No. 91387-1

SUPREME COURT

OF THE STATE OF WASHINGTON

BEVERLY VOLK, et al., *Appellants*,

v.

JAMES B. DEMEERLEER, et al., *Respondents.*

VOLK'S ANSWER TO HOWARD ASHBY, M.D.'S PETITION FOR REVIEW

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I. INTRODUCTION AND RELIEF REQUESTED.

This is in answer to Dr. Ashby's Petition for Review. Division III of the Court of Appeals correctly determined Plaintiff Volk has viable claims against Dr. Ashby and Spokane Psychiatric Clinic (SPC) for damages arising from and relating to the murder of Phillip Lee Schiering and Rebecca Leigh Schiering, the attempted murder of Brian P. Winkler, and infliction of emotional distress and other harm to Jack Alan Schiering. For the reasons that follow, the court is requested to deny Dr. Ashby's Petition for Review.

II. DECISION FOR REVIEW.

In Dr. Ashby's petition (see Section B, Petition for Review), Dr. Ashby incorrectly recasts the nature of the appellate court decision. A review of the decision in *Volk v. DeMeerleer,* 184 Wn. App. 389, 432, 337 P.3d 372 (2014), (attached as Appendix A to Ashby's Petition for Review) and the declaration of Dr. Knoll, Volk's expert (CP 82-91), clearly frames the case as a psychiatrist's breach of the standard of care in treating his clinical patient giving rise to liability to a foreseeable third party.

No standard of care issues are raised concerning disclosure of patient confidentiality. No duty to warn is at issue. (See Knoll Dec. paragraphs 11-14, CP 90-91).

III. COUNTER STATEMENT OF THE CASE.

On or about February 27, 2015, Dr. Ashby filed and served a thirty-eight (38) page brief in support of his Petition for Review. On March 9, 2015, he filed and served a Motion to File an Overlength Brief, which was granted in part and denied in part, allowing for 25 pages. In his (second) brief in support of his Petition for Review, filed and served on March 17, 2015, Dr. Ashby provides no reference to the record in the "Statement of the Case" portion of his brief. This is contrary to RAP 13.4(c)(6).

In addition, several purported facts are either incorrect or not supported by the record. For example, Dr. Ashby writes on page five of his brief that the frequency of DeMeerleer's office visits was largely driven by his life circumstances and the waxing and waning of his disorder. This assertion is made without support in the record. The only expert opinions in the record are those of Dr. Knoll, the plaintiff's expert, and he makes no such assertion. (CP 82 - Knoll Dec.). Similarly, on page five, Dr. Ashby contends that he and Mr. DeMeerleer developed a close, personal relationship. This assertion is also made without support in the records of Dr. Ashby. (CP 82). Dr. Knoll provides no such opinion. (CP 82). Finally, also on page five, he asserts between 2001 and July 18, 2010, Mr. DeMeerleer did not assault anyone. This is incorrect. In December, 2009, DeMeerleer struck Jack Schiering, a minor, in the mouth with his fist. (CP 42, 87, 160).

Since Dr. Ashby provided no reference to the record in support of any of the assertions made in his "Statement of the Case" and other statements he made are in error or otherwise unsupported in the record, Volk requests the Court disregard Dr. Ashby's "Statement of the Case" in its entirety. For the purpose of considering Dr. Ashby's petition for review, the following should be considered by the court as the "Statement of the Case".

In the original complaint, plaintiffs claimed damages for, failure of Dr. Howard Ashby ("Dr. Ashby") to properly assess Jan DeMeerleer's ("DeMeerleer") mental state; and follow-up on his multiple expressed thoughts of suicide and homicide; and actions taken on those thoughts, during the period of care and treatment.

In September of 2001, DeMeerler, then a 30-year old married father of a young girl, began psychiatric treatment with Dr. Ashby. At that time DeMeerleer related to Dr. Ashby that: he had previously been diagnosed with bipolar disorder ("BPD"), had made one or more legitimate attempts at suicide, and had been civilly committed at a mental institution, all prior to his relocation to Spokane, from the Mid-West. (CP 85-86).

During the course of treatment and therapy with Dr. Ashby, DeMeerleer's marriage failed and caused him distress and homicidal thoughts toward his ex-wife and her new male companion. (CP 87). DeMeerleer caused his family to alert Dr. Ashby that he had homicidal thoughts and had

taken action on them by laying in wait with loaded firearms in order to attempt to take retribution on one or more individuals he suspected of damaging one of his vehicles (CP 87-88), and was also known to have extended periods of manic behavior, depression, and mixed affect, especially when it concerned pre and post divorce relationships with his ex-spouse and then with Ms. Schiering. (CP 85-89). During psychiatric sessions with Dr. Ashby, it was DeMeerleer's practice to discuss his mental status, including thoughts of homicide and suicide. However, during the almost nine year course of treatment, Dr. Ashby never once formally assessed DeMeerleer for risks of suicide or harm to others. (CP 87-91). DeMeerleer was treated exclusively by prescription medication and clinical counseling sessions. (CP 87-90). In the last clinical visit with Dr. Ashby in April of 2010, DeMeerleer appeared to be in obvious distress, and presented with suicidal thoughts. However, DeMeerleer was not scheduled by Dr. Ashby for any follow-up assessment or treatment. (CP 89-90).

In the early morning hours of July 18, 2010, DeMeerleer murdered Rebecca Leigh Schiering and her nine year old son, Phillip Lee Schiering, by gunshots to the head, and attempted to murder one of Rebecca Leigh Schiering's other sons, Brian Winkler, by knife wounds to Winkler's throat. DeMeerler did not murder or attempt to murder Rebecca Leigh Schiering's other nine year old son, Jack Alan Schiering. (CP 27-32). Later that day,

DeMeerleer was found by a Spokane County Sheriff's Department S.W.A.T team in the garage of his house, dead, by an apparent self-inflicted gunshot to his head. This tragic sequence of events is hereinafter referred to collectively as "the Incident."

Various litigation was commenced, and consolidated into a single, amended complaint on May 22, 2012. (CP 27-32). Dr. Ashby moved for summary judgment. (CP 57-59 and 60-62). The plaintiffs responded with competent, uncontested expert psychiatric testimony that negligence in treatment of DeMeerleer by Dr. Ashby (and the Spokane Psychiatric Clinic, by agency) was a proximate cause of both the Incident, and a loss of chance of a better outcome/survival. (CP 82-92). Plaintiffs argued that third parties could recover damages for harm caused by a patient, where: the psychiatrist breached the standard of care in failing to properly assess and follow-up on treatment of a patient for suicidal and homicidal thoughts and actions; and the third party was reasonably foreseeable as at risk for harm from the patient. (CP 70-81). Defendant/Respondents argued that such causes of action are not recognized in Washington and RCW 71.05.120 would bar such a cause of action. (CP 249-59).

On June 21, 2013, the trial court granted defendants/respondents' summary judgment motion and dismissed plaintiffs/petitioners' claims, followed by entry of judgment, giving rise to appeal. (CP 274-77). On

appeal, the Division III court upheld dismissal of loss of chance claims, but reversed the trial court's dismissal of negligence claims for causation of the Incident. *Volk v. DeMeerleer, 184 Wn. App. 389, 432, 337 P.3d 372 (2014).*

Undisputed Factual Detail

As of 2001, DeMeerleer had married, fathered a child, and was residing in Spokane County. DeMeerleer began treatment with Dr. Ashby on September 13, 2001. (CP 85). DeMeerleer disclosed to Dr. Ashby that he had previously had suicidal ideas upon which he acted, in attempting suicide, the mitigation of which required extended in-patient psychiatric therapy and treatment. (CP 85-86). DeMeerleer also reported that he had played "Russian Roulette" with a loaded firearm, recently during the Summer of 2001. (CP 86). At the time DeMeerleer began treatment with Dr. Ashby, it was also disclosed that he had previously had homicidal ideas. Written submissions provided to Dr. Ashby as part of the June 27, 2002 session by DeMeerleer and his wife, characterized his mental state included (but was not limited to) the following characteristics:

1. Despises lesser creatures; no remorse for my actions/thoughts on other living creatures.
2. Delusional and psychotic beliefs argued to the point of verbal abuse and fighting.
3. No need for socialization; in fact, prefers to psychotically depopulate the world (i.e. "do Your Part" [CYP] terrorist philosophies).
4. Wants to destroy; pounds on computer keyboard, slams phone receiver, swings fists.
5. Has no use for others; everyone else in world is useless.

6. Reckless driving; no fear of danger in any circumstance, even "near misses."
7. Acts out fantasies of sex with anyone available. (CP 86)

DeMeerleer's then-current spouse also assessed, in a written submission at that same time, that DeMeerleer's hypomanic and manic mental state was as follows:

1. Makes mistakes on projects (i.e. breaking something) and quickly moves into dangerous rage; actually easily slips into depression after this type of trigger.
2. Severe lack of sleep coupled with dreams of going on killing or shooting sprees.
3. Drives automobiles very fast (at least 20 to 30 MPH above speed limit) without a seat belt while showing no fear at all when in dangerous situations; applies even with a child in the car.
4. Expresses severe "road rage" at other slower drivers, even as a passenger (he's NOT driving).
5. Has an "all or nothing" attitude; will actually verbally express "Live or Die!" (CP 86-87)

When DeMeerleer expressed suicidal and homicidal ideas on several occasions during treatment, no thorough inquiry was made by Dr. Ashby as to the nature and extent of the ideas, such as: planning; access to weapons; prior attempts; acting out, etc; stress; access to victims; and so forth. (CP 87).

At the time DeMeerleer began clinical treatment with Dr. Ashby, and during treatment, issues of DeMeerleer's sexuality and sexual experimentation were identified by DeMeerleer. (CP 87). A review of the police records confirm that a significant issue in DeMeerleer's estrangement from Ms. Schiering was: his interest in pornography; his experimentation

with homosexuality and/or bi-sexuality; and Ms. Schiering's disdain for these activities. (CP 87). Dr. Ashby's clinical records and chart notes, however, reflect no inquiry into issues of DeMeerleer's sexuality, even though excessive sexual preoccupation is a well-known symptom of BPD. (CP 87).

During treatment by Dr. Ashby, after the failure of his marriage, DeMeerleer expressed homicidal ideas toward his former spouse and her then-current boyfriend. (CP 87). Subsequently, DeMeerleer's family was greatly concerned about his access to firearms, and his overt acting upon homicidal ideas. (CP 87). Out of deep concern, DeMeerleer's mother's sent a letter to Dr. Ashby dated September 24, 2005. (CP 87). The following is an excerpt from that letter:

> We were all extremely concerned that Jan's reaction to vandalism to his "beater" pickup truck was dangerous and unrealistic. Jan placed two powerful guns (a .357 pistol and a shotgun, both with lots of ammunition) into his car and then drove himself to the area where this theft had been perpetrated in order to "wait" for the thieves to return. Jan's two fathers (biological and step) and I do have a huge issue with Jan hauling loaded guns around in case he finds the guys who ripped into his truck! ***Jan assured us that he no longer has visions of suicide but that he has now progressed into a homicidal mode.*** Believe me, Dr. Ashby, we are NOT comforted by this information! Jan's several guns were removed from his home (by his two fathers) and taken to Moscow. (CP 88)

DeMeerleer had been placed on various psychotropic medications by Dr. Ashby, but Dr. Ashby knew DeMeerleer had a penchant for failing to take medication (non-compliance), especially in times of his manic and/or mixed

mood states. (CP 88) Based on toxicology results, DeMeerleer was non-compliant with taking his medications at the time of the Incident. (CP 88).

It was known to Dr. Ashby that, after DeMeerleer's failed marriage, DeMeerleer entered a serious relationship with Ms. Schiering and her children. (CP 85). However, DeMeerleer's coping ability was tested severely by Ms. Schiering's autistic son, Jack, to the extent that DeMeerleer physically attacked Jack by striking the then 9 year old squarely in the mouth with his fist. This apparently caused Ms. Schiering to separate from DeMeerleer. (CP 88).

Dr. Ashby initially appeared to have diagnosed DeMeerleer with a mild form of BPD (cyclothymic personality disorder). (CP 85). Dr. Ashby did not attempt to evaluate DeMeerleer's apparent obsessive/compulsive threats. Throughout treatment by Dr. Ashby, DeMeerleer was often mentally unstable. (CP 85). However, no systematic or focused inquiry into DeMeerleer's psychiatric symptoms was made, nor a treatment plan with periodic follow-up initiated. (CP 85-86).

DeMeerleer was clinically seen by Dr. Ashby on June 11, 2009, and appeared to be in distress. (CP 88). His medication and medication levels were changed, but no follow-up was scheduled. (CP 88). DeMeerleer also phoned Dr. Ashby's clinic on December 1, 2009, in obvious distress due to loss of employment and separation from Ms. Schiering, and specifically

expressed his desire to get back into counseling, and medication management. (CP 88). Dr. Ashby referred him to community based mental healthcare, and advised him to come return if the referral didn't work out. (CP 88). DeMeerleer returned to Dr. Ashby on April 16, 2010, appeared to be in the middle of frequent mood cycling, and reported he was mending his relationship with Ms. Schiering. (CP 88). However, his mood was unstable and he also stated he was having depression related, intrusive suicidal ideas. (CP 88-89). No focused inquiry was made by Dr. Ashby. Instead, Dr. Ashby relied on DeMeerleer's self-report that he wouldn't act on his suicidal ideas. (CP 89). Again, DeMeerleer's suicide risk was not assessed at this time. Also, no follow-up appointment was made for DeMeerleer, in order to adequately monitor his clinical condition. (CP 89). Dr. Ashby never conducted an evaluation of suicide risk during the approximate nine years of treatment. (CP 89-90).

IV. ARGUMENT.

A. Washington law is settled. Dr. Ashby's duty of care extends to foreseeable third-parties such as those represented by Volk in this case.

Liability for breach of a duty to third parties, based on foreseeability, is well established in Washington.

> "The better reasoned authorities do not regard foreseeability as the handmaiden of proximate cause. To connect them leads to too many false premises and confusing conclusions. Foreseeability is, rather,

> one of the elements of negligence; it is more appropriately attached to the issues whether defendant owed plaintiff a duty, and, if so, whether the duty imposed by the risk embraces that conduct which resulted in injury to plaintiff. The hazard that brought about or assisted in bringing about the result must be among the hazards to be perceived reasonably and with respect to which defendants' conduct was negligent. ... **It is not, however, the unusualness of the act which resulted in injury to plaintiff that is the test of foreseeability, but whether the result of the act is within the ambit of the hazards covered by the duty imposed upon defendant."**
>
> *Rikstad v.* Holmberg, 76 Wn.2d 265, 268–269, 456 P.2d 355 (1969)(Emphasis added).
>
> **"The sequence of events, of course, need not be foreseeable. The manner in which the risk culminates in harm may be unusual, improbable, and highly unexpected, from the point of view of the actor at the time of his conduct.** And yet, if the harm suffered falls within the general danger area, there may be liability provided other requests of legal causation are present."
>
> *Berglund v. Spokane* County, 4 Wn. 2d 309, 319 – 320, 103 P.2d 355 (1940)(Emphasis *added*).

In *Peterson v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983), this court concluded a psychiatrist has a duty to protect against a third party's injuries caused by a patient. The court held the defendant psychiatrist "incurred a duty to take reasonable precautions to protect **anyone** who might foreseeably be endangered by [his patients] drug related mental problems." *Id.* at 428. (Emphasis added). The court explained: "In the present case, we follow the approach utilized in *Lipari v. Sears Roebuck & Co.*, 497 Fed. Supp. 185, 193 (D. Neb. 1980) and *Kaiser v. Suburban Transp. Sys., supra.*" *Peterson,* 100 Wn. 2d. at 428 (emphasis added).

The issue presented in *Lipari* was the same as presented in *Peterson* and in the case at bar. Specifically, whether a psychotherapist owes a duty of care to third persons injured by a patient. The court concluded:

> "... the relationship between a psychotherapist and his patient gives rise to an affirmative duty for the benefit of third persons. This duty requires that the therapist initiate whatever precautions are reasonably necessary to protect potential victims of his patient. This duty arises only when, in accordance with the standards of his profession, the therapist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others."
>
> *Lipari*, 497 Fed. Supp. 185, 193 (D. Neb. 1980).

Lipari's holding was based primarily on Restatement (Second) of Torts § 315 (1965).

> "Under the common law, a person had no duty to prevent a third party from causing physical injury to another. A number of courts, however, have recognized an exception to this general rule. Under this exception, a person has a duty to control the conduct of a third person and thereby to prevent physical harm to another if:
> (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
> (b) a special relation exists between the actor and the other which gives rise to the other a right to protection."
>
> *Lipari*, 497 Fed. Supp. at 188. See also, *Tarasoff v. Regents of the* University *of California*, 17 Cal. 3d 425, 551 P.2d 334 (1976) (applying section 315).

In *Kaiser v. Suburban Transp. Sys.*, 65 Wn. 2d 461, 398 P.2d 14 (1965), a bus driver lost consciousness due to the side effects of a drug which had been prescribed by his physician and the bus struck a telephone

pole. One of the passengers on the bus was injured and commenced an action against the bus driver's physician, among others. 65 Wn. 2d 461, 462-463. Without citation to the Restatement of Torts, the court concluded there was sufficient evidence to submit the issue of the doctor's negligence to the jury.

> "A physician is responsible in damages when he fails to possess such skill and learning as is usually possessed by the average member of the profession in the locality where he practices and to apply that learning with reasonable care. ... Doctors Smith, Van Arsdel and Faghin all testified that a warning should have been given when the drug is prescribed because of its potential known dangers. About 20 percent of the people who take the drug experience unwanted side effects ... there is evidence in the record that the doctor failed to warn his patient, who he knew to be a bus driver, of the dangerous side effects of drowsiness ... that may be caused by the taking of this drug. This evidence was sufficient to submit the issue of the doctor's negligence to the jury."
>
> *Id.* at 464.

It is well settled that, in a claim of negligent treatment, the plaintiff need not be the patient. *Webb v. Neuroeduc. Inc., P.C.*, 121 Wn. App. 336, 346, 88 P.3d 417 (2004). (Citing *Kaiser v. Suburban Transp. Sys., supra).* A non-patient can state a cause of action for negligent treatment by showing the injury resulted from the failure of a healthcare provider to follow the accepted standard of care. *Webb,* 121 Wn. App. at 346. In *Webb*, the plaintiff was the patient's father. He sued the defendant psychologist for negligently implanting and developing false memories of sexual abuse in his son. *Id.* at 339. One of the issues on appeal was whether the defendant owed the non-

patient father a duty of care in a medical malpractice case. The court concluded the psychologist did owe a duty and reversed the trial court's summary judgment dismissal. *Id.* at 351.

In *Est. of Davis v. Dept. of Corrections*, 117 Wn. App. 833, 113 P.3d 487 (2005), the court recognized a cause of action pursuant to *Peterson, supra.* The court wrote:

> "There is no general duty to protect others from the criminal acts of a third party. An exception to this rule exists, however, if there is a **special relationship between the defendant and the victim or the defendant and the criminal.** Such a duty is imposed only if there is a definite, established, and continuing relationship between the defendant and the third-party criminal actor."
>
> *Estate of Davis v.* Dept. *of Corrections*, 127 Wn. App. 833, 841 – 842, 113 P.3d 487 (2005). (Emphasis added).

In *Davis*, the court rejected the plaintiffs "special relationship" theory because the defendant saw the counselor only one time. *Id.* at 842. In the present case, DeMeerleer saw Dr. Ashby more than 50 times over a period of nine years. Dr. Ashby had a "special relationship with DeMeerleer, upon which plaintiffs have a cause of action.

As demonstrated above, Washington has historically imposed a duty of care on defendant healthcare providers who breach the standard of care with respect to foreseeable events.

Dr. Ashby relies upon the declarations of DeMeerleer's family and prior spouse for the proposition harm to the Schiering family was

unforeseeable. These are irrelevant, as they are based on then current lay impressions, not the confidential, professional knowledge and treatment of DeMeerleer by Dr. Ashby. They lack foundation in this medical negligence action. Dr. Knoll, on behalf of Volk, provides the only expert medical testimony that addresses standard of care issues. Dr. Knoll provides substantial elements from Dr. Ashby's treatment records to establish that the Schiering family was foreseeably within the ambit of risk from DeMeerleer. (CP 88-91). Harm to the Schiering family was, for summary judgment, foreseeable.

> It is not, however, the unusualness of the act which resulted in injury to plaintiff that is the test of foreseeability, but whether the result of the act is within the ambit of the hazards covered by the duty imposed upon defendant.
>
> *Rikstad v. Holmberg*, 76 Wn.2d 265, 268–269, 456 P.2d 355 (1969). See also *Berglund v. Spokane County*, 4 Wn. 2d 309, 319 – 320, 103 P.2d 355 (1940).

In this case, the court of appeals concisely addressed Dr. Ashby's duty of care:

> Imposing a duty on Dr. Ashby, in the setting of our case, entails addressing whether the Schiering family was a foreseeable victim. The family was more foreseeable as a victim than Cynthia Petersen in *Petersen v. State*, since Larry Knox, the criminal actor in *Petersen*, had no prior connection to Cynthia Petersen. Jan DeMeerleer had a prior connection to Rebecca Schiering and her three sons. DeMeerleer had already slugged one son. According to the evidence before the court on summary judgment, Dr. Ashby knew that Jan DeMeerleer had already threatened to use violence against his former wife and her boyfriend. Dr. Ashby knew DeMeerleer suffered from distress and

depression resulting from the breakup with Rebecca Schiering.

Petersen v. State also answers the dissent's position that no liability should attach to Dr. Ashby because there were no threats uttered about the Schierings. Cynthia Petersen was not the subject of prior threats.

Volk *v. DeMeerleer,* 184 Wn. App. 389, 432, 337 P.3d 372 (2014).

Based on the foregoing and when considering Dr. Knolls' testimony, Dr. Ashby clearly had a duty of care to the Schiering family, as correctly determined by the court of appeals.

B. RCW 70.02.050 Does Not Prohibit Dr. Ashby From Sharing DeMeerleer's Healthcare Information.

The claimed of breach of the standard by Dr. Ashby does not rely on disclosure of healthcare information. Tangentially, Dr. Knoll states, hypothetically, if Ashby had provided proper care, the incident probably would not have happened; and, otherwise, Dr. Ashby may have had other options, such as warning the Schierings family. In that hypothetical context, and as of the date of the Incident, RCW 70.02.050 provided in relevant part:

RCW 70.02.050 Disclosure without patient's authorization:

"(1) A healthcare provider or healthcare facility may disclose healthcare information about a patient without the patient's authorization to the extent a recipient **needs to know** the information, if the disclosure is: ...

(d) To any person if the healthcare provider or healthcare facility **reasonably believes** that disclosure will avoid or minimize an imminent danger to the health or safety of the patient **or any other individual**, however, there is **no obligation** under this chapter on the

part of the provider or facility to so disclose;

(e) To immediate family members of the patient, including a patient's state **registered** domestic partner, **or any other individual with whom the patient is known to have a close personal** relationship, if made in accordance with **good medical or other professional practice,** unless the patient has instructed the healthcare provider or healthcare facility in writing not to make the disclosure ..."

RCW 70.02.050(1)(d)(e) (Emphasis added).

Disclosure of healthcare information based upon the "needs to know" portion of RCW 70.02.050(1) is a jury question. *Doe v. Group Health Cooperative*, 85 Wash. App. 213, 220, 932 P.2d 178 (1997), *overruled on other grounds*, 136 Wn.2d 195, 961 P.2d 333 (1998). Therefore, to the hypothetical extent disclosure might have been made, per Dr. Knoll, it would be a jury question.

Again, however, Volk, through the only medical expert testifying in this matter, Dr. Knoll, does not consider disclosure of healthcare information, or warning the Schiering family, as part of the actual breach of Dr. Ashby's standard of care. (CP 82-91).

C. The Immunity Afforded by RCW 71.05.120 is Inapplicable to This Case.

RCW 71.05.120 states, in part (emphasis added):

"(1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter,

> nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the State, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable ***for performing duties pursuant to this chapter*** with regard to the decision of whether to admit, discharge, release, administer anti-psychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

In 1987, the Washington legislature narrowed the duty created by *Peterson* by enacting the Involuntary Treatment Act. *Volk v. DeMeerleer*, 184 Wn. App. at 422. However, RCW 71.05.120 applies only to situations concerning involuntary mental health treatment and voluntary in-patient mental health treatment. *Poletti v. Overlake Hospital Medical Ctr.*, 175 Wn. App. 828, 832, 303 P.3d 1079 (2013). The legislature chose not to address private psychiatric clinic settings.

In the instant case, Dr. Ashby's treatment of DeMeerleer was not for involuntary mental health treatment. DeMeerleer was not an in-patient voluntarily seeking mental health treatment. Therefore, the "Involuntary Treatment Act" is not applicable and Dr. Ashby is not entitled to the immunity set forth in RCW 71.05.120.

Est. of Davis v. Dept. of Corrections, 117 Wn. App. 833, 113 P.3d 487 (2005), does not compel a different result. In *Davis,* the defendant was under community supervision for taking a motor vehicle without permission and for a violation of his community service sentence resulting from that

offense. His community service mandated that he submit to a psychological anger control evaluation and comply with the resulting treatment requirements.

Unlike the defendant in *Davis*, DeMeerleer did not face confinement, evaluation and treatment requirements. Therefore, the "Involuntary Treatment Act" is not applicable and Dr. Ashby is not entitled to the immunity from liability set forth in RCW 71.05.120.

Dr. Ashby's reliance upon Justice Talmadge's concurring opinion in *Hertog v. City of Seattle*, 138 Wn. 2d 265, 293 n.7, 979 P.2d 400 (1999), is misplaced. As noted by Dr. Ashby, Justice Talmadge wrote in pertinent part:

> "The legislature statutorily abrogated our holding in *Peterson* in Laws of 1987, ch. 212, § 301 (1) (codified at RCW 71.05.120(1)), **with respect to the liability of the state.**" (emphasis added)

Clearly, Justice Talmadge is referring to the fact that RCW 71.05.120(1) addresses only the involuntary commitment settings, where a person is acting within statutory framework. In Justice Talmadge's concurrent opinion in *Hertog, supra,* he addresses the issue of "control" of a subject, an issue often associated with state liability. Control is not an issue in this matter.

D. Dr. Knoll's Admissible Declaration Presents Questions of Fact with Respect to Dr. Ashby's Breach of Duty and Proximate Causation Precluding Summary Judgment

James L. Knoll, IV, M.D. is a board-certified psychiatrist and

neurologist. He earned a subspecialty certification in forensic psychiatry. (CP 82 para 2; CP 93). The factual basis upon which he formed his opinions in this case is: (1) his review of the clinical records of Jan DeMeerleer from the Spokane Psychiatric Clinic; (2) his review of the Spokane Valley Police/Spokane County Sheriff Department's investigative files pertaining to the July 18, 2010 incident in question; and (3) his review of the Spokane County Medical Examiner's autopsy report and related toxicology report with respect to DeMeerleer. (CP 83 para 4). Dr. Knoll is knowledgeable of the applicable standard of care in the State of Washington. (Id. at para 5). His opinions and conclusions are made on a more probable than not basis, and when made with respect to clinical psychiatric practice, made with reasonable medical certainty, on a more probable than not basis. (CP 84 at para. 6).

Dr. Knoll's declaration sets forth testimony creating a question of fact with respect to Dr. Ashby's breach of the applicable standard of care. Specifically, at CP 90, para. 11, Dr. Knoll testifies in pertinent part:

> "SPC breached the applicable standard of care by failing to exercise the decree of care, skill and learning expected of a reasonably prudent healthcare provider of psychiatric medical services, in the State of Washington, acting in the same or similar circumstances ... These breaches include, but are not limited to: failing to perform adequate assessments of DeMeerleer's risk of harming himself, and others when clinically indicated to do so; and failing to adequately monitor DeMeerleer's psychiatric condition, and provide appropriate treatment."
>
> CP 90, para. 11.

"SPC" refers to Dr. Ashby and his colleagues at the Spokane Psychiatric Clinic. (CP 83, para. 5). Dr. Knoll's testimony, set forth in paragraph 11, creates genuine questions of fact as to whether Dr. Ashby breached the applicable standard of care. Accordingly, the trial court erred in granting the respondent's motion for summary judgment and the court of appeals correctly reversed.

Dr. Knoll's declaration properly addresses proximate cause. In paragraph 12, he testifies:

> "But for the referenced Breaches by SPC, it is unlikely the Incident would have occurred."

In paragraph 13, he testifies:

> "The referenced Breaches were, collectively and individually, most likely a causal and substantial factor contributing to and in bringing about the Incident and the resulting harm ..."
>
> (CP 91, at para. 12 and 13).

"Unlikely" and "most likely" are simply alternative expressions of "more probably than not." Moreover, any opinions or conclusions made by Dr. Knoll in his declaration are made on a more probable than not basis with reasonable medical certainty. (CP 84, para. 6). As demonstrated above, Dr. Knoll's declaration addresses Ashby's breach of the standard of care and proximate cause on a more probable than not basis with reasonable medical certainty. Accordingly, the court is requested to deny Dr. Ashby's petition

for review.

Dr. Ashby's contention that Dr. Knoll's opinions are speculative is without merit. On pages 20-21 of his brief, Ashby contends that Dr. Knoll speculates: (1) DeMeerleer would have *attended* additional office visits if suggested or requested; (2) DeMeerleer would have had homicidal ideation despite the absence of any factually specific evidence in support of this proposition; (3) DeMeerleer would have expressed this speculative homicidal ideation to Dr. Ashby; and (4) DeMeerleer would have been amenable to any treatment offered in response to this hypothetical homicidal ideation. (Ashby Brief pp. 20-21).

First, Dr. Knoll did not opine DeMeerleer would have *attended* additional office visits. He testified it was below the standard of care for Dr. Ashby to fail to *monitor* him in a timely manner and to *schedule* regular clinical follow-ups. (CP 89, para 9, ll. 11-17). The question of whether DeMeerleer would have *attended* additional office visits is irrelevant to Dr. Ashby's breach of the standard of care. Secondly, the record unequivocally contains factually specific evidence of DeMeerleer's homicidal ideation. (CP 89, para 9, ll.19-22; CP 243). Third, DeMeerleer had expressed homicidal ideation to Dr. Ashby. (CP 89, para 9, ll. 11-17; CP 90, ll.1-2). In addition, DeMeerleer's mother had also informed Dr. Ashby of his homicidal ideation and action to realize that ideation. (CP 243-244). Fourth, whether DeMeerleer

would have been amenable to any treatment offered by Dr. Ashby is irrelevant to the issue of Ashby's breach of the standard of care.

For the reasons demonstrated above, Dr. Knoll's declaration contains legally admissible opinion evidence. The court of appeals correctly determined summary judgment was improper. Accordingly, this court is requested to deny Dr. Ashby's petition for review.

E. The Court is Requested to Preserve and Promote the Public Policy of Protecting Innocent Third-Parties

The argument advanced by Dr. Ashby, that adverse unintended consequences will envelop the world of mental healthcare, is ironically speculative, given his attack on Dr. Knoll's opinions. Volk respectfully notes there is no legal or empirical research citation to support Ashby's argument. The court in *Tarasoff* spoke to a psychiatrist's duty to exercise reasonable care:

> "The role of the psychiatrist, who is indeed a practitioner of medicine, and that of the psychologist who performs an allied function, are like that of the physician who must conform to the standards of the profession and who must often make diagnoses and predictions based upon such evaluations. Thus, the judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility. ... We do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances."

Tarasoff v. Regents of Univ. of Calif., 17 Cal. 3d 425, 438, 551 P.2d 334 (1976).

Volk submits the public interest in safety from violent assault is paramount to the public interest in protecting confidential communications between a patient and his or her mental healthcare provider.

Washington has long had a public policy of imposing a duty of reasonable care upon healthcare practitioners. This duty extends to third parties. Washington's public policy can and should continue to promote the protection of innocent third parties, foreseeably within the orbit of danger.

V. CONCLUSION

A psychiatrist's duty of care extends to all reasonably foreseeable third parties, such as the plaintiffs' in this matter. RCW 71.05.120 and 70.02.050 do not prevent disclosure of healthcare information, given the facts of this case. Dr. Knoll's testimony is not speculative and provides the jury with an opportunity to determine whether Dr. Ashley's breach of the standard of care caused Volk's damages. For these reasons, the court is requested to deny Ashby's petition for review.

RESPECTFULLY SUBMITTED this 15th day of May, 2015.

MICHAEL J RICCELLI PS

By: Michael J Riccelli

Michael J. Riccelli, WSBA #7492
Bruce E. Cox, WSBA #26856

DECLARATION OF SERVICE

I caused to be served a true and correct copy of the foregoing by the method indicated below, and addressed to the following:

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

Dated this 15 day of May, 2015.

Holly Eastwood

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Please see attached Volks Answer to Ashby's Petition for Review for filing in the above-referenced matter.

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