

FILED
Court of Appeals
Division II
State of Washington
7/11/2018 1:35 PM

NO. 51827-9-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

LESA SAMUELS,

Appellant,

v.

CITY OF TACOMA,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

Lesla Samuels filed a medical malpractice action against MultiCare Health Systems, Gloria Lem, ARNP, and the City of Tacoma, alleging against the City that it was vicariously liable for the claimed negligence of Tacoma Fire Department emergency medical technicians and paramedics who responded to a 9-1-1 call that Ms. Samuels asked her significant other to make on December 24, 2015. After discovery as to the City was completed, the City moved for summary judgment, invoking its statutory qualified immunity and seeking dismissal of Ms. Samuels' claims under RCW 18.71.210. The trial court granted the City's summary judgment motion, holding that Ms. Samuels did not demonstrate gross negligence and that the City was therefore statutorily immune from suit. Ms. Samuels moved for discretionary review of that summary judgment ruling, and her motion was denied for lack of obvious or probable error. Now, having settled her remaining claims against MultiCare and ARNP Lem, Ms. Samuels appeals the trial court's summary judgment dismissal of her claims against the City.

Because, absent gross negligence or willful or wanton misconduct, the City is entitled to qualified immunity from suit for the good faith acts or omissions of its first responders, and because Ms. Samuels failed to establish gross negligence and never attempted to claim willful or wanton

misconduct, the trial court's grant of summary judgment dismissing her claims against the City on grounds of qualified immunity was proper and should be affirmed.

II. ISSUE PRESENTED FOR REVIEW

1. Whether RCW 18.71.210 applies to provide the City of Tacoma qualified immunity for the acts or omissions of its first responders taken in good faith when there is no evidence of gross negligence or willful or wanton misconduct.
2. Whether summary judgment dismissal of Ms. Samuels' claims against the City of Tacoma was proper because Ms. Samuels failed to show gross negligence on the part of the City's first responders.

III. COUNTERSTATEMENT OF THE CASE

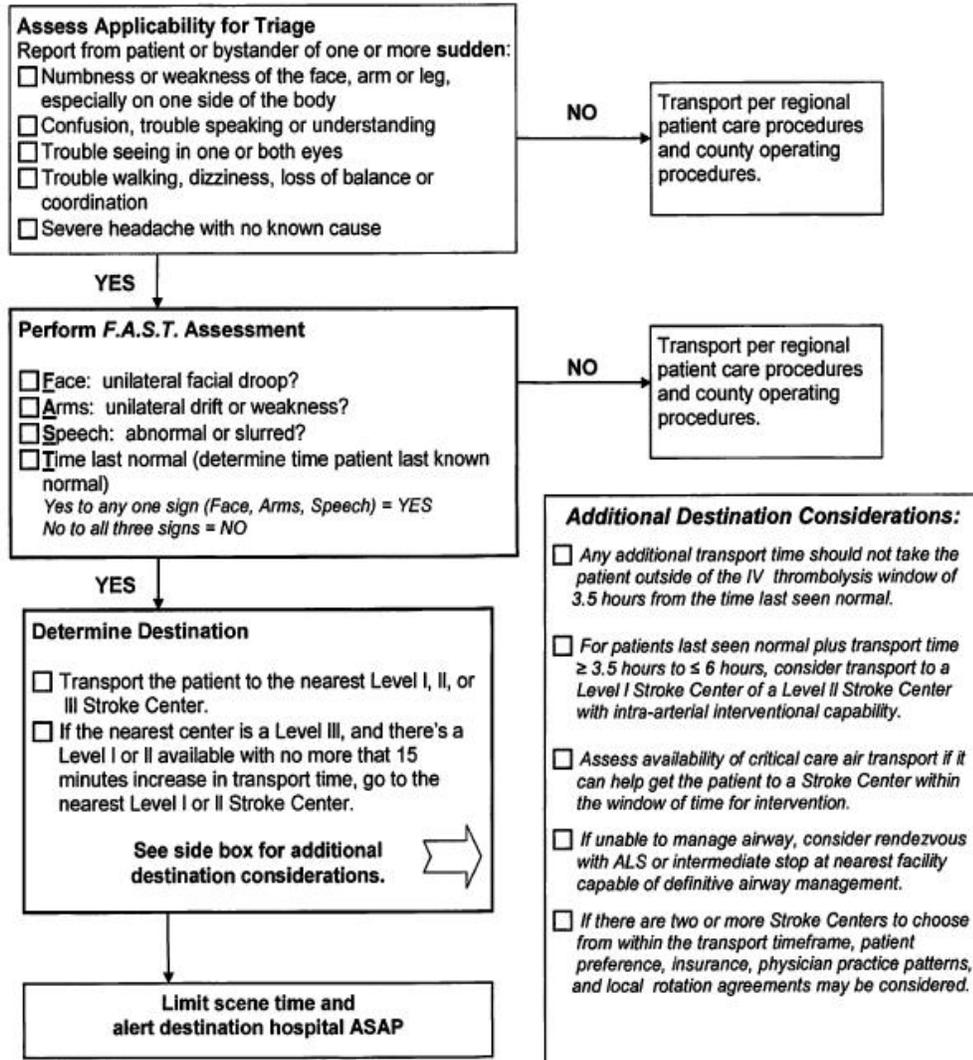
A. **EMS Protocols and Stroke Triage Procedures.**

In 2015, Tacoma Fire Department's emergency medical technicians (EMTs) and paramedics (collectively "first responders") operated under a set of Patient Care Protocols established by the Pierce County Emergency Medical Services and the Pierce County Emergency Medical Director. CP 66-71. The Protocols incorporate the Washington Department of Health's "Prehospital Stroke Triage (Destination) Procedures,"¹ CP 69-71, 241-43, and include a flowchart that informs the first responders how to handle potential strokes.

¹ Compare <https://www.doh.wa.gov/Portals/1/Documents/Pubs/346049.pdf> with CP 69.



**D. PIERCE COUNTY
PREHOSPITAL STROKE TRIAGE (DESTINATION) PROCEDURES**



CP 69, 241.

According to the stroke triage procedures, the first responders were required to assess applicability for triage by obtaining the patient's medical history as to:

- Numbness or weakness of the face, arm or leg, especially on one side of the body
- Confusion, trouble speaking or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

Id. If the first responders observed any of these symptoms, or if any of these symptoms were reported to them, then the first responders were required to perform a F.A.S.T. exam – a screening exam used to determine the urgency of transport for potential stroke victims. CP 69, 241.

Face: unilateral facial droop?

Arms: unilateral drift or weakness?

Speech: abnormal or slurred?

Time: last normal (determine time patient last known normal)

CP 69, 241. Under the F.A.S.T. exam, if the face, arms, or speech were abnormal, then the exam was considered “positive.”² *Id.* Whether the F.A.S.T. exam was “positive” or “negative” determined whether the patient qualified for advanced life support (ALS) transport or basic life support (BLS) transport. CP 69, 71, 241, 243.

According to the transport guidelines contained in the Protocols, a patient qualified for ALS transport if the patient’s F.A.S.T. exam was positive. CP 71, 243 (a patient meets ALS criteria if they exhibit “signs of

² If an exam was “positive,” then the “T” (time last normal) would be used to determine *where* to transport the patient to. CP 69, 241.

stroke.”). ALS transport mandated that the first responders immediately transport the patient to the nearest stroke center. CP 60-61, 69, 71, 241, 243. Conversely, if the patient’s F.A.S.T. exam was negative, the patient qualified for BLS transport – a private ambulance. CP 60-61, 69, 71, 241, 243. A patient who qualified for BLS transport did not have to accept the transport. CP 71, 243 (*compare* a patient who meets BLS criteria “**may** be transported” *with* a patient who meets ALS criteria, “**must** be transported”).

B. Tacoma Fire Department’s Contact with Lesa Samuels

On December 24, 2015 Lesa Samuels, a 45-year-old woman, had her partner call 9-1-1 because her face felt numb and she thought she was having a stroke. CP 64, 234, 60-61, and 47 (84:14-23). Tacoma Fire Department’s Ladder Truck 3 and Medic Unit 1 were dispatched at 11:13 p.m., and promptly arrived at Ms. Samuels’ apartment. CP 64, 234, 60-62. Three EMTs (Nate Kaiel, Ben Baker, and Bill Jones) staffed Ladder Truck 3, CP 65, 236, 60 (¶2), and two paramedics (Kris Johnson and Anthony Brakebush) staffed Medic Unit 1. CP 65, 236, 60 (¶2).

The first responders began by taking Ms. Samuels’ medical history, which Ms. Samuels acknowledged at her deposition. CP 49 (91:6-8); CP 51-52 (101:15 – 102:16). They also took her vital signs, including pulse, respiratory rate, blood pressure, glucose, and pulse oximetry. CP 48

(88:1-8), 49 (91:16 – 93:23), 64. Ms. Samuels reported that she had started experiencing facial numbness about an hour earlier. CP 51 (101:15-25), 64. She denied experiencing any loss of consciousness, chest pain, shortness of breath, nausea, vomiting, or diarrhea, and reported no significant medical history. CP 52 (102:1-11), 64.

The Patient Contact Report reflects this medical history.

45 [year old female] called because she thought she was having a stroke because her face felt numb. The [patient] stated it started about an hour prior to the 911 call. The [patient] denies any [loss of consciousness], chest [pain], [shortness of breath], or [nausea, vomiting, or diarrhea]. The [patient] does not have any [medical history], and does not take any [medications]. The [patient] did take an over the counter cold medicine that she has taken in the past [without] any incident.

CP 64, 234 (abbreviations spelled out for ease of reading).

Because Ms. Samuels reported having experienced numbness of the face (a potential indicator of a stroke) when her history was being taken, the first responders performed a F.A.S.T. exam in accordance with the Protocols. Ms. Samuels described the examination:

A. He looked in my eyes, and he looked in my throat, and then he also did the – the resistant test.

Q. Did – when you say “the resistance test,” you’re – you held your hands out – we have to get this for the record – you held your hands out in front of you?

A. Yes.

Q. And you put your palms up and down?

A. Yes.

Q. Did he actually press on your hands to see whether –

A. Yes.

Q. – you could hold them up?

A. Yes. He pushed down a little bit; so I had to push and pull.

Q. Okay.

A. I mean push and – and – and lift.

Q. Okay.

A. Right.

Q. And did you have any trouble resisting the pressure that he put on your hands?

A. No.

CP 50 (94:2-25).

The first responders observed that Ms. Samuels' skin was pink, warm, and dry, and that her lungs were clear. CP 64. They found her facial grimace was equal, her pupils were normal, her grip on both sides was equal, she had control over her upper extremities, and she was able to lift both palms equally and steadily. CP 64. They noted that she was oriented and able to communicate orally. CP 64. Ms. Samuels acknowledged that she was able to communicate with the first responders and answer their questions. CP 50 (97:2-9).

Because the first responders (1) did not observe a unilateral facial droop (the "F"), (2) did not find any unilateral drift or weakness in Ms. Samuels' arms (the "A"), and (3) observed that her speech was normal (the "S"), **the F.A.S.T. exam was negative.** See CP 69; CP 64. Pursuant

to the Protocols, a negative F.A.S.T. exam meant that Ms. Samuels qualified for BLS transport, if she wanted it. CP 69, 71, 60-61. Abiding by the Protocols, the first responders recommended that she either take a private ambulance to the hospital, or have her significant other transport her to Tacoma General Hospital's Emergency Room. CP 64, 53 (113:17-20), 43 (46:1-6).

Although Ms. Samuels now contends that the first responders told her she was not having a stroke, during her deposition she confirmed that one of the first responders informed her:

“We could take you to the hospital to ease your mind or” – they pointed at Arnold³ and said he could take me.

CP 53 (113:10-23), 43 (46:1-6).

After about ten minutes (a typical amount of time for a call of this nature), the first responders left Ms. Samuels' apartment with the understanding that her significant other, Arnold Williams, would transport her to Tacoma General's emergency room. CP 64 (run sheet from the contact states that “spouse of [patient] was going to [transfer] the [patient] [via] [privately owned vehicle] to [Tacoma General Emergency Room]” (abbreviations spelled out for ease of reading)).

³ Arnold Williams, Ms. Samuels' significant other, was present during the first responders' examination.

After the first responders left, Ms. Samuels decided, contrary to their recommendation, not to go to emergency room. CP 43 (46:1-6). Instead, she went to bed and, less than six hours later, was feeling well enough to work her 5:00 a.m. shift. CP 43 (46:25 – 47:11).

Six days later, on December 30, again suspecting that she was having a stroke, Ms. Samuels presented to the MultiCare Westgate Urgent Care Center, where ARNP Lem examined her, treated her for a headache, and sent her home. CP 45-46 (70:7 – 75:16).

Then, on January 5, 2016, nearly two weeks after her encounter with the first responders, Ms. Samuels went to the Emergency Department at Tacoma General, where an emergency department physician found, for the first time, that she exhibited symptoms consistent with a positive F.A.S.T. exam. CP 58.

C. Procedural History

Ms. Samuels initially sued MultiCare and ARNP Lem for medical malpractice under Chapter 7.70 RCW. She later amended her complaint to add the City of Tacoma as a defendant,⁴ alleging vicarious liability for the conduct of its first responders.⁵ CP 1-11, 8-9 (¶4.4).

⁴ Contrary to Ms. Samuels' assertion, *App. Br. at 3*, she never sued the individual first responders. *See* CP 1. Thus, there was never a need for the City to move to dismiss them as individual defendants.

⁵ Ms. Samuels also alleged that the City was liable for the negligent hiring, training, and supervision of its first responders. CP 9 (¶4.5). The City also moved to dismiss Ms.

The parties conducted discovery, and Ms. Samuels deposed all five of the first responders. *See* CP 232. After pertinent discovery was completed, the City moved for summary judgment dismissal on grounds of qualified immunity, claiming that, because there was no evidence of gross negligence, it was entitled to statutory qualified immunity under RCW 18.71.210(1).⁶ CP 18-32.

In response to the City's summary judgment motion, Ms. Samuels argued that the first responders did not follow the protocols because, according to her experts but contrary to her own deposition testimony, the first responders did not take a patient history. CP 466-94. She also argued that the first responders did not follow the Department of Health regulations because they did not call a "base station physician." *Id.* She submitted three declarations: one from counsel, CP 231-465, one from a California neurologist (Dr. Lombardi), CP 140-62, and one from a New York Emergency Room physician (Dr. Brown), CP 163-230.

In reply, the City reiterated that the undisputed facts (Ms. Samuels' own testimony) established that the first responders took a patient history,

Samuels' claims for negligent hiring, training, and supervision of the first responders, *see* CP 29-30, which the trial court granted. CP 778-79. On appeal, Ms. Samuels has not disputed the propriety of the dismissal of that claim.

⁶ Ms. Samuels incorrectly asserts, *App. Br. at 3*, that the City moved for dismissal on grounds that its first responders had qualified immunity under "RCW 18.27.210." The City's motion was based on the qualified immunity afforded by RCW 18.71.210.

and that, because the Protocols included direction on how to proceed in suspected stroke situations, under the applicable regulations, the first responders were not required to call a base physician for additional direction. CP 519-30. The City also challenged the admissibility of the opinions contained in Ms. Samuels' experts' declarations. CP 527-28. In particular, the City argued that adequate foundations were not laid to qualify either Dr. Brown or Dr. Lombardi as an expert on the standard of care of a paramedic in the State of Washington, and that both of their declarations contained conclusory opinions based on facts contrary to the record, and impermissible opinions on the "credibility" of witnesses. CP 527-28; *see* CP 163-230.

On the same day that the City filed its reply, Ms. Samuels, without seeking leave from the court, filed an amended response to the City's summary judgment motion, which relied on the same legally deficient declarations that were filed with her initial response. CP 495-518.

At the hearing on the summary judgment motion, the City argued, as it had briefed, that it was entitled to qualified immunity because (1) reasonable minds could reach but one conclusion – there was no gross negligence, and (2) Ms. Samuels failed to present any competent evidence of gross negligence. RP 5-12. Ms. Samuels, essentially suggesting that, before RCW 18.71.210's qualified immunity could apply the City's first

responders' actions had to be perfect, argued that RCW 18.71.210 did not apply. RP 14-16.

The trial court granted the City's summary judgment motion, finding that RCW 18.71.210 applied and that reasonable minds could reach but one conclusion – the first responders were not grossly negligent.

I believe that the firefighters in this matter, pursuant to RCW 18.71.210, as first responders, including their employing entities, are entitled to the immunity that the City seeks. ... I find no basis whatsoever for anything in willfulness conduct. I find nothing that supports gross negligence. I believe they're entitled to the immunity that RCW Title 18 provides them.

RP 27; *see* CP 778-80. The trial court also awarded the City its statutory costs and fees of \$200 under RCW 4.84.010. CP 783-84.

Ms. Samuels sought discretionary review of the trial court's summary judgment ruling, which Court of Appeals Commissioner Schmidt denied, finding the trial court committed neither obvious nor probable error. *Ruling Denying Review* 501413-8-II (Sept. 21, 2017).

Subsequently, in January 2018, Ms. Samuels settled and dismissed her remaining claims against MultiCare and ARNP Lem. CP 801-02. Ms. Samuels then filed this appeal from the trial court's summary judgment dismissal of her claims against the City. CP 788.

IV. STANDARD OF REVIEW

This Court reviews an order granting summary judgment *de novo*.

Lyons v. U.S. Bank Nat'l Ass'n, 181 Wn.2d 775, 783, 336 P.3d 1142 (2014). In reviewing a trial court's grant of summary judgment, an appellate court may consider any argument raised and argued at the trial court, even if the trial court did not adopt the argument in reaching its conclusion. See *Alton v. Phillips Co.*, 65 Wn.2d 199, 202, 396 P.2d 537 (1964). An order granting summary judgment may be affirmed on any basis supported by the record. *LaMon v. Butler*, 112 Wn.2d 193, 200-01, 770 P.2d 1027, cert. denied, 493 U.S. 814 (1989); *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 789 n.3, 954 P.2d 319 (1998).

V. SUMMARY OF THE ARGUMENT

Under RCW 18.71.210, as long as the first responders' acts or omissions did not constitute gross negligence or willful or wanton misconduct, the City is entitled to qualified immunity for the acts or omissions of its first responders. Here, because Ms. Samuels made no claim of willful or wanton misconduct, and because, even taking the facts in the light most favorable to Ms. Samuels, reasonable minds could reach but one conclusion – the first responders were not grossly negligent, the trial court properly granted summary judgment dismissal.

Additionally, Ms. Samuels failed to present competent evidence to establish gross negligence and thus did not create a question of fact on each essential element of her claim. Her experts, Dr. Brown and Dr.

Lombardi, were not qualified to opine on the standard of care applicable to a paramedic in the State of Washington. Moreover, the opinions they offered were based on facts contrary to the record and were conclusory in nature. Because she failed to create a genuine issue of material fact on the issue of gross negligence, the City was entitled to summary judgment.

VI. ARGUMENT

Generally, under RCW 18.71.210(1)(g), the City cannot be sued for the acts or omissions of its first responders because it has qualified immunity.

No act or omission of any physician’s trained advanced emergency medical technician and paramedic, as defined in RCW 18.71.200, or any emergency medical technician or first responder, as defined in RCW 18.73.030, done or omitted in good faith while rendering emergency medical service under the responsible supervision and control of a licensed physician or an approved medical program director or delegate(s) to a person who has suffered illness or bodily injury shall impose any liability upon: ... [a]ny ... city.

RCW 18.71.210(1)(g) (emphasis added).

“RCW 18.71.210 applies to emergency medical service personnel, allowing them immunity from liability for actions or omissions done in good faith while rendering emergency medical service.” *Timson v. Pierce County Fire Dist. No. 15*, 136 Wn. App. 376, 384-85, 149 P.3d 427 (2006); *Marthaller v. King County Hosp.*, 94 Wn. App. 911, 915-16, 973

P.2d 1098 (1999). “Its purpose is to protect an individual government employee from ‘the unduly inhibiting effect the fear of personal liability would have on the performance of his or her professional obligations.’” *Marthaller*, 94 Wn. App. at 916 (quoting *Savage v. State*, 127 Wn.2d 434, 441-42, 899 P.2d 1270 (1995)). The policy is so strong, that the qualified immunity provided under RCW 18.71.210 is “*immunity from suit*, not simply from liability.” *Id.* (emphasis added).

That immunity from suit, however, does not extend to acts or omissions that constitute gross negligence or willful or wanton misconduct. RCW 18.71.210(5). Here summary judgment was proper because Ms. Samuels presented no evidence of gross negligence on the part of the City’s first responders, and never even attempted to claim willful or wanton misconduct. Thus, the City was entitled to qualified immunity.

A. Ms. Samuels’ argument that RCW 18.71.210 does not apply ignores the plain language of the statute, ignores the policy behind the statute, and is based on facts contrary to the record.

Based on the erroneous assumption that *any* alleged failure of the first responders to follow the Protocols precludes the City from invoking qualified immunity, Ms. Samuels contends, *App. Br. at 30-36*, that RCW 18.71.210 does not apply in this case, and that simple negligence – not gross negligence – is the correct fault standard. Her contention that RCW 18.17.210’s qualified immunity does not apply should be rejected because

it is contrary to both the plain language of the statute and the policy behind the statute, and because it is based on factual assertions contrary to the facts of record – namely that a patient history was not taken, that the Protocols required a base station physician be contacted, and that the Protocols precluded first responders from determining whether or not Ms. Samuels exhibited symptoms requiring emergent transport.

1. Under the plain language of the statute and the purpose behind it, RCW 18.71.210's qualified immunity applies in this case.

Contrary to Ms. Samuels' contention that first responders must strictly comply with the Protocols before RCW 18.71.210's qualified immunity may apply, the plain language of RCW 18.71.210(1) indicates that the statutory qualified immunity applies even absent strict adherence to the Protocols. "No act or omission of any [first responder] done or omitted in good faith while rendering emergency medical service ... shall impose any liability." RCW 18.71.210(1). The language is broad; it does not include a precondition that first responders must strictly adhere to the Protocols for them or their employing city to qualify for immunity.

Rather, RCW 18.71.210(1) provides a general rule of no liability for good faith acts or omissions of first responders, subject to the exception provided under RCW 18.71.210(5) for "any act or omission which constitutes either gross negligence or willful or wanton

misconduct.” Ms. Samuels’ suggestion that anytime a first responder allegedly strays from the Protocols, RCW 18.71.210’s qualified immunity is “stripped” and liability may be imposed is contrary to both the plain language of the statute and the statute’s purpose, which “is to protect [first responders] from the unduly inhibiting effect the fear of personal liability would have on the performance of [their] professional obligations.” *Marthaller*, 94 Wn. App. at 916.

Focusing on language in RCW 18.71.210 that provides immunity for the acts or omissions of first responders “done or omitted in good faith while rendering emergency medical service **under the responsible supervision and control of a licensed physician or an approved medical program director or delegate(s) ... and not in the commission or omission of an act which is not within the field of [their] medical expertise,**” RCW 18.71.210(1), Ms. Samuels asserts, *App. Br. at 34-36*, that any deviation from the Protocols by the first responders means that their rendering of care was not under the supervision and control of a licensed physician, and was not within their field of expertise as defined by WAC 246-976-182(1)(c)(iii), thereby stripping the City of immunity under RCW 18.71.210.

Ms. Samuels’ interpretation of the statute is patently wrong. Even assuming that she had factual support for her allegation that the first

responders did not follow the Protocols, which she does not (*see infra* at pages 19-24), her interpretation of the statute would lead to absurd results. Stripping immunity and permitting liability based on any trivial act or omission not strictly in compliance with the Protocols (even if the act was taken in good faith and in the course of duty), would amount to an abrogation of the legislature's clear intent that first responders should be able to act free from the unduly inhibiting fear of liability. *See Marthaller*, 94 Wn. App. at 916.

In codifying RCW 18.71.210, the legislature implicitly recognized that first responders must act in emergencies, and must make quick decisions in real time. Accordingly, the legislature determined it would limit suits against first responders and their employing agencies to those that involve acts or omissions that rise to the level of gross negligence or willful or wanton misconduct. Ms. Samuels' argument to the contrary – that the first responders were required to abide perfectly by the protocols, otherwise a simple negligence standard applies – contravenes the purpose of RCW 18.71.210. Contrary to Ms. Samuels' assertions, a simple negligence standard is not the standard that governs this case. Absent a showing of gross negligence or willful or wanton misconduct, which Ms. Samuels has not shown, RCW 18.71.210's qualified immunity applies.

2. The undisputed facts show the first responders complied with the Protocols.

Ms. Samuels argues, *App. Br. at 32, 35*, contrary to her deposition testimony, that no patient history was taken and that as a result, the first responders did not follow the Protocols. Because Ms. Samuels' own testimony confirmed the first responders obtained her patient history, CP 48 (89:4-11), 51-52 (101:15 – 102:19), and because the first responders accepted Ms. Samuels' representations regarding her facial numbness and proceeded to triage her to determine whether she required transport, CP 50 (94:2-25, 97), Ms. Samuels' argument that the first responders did not follow the Protocols fails.

The undisputed facts demonstrate that the first responders followed the Protocols' stroke triage procedures, including taking a patient medical history. Ms. Samuels acknowledged that the first responders took her medical history. CP 48 (89:4-11), 51-52 (101:15-102:19). Then, after taking her medical history and because the Protocols listed facial numbness as a symptom that triggered the F.A.S.T. exam, the first responders performed the F.A.S.T. exam, as Ms. Samuels has acknowledged. CP 50 (94:2 – 95:18, 97). Because the F.A.S.T. exam was negative, *see* CP 52 (94:2-95:18, 97), 64, 69, Ms. Samuels did not qualify for ALS transport. CP 69, 71. Pursuant to the Protocols, the first

responders offered Ms. Samuels BLS transport (which she declined), and recommended alternatively that Mr. Williams take her to the hospital. CP 53 (113:11-20), 43 (46:1-6), 64.

As the evidence demonstrates, the first responders followed the Protocols. Ms. Samuels' assertions otherwise are not supported by the facts of record. Her argument that, because of some failure of the first responders to follow the Protocols, the City is not entitled to immunity under RCW 18.71.210 should be rejected.

3. The first responders were not required to call a base station physician because the Protocols governed the interaction with Ms. Samuels.

Ms. Samuels also contends, *App. Br. at 31-32*, that under WAC 246-976-182(2), the first responders should have contacted the medical program director (MPD) or MPD delegate – a “base-station physician”. Because Ms. Samuels' presentation was not outside the scope of the Protocols, and the Protocols were adequate to address the care she needed, Ms. Samuels' contention is contrary to the plain language of WAC 246-976-182, which provided that the MPD need only be contacted when the protocols did not provide direction.

Under WAC 246-976-182, “certified EMS personnel are only authorized to provide patient care ... [w]ithin the scope of care that is ... included in state approved county MPD protocols.” WAC 246-976-

182(1)(c)(iii). First responders could not act outside the scope of what the protocols prescribed. *Id.* If the Protocols did not provide direction for a situation, then the first responders needed to contact their online medical control and receive instruction from the MPD, or its delegate. WAC 246-976-182(2); WAC 246-976-010(44), (46). Such contact was *only* required when the protocols did not address how to treat a patient in a given situation. WAC 246-976-182(1), (2).

Nonetheless, Ms. Samuels argues, *App. Br. at 32*, that because she exhibited “unresolved facial numbness” and high blood pressure, the first responders should not have ended their contact with her. This argument is contrary to the Protocols, which provided direction for both of those situations (and that direction did not require ALS transport). CP 69, 71.

The Protocols contemplated that an individual may experience facial numbness and yet still not require emergent transport for a stroke. CP 69. In fact, facial numbness was merely a symptom that indicated a F.A.S.T. exam should have been performed. CP 69. Facial numbness was not a symptom that triggered automatic ALS transport. CP 71.

Moreover, the Protocols provided that a blood pressure higher than 180/120 should result in ALS transport. CP 71. Here, Ms. Samuels’ blood pressure was 176/98, CP 64, and thus lower than the blood pressure

that would have resulted in ALS transport. She did not exhibit any signs that qualified her for ALS transport. *Compare* CP 64 with CP 69, 71.

It is undisputed that the Protocols contained procedures for triaging stroke, including symptoms of facial numbness and high blood pressure. CP 69, 71. Because the Protocols provided adequate instruction for how to determine whether to transport an individual with suspected stroke symptoms, *see* CP 69, the first responders were not required to call the MPD or its delegate. *See* WAC 246-976-182(1), (2); WAC 246-976-010(44), (46). Ms. Samuels' argument that the first responders cannot avail themselves of RCW 18.71.210 because they did not call a base station physician fails.

4. The first responders did not act outside the scope of the Protocols when they determined Ms. Samuels did not qualify for ALS transport.

Ms. Samuels also contends, *App. Br. at 33*, the first responders violated the Protocols and acted outside the scope of their authority when they purportedly told her she was not having a stroke. Even assuming that one of the first responders said Ms. Samuels was not having a stroke, her contention fails because the first responders had authority under the Protocols to triage individuals for transport and part of that process included determining what symptoms a patient was exhibiting and whether those symptoms were severe enough to warrant emergent

transport. CP 69. Her argument also fails because the first responders encouraged Ms. Samuels to seek medical treatment for her unresolved symptoms, and in fact believed she was going to seek treatment. CP 53 (113:10-23), 43 (46:1-6), 64.

Ms. Samuels relies on her purported experts, Drs. Brown and Lombardi, *App. Br. at 28*, to suggest that the first responders “violated” the protocols when they allegedly told Ms. Samuels she was not having a stroke. Dr. Brown asserts, CP 168, the Protocols did not give the first responders the authority to rule in or rule out a stroke. Dr. Lombardi also opined, CP 147, that communicating that she was not having a stroke was outside the scope of the Protocols. It is undisputed, however, that the protocols authorize the first responders to triage symptoms and determine whether an individual required emergent transport, CP 69 – exactly what the first responders did here. CP 50 (94:2 – 95:18, 97), 52 (105:12-23), 64. The first responders, consistent with the stroke triage protocols, appropriately triaged Ms. Samuels and determined that she was not exhibiting symptoms that required ALS transport.

The undisputed testimony shows that the first responders encouraged Ms. Samuels to seek medical treatment. CP 53 (113:10-23), 43 (46:1-6). She testified under oath that she was offered BLS transport. *Id.* She also testified that the first responders recommended that if she did

not accept the BLS transport, she should have Mr. Williams transport her. *Id.* In fact, when they left the contact, the first responders believed Mr. Arnolds was going to take Ms. Samuels to the hospital and recorded as much on their run sheet. CP 64.

Because the first responders were acting within the scope of the Protocols when they determined that Ms. Samuels was not showing symptoms that required transport, *see* CP 69, and also because the first responders encouraged Ms. Samuels to seek medical treatment for her unresolved symptoms, CP 53 (113:10-23), 43 (46:1-6), there is no evidence that the first responders violated the Protocols.

Ms. Samuels has failed to demonstrate that the first responders violated the Protocols or acted outside the scope of their authority. Contrary to Ms. Samuels' assertions, RCW 18.71.210 applies and the City is entitled to immunity absent evidence of gross negligence or willful or wanton misconduct.

B. Because reasonable minds could only conclude that the first responders were not grossly negligent, the trial court properly granted the City's motion for summary judgment.

Ms. Samuels argues, *App. Br. at 37-41*, that, even if gross negligence is the applicable standard, summary judgment was improper because gross negligence is a question for the jury. In support of her contention that there is a question of fact on gross negligence, Ms.

Samuels argues (again) that the first responders did not follow the Protocols based on her assertions that they failed to take a patient history, should have contacted a base station physician, and should not have said she was “not having a stroke.” Ms. Samuels’ argument fails. As previously noted, the first responders took a patient history, CP 48 (89:4-11), 51-52 (101:15 – 102:19), were not required to contact a base station physician, CP 69, 71, WAC 246-976-182, and, even assuming they told Ms. Samuels she was not suffering a stroke, still recommended she seek medical treatment and left the contact believing that Mr. Arnold was going to drive her to the emergency room, CP 53 (113:10-23), 43 (46:1-6), 64. Reasonable minds could reach but one conclusion – the first responders were not grossly negligent. Accordingly, under RCW 18.71.210, the City was entitled to qualified immunity and summary judgment was properly granted.

Gross negligence may be decided as a matter of law when reasonable minds could reach but one conclusion. *See Kelley v. Dep’t of Corrs.*, 104 Wn. App. 328, 332, 338, 17 P.3d 1189 (2000) (affirming a trial court’s determination on summary judgment that the facts, even taken in the light most favorable to the plaintiff, did not rise to a level of gross negligence); *see also Dutton v. Wash. Physicians*, 87 Wn. App. 614, 622-23, 943 P.2d 298 (1997) (finding that good faith, which is normally an

issue of fact, properly can be determined as a matter of law for purposes of qualified immunity).

Indeed, “a prompt determination is vital because qualified immunity is not simply a defense to liability but a protection from suit.” *Dutton*, 87 Wn. App. at 623.

In *Nist v. Tudor*, 67 Wn.2d 322, 407 P.2d 798 (1965), the Washington Supreme Court analyzed state and federal jurisprudence surrounding gross negligence. After reciting prior definitions from this state and other jurisdictions, the Court clarified that:

The term gross negligence, then, to have practical validity in the trial of a cause, should be related to and connected with the law’s polestar on the subject, ordinary negligence. ... It means, therefore, gross or great negligence, that is, negligence substantially and appreciably greater than ordinary negligence. Its correlative, failure to exercise slight care, means not the total absence of care but care substantially or appreciably less than the quantum of care inhering in ordinary negligence.

Nist, 67 Wn.2d at 331; *see also Swank v. Valley Christian Sch.*, 188 Wn.2d 663, 684, 398 P.3d 1108 (2017). And, as courts since *Nist* have recognized: “[T]here is no issue of gross negligence without substantial evidence of serious negligence.” *Whitehall v. King County*, 140 Wn. App. 761, 767, 167 P.3d 1184 (2007) (quoting *Kelley*, 104 Wn. App. at 333).

Nonetheless, Ms. Samuels cites four cases in support of her claim that gross negligence cannot be decided as a matter of law. First, she cites *Nist*. *Nist*, though, rather than standing for the proposition that the jury has “discretion” to determine the “standard of gross negligence” (something a jury would certainly be instructed on, if necessary), as Ms. Samuels’ contends, *App. Br. at 38-39*, clarified the definition and legal standard for gross negligence. In *Nist*, the trial court granted a directed verdict in favor of the defendant finding that the plaintiff failed to demonstrate that the defendant exercised “slight care.”⁷ *Nist*, 67 Wn.2d at 324. On review, the Washington Supreme Court clarified and expounded on the definition of gross negligence, abrogating prior definitions courts had applied. *Id.* at 330-31. Because the trial court granted a directed verdict misapplying the law, the matter was remanded. *Id.* at 333. Contrary to Ms. Samuels’ assertion, the *Nist* court did not remand the matter because gross negligence cannot be determined as a matter of law when reasonable minds could reach but one conclusion.

The second case Ms. Samuels cites, *App. Br. at 39-40*, is *Brainerd v. Stearns*, 155 Wash. 364, 284 P. 348 (1930), a 1930 case that was abrogated by *Nist* and is no longer good law.

⁷ The failure to exercise “slight care” was part of the previous definition of gross negligence prior to *Nist*’s redefining of the gross negligence standard.

The third case Ms. Samuels cites is *Bader v. State*, 43 Wn. App. 223, 716 P.2d 925 (1986). In *Bader*, the court determined that the plaintiff presented adequate evidence to create a question of fact on the issue of gross negligence and that summary judgment was not proper. Contrary to Ms. Samuels' contention, the case does not stand for the proposition that gross negligence may never be determined as a matter of law. Rather, the case simply applied well-established law, that where there is a question of fact because reasonable minds could differ, summary judgment is not proper.

Finally, Ms. Samuels cites *Schulte v. Mullan*, 195 Wn. App. 1004 (2016), an unpublished Division I opinion. In *Schulte*, the trial court denied defendant's motion for summary judgment, finding there were questions of fact as to whether the defendant acted with gross negligence. On interlocutory review, Division I affirmed, determining that, where a city's policy required probation officers to follow-up on new information about the individual they were supervising, and where plaintiff presented evidence that the probation officer did not follow-up as required, then there was a question of fact as to gross negligence. *Schulte*, like *Bader*, simply applies the well-known standard that where a question of fact exists, summary judgment is not proper. Although Ms. Samuels attempts to analogize the present case to *Schulte* arguing that a violation of the

Protocols, like a violation of the city policy in *Schulte*, suggests evidence of gross negligence, here, there was no violation of the Protocols.

Contrary to Ms. Samuels' assertions, gross negligence (like other questions of fact) may be determined as a matter of law on summary judgment when reasonable minds could reach but one conclusion. *E.g.*, *Kelley*, 104 Wn. App. at 332 (affirming trial court's summary judgment determination that the facts, even taken in the light most favorable to the plaintiff, did not rise to a level of gross negligence); *Hartley v. State*, 103 Wn.2d 768, 775, 698 P.2d 77 (1985) ("when reasonable minds could reach but one conclusion, questions of fact may be determined as a matter of law.").

Here, the trial court's grant of summary judgment was proper because reasonable minds could only conclude that the first responders were not grossly negligent. When the first responders arrived at Ms. Samuels' residence, they took a patient history. Because she reported experiencing facial numbness, they conducted a F.A.S.T. exam. CP 49 (94:2-25), 50 (97:2-9), 52 (105:12-23), 64. Because the F.A.S.T. exam was negative, Ms. Samuels did not qualify for ALS transport, and the first responders accordingly recommended non-emergent medical transport, or in the alternative that Mr. Williams take Ms. Samuels to the hospital. CP

53 (113:10-23), 43 (46:1-6). The first responders left the contact believing that Mr. Arnolds was going to take Ms. Samuels to the hospital. CP 64.

After the first responders left, Ms. Samuels was well enough that she was able to work a 5:00 a.m. shift the next morning. CP 43 (46:25 – 47:10). Her intermittent symptoms were such that she was able to work another week before she went to an urgent care clinic. CP 45-46. There, she was examined by a medical provider and was ultimately sent home with medication to treat a headache. *Id.* Then, on January 5, 2016, after yet another week of work, Ms. Samuels went to Tacoma General Hospital. It was then, that she was diagnosed as having suffered a stroke.⁸ CP 58.

Reasonable minds could reach but one conclusion – the first responders were not grossly negligent. Ms. Samuels did not exhibit symptoms requiring ALS transport. In fact, Ms. Samuels’ symptoms were such that it required an additional week for her to seek medical care, and even then a medical professional did not diagnosis her as having a stroke.

C. Ms. Samuels failed to produce competent evidence to support her claim.

Summary judgment was also proper because Ms. Samuels failed to produce competent evidence to support her claim. To survive summary judgment, Ms. Samuels was required to produce expert testimony

⁸ Although relevant to causation (not standard of care), it is noteworthy, that Dr. Kyra Becker, a neurologist at Harborview Medical Center opined that Ms. Samuels did not suffer a stroke until or shortly before January 5, 2016. CP 72-74 (¶3).

regarding the standard of care for a reasonably prudent first responder in the State of Washington acting in the same or similar circumstances in 2015. She failed to do so.

1. Chapter 7.70 RCW requires plaintiff to produce competent expert testimony to establish the standard of care.

RCW 7.70.040(1) requires a medical malpractice plaintiff to prove “[t]he health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances.” The applicable standard of care, and breach thereof, must be established by expert testimony. *Reyes v. Yakima Health District*, ___ Wn.3d ___, 419 P.3d 819, 823 (June 21, 2018); *Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 144, 341 P.3d 261 (2014). Said differently, “[i]f a plaintiff lacks competent expert testimony to create a genuine issue of material fact with regard to one of the elements of the claim and is unable to rely on an exception to the expert witness testimony requirement, a defendant is entitled to summary judgment.” *Reyes*, 419 P.3d at 823.

The expert may not merely allege that the defendants were negligent and must instead establish the applicable standard and how the defendant acted negligently by breaching that standard. Furthermore, the expert must link his or her conclusions to a factual basis.

Id. at 823 (citing *Keck v. Collins*, 184 Wn.2d 358, 371, 373, 357 P.3d 1080 (2015)).

Here, to survive summary judgment, Ms. Samuels was required to produce expert testimony establishing the standard of care of a reasonably prudent first responder in the State of Washington in 2015, *see Young v. Key Pharms.*, 112 Wn.2d 216, 230-31, 770 P.2d 182 (1989), as well as how the specific facts in this case show that the first responders did not comply with that standard of care, *Reyes*, 419 P.3d at 824.

Ms. Samuels failed to provide the requisite expert testimony to support her claim. Neither of her experts was properly qualified to opine on the standard of care of a first responder in the state of Washington in 2015. Moreover, neither of her experts relied on specific facts in the record to establish that there was a breach of the standard of care, let alone a breach rising to the level of gross negligence.

- a. Neither Dr. Brown nor Dr. Lombardi were qualified to opine on the standard of care of a first responder in the state of Washington in 2015.

Ms. Samuels' experts were not qualified to opine on the standard of care for a first responder in the State of Washington in 2015. The Legislature has determined that it is the Washington standard of care – not the national standard – to which a medical provider will be held. RCW 7.70.040(1); *see also Driggs v. Howlett*, 193 Wn. App. 875, 898-99, 371

P.3d 61 (2016) (noting that in order to lay an adequate foundation for a national expert there needed to be testimony that Washington's standard of care was the same as the national standard).

Neither Dr. Brown's nor Dr. Lombardi's declaration establishes that they are familiar with the standard of care for a first responder in the state in 2015. Thus, their declarations do not provide competent expert testimony on the standard of care.

The only state-specific references Dr. Brown made in his lengthy declaration were: (1) that a base station physician needed to be available to the first responders at all times,⁹ CP 164 (¶¶ 8, 9); and (2) that New York, like Washington, had protocols that directed how a first responder was to act in most situations, CP 165 (¶ 12). Critically, what Dr. Brown's declaration omitted was any foundation that the standard of care for Washington first responders was the same as the standard of care for New York first responders. Dr. Brown did not state that he was familiar with the Washington standard of care; nor did he state that Washington's standard was the same as the national standard (or even the New York standard). Dr. Brown's declaration was based on what he, as a base station physician, expected of a reasonably prudent paramedic in New

⁹ This is more of an opinion on the standard of care of a base station physician, not the standard of care of a first responder.

York, not what was expected of a reasonably prudent first responder in Washington. His testimony was not competent to establish the applicable standard of care.

Similarly, Dr. Lombardi, a California neurologist, is not qualified to offer opinions on the standard of care of a Washington first responder in 2015. Dr. Lombardi does not purport to be familiar with the proper standard, CP 141 (§9), but rather speciously asserts that he is qualified to offer opinions because he is a medical doctor and is familiar with whether individuals “assisting with care” must follow directions from their superiors. CP 141 (§9). Moreover, Dr. Lombardi’s criticisms of the first responders for allegedly not taking a proper patient history or properly performing a sensory exam, CP 143 (§§15, 16, 17), far exceed what he is qualified to opine on as an out-of-state neurologist. Dr. Lombardi’s declaration does not contain the proper foundation to qualify him as an expert on the standard of care for a first responder in the State of Washington in 2015.

- b. Dr. Brown’s and Dr. Lombardi’s reliance on facts contrary to the record, improper speculation, and conclusory statements, are insufficient to establish a breach of the standard of care, let alone gross negligence.

Ms. Samuels’ experts’ declarations fail to create a question of fact as to gross negligence because they contain conclusory statements that do

not rely on facts in the record, but rather rely on facts contrary to the undisputed evidence.

Conclusory statements, not supported by fact or application, are not adequate to defeat summary judgment. *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 25, 851 P.2d 689 (1993). As the Washington State Supreme Court recently determined in *Reyes*, a declaration from an expert in a medical malpractice case must state *specific facts* establishing a breach of the standard of care: “Allegations amounting to an assertion that the standard of care was to correctly ... treat the patient are insufficient. Instead, the affiant must state *specific facts showing what the applicable standard of care was and how the defendant violated it.*” *Reyes*, 419 P.3d at 824 (emphasis added).

Without applying the facts in this case, Dr. Brown conclusorily asserts, CP 146-47 (¶34), 170, 174; *see App. Br. at 26*, that the first responders did not take a medical history and thereby breached the standard of care. Contrary to Dr. Brown’s assertion, Ms. Samuels herself admitted that a medical history was taken. CP 48 (88:6-8, 89:4-11), 49 (91:16-24), 51-52 (101:15 – 102:19, 105:20-23). Dr. Brown’s opinion that the standard of care was breached must be supported by specific facts in the record. *See Reyes*, 419 P.3d at 824. Because his opinion was contrary to the facts in the record, it does not constitute competent evidence.

Dr. Brown also summarily concluded, CP 167 (¶ D), that the protocols did not govern a patient like Ms. Samuels, and the first responders should have called a base station physician. Again, his underlying assumption – that the Protocols did not govern Ms. Samuels’ situation –was contrary to the record, and was nothing more than an improper conclusory statement. The protocols contain express procedures for triaging suspected stroke victims like Ms. Samuels. *See* CP 69. Because Dr. Brown did not state specific facts showing what the applicable standard was and how the first responders breached it, his declaration was insufficient to establish a breach of the applicable standard of care. *See Reyes*, 419 P.3d at 824.

Dr. Lombardi’s declaration is similarly deficient. Although Dr. Lombardi’s declaration mainly addresses causation issues, it also contains criticisms of the first responders for “not taking a patient history,” CP 144 (¶¶25, 33 – 36). Again, his opinions do not apply the specific facts in the case, as his assumption that the first responders did not take a patient history or follow the Protocols is contrary to the facts of record, including Ms. Samuels’ own recollection of events. A declaration containing conclusory statements not supported by specific facts in the record is insufficient. *See Reyes*, 419 P.3d at 824.

- c. Dr. Brown, in his declaration, improperly opines on the credibility of witnesses.

Finally, Dr. Brown, in his declaration, improperly opines on the credibility of witnesses, when he expresses his skepticism regarding one of the first responder's (Lieutenant Jones's) testimony, and his beliefs about the credibility of Ms. Samuels and Mr. Arnold's testimony. CP 170-71. An expert cannot properly opine on the credibility of a witness. *See State v. Camarillo*, 115 Wn.2d 60, 71, 794 P.2d 850 (1990); *Burnside v. Simpson Paper Co.*, 123 Wn.2d 93, 108, 864 P.2d 937 (1994) ("The credibility of witnesses ... are matters within the province of the jury."). To the extent Dr. Brown's declaration is riddled with improper opinion testimony on the credibility of witnesses, it should not be considered.

2. Because Ms. Samuels has no competent evidence of essential elements of her claim, summary judgment was proper.

Ms. Samuels provided no competent evidence to establish what the standard of care was or how it was breached, let alone that any breach amounted to gross negligence. Because Ms. Samuels did not establish each element of her medical malpractice claim with competent evidence, summary judgment was proper. *See Young*, 112 Wn.2d 216.

VII. CONCLUSION

RCW 18.71.210 provides the City with qualified immunity for the acts or omissions of its first responders taken in good faith, as long as

there is no gross negligence or willful or wanton misconduct. The trial court's summary judgment of Ms. Samuels' claims was proper because reasonable minds could reach but one conclusion –the first responders were not grossly negligent. Accordingly, the City was entitled to qualified immunity from suit. Summary judgment dismissal was also proper because Ms. Samuels' experts were not competent to establish the applicable standard of care to a reasonably prudent first responder, or a breach of that standard of care. This Court should affirm the trial court's grant of the City's motion for summary judgment.

RESPECTFULLY SUBMITTED this 11th day of July, 2018.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on the 11th day of July, 2018, I caused a true and correct copy of the foregoing “Brief of Respondent” document, to be delivered in the manner indicated below to the following counsel of record:

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s/Cynthia L. Kusick
Cynthia L. Kusick, Legal Assistant

FAVROS LAW

July 11, 2018 - 1:35 PM

Transmittal Information

Filed with Court: Court of Appeals Division II
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Appellate Court Case Title: Lesa Samuels, Appellant v. City of Tacoma, Respondent
Superior Court Case Number: 16-2-07199-1

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