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NO. 63568-9

COURT OF APPEALS, DIVISION ONE
STATE OF WASHINGTON

(King County Cause No. 08-2-07948-1)

NICHOLE POLETTI,

Appellant,

vs.

OVERLAKE HOSPITAL MEDICAL CENTER, and KING COUNTY,

Respondents.

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JULIA M. HARRIS

BRIEF OF APPELLANT

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TABLE OF CONTENTS

| | | |
|------|---|----|
| I. | INTRODUCTION | 1 |
| II. | ASSIGNMENTS OF ERROR..... | 3 |
| | A. The Trial Court erred in granting summary judgment against Plaintiff Poletti and in favor of Defendants Overlake Hospital Medical Center (“Overlake”)..... | 3 |
| | B. The Trial Court erred in granting summary judgment against Plaintiff Poletti and in favor of Defendant King County | 3 |
| III. | ISSUES PERTAINING TO ASSIGNMENTS OF ERROR . | 3 |
| | A. What is the appropriate appellate standard of review of a summary judgment and evidentiary rulings pertaining to the motions? (Assignments of Error A and B) | 3 |
| | B. Were Plaintiff’s experts qualified to provide opinions as to the standard of care of Overlake and King County? (Assignments of Error A and B)..... | 3 |
| | C. Were the declarations of Plaintiff’s experts Dr. Bruce Olson, Ph.D., and Dr. G. Christian Harris, MD, improperly conclusory with respect to negligence and proximate causation? (Assignments of Error A and B) .. | 4 |
| | D. Did County owe decedent Poletti a duty of care? (Assignment of Error B) | 4 |
| | E. Was a material fact in dispute as to whether the negligence of defendants, or either of them, was a proximate cause of Plaintiff’s decedent’s death? (Assignment of Error A) | 4 |
| IV. | STATEMENT OF THE CASE..... | 4 |
| | A. Facts | 4 |
| | B. Procedural History | 16 |
| V. | ARGUMENT | 19 |

| | |
|--|----|
| A. This Court reviews all determinations by the trial court in summary judgment proceedings de novo..... | 19 |
| B. The Trial Court Erred in Granting Overlake’s Motion for Summary Judgment | 20 |
| 1. There Was Sufficient Evidence Before the Court to Support a Finding that Overlake Violated the Standard of Care | 20 |
| a. Plaintiff’s Experts Were Qualified to Give Opinions as to the Standard of Care of Overlake and the County..... | 22 |
| b. Similarly, the Declarations of Plaintiff’s Experts Were Not Conclusory..... | 24 |
| 2. There Is Sufficient Evidence to Support a Finding that Overlake’s Violation of the Standard of Care Was a Proximate Cause of Poletti’s Injury | 27 |
| C. The Trial Court Erred in Granting King County’s Motion For Summary Judgment | 31 |
| CONCLUSION..... | 35 |

TABLE OF AUTHORITIES

Cases

| | |
|---|--------------------|
| <i>Conrad v. Alderwood Manor</i> , 119 Wn. App. 275, 78 P.3d 177 (2003)..... | 30 |
| <i>Eng v. Klein</i> , 127 Wn. App. 171, 172, 110 P.3d 844 (2005)..... | 23 |
| <i>Folsom v. Burger King</i> , 135 Wn.2d 658, 663, 958 P.2d 301 (1998)..... | 19 |
| <i>Guile v. Ballard Community Hospital</i> , 70 Wn. App. 18, 851 P.2d 689 (1993)..... | 26 |
| <i>Hill v. Sacred Heart Hospital</i> , 143 Wn. App. 438, 177 P.3d 1152 (2008)..... | 21, 23 |
| <i>Lipscomb v. Farmers Ins. Co. of Washington</i> , 142 Wn. App. 20, 27, 174 P.3d 1182 (2007)..... | 20 |
| <i>Morton v. McFall</i> , 128 Wn. App. 245..... | 26 |
| <i>Petersen v. State</i> , 100 Wn.2d 421, 671 P.2d 230 (1983) | 20, 21, 28, 29, 30 |
| <i>Rothweiler v. Clark County</i> , 108 Wn. App. 91, 100, 29 P.3d 758 (2001), <i>rev. denied</i> , 145 Wn.2d. 1029 (2002)..... | 25 |
| <i>Schooley v. Pinch's Deli Market</i> , 134 Wn.2d 468, 475, 951 P.2d 749 (1998)..... | 35 |
| <i>Selberg v. United Pacific Ins. Co.</i> , 45 Wn. App. 469, 726 P.2d 468 (Div.I. 1986)..... | 20 |
| <i>Seybold v. Neu</i> , 105 Wn. App. 666, 678, 19 P.3d 1068 (2001) | 19-20, 23 |
| <i>Walters v. Hampton</i> , 14 Wn. App. 548, 543 P.2d 648 (1975)..... | 29 |

Statutes

| | |
|------------------------|--------|
| RCW 7.70.040(1)..... | 24 |
| RCW 71.05..... | 17 |
| RCW 71.05.010(2)..... | 34 |
| RCW 71.05.010(4)..... | 34 |
| RCW 71.05.020(25)..... | 22 |
| RCW 71.05.020(28)..... | 22 |
| RCW 71.05.050..... | 18, 21 |
| RCW 71.05.120..... | 17, 30 |
| RCW 71.05.120(1)..... | 1, 20 |

Other Authorities

| | |
|--|---|
| <i>Merck Manual</i> , 16 th . Ed., p. 1606..... | 5 |
|--|---|

Rules

| | |
|------------------------|----|
| KC LCR 7(b)(5)(B)..... | 31 |
|------------------------|----|

I. INTRODUCTION

This is an appeal from orders granting summary judgment to Overlake Hospital Medical Center (“Overlake”) and King County on March 2, 2009 and April 30, 2009, respectively, Hon. Barbara Mack, Judge. A notice of appeal was timely filed on May 27, 2009.

Plaintiff Nichole Poletti is the personal representative of Sherri Poletti, deceased (“Poletti”). The claims against each defendant are that their gross negligence¹ was a proximate cause of the death of Poletti because both separately, and in combination, each defendant breached the standard of care by failing to detain her for psychiatric observation on the evening of December 31, 2006.

Both Overlake and County concede that Ms. Poletti was deeply disturbed, with a documented history of suicidal ideation and paranoia. Both Overlake and King County concede that Ms. Poletti had stopped taking her antipsychotic medications, and further that in the days before her admission to Overlake, had driven aimlessly throughout Washington, Oregon and Canada, while suffering from visual and auditory hallucinations.

Overlake admitted Poletti in the early morning hours of December 31, 2006. Dr. Koenig, the only physician to evaluate Poletti while at

¹ ‘Gross negligence’ is required to overcome the qualified immunity of certain health care providers and others with respect to involuntary commitment of individuals. See RCW 71.05.120(1). Whether this standard applied to Hospital here was not developed or argued. The issue is not pertinent to this appeal. See also n. 10, *infra*.

Overlake, indicated that she “currently” met the criteria for involuntary commitment and further indicated that if she did not start taking her medication, she “will” be referred for an “involuntary assessment.”

On December 31, 2006, shortly after Dr. Koenig went off duty, Poletti requested a discharge. The on duty nurse, Elaine Short, called the on call physician and was instructed to obtain an evaluation from King County. Ms. Short called Joseph Militello of King County to seek an evaluation. However, after discussing the matter, Militello and Short agreed that she had sought only a consultation (but not a referral) and King County did not evaluate Poletti for involuntary commitment.

Had Overlake and King County scheduled an evaluation of Ms. Poletti, Overlake could have held her for up to six hours before the evaluation. Instead, Overlake discharged Ms. Poletti Against Medical Advice (“AMA”). Four hours later, she was dead in a one-car accident in Thurston County. At the time of her death she was not taking her antipsychotic medications that were necessary in order to prevent her from suffering from delusions and hallucinations, and was therefore likely experiencing and exhibiting psychotic behavior at the time of the accident.

Overlake moved for summary judgment claiming that plaintiff’s expert medical testimony was insufficient and further claiming that there was

insufficient evidence for a jury to conclude that any negligence by Overlake was a proximate cause of the accident. The trial court granted that motion.

King County then moved for summary judgment claiming that there was no referral by Overlake, but only a consultation, and that King County therefore owed no duty to Ms. Poletti. The trial court granted that motion as well.

This appeal followed.

II. ASSIGNMENTS OF ERROR

A. The Trial Court erred in granting summary judgment against Plaintiff Poletti and in favor of Defendant Overlake Hospital Medical Center (“Overlake”).

B. The Trial Court erred in granting summary judgment against Plaintiff Poletti and in favor of Defendant King County.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

A. What is the appropriate appellate standard of review of a summary judgment and evidentiary rulings pertaining to the motions? (Assignments of Error A and B);

B. Were Plaintiff’s experts qualified to provide opinions as to the standard of care of Overlake and King County? (Assignments of Error A and B);

C. Were the declarations of Plaintiff's experts Dr. Bruce Olson, Ph.D., and Dr. G. Christian Harris, MD, improperly conclusory with respect to negligence and proximate causation? (Assignments of Error A and B);

D. Did County owe decedent Poletti a duty of care? (Assignment of Error B);

E. Was a material fact in dispute as to whether the negligence of defendants, or either of them, was a proximate cause of Plaintiff's decedent's death? (Assignment of Error A).

V. STATEMENT OF THE CASE

This action is brought by Nichole Poletti, the daughter of Sherri Poletti ("Poletti") and the Personal Representative of the Estate of Sherri Poletti in King County Cause No. 07-4-00181-3 SEA.

A. Facts.

Defendant Overlake admitted Sherri Poletti in the early morning hours of December 31, 2006, on a psychiatric referral from Swedish/Ballard which does not have facilities to treat severely mentally ill patients. CP 20.

Sherri Poletti had gone to the Swedish/Ballard Emergency Department on December 30, 2006. She initially requested an evaluation of "sores around my eyes," (which did not exist) but subsequently admitted she was bipolar, off medications, and increasingly paranoid. She believed people were after her and had been driving around since

December 25th, to Oregon and to Canada, returning to Seattle on December 29. CP 119.

The note from Swedish/Ballard dated December 30, only a few hours before Poletti's admission to Overlake, states in part:

Pt says she has been increasingly paranoid and believes that people are following her, reading her thoughts, and are against her. She says she left her home in Ballard on Christmas and traveled to Oregon and then to Canada "to get away from people who are after me." Pt says she has been desperate and has been thinking of suicide by taking OD. She reports taking OD of Lithium (sic) recently but told no one. "I'm so scared...I'm so tired of it."

Veg Symptoms: Pt reports not sleeping for past several nights. She has been driving since 12/25 and returned to Seattle yesterday.

CP 119.²

When Sherri Poletti arrived at Overlake early in the morning of December 31, 2006, she admitted to the staff that she was having hallucinations, but she refused to divulge their content. CP 216. She refused antipsychotic medications. CP 216. Overlake admits that "the medical records document that Sherri Poletti was seen and evaluated for

² At Swedish/Ballard she reported recently taking an overdose of Lithium but "told no one." CP 119. Lithium is commonly used to control bi-polar mood swings. *Merck Manual*, 16th. Ed., p. 1606. Toxic effects of the medication include gross tremor, persistent headache "and mental confusion and may progress to stupor, seizures, and cardiac arrhythmias." *Id.* at p. 1612. Lithium was found in Poletti's blood following her death according to a report from the Washington State Toxicology Laboratory. CP 47.

paranoia and other mental health conditions and that she had refused to take anti-psychotic medications for 2 weeks.” CP 21.

Overlake was also aware that Poletti had admitted herself to Swedish/Ballard on the evening of December 30, 2006, because she was suicidal and delusional. Complaint at ¶ 3.1, CP 8 and Answer of Overlake at CP 20 and of County at CP 16.

At 4:00 a.m. on December 31, 2006, shortly after admission, Overlake’s nurse specifically noted that Poletti was refusing to take her medications. CP 123. (“I don’t need any antipsychotics; I’m not going to take that.”) Overlake’s attending nurse observed that Poletti’s “good faith status [is] in question as she had left Swedish, Prov[idence] recently AMA [against medical advice].” CP 216. Poletti refused to “divulge content of her thoughts.” *Id.* She was assessed as “guarded, paranoid refusing treatment at this time.” CP 216. She was put on “close observation” every thirty minutes, but she was observed only from 2:00 a.m. until 9:00 a.m. CP 129.

At 8:30 a.m. Poletti told the nurse she had “blisters around her” eyes, a delusion, since her “skin is clear.” CP 123.

Overlake had prior history with Ms. Poletti because she had been treated there in the past for psychiatric disorders. Just before admission to Overlake, and while at Swedish/Ballard, Ms. Poletti reported that she had

been diagnosed with bipolar disorder six years previously and had been hospitalized seven times at Overlake, Providence and University of Washington Medical Center. CP 119.

Dr. Kalen Koenig was the evaluating physician at Overlake. His handwritten chart note at 1:00 p.m. on December 31, 2006, indicates Ms. Poletti stated to Dr. Koenig that I “get manic and don’t know what I am doing” and that “people can follow me using my tooth.” CP 218. She admitted having hallucinations, but refused to talk about them. CP 218.

Dr. Koenig dictated a detailed assessment of Sherri Poletti at 4:16 p.m. on December 31, and that note was transcribed at 6:50 p.m. CP 220-225. Dr. Koenig’s assessment states flatly that Poletti “endors[ed] suicidal ideation and paranoia. The patient has a long history of poor compliance with psychiatric care frequently stopping her medications.... Sherri is continuing to decline medications....” CP 127, 223.

Most tellingly, Dr. Koenig stated, “If the patient persists in not taking psychiatric medications **she will be referred to the mental health professional [CDMHP] for an involuntary assessment.**” *Id.* (emphasis added). Dr. Koenig also concluded, that although the patient was currently denying delusions,³ [Ms Poletti] “**is felt currently to meet MHP criteria [for detention] due to psychosis and suicidal ideation with a recent**

³ CP 125, Dr. Koenig’s handwritten chart entry indicates that Ms. Poletti “denies delusions.”

suicide attempt and a lack of compliance with voluntary care.” *Id.*
(Emphasis supplied.)

While at Overlake, Dr. Koenig was the only physician to examine Poletti. Dr. Koenig concluded that “she will continue to be closely monitored.” CP 224. But that monitoring never resumed after it was discontinued at 9:00 a.m. for reasons that were not explained. CP 129.⁴

At 5:00 p.m. on December 31, Overlake concedes that Dr. Koenig left duty. Short Dep. at 41:19-23, CP 137. At about 6:30 p.m. Ms. Poletti indicated that she wanted to leave. CP 95.

Ms. Short knew that Dr. Koenig evaluated Poletti and she had his chart notes. Short Dep., 42:2-10, CP 138.⁵ However, she did not have the evaluation he dictated earlier—which indicated that Poletti **currently** met the criteria for involuntary commitment. Short Dep., 16:6-8, CP 57. *Id.* at 42:5-10, CP 138.

Ms. Short then assessed Ms. Poletti. CP 95. Ms. Short attempted to persuade Poletti to stay and told her it would be in her best interests to do so. CP 95-96. According to Overlake, Ms. Short, relying on her “professional judgment,” reached a determination that Ms. Poletti did not meet the criteria for involuntary commitment. CP 96. Ms. Short,

⁴ Ms. Short assumed there were observations made of Poletti after 9:00 a.m. Short Dep. at 36:11-17, CP 136. Failing to write down observations of a patient is “not following protocol” according to Ms. Short. *Id.* at 37:11-18, CP 136 (Hospital).

⁵ Dr. Koenig’s notes are found at CP 218.

however, reached that conclusion without the benefit of Dr. Koenig's note, where he reached the opposite conclusion.

Ms. Short never spoke with Dr. Koenig. But she did call Dr. Mathiasen, the on call physician. Ms. Short could not have shared Dr. Koenig's evaluation that Ms. Poletti met the criteria for evaluation, because she did not have that report, and had not read it.

Nonetheless, Ms. Short asked Dr. Mathiasen "if he wanted a mental health evaluation before [Poletti's] discharge." Short Dep. at 14:19-20, CP 55. He indicated she should request one.

Ms. Short confirmed in her deposition that she was seeking an evaluation of Poletti from King County:

Q. And you didn't ask for such an evaluation, did you?

A. **That's what we did when we called the MHP's.**

Id. at 14:21-24, CP 55. (Emphasis added.)

At 6:45 p.m. on December 31, 2006, Ms. Short then spoke with defendant King County's Designated Mental Health Professional, Joseph Militello by telephone. CP 193. Mr. Militello's title is "involuntary commitment specialist." Militello Dep., 6:13-17, CP 71.

Mr. Militello concedes he understood that while at Swedish/Ballard, within a few hours of the admission to Overlake, Poletti had "endorsed" "suicidal ideation," "paranoid ideation" and "auditory hallucinations."

Militello Dep., 92:22-93:9, CP 80-81. But, based on his conversation with Ms. Short, and without having evaluated Ms. Poletti for himself, Mr. Militello decided that there were insufficient grounds to seek involuntary commitment. CP 88, Militello Dep., 27:21-28:6, CP 237.

Ms. Short did not disclose Dr. Koenig's opinion that Ms. Poletti currently met the criteria for evaluation. To the contrary, Mr. Militello's note acknowledges only that Ms. Short provided her own opinion that Ms. Poletti was not presenting with indications of "imminent dangerousness." CP 88. Ms. Short also had concerns that Ms. Poletti may be getting hypomanic. *Id.*

Militello stated in his note: "I validate [Ms. Short's] assessment re: the apparent lack of issues of imminent dangerousness.... [Ms. Short] is not making referral for MHP eval at this time; she thanks me for the consultation." CP 88. Militello then closed his file. *Id.*

Mr. Militello also testified that "we do not make detention decisions over the phone" and that he "would not have communicated to [Ms. Short] or anybody else what I would do or not do until I had evaluated a person face to face" because there "are too many other potential variables involved." Militello Dep., 98:8-12, CP 86. Mr. Militello also testified that he does not make commitment decisions over the phone because he needs to assess the

“credibility” of the patients reporting, not just the symptoms. Militello Dep., 17-22, CP 87.

Mr. Militello, and his office, were acquainted with Ms. Poletti and her history. On August 18, 2006, they were called when she held a knife to her throat. CP 190. She was known by them to be “bipolar.” *Id.* The County knew of medical problems Poletti sustained by reason of being “tazered by police” on August 18. *Id.* In February of 2005, she had ordered her daughters out of her home “w/ knife in hand.” *Id.*

But Joseph Militello never met or talked to Sherri Poletti. Militello Dep., 27:21-28:6, CP 237. Mr. Militello did not know whether Ms. Poletti had been evaluated at Overlake Hospital or the results of that evaluation. Militello Dep., 39:14-18, CP 238. After Ms. Short told him that Sherri Poletti denied being suicidal or having hallucinations, Mr. Militello “validated her assessment” that Sherri Poletti was not detainable, without ever having seen her. CP 193.⁶

King County argues that Ms. Short did not ask for an “evaluation” during her telephone call although her testimony in her deposition was that

⁶ Mr. Militello’s note of his conversation with Ms. Short states that Poletti presented with complaints of “A/H” (auditory hallucination). *Id.* His note does not reflect that Dr. Koenig had assessed suicidal ideation earlier that afternoon. This is apparently due to Ms. Short failing to inform him of that fact. However, his testimony states that he knew of Poletti’s presentation at Swedish/Ballard with suicidal and paranoid ideations and auditory hallucinations. Militello Dep. at 92:24-93:6, CP 80. Mr. Militello’s note of his conversation with Ms. Short also stated “she [Ms. Short] has concerns that pt may be getting hypomanic.”

she initially called him for just that purpose. *Id.* Militello testified: “We do not make detention decisions over the phone. I would not have communicated to this person or anybody else what I would do until I had evaluated a person face to face.” *Id.* at 98:8-11, CP 86.

However, he went on to “validate [Ms. Short’s] assessment re: the apparent lack of issues of imminent danger.” CP 193. Yet Ms. Short, despite her “assessment” was not, according to Mr. Militello, qualified to make a determination as to whether Ms. Poletti was subject to detention. Militello Dep., 44:24-45:20, CP 239.

Ultimately, the decision not to do an evaluation of Ms. Poletti by Mr. Militello was a “collaborative process,” between Mr. Militello and Ms. Short. Militello Dep., 113:18-22, CP 240.

Ms. Short testified:

Q Well, are you aware of the fact that the mental health professionals have indicated that you did not ask for an evaluation?

A Okay, during the conversation it was termed—you know, it was a moderate conversation. So I give the symptoms of why I’m concerned about the patient and during this conversation he said we have recently seen this patient and I will not be detaining her. And so then he said do you want to consider this a consultation?

So my response was if you know you’re not going to detain her, you know, and we really did not have criteria for a detention, so I said then we can consider it a consultation if you clearly know you’re not going to detain her.

Short Dep., 14:25-15:14, CP 55-56.

Both Ms. Short and Mr. Militello characterized their conversation as a “consultation” and not an “evaluation.” CP 193 (Militello note of conversation, County); CP 131, 227 (7:10 p.m. note by Ms. Short, both Overlake and County). According to Ms. Short, Mr. Militello “said we have recently seen this patient and I will not be detaining her.” Short Dep. at 15:6-8, CP 56. Then, according to Ms. Short, Mr. Militello asked, “do you want to consider this a consultation?” *Id.* at 15:8-9, CP 56. To this, Ms. Short replied, “we can consider it a consultation **if you clearly know you’re not going to detain her.**” *Id.* at 15:12-13, CP 56. (Emphasis added.)

Ms. Short testified that she relied upon Mr. Militello:

A. ...I have to trust their professional advice that they have sufficient documentation that they have not seen that kind of, something that warrants her detention.

Q. So you were relying on the mental health professional’s experience with her at previous times; is that correct?

A. Plus my assessment that quite honestly she did not meet the criteria.

Short Dep. at 60:2-10, CP 196. (Emphasis added).

According to Mr. Militello, Ms. Short was not qualified to make a determination as to whether Ms. Poletti was subject to detention. Militello Dep. at 44:24-45:20, CP 239.

Ms. Short testified that there are “varying degrees on how psychotic someone is” and that she did not consider Sheri Poletti “gravely disabled.”

CP 63. But Ms. Short was plainly relying on the County’s advice:

I called the mental health professionals saying there are concerns. These are what we’re seeing, and the comment back is we do not have enough criteria to detain her. We will not detain her. So that’s where we stopped.

CP 68.

At 7:10 p.m. after the exchange between Ms. Short and Mr. Militello, Overlake discharged Poletti. At that time, Ms. Short had not consulted with Dr. Koenig again, and he had no knowledge of the discharge.

At the time of discharge, according to Ms. Short, Ms. Poletti told her that “her earlier fears that someone could or would harm her are gone.” But neither an Overlake physician nor Mr. Militello were present to evaluate the credibility of these representations. CP 131, 227. And Ms. Poletti remained “very tense and guarded” in talking to Ms. Short. CP 227.

Ms. Short knew at the time of discharge that Ms. Poletti was not taking her medications. Short Dep., 50:21-23, CP 140. Ms. Short also knew that there was a “high probability” that someone who has been having hallucinations but isn’t taking their antipsychotic medication will continue to have hallucinations.⁷ CP 140. Finally, Ms. Short had not seen

⁷ Ms. Short knew that auditory hallucinations, a reason for Poletti being at Overlake, were not likely to go away without treatment. *Id.* at 53:14-17, CP 140. Ms. Short testified there is

Dr. Koenig's report at the time of discharge and "was not aware" that he thought Ms. Poletti currently met the civil commitment standards, and that she would be referred to King County for an evaluation if she did not start taking her medications. CP 141.

Overlake then discharged Poletti AMA. Overlake has procedures for a discharge AMA. CP 132-133. But, those procedures were not followed. CP 138-140.⁸ Overlake requires documentation of AMA discharges in a specified manner. CP 132-133. A "Key Point" in that protocol is that "The staff nurse or charge nurse will discuss with the physician the risks that need to be shared with the patient, if they leave against medical advice..." And, "the staff nurse will document in the patient's medical record the sequence of events. **Included in the documentation will be the risks that were explained to the patient...**" CP 133. (Emphasis added). But Overlake failed to follow its own protocol in this case.

Despite Overlake's AMA discharge policy, Ms. Short testified: "You know, I'm not clearly in my mind seeing what would be a risk other than the fact that we explained to them that they're not, you know, they're

a "high probability" that auditory hallucinations will continue. *Id.* at 53:21-54:1, CP 140-141. Whether a person with auditory hallucinations could be a safe driver "would depend on how much hallucinations they're having..." *Id.* at 55:12-17, CP 141.

⁸ For example, Ms. Short did not inform Poletti of the risk of driving. Short Dep. at 45 -46, CP 139-140.

being discharged AMA...And so far as a risk, that leaves me with a big void. I'm not clearly understanding what would be demonstrated as a risk." Short Dep. at 45:22-46:6 CP 138-139. However, Ms. Short knew Poletti's auditory hallucinations could impair driving, depending on their severity.

After Overlake discharged Sherri Poletti, she took a taxi home, got into her car and, on New Year's Eve, started driving. There is no evidence she had a known destination. Within four hours after her discharge, Sherri Poletti drove off the road in Thurston County and was killed instantly. CP 31-38. She was wearing sweatpants, and was driving in socks but not shoes and had food and other personal items in the car at the time of the accident. CP 37. She was not wearing her seatbelt in obvious disregard for her own safety. CP 94. Her driving behavior appears to have been substantially identical to that which had occurred prior to the Overlake admission—driving aimlessly, without medication necessary to stop her hallucinations, and in all probability suffering paranoid delusions that she was being followed.

B. Procedural History

On March 4, 2008, Defendants Overlake and King County were named as defendants. CP 9. On March 8, 2008, both defendants were served with a certificate of merit signed by Dr. G. Christian Harris who stated:

I, G. Christian Harris, am a physician specializing in psychiatry. I am familiar with the standard of care expected of a reasonably prudent hospital evaluating and treating psychiatric patients. I am also familiar with the standard of care expected of a county designated mental health professional acting under RCW Chapter 71.05 (Mental Illness). Based on the information known to me at this time, I believe there is a reasonable probability that the conduct of both Overlake Hospital (through its psychiatric unit staff) and King County (through its county designated mental health professional) did not follow the accepted standard of care required to be exercised and provided to the deceased, Sherri Poletti.

CP 13.

On April 28, 2008 King County filed an Answer alleging among other things that “its mental health personnel at all times acted in good faith, without malice, and without gross negligence in the performance of duties established under RCW 71.05. CP 18. King County therefore claimed it was immune pursuant to RCW 71.05.120. *Id.*

On May 30, 2008, Overlake filed its Answer. Overlake defended the claim in part by asserting it relied upon King County: [Overlake] admits “that the County Designated Mental Health Professional was contacted, who determined that Ms. Poletti did not meet the criteria for involuntary detention.” CP 21.

On January 30, 2009, Overlake moved for summary judgment arguing that Overlake should be dismissed because plaintiff did not have

adequate expert testimony and because according to Overlake, plaintiff could not establish proximate cause. CP 93-104.

On February 13, 2000, plaintiff submitted the Declaration of Bruce Olson, a psychologist and Clinical Instructor at the University of Washington. CP 104-114. Dr. Olson opined that Overlake, through Ms. Short, had violated the standard of care and that its conduct amounted to gross negligence. CP 105. Dr. Olson further stated that Ms. Poletti was “gravely disabled and delusional after her transfer to Overlake Hospital.” *Id.* Dr. Olson then gave specific examples of how Ms. Short had departed from the standard of care. CP 105-106.⁹

On February 24, 2009, the County filed a brief, taking issue with Overlake’s characterization of the facts. The County argued that Overlake could have detained Poletti for up to six hours under RCW 71.05.050 but only if the Overlake staff regarded Poletti as presenting an imminent likelihood of serious harm or as presenting an imminent danger because of grave disability. CP 157-161. The County argued that it had no duty because Ms. Short reported facts to Mr. Militello that did not provide the legal grounds to trigger a mental health evaluation. *Id.*

On March 2, 2009, the trial court granted Overlake’s motion for summary judgment. The trial court found the declarations of both Dr. Olson

⁹ Plaintiffs later filed a second Declaration of Bruce Olson, PH.D, which also addressed standard of care. CP 267.

and Dr. Harris to be insufficient to establish a violation of the standard of care. The trial court alternately concluded that there was insufficient evidence to establish proximate cause. CP 173.

On March 24, 2009, King County moved for summary judgment. King County argued that there was no “referral” from Ms. Short, and therefore no duty to investigate on the part of the County. CP 177.

On April 9, 2009, the trial court granted King County’s motion, reasoning that King County had no duty because there had been no referral for an evaluation by Overlake. CP 248. The trial court also added lack of evidence of proximate cause as an additional ground, although that was not a part of King County’s motion.

The Notice of Appeal was timely filed on May 27, 2009. CP 250.

V. ARGUMENT

A. This Court reviews all determinations by the trial court in summary judgment proceedings *de novo*.

An order granting summary judgment is reviewed on appeal *de novo*. This level of review includes evidentiary rulings by the trial court in conjunction with a summary judgment motion. *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998). (“The *de novo* standard of review is used by an appellate court when reviewing all trial court rulings made in conjunction with a summary judgment motion.”) *See also, Seybold v. Neu*,

105 Wn. App. 666, 678, 19 P.3d 1068 (2001) (A medical negligence action, in which the Court determined, “we review the trial court’s evidentiary rulings made for summary judgments de novo”).

This Court has observed that “[s]ummary judgment is inappropriate if the record shows any reasonable hypothesis which entitles the non-moving party to relief.” *Selberg v. United Pacific Ins. Co.*, 45 Wn. App. 469, 726 P.2d 468 (Div.I. 1986) (citations omitted). All facts and inferences must be drawn in favor of the non-moving party. *Lipscomb v. Farmers Ins. Co. of Washington*, 142 Wn. App. 20, 27, 174 P.3d 1182 (2007).

B. The Trial Court Erred in Granting Overlake’s Motion for Summary Judgment.

1. There Was Sufficient Evidence Before the Court to Support a Finding that Overlake Violated the Standard of Care.

Overlake failed to meet the standard of care when it discharged Sherri Poletti on New Year’s Eve, when she was psychotic and suicidal and without having an evaluation done by a county designated mental health professional or an Overlake physician. CP 9.¹⁰

There can be no doubt that Overlake owed a duty to Poletti. *Petersen v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983) (Jury verdict against state

¹⁰ Although not an issue addressed by the trial court, Overlake claims it is entitled to qualified immunity under RCW 71.05.120(1) and that plaintiff must establish gross negligence.

upheld where patient wrongfully discharged from civil detention injured third party in auto accident five days after discharge).

RCW 71.05.050 states, in part:

...if the professional staff of any...hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a mental disorder, an imminent likelihood of serious harm...they may detain such person for sufficient time to notify the county designated mental health professional...held in custody or transported to an evaluation and treatment center....

Poletti has demonstrated, through the declarations of Drs. Olson and Harris, how Overlake deviated from the care required under that statute. CP 104-106, 264-266. “Even in a professional malpractice case, however, expert testimony is not required if the practice of a professional is such a gross deviation from ordinary care that a lay person could easily recognize it.” *Petersen v. State, supra*, at 100 Wn.2d 437; *Hill v. Sacred Heart Hospital*, 143 Wn. App. 438, 446, 177 P.3d 1152 (2008) (“Indeed, expert testimony is not even required if a reasonable person can infer a causal connection from the facts and circumstances and the medical testimony given.”).

Here, a reasonable person could easily conclude under the facts that Ms. Short’s determination that Poletti did not meet the civil commitment standards for a referral to King County violated the standard of care, particularly given that Dr. Koenig, who had evaluated Poletti several hours earlier had reached the opposite conclusion.

a. Plaintiff's Experts Were Qualified to Give Opinions as to the Standard of Care of Overlake and the County.

Plaintiff submitted the declaration of Dr. Bruce Olson, Ph.D, a psychologist and former CDMHP for Snohomish County, to opine on the standard of care of Overlake and its nurse, Elaine Short, RN. Overlake objected to this testimony. In addition, Plaintiff also submitted the declaration of Dr. G. Christian Harris, MD, a psychiatrist.

Overlake attempted to focus on the fact that Ms. Short is a psychiatric nurse, but it is important to observe that for purposes of the commitment statute, Ms. Short fell into the broad category of “mental health professional” or a “professional person” defined at RCW 71.05.020(25) and RCW 71.05.020(28), respectively. There is no definition for psychiatric nurse under the statute. Rather, the terms “mental health professionals” and “professional persons” include psychiatrists, psychologists, psychiatric nurses, social workers “and such other mental health professional as may be defined by rules...” (RCW 71.05.020(25) “and such others as may be defined by rules...” (RCW 71.05.020(28). With respect to the standard of care applicable to Ms. Short, it is that of a “mental health professional” or “professional person.” Dr. Olson’s declaration was sufficient to establish the standard of care of a nurse falling into these categories.

In other words, contrary to the trial court's decision, Dr. Olson was fully qualified to evaluate Ms. Short in her capacity as either a "mental health professional" or "professional person." This is consistent with the discussion of the scope of expertise required to defeat a defense summary judgment motion found in *Hill v. Sacred Heart Hospital*, 143 Wn. App. 438, 177 P.3d 1152 (2008). There, the Court observed, "[t]he scope of the expert's knowledge, not his or her professional title, should govern 'the threshold question of admissibility of expert medical testimony in a malpractice case.'" *Hill*, 143 Wn. App. at 447 (Internal citations omitted.) The court in *Hill*, held that it was appropriate for a physician to "express an opinion on any sort of medical question...so long as the physician has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue..." *Id.* See also *Seybold v. Neu, supra*, at 105 Wn. App. 679-680 and see, *Eng v. Klein*, 127 Wn. App. 171, 172, 110 P.3d 844 (2005), rev. denied, 156 Wn.2d 1006 (2006) ("It is the scope of a witness's knowledge and not artificial classification by professional title that governs the threshold question of admissibility of expert medical testimony in a malpractice case.") Dr. Olson was fully qualified by training and experience to opine on what Ms. Short should have done to comply with the standard of care.

Similarly, Dr. Harris, a psychiatrist, is also a “mental health professional” and a “professional person” and was likewise qualified to opine about Ms. Short.

The trial court erred when it granted Overlake’s motion to the extent that the court thought that neither Dr. Olson nor Dr. Harris were qualified “to testify to the standard of care of a psychiatric nurse...” CP 173-175.

b. Similarly, the Declarations of Plaintiff’s Experts Were Not Conclusory.

The trial court also ruled that both Drs. Olson and Harris provided conclusory declarations with respect to Overlake’s conduct. CP 173-175. But there is a difference between being economical and being “conclusory.” Dr. Olson testified sufficiently about how Ms. Short “failed to exercise that degree of care, skill and learning for a reasonably prudent health care provider” (RCW 7.70.040(1)). Dr. Olson testified, in part:

There are no [Overlake] records verifying that Sherri Poletti was watched at all after Dr. Koenig finished his evaluation on the afternoon of December 31, 2006. ...Nurse Short did not confer with Dr. Koenig, nor did she read his dictated evaluation of Sherri Poletti. Instead, nurse Short called another psychiatrist at [Overlake], who she knew had never seen Sherri Poletti, to get approval to discharge Sherri Poletti against medical advice. In addition, nurse Short did not follow the [Overlake] protocol for discharging a patient against medical advice. Finally, nurse Short called a county designated mental health professional, who had never seen or had any interaction with Sherri Poletti. Nurse Short gave him incomplete and incorrect information as to the history and condition of Sherri Poletti.

CP 105-106. (Emphases in original.)

Dr. Olson's testimony essentially embedded his standard of care opinions into his specific statements of how the standard of care was violated. Fairly read, his declaration allows the reader reasonably to understand that the appropriate standard of care would require: 1) close observation of Poletti, as ordered; 2) that Ms. Short confer with Dr. Koenig, the only physician to examine Poletti; 3) that Ms. Short read Dr. Koenig's evaluation of Poletti before reaching her determination that the civil commitment criteria were not met; 3) that Ms. Short not defer to a psychiatrist who had not examined Poletti regarding discharge AMA; 4) that Ms. Short adhere to the Overlake policy regarding AMA discharges by requiring notice to the patient of risks of such a discharge and 4) that Ms. Short not collaborate with the County under the facts presented here to determine that Poletti was not subject to detention.

Dr. Olson's opinions were based upon his review of Poletti's medical records and the deposition testimony of Dr. Koenig and Ms. Short. CP 104.

"[A]n expert must support his opinion with specific facts..." *Rothweiler v. Clark County*, 108 Wn. App. 91, 100, 29 P.3d 758 (2001), *rev. denied*, 145 Wn.2d. 1029 (2002). Dr. Olson enumerated specific facts from the medical records of Poletti and from the deposition testimony of her health care providers.

Of particular note, in *Morton v. McFall*, 128 Wn. App. 245, 115 P.3d 1023 (2005), the court reversed a summary judgment in favor of physician in a medical negligence case. The defense claimed successfully in the trial court that the plaintiff's expert was deficient in his declaration because it was conclusory and not based on facts in the case. *Morton*, 128 Wn. App. at 254. The Court of Appeals was not persuaded. As in this case, the testifying physician for plaintiff recited which facts established a breach of the standard of care. ("My conclusion is based upon the fact that the doctors...did not obtain the results...") *Id.* at 250. This, according to the decision in *Morton*, was far different from the situation presented in *Guile v. Ballard Community Hospital*, 70 Wn. App. 18, 851 P.2d 689 (1993), cited by the trial court in both of its orders in this case and by the defense in *Morton*. In *Guile*, the plaintiff expert really did offer a conclusory opinion because he merely stated that certain complications were caused by an allegedly "faulty technique." *Id.* at 70 Wn. App. 26.

Dr. Harris' declaration of February 23rd is substantially in accord with that of Dr. Olson, and also should have been considered by the trial court. Either declaration, alone, was sufficient to defeat summary judgment on the standard of care.

2. There Is Sufficient Evidence To Support A Finding That Overlake's Violation of the Standard of Care Was a Proximate Cause of Poletti's Injury.

Overlake also claimed that there was no evidence to support the claim that its negligence was a proximate cause of Ms. Poletti's death. But Overlake, and ultimately the trial court, ignored substantial evidence in the record from which a jury could conclude that the malpractice culminating in her discharge was a proximate cause of her death.

Overlake and the County concede that after discharge, Poletti took a cab home; that she drove to Thurston County on SR 8 without a seat belt and that she died when she was ejected from her car, less than four hours after discharge AMA from Overlake. Likewise, there is no dispute that for several days before her admission, she had exhibited the same behavior, driving while off of her medications and in a psychotic condition, convinced that she was being chased. At the time of discharge, Overlake knew Poletti was not taking her medication, and knew that her hallucinations were likely to continue. CP 140-141.

From the record, a jury could (and probably would) conclude that in the hours before her discharge AMA, Poletti was delusional, psychotic, off of her prescribed anti-psychotic medications and having suicidal ideation, and that she remained in that condition as she drove to her death. It is further undisputed that Ms. Short knew that people with

hallucinations are likely going to have them in the future and that Poletti was discharged AMA without being advised of the risks of driving, contrary to Overlake's policy on AMA discharge.

In an earlier decision, *Petersen v. State, supra*, the Supreme Court examined the consequences of a negligent release of a mentally ill person who, five days following release, injured a third party in an auto collision. The patient had consumed "angel dust" and, as a result, sustained a "schizophrenic-like reaction" from the drug. 100 Wn.2d at 424. The physician determined the patient had recovered from the reaction and "was in full contact with reality, and was back to his usual type of personality and behavior." *Id.* At the time of the collision, the former patient was under the influence of drugs. *Id.*

The action in *Petersen* was brought, like this one is, under RCW 71.05.120, with the same legal standard. A jury verdict was returned in favor of the plaintiff for \$250,000 and the Court affirmed, rejecting the claim by the defendant that there was no duty to protect Plaintiff from the dangerous propensities of the patient and that there was no proximate causation between the decision to release the patient and the injury to the third person occurring five days later. *Petersen*, 100 Wn.2d at 425.

Long-standing Washington precedent was cited in *Petersen* for the proposition that "the question of proximate causation is for the jury...only

when the facts are undisputed and the inferences...plain and incapable of reasonable doubt...that it may be a question for the Court.” 100 Wn.2d at 436, internal citations omitted.

The Court in *Petersen* distinguished *Walters v. Hampton*, 14 Wn. App. 548, 543 P.2d 648 (1975), where summary judgment for a city was affirmed. There, a man had encounters with police but was not prosecuted. Two years later, the same man shot plaintiff. Plaintiff sued the shooter and the city and claimed the city was at fault for its failure to prosecute the shooter years earlier. The causation issue in *Walters* was addressed by the Court in this manner:

[T]here are too many gaps in the chain of factual causation to warrant submission of that issue to the fact finder. It would require a high degree of speculation for the jury or the court to conclude that some sort of prosecutorial action...in September, 1970 would have prevented plaintiff's injuries ...in February, 1972.

14 Wn. App. at 548. But in *Petersen*, the Court observed of *Walters*, “there are not in this case ‘too many gaps in the chain of factual causation to warrant submission of that issue to the fact finder.’” 100 Wn.2d at 436.

As in *Petersen*, here “there are not...too many gaps in the chain of factual causation...” A fact-finder could reasonably conclude that Poletti was delusional and suffering from auditory hallucinations. A fact finder would know, for example, that medical professionals were suspect of her

“good faith status” on the morning of December 31, CP 123; that she had a “long history of poor compliance with psychiatric care frequently stopping her medications,...”, CP 127 (Dr. Koenig’s assessment the afternoon of the 31st); that she had suicidal ideation, recently attempted suicide and was not following through on her treatment “contract.” *Id.* We also know that Ms. Short failed to adhere to Overlake’s AMA discharge protocol and was completely unaware of what risks Poletti could face as a result of her discharge.

From all of these facts, and others, a fact finder would be able reasonably to conclude that Poletti either took her life or was unable to manage driving a car because of her impaired mental condition. Certainly, these facts are every bit as compelling as those presented in *Petersen*. Moreover, unlike *Petersen* the temporal scope between the negligence and the ultimate injury is far less: fewer than four hours here as opposed to five days.

Finally, *Conrad v. Alderwood Manor*, 119 Wn. App. 275, 78 P.3d 177 (2003) holds, “plaintiff need not establish causation by direct and positive evidence. She need only show by a ‘chain of circumstances from which the ultimate fact required is reasonably and naturally inferable.’” *Id.* at 119 Wn. App. 281 (internal authorities omitted). The facts of that case concerned a nursing home resident who sustained a spiral leg fracture

which could only occur through dropping during a bed transfer or becoming entangled in bed rails. There was no evidence of either event occurring, but the proximate cause element was supported by circumstantial evidence.

Here, based on the circumstantial evidence, a jury could easily conclude a proximate cause (there can be more than one) of Poletti's death was her untreated psychotic condition, and the fact that she was likely suffering paranoia and hallucinations while driving.

C. The Trial Court Erred in Granting King County's Motion For Summary Judgment.

King County moved for summary judgment on the basis that it did not have a duty to Poletti. (See CP 177 of County's Statement of Issues, required by KC LCR 7(b)(5)(B): "Did CDMHP Militello have a legal duty to investigate Ms. Poletti for involuntary detention on December 31, 2006...?"). The trial court erred in granting the motion because Ms. Short requested an evaluation when she contacted the CDMHP. CP 55. Rather than comply with the request, Mr. Militello conducted a telephone consultation and determined that Ms. Poletti did not meet the criteria for involuntary detention. By failing to meet the requirement of performing an in-person evaluation Mr. Militello violated the standard of care, and that violation was a proximate cause of her death.

The County argued to the trial court that no duty arose because no evaluation was requested. But a jury could find (even without the need for expert testimony) that the interchange between Ms. Short and Mr. Militello amounted to a request for an evaluation, even if those exact words were not used. Certainly, the evidence supported an inference that Ms. Short had concerns, or else she would not have bothered to call the CDMHP. Rather, Ms. Short called because she initially sought an evaluation from the CDMHP. But she was talked out of it on New Year's Eve by Mr. Militello, who convinced Ms. Short to agree that their telephone conversation was a "consultation" or "collaboration." By doing so, CDMHP Militello "validated" Ms. Short's decision to discharge Poletti although only he, as a CDMHP, could perform an evaluation potentially leading to her detention.

Mr. Militello knew that Ms. Short was not qualified to make a detention determination by herself. *Id.* at 44:24-45:20, CP 138, CP 239. Thus, Mr. Militello inserted himself into Ms. Short's decision making about whether she should request an evaluation at all.¹¹ The fact that Ms. Short and Mr. Militello chose to call their interaction something other than a referral does not change the fact that Ms. Short relied on Militello's telephonic evaluation. A jury could find on the evidence presented that either Ms.

¹¹ Ms. Short testified "...there was something that triggered me to ask Dr. Mathiasen, who was consulting, first, if he wanted a mental health evaluation before discharge. Q. And you didn't ask for such an evaluation, did you? A. **That's what we did when we called the MHPs.** Short Depo.. at 14:18-24, CP 55 (Hospital).

Short, or Mr. Militello—or both—violated the standard of care, and that was the evidence provided by plaintiff’s experts.

In speaking with Ms. Short, Mr. Militello testified he “was not clear what the current presenting symptoms of mental disorder were at that time...” *Id.* at 39:1-13, CP 238. He did not ask her if a psychiatrist at Hospital examined Poletti. *Id.* Ms. Short did not tell, nor did Mr. Militello inquire about, Poletti’s psychotic state at Swedish/Ballard and Overlake. *Id.* at 40:21-41:5, CP 238. In his experience, Mr. Militello was aware that patients have the ability to be disingenuous in order to be released from a hospital setting. *Id.* at 42:121-24, CP 239.

While a patient’s history is “useful” to him, Mr. Militello had no idea of what Poletti had been doing in the days before she presented at Swedish/Ballard: driving around the Northwest while suffering from hallucinations. *Id.* at 43:10-24, CP 239.

Plaintiff’s expert, Dr. Bruce Olson, Ph. D. in his declaration signed April 7, 2009, testified:

It is my opinion the King County Designated Mental Health Professional, Joseph Militello, violated the standard of care of a reasonably prudent designated mental health professional when he told nurse Short that Sherri Poletti was not subject to detention, when he had never seen Sherri Poletti or evaluated her. In addition to violating the standard of care, by his response he caused nurse Short not to ask for an evaluation. The standard of care of a reasonably prudent designated mental health professional does not allow Mr. Militello to rely solely on a telephone report by a psychiatric nurse to determine whether or not Sherri Poletti was detainable...

CP268.

Dr. Olson also testified that the standard of care does not allow a CDMHP “to rely on written evaluations of Sherri Poletti done by other designated mental health professionals two weeks earlier...” *Id.*

The County’s reply to Dr. Olson’s testimony was that there was no disputed fact with regard to Poletti’s “mental condition when she asked to be discharged from her voluntary admission to [Overlake].” Reply at p.2:7-8, CP 242. To the contrary, there is a real dispute as to that issue. To begin with Militello recognized that evaluations need to be done in person, which he did not do in this case. But more, the only doctor to see Ms. Poletti was Dr. Koenig just a short while earlier. He concluded that she **currently** met the detention criteria. CP 223.

Finally, a jury could conclude that Ms. Short and Mr. Militello colluded in bad faith to deny Ms. Poletti the in-person evaluation that she was due. Research has not uncovered authority holding that improper collusion between hospital staff and county designated mental health professionals creates a duty of care for the County. But the legislative intent expressed at RCW 71.05.010(2) is “[t]o provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders...” and “[t]o provide continuity of care for persons with serious mental disorders...” RCW 71.05.010(4). It would frustrate the legislative

intent to permit improper collusion to result in the denial of evaluations for persons with serious mental disorders without consequence. Cf. *Schooley v. Pinch's Deli Market*, 134 Wn.2d 468, 475, 951 P.2d 749 (1998) (“Where harm to a person protected by a statute is a foreseeable result of the statute’s violation, liability may be imposed”).

CONCLUSION

For the reasons set forth above, both orders of summary judgment should be reversed, and this case should be remanded to the trial court for trial against both defendants.

Dated at Seattle this 7 day of September, 2009.

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| CERTIFICATE OF TRANSMITTAL | |
| On this day, the undersigned in Seattle, Washington, sent to the attorneys of record for respondents a copy of this document by ABC Messenger Service. I certify under the penalties of perjury under the laws of the State of Washington that the foregoing is true and correct. | |
| 9/8/09 |  |
| Date | Signed |