaving off her statement
13 because I was not-- I failed to get her name or her
14 contact information.
15 Q Did Curtis Robinson tell you to leave out information
16 that you had taken from the bystander?
17 A Just her statement.
18 Q The bystander's statement, correct?
19 A Mm-hm, yes.
20 Q I assume that you're nervous about telling the full
21 truth because you're still employed with Franciscan
22 Health Systems and you're still under Mike Hill's
23 supervision, right?
24 MR. ASHCRAFT: Object to the form.
25 Q (By Mr. Cochran) Go ahead.

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1 A The only thing I'm worried about is whether I'll end
2 up losing my job because-- if I made any mistakes.
3 Q You understand you're protected by whistle-blower
4 statutes for telling the truth, right?
5 I want you to know you are protected by
6 whistle-blower statutes, okay?
7 Do you understand that?
8 A Yes.
9 Q Is Curtis Robinson still working with St. Joe's?
10 A No.
11 Q Is he working with Allied Barton, your security
12 company now?
13 A No.
14 Q But Mike Hill still is, right?
15 A Mike Hill is employed by Franciscan Health Systems.
16 Q Okay.
17 A So he's separate.
18 Q Did Curtis Robinson get terminated for any reason
19 that you're aware of?
20 A I don't know all the circumstances of him leaving.
21 Q What do you know?
22 A All I know is that he was on-- at one point he was
23 employed and at the next point we were basically
24 aware of him not being with the company anymore.
25 Q Okay. What did you hear about why he was no longer

Page 44

1 with the company?
2 A What I did hear was that he told some higher-up in
3 Allied Barton about something when they were asking
4 about, I guess, his job performance. I don't know.
5 I know that he did tell off some of the
6 higher-ups of Allied Barton, and that is part of what
7 I believe led to him being fired.
8 Q You consider yourself to be a good security officer,
9 right?
10 A Yes.
11 Q You took down a statement from the bystander who was
12 there when Helena Schweikart died, correct?
13 A Correct.
14 Q And you--
15 A She died?
16 Q She fell, and she later died.
17 A Okay.
18 Q You took down a statement at the scene where Helena
19 Schweikart died or where she fell?
20 A The statement from the bystander was pretty much
21 actually what went into the report because she had
22 told John, the tech in ER, pretty much what she told
23 me.
24 Q Let me ask you a specific question.
25 You took a statement from the bystander that day,

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1 correct?
2 A Mm-hm, yes.
3 Q Let's walk through the report, if we can.
4 On Page 1 of Exhibit No. 2-- first let me ask you
5 about Exhibit No. 1.
6 (Exhibit No. 1 marked for
7 identification.)
8
9 Q (By Mr. Cochran) Tell us what Exhibit No. 1 is.
10 A Exhibit No. 1 is a contact card for security that we
11 fill out with our name on it, and it has the number
12 to the security operations center, and on the reverse
13 side we write the report number and the date of the
14 report to be given to an individual who was involved
15 with the report if they so wanted a copy of the
16 report.
17 Q And here-- this is your handwriting, correct?
18 A Correct.
19 Q And you wrote on the report, "For a copy of the
20 report, contact Mike Hill," correct?
21 A Correct.
22 Q Did you give this card to anybody with respect to
23 Helena Schweikart's fall?
24 A I believe I gave it to her husband.
25 Q Let's walk through the report now, which is Exhibit

12 (Pages 42 to 45)

Matthew W. Dunne
November 2, 2006

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<p>1 No. 2.</p> <p>2 A Okay.</p> <p>3 Q Is that an original or is that a copy?</p> <p>4 A This is a copy.</p> <p>5 Q And does it have three pages?</p> <p>6 A Yes.</p> <p>7 Q I want to make sure that it's the same thing as our 8 Exhibit No. 2.</p> <p>9 It seems to be a more legible copy than the one 10 I've got, so I'm going to have you help me understand 11 what some of the words are.</p> <p>12 In fact, I'll probably get a copy of that since 13 it's a much better one than I've got.</p> <p>14 Up here in the "Incident" section, tell us what 15 that says.</p> <p>16 A It says the accident is nonvehicular.</p> <p>17 Q And then it says, "Type: Fall"; is that right?</p> <p>18 A Yes.</p> <p>19 Q And then the report number, is that the same report 20 number you've written here on Exhibit No. 1, the 21 05042055?</p> <p>22 A Yes.</p> <p>23 Q "Cite code," tell us what that says and what it 24 means.</p> <p>25 A It says, "FHS SJMC," which stands for Franciscan</p>	<p>1 Q And then you've written down ER tech John's home 2 address; is that right?</p> <p>3 A No. That is the address of the hospital.</p> <p>4 Q And that's for his contact information?</p> <p>5 A Yeah, and phone number is the internal line for the 6 emergency care unit, which is 1276963.</p> <p>7 Q And you wrote that down so you would later know where 8 to contact ER John if there were questions about the 9 incident, right?</p> <p>10 A Correct.</p> <p>11 Q That's part of your standard practice as a security 12 officer?</p> <p>13 A Yes.</p> <p>14 Q And to put his phone number down so you or somebody 15 else could contact him later, right?</p> <p>16 A Yes.</p> <p>17 Q Then the next box down says, "Security officer 18 reporting," and that's you, right?</p> <p>19 A Yes.</p> <p>20 Q So you wrote your own address so somebody could 21 contact you and your internal line as well, right?</p> <p>22 A The address at the hospital and the contact line of 23 the security operations center.</p> <p>24 Q And so when it says, "Security officer reporting," 25 tell us what that means.</p>
Page 47	Page 49
<p>1 Health Systems, St. Joseph's Medical Center.</p> <p>2 Q Then tell us what "Security response time notified" 3 means.</p> <p>4 A Their response time notified, time notified would be 5 the time the SOC was notified of the incident. The 6 time of arrival would be when the security officers 7 assigned the task of investigating the incident and 8 arriving at the incident--</p> <p>9 Q What does "time cleared" mean?</p> <p>10 A When the incident was cleared, which we-- basically 11 ended the incident.</p> <p>12 Q What happens to end the incident?</p> <p>13 A Excuse me?</p> <p>14 Q What happens to actually end the incident?</p> <p>15 A We were cleared by the supervisor or we're finished 16 gathering the information that was needed.</p> <p>17 Q Do you remember which it was in this case?</p> <p>18 A No, I do not.</p> <p>19 Q In the section where it says, "First reported or 20 observed by," you've written whom?</p> <p>21 A That's ER tech John.</p> <p>22 Q And tell us what else you wrote.</p> <p>23 A It says, "FHS SJMC ECU."</p> <p>24 Q Which means emergency?</p> <p>25 A Emergency care unit.</p>	<p>1 A It's the security officer that is filling out the 2 report who has investigated the incident initially.</p> <p>3 Q Tell me about when you started filling out this 4 security incident report we have here as Exhibit 5 No. 2.</p> <p>6 When did you start doing it?</p> <p>7 A It would have been right after or shortly after the 8 incident was cleared.</p> <p>9 Q So it would have been after 12:49?</p> <p>10 A Correct.</p> <p>11 Q Before that time you would have responded to the 12 incident, right?</p> <p>13 A Mm-hm.</p> <p>14 Q In fact, we know that you were responding at 12:20 or 15 12:21, correct?</p> <p>16 A Correct.</p> <p>17 Q And you would have had a notepad with you at that 18 point, right?</p> <p>19 A Yes.</p> <p>20 Q And you would have been taking down the information 21 that you included in the security incident report on 22 your notepad, right?</p> <p>23 A Right.</p> <p>24 Q And typically you would keep your notepad pages for 25 this incident report, right?</p>

13 (Pages 46 to 49)

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1 A - Yes.
2 Q Did you do that here?
3 A I had kept my notepad, and I am still looking for
4 that notepad.
5 Q Would you typically have kept or made a xerox copy of
6 your notepad pages to enter with this report?
7 A No.
8 Q Would you typically have turned your notepad in after
9 moving away from St. Joe's?
10 A No, because we're still part of the same system.
11 Q Was the notepad issued to you by your security
12 company?
13 A No.
14 Q Was it issued by Franciscan Health Systems?
15 A No. It is a pad that we-- basically, I bought it at
16 a convenience store.
17 Q Is that true with the other officers as well, to your
18 knowledge?
19 MR. ASHCRAFT: Object to the form.
20 THE WITNESS: To my knowledge, yes.
21 Q (By Mr. Cochran) Does Brianna Miller buy her own
22 notepad?
23 A As far as I know, she does, yes.
24 Q And your practice has always been to keep those
25 notepads in case there's a question later about what

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1 you wrote?
2 A Yes.
3 Q And am I correct in understanding that you are
4 currently looking for the one that contains the notes
5 of your investigation of Helena Schweikart's fall?
6 A Yes.
7 Q And you usually keep your notepads in a particular
8 place?
9 A I usually keep them in my fire safe.
10 Q Is that at your residence?
11 A At my residence, yes.
12 Q And have you looked there?
13 A Yes.
14 Q Have you been asked not to find it by Mike Hill or
15 anyone else?
16 A No.
17 Q Do you intend on finding it?
18 A Yes, I am fully intending on finding it.
19 Q Are you going to produce those to the attorneys for
20 this case when you find it?
21 A Yes.
22 Q Is there any reason why you would not do that?
23 A No.
24 Q Does fear for your job play into that?
25 A No.

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1 Q On the section of Exhibit No. 2, Page 1 where it
2 says, "Persons involved as witnesses," you listed
3 John, the emergency room tech, correct?
4 A Yeah.
5 Q You listed Helena Schweikart, and you got her address
6 and phone number, correct?
7 A Correct.
8 Q You haven't listed the bystander who you encountered,
9 correct?
10 A Correct.
11 Q And you did that because Curtis Robinson told you not
12 to put it down, correct?
13 A Correct.
14 Q In the section that says, "What was done for injured
15 persons," can you read that for us? Our copy is bad.
16 A What was done for the injured person was the injured
17 person was taken to triage and treated in the ER.
18 She was still in the ER at the time, so she was
19 being treated at ER.
20 Q Back up to the witness's name for a second. You
21 recorded the bystander's name, address, and phone
22 number in your notepad notes, correct?
23 A No. I neglected to get the bystander's name.
24 Q My question to you: Are you telling the truth?
25 A Yes.

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1 Q And your notes would reflect that?
2 A Yes.
3 Q Why do you think it was, after having recorded John's
4 name and phone number and address and Helena
5 Schweikart's phone number and address, that you have
6 neglected to obtain the address and phone number for
7 the bystander?
8 A Because I was nervous and this was my first accident
9 report.
10 Q But you succeeded in doing it for John and Helena
11 Schweikart.
12 You were nervous while you were taking their
13 names down too, right?
14 MR. ASHCRAFT: Object to the form.
15 Q (By Mr. Cochran) Go ahead.
16 A Yeah, I would say I was probably nervous at that
17 point.
18 Q So what would have been different about the
19 bystander's address and phone number than Helena
20 Schweikart's and John's in terms of your nervousness?
21 A There was a lot more activity going on around when
22 the bystander was there because John and the other ER
23 personnel were helping Ms. Helena Schweikart into the
24 wheelchair and moving her to the ER.
25 Q You did get the bystander's name in your notepad,

14 (Pages 50 to 53)

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1 correct?
2 MR. ASHCRAFT: Object to the form.
3 THE WITNESS: No, I did not.
4 Q (By Mr. Cochran) How can you be sure about that?
5 A Because I remember being chastised by Curtis Robinson
6 for not doing so.
7 Q Let's drop down in the report, and let me ask you to
8 explain to me everything that you recall from first
9 learning anything about Helena Schweikart falling to
10 the end of your shift on April 28th, 2005.
11 A Okay. The first thing I remember was being told by
12 Brianna Miller that there was an accident by the
13 south pavilion elevators, which needed to be
14 investigated, and I was then dispatched to that area.
15 At that time I went to the south pavilion area to
16 see what I could do to help, and ER tech John and the
17 other ER tech personnel were getting Ms. Schweikart
18 into the wheelchair to be moved down to the ER triage
19 area.
20 John had indicated the bystander to me, saying
21 that she had seen the fall and that he had come upon
22 it while he was returning from-- I believe it was the
23 cafeteria.
24 Q That John had?
25 A Yeah. He was on his way back to the ER.

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1 I then spoke to the bystander and recorded what
2 she had told me.
3 Q And you recorded that on your notepad?
4 A Yes.
5 Q Then what did you do?
6 A Then I was looking the area over to see if there was
7 any hazards. I do not recollect seeing any hazards
8 at the time, such as water, and then I went from
9 there back to the SOC to find out from triage which
10 room Ms. Schweikart was going to be entered in and to
11 tell Curtis Robinson what I had learned so far.
12 It was at that time that Curtis Robinson had
13 chastised me for not getting the bystander's name,
14 and I was then sent back to that area to see if she
15 was still there over by the south pavilion elevators,
16 and she was not.
17 Q Then what did you do?
18 A I then went to the ER, and at that point it was
19 Mr. Schweikart and Mrs. Schweikart that were inside
20 the UCU area, which was urgent care. I don't
21 recollect which room number it was.
22 I asked if I could come in and take a statement.
23 Mrs. Schweikart was apparently in pain.
24 Mr. Schweikart was in a wheelchair because I remember
25 that he was already entered into the hospital, I

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1 believe in the acute care area, which is in the south
2 pavilion.
3 I then asked Mrs. Schweikart what her-- what
4 basically happened, which is what was entered into
5 the report, which went in under her statement in the
6 report. It was recorded in my notebook.
7 I had originally brought a statement sheet to
8 have her write it out, but she was unable to at the
9 time because she was in too much pain.
10 Q And then what happened?
11 A After taking her statement, I then went back to the
12 SOC and told Curtis and Brianna that I was going to
13 go back to the south pavilion area to recheck it to
14 make sure-- to see if there was any water on the
15 ground because it was at that time, after speaking to
16 Mrs. Schweikart, that I had learned that-- in her
17 statement that she said she had slipped on some
18 liquid on the floor.
19 I went back to the elevator she had indicated
20 that she was going to and did not find any slipping--
21 any liquid there at the time I had gone back to
22 check.
23 Q Which was quite a while after she'd fallen, right?
24 A It would have been probably closer to the 12:49 time
25 frame.

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1 Q That you went back and checked?
2 A When I went back to double check, yes.
3 Q So almost 30 minutes after she'd fallen, probably
4 over 30 minutes after she'd fallen, right?
5 A It was probably 20 minutes by the time I was able to
6 be absolutely certain--
7 Q Well, the SOC was notified by ER tech John who came
8 upon the scene after she'd already fallen, correct?
9 A Correct.
10 Q And we know that the security office wasn't even
11 notified until 12:20, so she had to have fallen
12 before 12:20, correct?
13 A Yes.
14 Q So your last act when you cleared at 12:49 was to go
15 back to that south pavilion to look for water,
16 correct?
17 A My last act was to speak to ER tech John to see if
18 the bystander had told him the same thing that she
19 had told me, and that is why ER tech John's statement
20 is in the report and not the bystander's.
21 Q Now, just to make sure we're clear, Helena Schweikart
22 told you she fell on liquid as she was going to the
23 elevator, correct?
24 A Yes, she did.
25 Q And she was hurting too badly to fill out a report

15 (Pages 54 to 57)

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<p>1 herself, correct? 2 A To fill out a statement, yes. 3 Q And one of the pains that she was having was an 4 injury to her head, correct? 5 MR. ASHCRAFT: Object to the form. 6 MS. ALVAREZ: Objection. 7 THE WITNESS: She had never indicated to 8 me that she was hurting in her head. 9 I asked her where she was hurting. She had 10 indicated to me her entire left side, which was her 11 arm and her leg. She had never indicated to me she 12 hit her head or hurt her head. 13 Q (By Mr. Cochran) Are you testifying under oath that 14 she did not mention that she had hit her head? 15 A Correct. 16 Q Why don't you tell me what you asked her specifically 17 about what was hurt. 18 Do you remember? 19 A Yes. I asked her what parts of her body were hurting 20 and if she had hit any portion or parts of her body 21 on the way down when she fell. 22 She had not indicated her head. She indicated 23 her arm and leg on her left side. 24 Q Was this a subject that you talked to Mr. Ashcraft 25 about when he telephoned you for the ten or 15</p>	<p>1 your own and could testify under oath about what body 2 parts she hit? 3 MR. ASHCRAFT: Object to the form. 4 Q (By Mr. Cochran) Go ahead. 5 A I believe I could, yeah. 6 Q Could you have denied under oath that she had 7 mentioned she hit her head? 8 A Could I deny under oath that she had mentioned she 9 hit her head? 10 Q Could you have done that before Mr. Ashcraft spoke to 11 you? 12 A No. 13 MR. ASHCRAFT: Object to the form. 14 Q (By Mr. Cochran) The answer is no, correct? 15 A No. 16 Q I am right in saying you couldn't do that? 17 A I couldn't say that. If she had told me she hit her 18 head, I would have said she hit her head in the 19 report and would say she hit her head right now, but 20 she never told me she hit her head. 21 Q Other than the fact that you have this incident 22 report, I am asking whether you have an independent 23 recollection of whether she told you she hit her head 24 or not. 25 A No.</p>
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<p>1 minutes, the issue of what parts of her body she hit? 2 A I believe that was part of the conversation. 3 Q In fact, that was the focus of his discussion, 4 correct? 5 MR. ASHCRAFT: Object to the form. 6 Q (By Mr. Cochran) Go ahead. 7 A The focus of the discussion, I believe, is what I had 8 written in the report. 9 Q Wasn't one of the focuses of Mr. Ashcraft's 10 discussion with you what body parts hit the ground? 11 A He had asked me that. 12 Q Okay. And he reminded you that your report said 13 "knee and shoulder," right? 14 A Yeah. 15 Q Did you have an independent recollection, prior to 16 looking at the report and talking to Mr. Ashcraft, 17 about what parts of the body Helena Schweikart had 18 hit? 19 A An independent recollection? 20 Q Right. Did you remember it on your own? 21 A Did I remember it on my own? Vaguely, when I was 22 speaking to Mr. Ashcraft. 23 Q But prior to talking to Mr. Ashcraft and him telling 24 you what was important to him and the hospital and 25 looking at this incident report, did you remember on</p>	<p>1 Q So you are just relying on what you wrote in your 2 report; is that fair to say? 3 A Mostly and-- 4 Q Talking to Mr. Ashcraft, I understand? 5 A Yeah. 6 MR. ASHCRAFT: Object to the form. Let 7 him finish his answer without coaching him. 8 Thank you, Counsel. 9 MR. COCHRAN: You're the one in the 10 coaching position. I'm the guy questioning-- 11 MR. ASHCRAFT: No. You're the guy in 12 the leading position. 13 MR. COCHRAN: Get used to it because 14 I'll be there in trial too. 15 Q (By Mr. Cochran) I want to talk to you about Page 16 3-- first let me go back to Page 1 of Exhibit No. 2. 17 Again, this is an incident report form which you 18 didn't start filling out until after you cleared, 19 right? 20 A Yes. 21 Q Down on this bottom part where it says, "Notification 22 made," it says, "House supervisor." 23 Who and what is that? 24 A The house supervisor is the supervising nurse of the 25 hospital.</p>

16 (Pages 58 to 61)

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1 Q Do you remember who that would have been?
2 A I don't know who was the house supervisor at the
3 time.
4 Q How would notification have been made to that
5 supervisor?
6 A The house supervisor would have been notified by
7 either the ER or the SOC.
8 Q You didn't do it in this case; is that correct?
9 A No. That wouldn't have been my-- at that point it
10 was-- at St. Joseph's, it would be the SOC that would
11 make any necessary notifications.
12 Q Right next to that it says, "Security management."
13 Who would that have been?
14 A The supervisor on duty and Mike Hill and the head
15 supervisor, which would have been Lee Archambeault.
16 Q Do you know how to spell the last name?
17 A Not off the top of my head I wouldn't be able to
18 spell it.
19 Q I am going to do an Exhibit No. 3 here. What I'm
20 going to do is have you draw, if you can, where the
21 south pavilion is and how that relates to where the
22 security operations center is.
23 Can you do that?
24 Is it on the same floor?
25 A Yes.

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1 Q Why don't I have you do that.
2 A (Witness complies.)
3 (Exhibit No. 3 marked for
4 identification.)
5
6 Q (By Mr. Cochran) I forgot you were an architecture
7 and graphic design guy.
8 Why don't you write up here what this is showing.
9 A (Witness complies.)
10 Q Maybe you can kind of lead us through exactly what it
11 shows.
12 Why don't you tell us what the various things
13 are.
14 You have ECU--
15 A The emergency care unit. "UCU" is the urgent care
16 unit. That's the triage center, the security
17 operations center.
18 Q And you labelled that "SOC"?
19 A Yes.
20 Q Where is the south pavilion elevators?
21 A This is the south pavilion lobby area here.
22 Q You have little doors, looks like "11," "12," "13,"
23 and what are the bottom ones?
24 A I'm not really sure on the numbers.
25 If I remember correctly, there was four elevators

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1 here, but I'm not absolutely certain.
2 Q But that shows where those were?
3 A Yeah.
4 Q Why don't you write "South pavilion elevators" right
5 inbetween those doors.
6 A (Witness complies.)
7 Q When you first reached the south pavilion elevator
8 lobby after finding out that there had been a fall,
9 you indicated that you saw ER tech John and some of
10 the other ER folks.
11 Do you remember seeing Brianna Miller there?
12 A She wasn't there. She would have been at the SOC
13 desk.
14 Q She would have been the one that dispatched you,
15 correct?
16 A Yes.
17 Q Do you remember where you were prior to being
18 dispatched?
19 A No.
20 Q Do you remember how long it took you to get to the
21 south pavilion elevator lobby?
22 A It would have taken me probably ten seconds.
23 Q Because you would have been on that floor level
24 somewhere?
25 A I would have been right in this area or around this

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1 area. (Indicating.)
2 Q And you pointed to the triage, ECU area?
3 A Yeah.
4 Q Was that your assignment that day? Do you remember?
5 A I don't remember exactly what my assignment was
6 before the incident.
7 Q Did Brianna Miller come and assist at the south
8 pavilion elevators at any time you were there?
9 A No.
10 Q Did you assist Helena Schweikart in getting in the
11 wheelchair at all?
12 A No.
13 Q That was done by the ER folks?
14 A Yes.
15 Q Did you watch the ER folks put Helena into a
16 wheelchair?
17 A I saw basically the tail end of it. She was being
18 seated into the wheelchair and then moved out of the
19 area to the triage.
20 Q Okay. And did you follow that situation or what did
21 you do?
22 A I had spoken to ER tech John initially here.
23 (Indicating.)
24 Q At the lobby elevators?
25 A At the south pavilion lobby elevators, and he had

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1 indicated the bystander to me, and I spoke to the
2 bystander here.
3 Q And how long was that do you think?
4 A It was probably a couple minutes, a few minutes,
5 however long it would have taken me to record her
6 statement.
7 Q And then where did you go after that?
8 A After that I went back to the SOC area to speak to
9 Curtis Robinson, and as I said before, I had to find
10 out from triage which room Mrs. Schweikart had gone
11 to.
12 Q Did you make any stops between the time that you left
13 the bystander and heading to talk to Curtis Robinson?
14 A Did I make any stops?
15 Q Right.
16 A Other than just before going to the back I looked
17 around the area of the elevator that was indicated
18 that she had fallen down to see if there was any
19 water out, and I didn't recollect seeing any.
20 Q When you say you don't recollect seeing any, again
21 that's the kind of word that you look for when you're
22 in an interview and you're fudging a little bit.
23 Did you really look at water at that point?
24 A Yes, I really did look for it.
25 Q Do you know where you were looking?

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1 A In front of Elevator 12, which was the elevator I
2 understand she was going to.
3 Q And if you looked then really, then why did you need
4 to go back afterwards 20 or 30 minutes later to--
5 A To double check.
6 Q Because you thought you had missed something?
7 A Possibly.
8 Q Okay. You indicated that you were so nervous that
9 you didn't take the witness's name down.
10 Are you sure you weren't so nervous that you
11 forgot to look for liquids on the floor and that's
12 why you went back later?
13 MR. ASHCRAFT: Object to the form.
14 THE WITNESS: No.
15 Q (By Mr. Cochran) The reason that you looked for
16 liquids when you were first at the elevator lobby was
17 that the bystander told you that she fell on liquids
18 as well, correct?
19 MS. ALVAREZ: Objection.
20 MR. ASHCRAFT: Objection.
21 THE WITNESS: The bystander didn't say
22 that she had slipped. The bystander said she saw her
23 fall--
24 Q (By Mr. Cochran) Right. Did the bystander say--
25 A --as she was trying to catch the elevator.

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1 Q Did she say that there was an obstruction or did she
2 say anything one way or the other about the mechanics
3 of why she fell?
4 A She said that she was trying to catch the elevator,
5 and I believe the doors were closing at the time or
6 beginning to close.
7 Q Is it fair to say that your notepads with the
8 statement you took from the bystander would be the
9 very best evidence of what that bystander said? Is
10 that true?
11 MR. ASHCRAFT: Object to the form.
12 THE WITNESS: Probably. That was--
13 because it was recorded right then and there.
14 Q (By Mr. Cochran) And you would have taken it down
15 truthfully, right?
16 A Yes.
17 Q No reason that you would have been altering or
18 changing the facts because of concern by the hospital
19 that they might be held liable for a dangerous
20 condition on the floor, right?
21 MR. ASHCRAFT: Object to the form.
22 THE WITNESS: No.
23 Q (By Mr. Cochran) So then after you talked to Curtis
24 Robinson at the SOC, you went back to the lobby; is
25 that correct?

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1 A After I spoke to Curtis at the SOC and found out
2 which room that Mrs. Schweikart had gone to, I then
3 went to the UCU to speak to Mrs. Schweikart.
4 Q We've looked at the business card you have here as
5 your business card, and you indicated you gave that
6 to whom now?
7 A I believe I had given it to Mr. Schweikart.
8 Q The man who was in the wheelchair?
9 A Yeah. He was in the room with his wife. They had
10 brought him down from the south pavilion.
11 Q Do you remember anyone else being with Mr. and
12 Mrs. Schweikart?
13 A No.
14 Q Do you remember ever speaking to one of her sons at
15 any point?
16 A I believe he had come by the following day.
17 Q Came by to see you?
18 A I know he had come by to get the report.
19 Q You recall one of the sons coming by to get a copy of
20 the report?
21 A Yes, which would have been the following morning, if
22 I remember correctly.
23 Q And you were on duty then?
24 A Yes.
25 Q Does that lead us to believe probably that it was a

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1 weekend or does that help us figure it out at all?
2 A No.
3 Q Because you might have been on the day shift?
4 A Yeah, if I was at day shift at that time.
5 Q Did the son come by and speak to you directly?
6 A No. He originally was speaking to the SOC, and then
7 I believe it was John Roche that had spoken to him.
8 Q Who was at the SOC the next morning?
9 A It would have been Brianna Miller.
10 Q And John Roche was the assistant supervisor?
11 A Mm-hm-- no. John Roche was the supervisor.
12 There's a very good possibility that I was on day
13 shift at this point.
14 John Roche was there. He was the day shift
15 supervisor.
16 Q Okay. So you learned that Helena Schweikart's son
17 had come by the next day to get a copy of the report;
18 is that correct?
19 A I was actually at the SOC desk when he did come by.
20 (Recess 11:48 to 11:50 a.m.)
21
22 Q (By Mr. Cochran) So we were talking about Helena
23 Schweikart's son coming by the security operations
24 center the following day after her fall to ask about
25 the report, and you were explaining to me that you

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1 were close by; is that correct?
2 A Yes.
3 Q And did you get a chance to talk to Helena's son at
4 that point?
5 A I don't think so.
6 Q Was a copy of the report given to Helena's son that
7 day?
8 A I don't know if a copy of the report was given to him
9 later that day, but I know it wasn't given to him at
10 the time because it wasn't completely gone through
11 the reviewing process.
12 Q What was left to be done in terms of the reviewing
13 process?
14 A The report goes from the security officer to the
15 supervisors and then is sent down to the regional
16 security office for, I believe, Mike Hill to review,
17 and I don't know where it goes from there.
18 Q You had said earlier that Helena Schweikart's fall
19 report was the first one that you'd ever done before;
20 is that right?
21 A The first accident report I'd done.
22 Q But you've done other reports where you've
23 interviewed witnesses before, correct?
24 A At that point, I don't believe I did.
25 The only reports I had done at that point was the

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1 code ones, code twos, code fours. It is possible I
2 may have done an accident report involving cars, like
3 there was an accident on the property.
4 Q So it's possible you had done an accident report
5 involving a car before?
6 A Yes.
7 Q So prior to Helena Schweikart's fall?
8 A Yes.
9 Q So you'd certainly done reports for code one
10 responses, two responses, and four responses,
11 correct?
12 A Yes.
13 Q What was unusual about filling out an accident report
14 such as you did with Helena Schweikart?
15 A It was the first time or one of the first times I was
16 actually interviewing witnesses and taking down their
17 statements.
18 Q You had been working there for about six months,
19 right?
20 A Yes.
21 Q Did you learn at some point that the hospital was
22 refusing to give a copy of the accident report to
23 Helena Schweikart's family?
24 A No.
25 Q Am I correct in understanding that until today you

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1 weren't aware that Helena Schweikart had died?
2 A It had been indicated to me that she may have died
3 when-- by Brianna when the subpoena said on it "The
4 Estate Of."
5 Q At least up until Brianna noticed that on the
6 subpoena, you hadn't been advised that Helena had
7 died?
8 A I had never been advised, no, that Helena had died.
9 (Exhibit No. 4 & 5 marked
10 for identification.)
11
12 Q (By Mr. Cochran) Tell me what Exhibit No. 4 is.
13 A An e-mail from Dylan White to Mike Hill.
14 Q Who is Dylan White?
15 A Dylan White was the assistant supervisor I couldn't
16 remember before who was the other assistant
17 supervisor who would have been on swing shift.
18 Q And how did you get this e-mail?
19 A I think Don Hall had put it in my box.
20 Q Put a copy of it in your box?
21 A Yeah. At the time I remember trying to get the
22 report number, I believe.
23 Q Say that again now.
24 A At the time we were trying to get the report number,
25 I believe.

19 (Pages 70 to 73)

Matthew W. Dunne
November 2, 2006

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1 Q Did your report change from the point that you
2 finished drafting it at the end of your shift on
3 April 28th, 2005 to what we see now?
4 A Not to my knowledge, no.
5 Q When you first sat-- strike that.
6 When did you first sit down to type what we have
7 as Page 3 of Exhibits 2 and 5?
8 A It would have been that afternoon on the 28th.
9 Q Is it my correct understanding that you got off at 2
10 that day or would have typically--
11 A I would have typically gotten off shift at 2, but I
12 may have been on overtime to complete the report.
13 Q We could look at your wage records to find that out,
14 right?
15 A Yes.
16 Q You don't mind if we do that just to see if you
17 worked overtime that day, do you?
18 A No, I don't mind.
19 Q So you would have sat down in the security operations
20 center to draft this on a computer using Word?
21 A It would have been handwritten. It would normally be
22 handwritten.
23 Q You would have handwritten out what became Page 3 of
24 this report?
25 A Normally the handwritten portion would be written

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1 physically on the report in the "Description of
2 incident" area.
3 Q Which we see on Page 1 of Exhibit No. 2?
4 A Yes.
5 Q But you didn't do that in this case or did you?
6 A I believe it was the-- we would have used-- I believe
7 I originally wrote it out, yes.
8 Q So this "See attached" that's diagonally through the
9 "Description of incident" section of Exhibit No. 2,
10 Page 1, that's not your handwriting, correct?
11 A No, that is not my handwriting.
12 Q Do you know whose handwriting that is?
13 A No.
14 Q Am I correct in understanding then that you filled
15 out a security incident report just like we see in
16 Exhibit No. 2 and Exhibit No. 5, filled it out
17 completely, and you wrote in a description of the
18 incident down here in the bottom section of Page 1,
19 but then you were asked to do it over again? Is that
20 right?
21 A Normally that would happen if there was gross
22 spelling errors or whatnot.
23 Q In this case with respect to Helena Schweikart's
24 investigation report, did you not do completely
25 with a description of incident report handwritten in

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1 on Page 1?
2 A That's what normally would happen, yes.
3 Q And did you do that here?
4 A I believe I did, yes.
5 Q And then who asked you to redo it and leave off a
6 handwritten description of the incident?
7 A I was told that it would be quicker if I typed it
8 out, so I would have-- so we would have refilled out
9 this portion of the report, and instead of writing
10 in-- I was then-- would have been asked to take what I
11 wrote on the initial report that I had written out
12 and type it out on Word.
13 Q And who told you to do that?
14 A I believe it was Curtis Robinson.
15 Q And when did Curtis Robinson tell you to do that?
16 A After I had written out the initial report,
17 including the description of the incident, correct?
18 A Yes.
19 Q And he reviewed it and then told you to do a new one
20 and leave off the description of the incident in
21 handwritten form; is that correct?
22 A Correct.
23 Q Where is that initial report that you filled out?
24 A I do not know.
25 Q Did he throw it away in front of you?

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1 A Did he throw it away in front of me?
2 Q Correct.
3 A No.
4 Q So then you started typing it, is that correct,
5 typing the incident report?
6 A Yeah. I typed the description of the incident.
7 Q Did your initial security incident report that you
8 filled out with the description of the incident
9 included contain the witness's name who was a
10 bystander?
11 A No, because I didn't get the name of the bystander.
12 Q But we could tell for sure if we had the initial
13 security incident report that you filled out
14 completely and handwritten, correct?
15 MR. ASHCRAFT: Object to the form.
16 Q (By Mr. Cochran) If we looked at that, we would be
17 sure if you had the witness's name there, correct?
18 MR. ASHCRAFT: Same objection.
19 Q (By Mr. Cochran) Go ahead.
20 A Yes.
21 Q Then who started the document for you on Word? Did
22 you?
23 A I opened up Word, yes.
24 Q Tell me about where the computer was, if we're
25 looking at Exhibit No. 3.

20 (Pages 74 to 77)

Matthew W. Dunne
November 2, 2006

4/28/05

My Documents

- Falls

- Accidents

2055 .

**ST. JOSEPH MEDICAL CENTER SAFETY COMMITTEE
MINUTES – September 19, 2002**

<p>V. EQUIPMENT MGMT</p>	<p>No new items to report</p> <p>Mike Anderson reminds us that there is no available space for storage of old equipment.</p>	<p>Can this surplus equipment be given to charity? It was suggested that we check with Debbie Raniero, who may know of a charitable organization that will come and pick it up.</p>	<p>Mike Anderson</p>
<p>VI. SAFETY SURVEILLANCE</p>	<p>The "Safety Surveillance Tool" form was passed out to all members. This is the new Safety Surveillance form to be used by Safety representatives regionally.</p>	<p>All attachments will be filed in Safety Committee Binder located in Risk Management department.</p>	<p>FHS Safety Committees</p>
<p>VII. EMPLOYEE SAFETY REPORT</p>	<p>Suzanne Metz provided an Employee Injury Summary:</p> <ul style="list-style-type: none"> • Unsafe Acts continue to be the main cause of employee injuries. • There has been a trend of employee's actions being the cause of other employee's injuries, such as wet floors, needles dropped, rushing/hurrying, and unsafe positions during patient transfers. • Employees wearing safety goggles and/or masks can avoid "Splash" incidents. • Suzanne sent out a quarterly reminder (email) to bring attention to the current trends that are the cause of injuries. 		
<p>VIII. RISK MANAGEMENT</p>	<p>Christy Karjeker reports:</p>	<p>The injury trends should be reviewed in Staff Meetings as a reminder to all employees.</p>	<p>Christy Karjeker</p>

1 A It was a very clean area. It looked like
2 it had been mopped and waxed. It was very tight.

3 Q You said you recognized liquids on her
4 person.

5 Where did you recognize the liquids on her
6 person?

7 A On her clothing and on her feet.

8 Q Okay.

9 How much liquid did you see on her
10 clothing and feet?

11 A Not enough to saturate her. Maybe just
12 damp. And maybe residual water on her shoes.

13 Q So you clearly saw residual water on her
14 shoes --

15 A Yes.

16 Q -- and water on her clothing?

17 A Yes.

18 One thing I do recall, when I do come to
19 work, is that my feet squeak as I walk down the
20 hallway until I reach the ER. They usually don't
21 stop squeaking from the water until I reach the ER.

22 Q Did you do an investigation to determine
23 where this water had come from?

24 A No.

25 I assumed that it came from the rain that

CERTIFICATE OF SERVICE

08 APR 22 PM 3:44

STATE OF WASHINGTON
BY Chm
DEPUTY

I, Becky J. Niesen, certify under penalty of perjury under the laws of the State of Washington that the following is true and correct:

A. I am a United States Citizen, over the age of 18 years, I am not a party to this cause, and am competent to testify to the matters set forth herein.

B. I am employed by the law firm of Gordon, Thomas, Honeywell, Malanca, Peterson & Daheim, P.L.L.C., 1201 Pacific Avenue, Suite 2100, Tacoma, Washington 98401, attorneys for plaintiff/respondent.

C. On April 22, 2008, I caused a copy of the attached to be served upon the following:

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COURT OF APPEALS – DIVISION II
950 Broadway, #300
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 U.S. Mail
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Scott Matthew O'Halloran
Timothy L. Ashcraft
WILLIAMS KASTNER & GIBBS
1301 "A" Street, Suite 900
Tacoma, WA 98402-4299
 U.S. Mail
 Overnight Mail
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Christopher H. Anderson
FAIN SHELDON ANDERSON &
VanDERHOEF, PLLC
701 Fifth Avenue, #4650
Seattle, WA 98104
 U.S. Mail
 Overnight Mail
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Becky J. Niesen