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AUG 27 2015

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 92216-1

**SUPREME COURT OF
THE STATE OF WASHINGTON**

JAMIE FAST, et al.,
Petitioners

v.

KENNEWICK PUBLIC HOSPITAL DISTRICT, et al.,
Respondents

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CLERK OF THE SUPREME COURT
STATE OF WASHINGTON
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Court of Appeals Cause No. 31509-6-III
Appeal from the Superior Court of Benton County
The Honorable Cameron Mitchell
Benton County Superior Court Cause No. 12-2-01660-4

PETITION FOR REVIEW

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A. IDENTITY OF PETITIONERS

Petitioners Shane Fast and Jamie Fast are plaintiffs to this cause, appellants to the Court of Appeals, and ask this Court to accept review of the decision designated in part B from the Court of Appeals, Division III.

B. COURT OF APPEALS DECISION

Petitioners seek review of the published opinion, *Fast v. Kennewick Public Hospital District*, as amended, filed on July 28, 2015, a copy of which is attached as Appendix A. Petitioners respectfully request the Supreme Court to review the decision which upheld summary judgment on the assertion that medical malpractice that causes the death of an unborn child is not an “injury” to the parents of the unborn child.

C. ISSUE PRESENTED FOR REVIEW

Which statute of limitations applies to a parent’s civil action for damages for injuries occurring as a result of health care, against the health care providers, based on professional negligence, where the health care negligently provided to the mother caused the death of her unborn child?

D. STATEMENT OF THE CASE

Plaintiff Jamie Fast established care with Defendant Dr. Smith on January 25, 2008, and became pregnant a couple of months later, (CP 401, 369-77, 243-47, 382-405, 446-706). Although Jamie never had diabetes, (CP 372), she presented to Dr. Smith with several high-risk factors for

diabetes, which mandated screening, (CP 401). During her pregnancy, Jamie complained of excessive thirst, excessive drinking of water, frequent urination, and resistant rashes, (CP 369-77). She lost ten pounds during her pregnancy, (*id.*, CP 458). Despite multiple risk factors and warning signs of diabetes, Dr. Smith ignored the risk factors and failed to screen for diabetes, but instead assured Jamie that all is well, (*id.*, CP 401-05, 458), even postponing a glucose challenge test, (CP 371, 402).

Defendant Dr. Schroff, covering for Dr. Smith, saw Jamie on August 25, 2008, (CP 525-28). He scheduled a glucose challenge test on August 29, 2008, (CP 529-34, 547), her first sugar test since establishing care with Dr. Smith, (CP 529-34, 372). Her blood glucose concentration was 649 mg/dL, *over six times* the upper limit of normal, (CP 531, 403), which poses “significant and overt metabolic abnormalities in the pregnant patient” and additional stress to the fetus, and requires inpatient admission to reduce the blood glucose level, (CP 403-05). Dr. Schroff informed Jamie that the lab results were so high that he did not believe them, (CP 372), so admission would not be necessary. He had her return to the hospital the next morning to have a repeat lab, (*id.*). That next day, Jamie’s blood sugar concentration was 450 mg/dL, over four times normal, (CP 536). She was admitted to the hospital, (CP 542-44).

In the hospital, Dr. Schroff failed to treat Jamie's blood sugar level as aggressively as he should have, resulting in fetal distress that could not be compensated, (CP 403). He ordered intermittent monitoring when he should have ordered continuous, (CP 403). The monitor detected decelerations that required the nurses to initiate intrauterine resuscitative procedures and to notify Dr. Schroff, (CP 403-04, 567-73, 560-61), but the alarms were acknowledged with no further action, (*id.*). Dr. Schroff failed to review fetal monitor strips which indicated that Jamie needed a Cesarean-section procedure to save the baby, (CP 404, 582-619).

Around 4:00 a.m. on August 31, 2008, nurses entered Jamie's room to apply the fetal heart monitor, but were unable to detect a heartbeat, (372, 561-62, 571-74). Jamie's baby had died, (*id.*). Defendants fell below the standard of care in providing health care to Jamie during her pregnancy, and as a result her unborn baby died. CP 404-05, 773. Jamie was left insulin-dependent, (CP 372).

On August 26, 2011, Plaintiffs served requests for mediation to Defendants, (CP 132-142, 143-212), tolling the medical negligence statute of limitations for one year, (RCW 7.70.110). Plaintiffs later proposed a list of mediators, (*id.*, CP 239-41). By July 10, 2012, Defendants stated they are not willing to mediate, (CP 132-142). On July 18, 2012, the Fast filed a complaint alleging medical negligence, (CP 1-16).

On November 19, 2012, Dr. Smith filed a motion for summary judgment to which the other Defendants joined, (CP 24-66, 76-104). The trial court awarded summary judgment, (RP 3-8, CP 1224-1236), ruling that this is not a medical negligence action; that the medical negligence statute of limitations does not apply; therefore the statute of limitations was not tolled by RCW 7.70.110 when the Fasts requested mediation; and thus the action is time-barred by the personal injury statute of limitations at RCW 4.16.080(2). The Fasts timely appealed, (CP 1224-1248, 1256-1257). The Court of Appeals upheld the summary judgment, (Appendix A), ruling that the medical negligence statutes apply only to personal injuries, and that the Fasts did not suffer personal injuries, therefore the personal injury statute of limitations applies, (Appendix A). The Plaintiffs now petition for review.

If the personal injury statute of limitations at RCW 4.16.080(2) applies here, then the Fasts' claim was untimely filed. If the medical negligence statute of limitations at RCW 4.16.350 applies, then the Fasts' claim was timely filed because the statute of limitations was tolled for one year by RCW 7.70.110 on making the good-faith requests for mediation.

E. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

This is an issue of first impression to determine which statute of limitations applies to parents' action for damages for injury from medical

negligence, where the negligent health care was provided to the mother, causing both the parents' and the unborn child's injuries. This review should be accepted because the decision of the Court of Appeals is in conflict with decisions of the Supreme Court, (RAP 13.4(b)(1)); because the decision is in conflict with other decisions of the Courts of Appeals, (RAP 13.4(b)(2)); and because this issue is of substantial public interest that should be determined by the Supreme Court, (RAP 13.4(b)(4)).

This cause is on appeal from summary judgment. It is reviewed *de novo*, with all materials viewed most favorably to the non-moving party; if there is any genuine issue of material fact undecided, or the moving party is not entitled to judgment as a matter of law, then summary judgment must be denied.¹ This issue is determined by statutory construction. The meaning of a statute is a pure question of law and is reviewed *de novo*.²

The fundamental purpose in construing statutes is to ascertain and carry out legislative intent. *Arborwood Idaho, LLC v. City of Kennewick*, 151 Wn.2d 359, 367, 89 P.3d 217 (2004). The legislature's intent can be discovered from the plain meaning of the statute, which is determined "from all that the Legislature has said in the statute and related statutes which disclose legislative intent about the provision in question." *Dep't of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002). The court must not add words where the legislature has chosen not to include

¹ *E.g.*, *Myles v. Clark County*, 170 Wn. App. 521, 289 P.3d 650 (2012) review denied by *Myles v. State*, 146 Wn.2d 1015, 297 P.3d 706 (2013); *Yakima Fruit & Cold Storage Co. v. Central Heating & Plumbing Co.*, 81 Wn.2d 528, 530, 503 P.2d 108 (1973); *see also* Brief of Appellant at 4-5 and cases cited therein.

² *E.g.*, *Dep't of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002); *Wilson v. Grant*, 162 Wn. App. 731, 258 P.3d 689 (Div. 3 2011) as corrected.

them, and the statute must be construed so that all language is given effect. *Restaurant Dev., Inc. v. Cananwill, Inc.*, 150 Wn.2d 674, 682, 80 P.3d 598 (2003). If the statute remains susceptible to more than one reasonable meaning, it is ambiguous and the legislative history and circumstances surrounding its enactment may be considered. *Id.* Constructions that yield unlikely, absurd, or strained consequences must be avoided. *Kilian v. Atkinson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002).

City of Seattle v. Fuller, 177 Wn.2d 263, 269-70, 300 P.3d 340 (2013).

1. The medical malpractice statutes are unambiguous and direct that the medical malpractice statute of limitations applies here.

Legislature declared emphatically:

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care which is provided after June 25, 1976.

RCW 7.70.010. Legislature modifies such civil actions “as set forth in this chapter [7.70 RCW] and in RCW 4.16.350,” (*id.*). RCW 4.16.350, the medical malpractice statute of limitations, provides in part:

Any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976, against [health care providers] . . . based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his or her representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be commenced more than eight years after said act or omission . . .

RCW 4.16.350. The statute of limitations is tolled for one year on making a good faith request for mediation:

The making of a written, good faith request for mediation of a dispute related to damages for injury occurring as a result of health care prior to filing a cause of action under this chapter shall toll the statute of limitations provided in RCW 4.16.350 for one year.

RCW 7.70.110. It is not disputed that the Fasts' claim is a civil action against health care providers resulting from health care, based on alleged professional negligence. It is not disputed that the Fasts delivered written, good faith requests for mediation within the limitations period prior to filing a cause of action. The dispute is whether the Fasts' claim for the loss of their unborn child is a claim "for damages for injury."

The statutes do not define the terms "damages" or "injury," thus it is presumed that the legislature intended their common law meanings.³ The court can consult a dictionary to ascertain a term's meaning,⁴ and has relied upon Black's Law Dictionary to define "injury" and "damages."⁵ This Court recognized the definition of "injury" at Black's Law Dictionary

³ E.g., *Baum v. Burrington*, 85 Wn.2d 597, 537 P.2d 266 (2003); see RCW 4.04.010; see also, e.g., *Rasor v. Retail Credit Co.*, 87 Wn.2d 516, 522, 530, 554 P.2d 1041 (1976) (construing "actual damages," ordinary terms are given common meanings, legal terms are given their common legal meanings) citing *Bradley v. United States*, 410 U.S. 605, 609, 93 S.Ct. 1151, 35 L.Ed.2d 528 (1973).

⁴ *State v. Alvarado*, 164 Wn.2d 556, 562, 192 P.3d 345 (2008).

⁵ E.g., *Brown v. MHN Gov't Servs., Inc.*, 178 Wn.2d 258, 277, 306 P.3d 948 (2013), concurrence of J. Gonzalez, (refers to *Black's Law Dictionary* as "the standard legal dictionary," for definitions of "exemplary damages" and "punitive damages."); *Martini v. Boeing Co.*, 137 Wn.2d 357, 367, 971 P.2d 45 (1999) (for definitions of "actual damages" and "compensatory damages").

856 (9th ed. 2009) as “the violation of another’s legal right.”⁶ The loss of an unborn child to medical negligence is an injury to the parents because it is a violation of their rights for which the law provides a remedy:

A mother or father, or both . . . may maintain or join as a party an action as plaintiff for the injury or death of the child. . . . In such an action, in addition to damages for medical, hospital, medication expenses, and loss of services and support, damages may be recovered for the loss of love and companionship of the child and for injury to or destruction of the parent-child relationship in such amount as, under all the circumstances of the case, may be just.

RCW 4.24.010.⁷ “A viable unborn child is a ‘minor child’ for purposes of RCW 4.24.010; the parents of such minor child are entitled to sue on their own behalf for the death of their child.”⁸ Parents can recover under RCW 4.24.010 for mental anguish, suffering, and grief over the death of their child.⁹ The Fastos suffer “injury.”

This Court recognizes the definition of “damages” in Black’s Law Dictionary 445 (9th ed. 2009) as “[m]oney claimed by . . . a person as

⁶ *Ambach v. French*, 167 Wn.2d 167, 174 n 3, 216 P.3d 405 (2009); see also *Rettkowski v. Dep’t of Ecology*, 128 Wn.2d 508, 517-518, 910 P.2d 462 (1996) (construing “injury” in RCW 90.14.190 as “[t]he invasion of any legally protected interest of another,” quoting Black’s Law Dictionary 785 (6th ed. 1990)); Black’s Law Dictionary 801-02 (8th ed. 2004) defines “injury” as “[t]he violation of another’s legal right, for which the law provides a remedy. . . .”

⁷ The full text of RCW 4.24.010 is provided at Ex. 3.

⁸ *Cavazos v. Franklin*, 73 Wn. App. 116, 867 P.2d 674 (Div. 3 1994) citing *Moen v. Hanson*, 85 Wn.2d 597, 537 P.2d 266 (1975).

⁹ *Moen v. Hanson*, 85 Wn.2d 597, 537 P.2d 266 (1975); *Wilson v. Lund*, 80 Wn.2d 91, 491 P.2d 1287 (1971).

compensation for loss or injury.”¹⁰ It is not disputed that the Fasts claim monetary remedy as compensation for their injuries, (CP 1-16). The Fasts’ cause is therefore a “civil action for damages for injury occurring as a result of health care . . . against [health care providers] . . . based on alleged professional negligence,” which precisely fits the medical malpractice statutory language. Legislature paralleled “damages for injury occurring as a result of health care” in its declaration at RCW 7.70.010, in RCW 4.16.350, and in the tolling provision at RCW 7.70.110.

The statutes are unambiguous on their face and do not require further interpretation. Nevertheless, courts look to all that legislature said in determining legislative intent in a statute’s plain meaning.¹¹ Legislature explicitly declared its intent within the acts’ preambles.¹² Legislature most recently amended chapter 7.70 RCW and RCW 4.16.350 in 2006:

The legislature finds that access to safe, affordable health care is one of the most important issues facing the citizens of Washington state. The legislature further finds that the rising cost of medical malpractice insurance has caused some physicians, particularly those in high-risk specialties such as obstetrics and emergency room practice, to be unavailable when and where the citizens need them the most. The answers [require] . . . making the civil justice

¹⁰ *Ambach v. French*, 167 Wn.2d 167, 174 n 3, 216 P.3d 405 (2009); Black’s Law Dictionary 416 (8th ed. 2004) (same).

¹¹ E.g., *Dep’t of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002).

¹² *Spokane Cty. Health Dist. v. Brockett*, 120 Wn.2d 140, 151, 839 P.2d 324 (1992) (“We recently affirmed our view that the preamble or statement of intent can be crucial to interpretation of a statute. *Roy v. Everett*, 118 Wn.2d 352, 356, 823 P.2d 1084 (1992)”); *State v. Day*, 96 Wn.2d 646, 649 n.4, 638 P.2d 546 (1981) (“It is a well recognized rule of statutory construction that the title of the act may be resorted to as one means of ascertaining intent. *In re Estate of Kurtzman*, 65 Wn.2d 260, 265, 396 P.2d 786 (1964)”).

system more understandable, fair, and efficient for all the participants. . . . It is the intent of legislature . . . to address the problem of high malpractice insurance premiums. . . . It is also the legislature's intent to provide incentives to settle cases before resorting to court

Laws of 2006 ch. 8 §1. Legislature addressed RCW 4.16.350 under “Part III – Health Care Liability Reform / Statutes of Limitations and Repose”:

The purpose of this section and section 302 of this act is to respond to the court's decision in *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998), by expressly stating the legislature's rationale for the eight-year statute of repose in RCW 4.16.350. The legislature recognizes that the eight-year statute of repose alone may not solve the crisis in the medical insurance industry. However, to the extent that the eight-year statute of repose has an effect on medical malpractice insurance, that effect will tend to reduce rather than increase the cost of malpractice insurance. Whether or not the statute of repose has the actual effect of reducing insurance costs, the legislature finds it will provide protection against claims, however few, that are stale, based on untrustworthy evidence, or that place undue burdens on defendants. In accordance with the court's opinion in *DeYoung*, the legislature further finds that compelling even one defendant to answer a stale claim is a substantial wrong, and setting an outer limit to the operation of the discovery rule is an appropriate aim. The legislature further finds that an eight-year statute of repose is a reasonable time period in light of the need to balance the interests of injured plaintiffs and the health care industry. . . .

Laws of 2006 ch. 8 §301. The legislative context reinforces the legislative intent embodied in the plain meaning of the statute. Legislature intends to lower medical malpractice premiums by limiting claims “for damages for injury occurring as a result of health care . . . against [health care providers] . . . based on alleged professional negligence,” (RCW

4.16.350), because such are the types of claims that affect medical malpractice premiums. Legislature intended to trump other laws with its superlative language, “exercising its police and sovereign power,” to modify “all actions and causes of action, whether based on tort, contract or otherwise,” (RCW 7.70.010), and “[a]ny civil action,” (RCW 4.16.350), and courts have recognized that the medical malpractice statutes sweep broadly and apply to all civil actions for damages resulting from health care, regardless of how the claim is styled.¹³ Finally, “to provide incentives to settle cases before resorting to court,” Legislature provided that requesting mediation in good faith will toll the statute of limitations for one year, (RCW 7.70.110). Therefore, the Fasts’ medical malpractice claim is subject to the medical malpractice statute of limitations and repose at RCW 4.16.350, and it was tolled by one year when the Fasts made a good-faith request to mediate. The summary judgment should be reversed.

2. Even if the medical malpractice statutes were unambiguous, (and they are not), then Legislative history would merely reinforce the interpretation above.

The medical malpractice statute of limitations was first enacted in 1971, providing a three-year limitation period with a one-year discovery

¹³ *E.g.*, *Harris v. Extendicare Homes, Inc.*, 829 F.Supp.2d 1023 (2011); *Hall v. Sacred Heart Medical Center*, 100 Wn.App. 53, 995 P.3d 539, as amended, review denied 141 Wn.2d 1022, 10 P.3d 1073 (2000).

rule, but no repose, (Laws of 1971 ch. 80). The medical malpractice insurance industry complained that the one-year discovery rule created a crisis by exposing them to “long-tail” claims, (claims that emerge many years later, asserting the discovery rule), which made it difficult for them to calculate risk, and increased medical malpractice insurance premiums.¹⁴ Legislature in 1976 passed an act creating the medical malpractice scheme at chapter 7.70 RCW, and extensively revised the medical malpractice statute of limitations to include a new eight-year repose, (Laws of 1975-76 2d Ex. Sess., ch 56), intended to stabilize the malpractice insurance industry by reducing the volume and costs of claims.¹⁵ It was then that the language “damages for injury occurring as a result of health care” was introduced at chapter 7.70 RCW, and the statute of limitations at RCW 4.16.350 was modified accordingly. Consistent with its intent to reduce the cost of medical malpractice insurance, Legislature targeted causes that seek to recover money – *damages* for injury – as opposed to causes that seek other remedies. But the *DeYoung* court in 1998 ruled the eight-year repose unconstitutional because legislature had knowledge that the repose would only affect a very small proportion of claims, insufficient to stabilize an insurance crisis: Even under rational basis scrutiny, the repose failed equal protection because it could not have been reasonably designed

¹⁴ See *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998).

¹⁵ See *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998).

to achieve the purpose in which the state had an interest.¹⁶ Legislature answered the *DeYoung* court by reenacting the repose with different – but similar – intent, (Laws of 2006 ch. 8; *see above*).

Legislative history demonstrates that the legislative intent is to reduce the cost of medical malpractice insurance, in part by incentivizing alternative dispute resolution, and to cut the tail of the discovery rule to protect health care providers and their insurers from stale claims. Legislative history reinforces that the statutes were intended to sweep into their purview any civil action seeking monetary compensation for medical negligence from health care providers and their insurers.¹⁷ The Fast's claim falls squarely within the medical negligence statutes, and they should control; the summary judgment should be reversed.

3. The personal injury statute of limitations at RCW 4.16.080(2) does not apply here.

The lower court characterizes the parents' injuries for losses, anguish, sorrow, and suffering under RCW 4.24.010 as a wrongful death claim for the death of their child, (*Op.* at 7-8), then cites a string of cases that apply the personal injury statute of limitations at RCW 4.16.080(2) to wrongful death cases, (*Op.* at 8). The lower court acknowledges that

¹⁶ *Id.*

¹⁷ *E.g.*, *Harris v. Extendicare Homes, Inc.*, 829 F.Supp.2d 1023 (2011); *Hall v. Sacred Heart Medical Center*, 100 Wn.App. 53, 995 P.3d 539, as amended, review denied 141 Wn.2d 1022, 10 P.3d 1073 (2000).

RCW 7.70.010 and 4.16.350 modify all civil actions for damages for injury occurring as a result of health care against health care providers based on professional negligence, (*Op.* at 9), but questions whether the phrase “damages for injury” includes the types of injury one suffers under wrongful death, (*Op.* at 9-12). The lower court cites a 1990 Division II case, *Wills v. Kirkpatrick*, 56 Wn. App. 57, 785 P.2d 834 (Div. 2 1990), which has only been cited by two published opinions. The lower court followed *Wills*, declaring that Legislature really meant “personal injury” when it wrote “damages for injury” at RCW 4.16.350, and really meant only “personal injury to the patient,” (*Wills*; *Op.* at 9-12). Having grafted words Legislature did not write, the lower courts then determined that wrongful death does not constitute personal injury, (*id.*). The lower courts reasoned that Legislature did not intend at RCW 4.16.350 to bar an action before it could accrue, (wrongful death), and therefore did not intend to sweep civil actions for wrongful death based on medical malpractice into the medical malpractice statutes, (*id.*). Interestingly, having determined that wrongful death *is not* personal injury, the lower courts applied the personal injury statute of limitations, (*id.*), at RCW 4.16.080(2): “any other injury to the person or rights of another not hereinafter enumerated.” The lower court here added to the *Wills* rationale that “the broad concept of injury is captured by the word ‘damages,’ leaving the word ‘injury’ to

describe the particular type of damage – injury suffered by the patient – to which the provisions apply,” although it made this distinction from whole cloth, (*Op.* at 11). Finally, the lower court suggested *stare decisis* and added that legislative inaction against the twice-cited *Wills* indicates legislative acquiescence, (*Op.* at 11-12).

(a). Legislature deliberately crafted RCW 4.16.350 to respond to the jurisprudence and practical effects of applying the limitations provisions at RCW 4.16.080(2) to medical malpractice actions.¹⁸ “With enactment of RCW 4.16.350, former RCW 4.16.010 and RCW 4.16.080(2) no longer apply to such actions.”¹⁹

(b). Even if the cause sounds in wrongful death – though it does not – RCW 7.70.010 applies to “all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care.” This Court has construed the meaning of “all causes of action” in another statute, and held, “‘All’ means all. It does not mean simply those causes of action that are not otherwise covered by [another statute].”²⁰ It applies to wrongful death. Courts recognize the harmony between medical malpractice statutes and damages for wrongful death. *Harbeson*, for example, applied the medical malpractice statutes to

¹⁸ *Gunnier v. Yakima Heart Ctr., Inc.*, 134 Wn.2d 854, 860-63, 953 P.2d 1162 (1998)

¹⁹ *Id.* at 862.

²⁰ *Wilson v. Grant*, 162 Wn.App. at 739 (citations omitted)

parents' claim for emotional damages for injury to their child under RCW 4.24.010.²¹ *Harbeson* cited *Herskovits* as a case wherein "the plaintiff mother brought a malpractice action for the death of her child from throat cancer," and later referred to a death case as "a medical malpractice suit for failure to diagnose and treat."²² *Herskovits* includes a survivorship action brought by the personal representative of the deceased, yet refers to it as a "medical malpractice case."²³ In *Harris*, the court applied the medical malpractice statute of limitations to an action resulting in death.²⁴ The trial court here cited *Bennett*, (RP 2-3), which applied medical negligence statutes to a case of death from negligent prescribing.²⁵ The *Wilson* court recognized that the decedent's father sued for damages "based on a claim of medical negligence."²⁶ Contrary to the lower court's assertion of *stare decisis*, *Wills* did not create the false dilemma between wrongful death and medical negligence causes. categorically can never occur as a result of health care. *Wills* is incorrect.

Wrongful death actions arise from the wrongful acts of the tortfeasor, not from the person of the deceased.²⁷ "[T]he gravamen of the

²¹ *Harbeson*, 98 Wn.2d 460 at 474-78

²² *Harbeson*, 98 Wn.2d at 477-78

²³ *Herskovits v. Group Health Coop.*, 90 Wn.2d 609, 610, 664 P.2d 474 (1983)

²⁴ *Harris* (829 F.Supp.2d at 1031).

²⁵ *Bennett v. Seattle Mental Health*, 150 Wn.App. 455, 208 P.3d 578 (Wn.App. Div. 1, 2009).

²⁶ *Wilson v. Grant*, 162 Wn.App. at 735

²⁷ *E.g., Johnson v. Ottomeier*, 45 Wn.2d 419, 423-24, 275 P.2d 723 (1954).

[wrongful death] action is negligence of the defendant causing the death of the deceased.”²⁸

(c). Courts recognize that the relevant portion of RCW 4.16.080(2) erects a *catch-all* statute of limitations for personal injury,²⁹ limiting only cases not fitting into other limitation provisions.³⁰ Because this case fits RCW 4.16.350, RCW 4.16.080(2) does not apply. This Court has further held that specific statutory language controls over general statutory language.³¹ RCW 4.16.350 is clearly more specific and therefore controls.

(d). This Court thus adopted the decision rule that “[w]hen there is uncertainty as to which statute of limitation governs, the longer statute will be applied.”³² RCW 4.16.350 is the longer statute here because it is tolled for one year. Moreover, “tolling provisions, by nature, exist to assure all persons subject to a particular statute of limitations enjoy the full benefit of the limitations period.”³³ Here, the intent of tolling provision is

²⁸ *Robinson*, 26 Wn. at 488

²⁹ *E.g.*, *Rose*, 654 F.2d at 547.

³⁰ *Stenberg v. Pacific Power & Light Co., Inc.*, 104 Wn.2d 710, 721, 709 P.2d 793 (1985); see also *Bond*, 59 Wn.2d at 497-98

³¹ *E.g.*, *Wilson*, 162 Wn.App. at 735-736.

³² *Stenberg*, 104 Wn.2d at 715 (citing *Rose*, 654 F.2d 546; *Shew v. Coon Bay Loafers, Inc.*, 76 Wn.2d 40, 51, 455 P.2d 359 (1969)); *Ruth v. Dight*, 75 Wn.2d 660, 664, 453 P.2d 631 (1969) citing *Lundgren v. Whitney’s Inc.*, 94 Wn.2d 91, 95, 614 P.2d 1272 (1980). *Stenberg*, 104 Wn.2d at 714 citing 51 Am.Jur.2d Limitation of Actions § 17 (1970).

³³ *Rivas v. Overlake Hospital Medical Center*, 164 Wn.2d 261, 189 P.3d 753 (2008), and cases cited therein.

encourage medical malpractice cases to settle before litigation.³⁴ Furthermore, a plea of the statute of limitations “is not such a meritorious defense that either the law or the facts should be strained in aid of it.”³⁵ Here, Defendants strain both the law *and* the facts to avoid reaching the merits, by declaring that the Fasts’ claim is not a claim for damages resulting from healthcare; by construing “all actions” to mean “all actions *except those involving death*”; and by grafting “personal injury to the patient” where Legislature wrote “injury.” “Courts will not read into statutes of limitations exceptions not embodied therein.”³⁶

(e). The lower courts ignore the long-standing black-letter law that wrongful death is indeed personal injury, even to the statutory beneficiaries, which is why the three-year personal injury statute of limitations at RCW 4.16.080(2) applies to most wrongful death cases instead of the two-year limitations at RCW 4.16.130.³⁷ It is still unclear whether the lower courts’ decisions, (directly contradicting themselves), stands for the principle that wrongful death cases in Washington are now

³⁴ Bennett, 150 Wn.App. at 460-61 *citing* 1976 Final Legislative Report, 44th Wn. Leg., 2d Ex. Sess., at 22. *See also* Laws of 2006 ch. 8 § 301.

³⁵ Bain v. Wallace, 167 Wn. 583, 10 P.2d 266 (1932) (*citing* Hein v. Forney, 164 Wn. 309, 2 P.2d 741 (1931)). *See also* Cannavina v. Poston, 13 Wn.2d 182, 188, 124 p.2d 787 (1942); Wickwire v. Reard, 37 Wn.2d 748, 226 P.2d 192 (1951) and cases cited therein; Guy F. Atkinson Company v. State, 66 Wn.2d 570, 573, 403 P.2d 880 (1965) and cases cited therein.

³⁶ Guy F. Atkinson Co., 66 Wn.2d at 575 and cases cited therein.

³⁷ Robinson v. Baltimore & S. Mining & Reduction Co., 26 Wn. 484 (1901); Dodson v. Cont'l Can Co., 159 Wn. 589, 294 P. 265 (1930), cited in Wills, 56 Wn.App. at 760.

subject to the two-year statute of limitations at RCW 4.16.130.

(f). The lower courts' decisions circumvent legislative intent by enabling medical malpractice cases to be brought forward where a patient dies over eight years after the negligent acts or omissions. Furthermore, because lost chance can be recovered in wrongful death for factors contributing to death,³⁸ this rule potentially opens a floodgate of litigation to escape the statute of limitations and repose, and for estates to sue health care providers decades after a negligent act or omission, no matter how slight was the contribution to death under the lost chance doctrine. This would have the absurd result of rendering the statute once again unconstitutional under *DeYoung*.

(g). The lower court ignores the fact that Jamie, the mother, was indeed the patient here, and she should be able to recover even under the strained decision.

(h). The decision renders absurd results and leads to strained consequences. Jamie can recover for the loss of her pregnancy, but not the loss of her child under medical negligence. Jamie can recover for the lost chance of giving live birth, even though she cannot recover for the loss of her child. Jamie and Shane can recover for injuries based on the fetus's injuries under RCW 4.24.010, but cannot recover for the death of the fetus

³⁸ *E.g., Estate of Dormaier v. Columbia Basin Anesthesia, PLLC*, 177 Wn.App. 828, 313 P.3d 431 (2013).

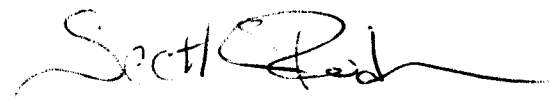
from those injuries. If Jamie can prove that her fetus was not viable at the time of death, then she can recover for the loss of the fetus under medical negligence, but if the fetus was viable, then her claim is time-barred.

(i). Acquiescence by legislative inaction is not conclusive, and is the weakest maxim to interpret statutory language, particularly as here, where the statute is plain on its face, does not need interpretation, where the case was not a Supreme Court case, where it has only been cited twice, where there are conflicting cases with conflicting rationales and holdings, where this is a case of new construction and application, and where there is absolutely no evidence that Legislature was even aware of the case.³⁹

F. CONCLUSION

The Supreme Court should accept this review to clarify the many conflicts in the lower courts' case law and to uphold the legislative intent of medical malpractice reform.

RESPECTFULLY SUBMITTED this 27th day of August, 2015



Scott E. Rodgers, WSBA 41368

³⁹ E.g., Ward v. LaMonico, 47 Wn.App. 373, 377, 795 P.2d 92 (Div. 1 1987); Auto Club of Wash. V. State, 27 Wn. App. 781, 785-86, 621 P.2d 760 (Div. 2 1980); Komm v. Department of Social & Health Servs., 23 Wn. App. 593, 600 n.5, 597 P.2d 1372 (1979); Seattle v. King Co., 52 Wn. App. 628, 762 P.2d 1152 (Div. 1 1998); Somer v. Woodhouse, 28 Wn. App. 262, 270, 623 P.2d 1164 (Div. 2 1981); Pringle v. State, 77 Wn.2d 569, 573, 464 P.2d 425 (1970); v. Dep't of Labor & Indus., 142 Wn.2d 801, 812, 16 P.3d 5083 (2001); Bostain v. Food Express, Inc., 159 Wn.2d 700, 716-717, 153 P.3d 846 (2007).

APPENDIX A
Opinion

FILED
JUNE 2, 2015
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

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

SHANE FAST, JAMIE FAST, the marital)
community comprised thereof, ROBERT)
DALTON FAST, and the estate thereof,)

Appellants,)

v.)

KENNEWICK PUBLIC HOSPITAL)
DISTRICT d/b/a KENNEWICK)
GENERAL HOSPITAL and d/b/a MID-)
COLUMBIA WOMEN'S HEALTH)
CENTER, a Washington public hospital)
district organized as a government entity,)
municipal or quasi-municipal corporation;)
ADAM T. SMITH, D.O., individually and)
for the marital community with spouse or)
registered domestic partner Jane Doe)
Smith; GREGORY SCHROFF, M.D.,)
individually and for the marital)
community with spouse or registered)
domestic partner Jane Doe Smith; and)
DOES 1 through 50,)

Respondents.)

No. 31509-6-III

PUBLISHED OPINION

SIDDOWAY, C.J. — The Benton County Superior Court granted summary judgment dismissing Shane and Jamie Fast's action seeking to recover damages for personal injury to Ms. Fast and the wrongful death of the couple's viable unborn son,

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Robert, which they attribute to the professional negligence of Dr. Adam Smith, Dr. Gregory Schroff, and the doctors' employer, the Kennewick Public Hospital District. The Fasts had proceeded with their lawsuit as if the claims for Robert's death and Ms. Fast's personal injury were both subject to the statute of limitations for injuries resulting from health care, RCW 4.16.350, which could be tolled for a year by a good faith request for mediation. On that basis—having served such a request—they filed suit more than three years after Robert's death.

The trial court concluded that the health care statute of limitations does not apply to a wrongful death claim, with the result that the running of the statute of limitations on that claim was not tolled. It also concluded that the Fasts had failed to comply with the statutory requirement to file a claim for damages with a local government entity (here, the hospital district) before commencing litigation against the entity or its employees, and on that basis dismissed the Fasts' claims based on Ms. Fast's injuries as well.

Division Two of this court held in 1990 that the limitations statute applicable to a wrongful death action is the general tort limitations statute, RCW 4.16.080(2), rather than the health care limitations statute. *Wills v. Kirkpatrick*, 56 Wn. App. 757, 785 P.2d 834 (1990). The Fasts' efforts to distinguish their claims from those in *Wills* or to convince this division to reject Division Two's analysis are unpersuasive.

We agree with the Fasts, however, that the defendants are not eligible to assert the defense of the Fasts' failure to present a prefiling notice of claim under RCW 4.96.010

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and RCW 4.96.020(4) in light of the hospital's failure to comply with its own obligations under that section.

We affirm the dismissal of the Fasts' claim for the wrongful death of Robert, reverse the dismissal of the Fasts' claims for Ms. Fast's injuries, and remand for further proceedings consistent with this opinion.

FACTS AND PROCEDURAL BACKGROUND

Jamie and Shane Fast's unborn son Robert (gestational age 28-weeks) died in utero in August 2008. The Fasts attribute his death to the failure of health care providers to timely recognize and act upon the risk that Ms. Fast would develop gestational diabetes.

Almost three years after Robert's death, the Fasts, individually and on behalf of Robert, served a written good faith request for mediation on Dr. Adam Smith, Dr. Gregory Schroff, and the hospital that employed them, the Kennewick Public Hospital District. Under chapter 7.70 RCW, entitled "Actions for Injuries Resulting from Health Care," the filing of a good faith request for mediation tolls the health care statute of limitations, RCW 4.16.350, for one year. RCW 7.70.110.

The defendants expressed no interest in mediating and eventually, on July 18, 2012, the Fasts commenced legal action against Dr. Smith, Dr. Schroff, and the hospital by filing a complaint. The Fasts characterized the action as one "for injuries resulting from healthcare under RCW Chapter 7.70," Clerk's Papers (CP) at 2

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(Complaint, ¶ 1.2), but they also sought to recover “for injury or death of a child . . . brought pursuant to the laws of the State of Washington to include . . . RCW 4.24.010.” CP at 7-8 (Complaint, ¶ 5.1). On the same day they filed the complaint, the Fastes filed with the court a completed form, entitled “Standard Tort Claim Form,” that had been promulgated by Washington State for use in filing notices of claim against the state with the department of enterprise services in Olympia. In a “supplemental response” section of the form, the Fastes’ lawyer stated, “This Standard Tort Form is not required for this cause. The Claimants, however, offer this Standard Tort Form as a courtesy and convenience to Respondent.” CP at 281. A copy of the standard tort claim form was not served on the hospital until August 1; copies were mailed to lawyers for Dr. Smith and Dr. Schroff, who accepted service for their clients on August 3 and September 12, respectively.

Several months later, the three defendants moved for summary judgment dismissal of the complaint on grounds that the Fastes failed to comply with the local government tort claim statute, RCW 4.96.020, which requires that claimants give 60-days’ notice before filing suit against a local governmental entity. Alternatively, they argued that the wrongful death claim was barred by the statute of limitations.

In resisting summary judgment, the Fastes initially argued that they were not asserting a “wrongful death” claim because they were not relying on the right of action created by chapter 4.20 RCW, which creates a statutory right of recovery for “the death

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of a person . . . caused by the wrongful act, neglect, or default of another.” RCW 4.20.010. They challenged the defendants’ right to raise the Fast’s failure to present a prefiling notice of claim as a defense, presenting evidence that the hospital had not made available the form or instructions on how to present it as required by RCW 4.96.020(3)(c). Alternatively, they argued that they had substantially complied with chapter 4.96 RCW.

In supplemental briefing, the Fast’s affirmed that they asserted the statutory claim for the wrongful death of a child provided by RCW 4.24.010 but argued that following the enactment of chapter 7.70 RCW and the related health care statute of limitations at RCW 4.16.350 in 1976, a statutory claim for the death of a child falls within the ambit of a “civil action for damages for injury occurring as a result of health care.” They argued that it is subject to the health care limitations period, which had been tolled for a year by their service of a good faith request for mediation. They also challenged the constitutionality of the prefiling notice of claim requirement imposed by chapter 4.96 RCW.

The trial court eventually granted summary judgment on both grounds urged by the defendants. The Fast’s appeal.

ANALYSIS

The Fast’s identify four issues raised by the trial court’s asserted error in dismissing their complaint summarily: first, that the trial court applied the wrong

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limitations statute to their claim for damages for Robert's death; second, that the trial court erred in granting summary judgment based on the tort claim defense where the defendants were not entitled to raise it; third, that if the tort claim defense was available to the defendants, the Fasts demonstrated substantial compliance with the statutory notice requirement; and fourth, that the requirement of the tort claim notice is unconstitutional, facially or as applied to this case.

We review summary judgment orders de novo, performing the same inquiry as the trial court. *Hisle v. Todd Pac. Shipyards Corp.*, 151 Wn.2d 853, 860-61, 93 P.3d 108 (2004). We view "the facts and the inferences from the facts in a light most favorable to the nonmoving party." *Jones v. Allstate Ins. Co.*, 146 Wn.2d 291, 300, 45 P.3d 1068 (2002). Summary judgment is proper where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c).

Here, it is undisputed that Robert's death occurred on August 31, 2008, and the Fasts did not commence this action until July 18, 2012, more than three years later. It is also undisputed that on August 26, 2011, the Fasts delivered a good faith request for mediation to each of the defendants.¹ Whether the time for bringing suit under RCW 4.24.010 is governed by RCW 4.16.080(2) or RCW 4.16.350 presents a question of statutory construction, as does the issue of whether a local government entity that has

¹ The defendants do not concede that the mediation request was sufficient under RCW 7.70.110, and reserve the right to contest its validity.

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failed to make a tort claim form and instructions available under RCW 4.96.020 may assert the defense of failure to present such a form before commencing legal action.

Issues of statutory construction are questions of law reviewed de novo. *Myles v. Clark County*, 170 Wn. App. 521, 527, 289 P.3d 650 (2012).

We find the first and second questions of law to be dispositive of the appeal and address them in turn.

I. *RCW 4.16.080(2) is the limitations statute that applies to actions for death of a child under RCW 4.24.010.*

“[A]t common law, no civil action could be maintained for damages resulting from the death of a human being.” *Hedrick v. Ilwaco Ry. & Nav. Co.*, 4 Wash. 400, 402, 30 P. 714 (1892), *overruled in part by Lockhart v. Besel*, 71 Wn.2d 112, 426 P.2d 605 (1967). That “defect” in the common law was addressed in the states, as it was in England, by statutes providing a remedy that inures to the benefit of relatives of the deceased designated by the statute. *Id.* at 402-03

By statute, Washington recognized the right of a parent to recover for the injury or death of a child before statehood. *See* LAWS OF 1869, § 9, at 4; presently *codified as* RCW 4.24.010. The action has repeatedly been characterized by Washington cases as an action for “wrongful death.” *E.g.*, *Lockhart v. Besel*, 71 Wn.2d 112, 116, 426 P.2d 605 (1967); *Clark v. Icicle Irr. Dist.*, 72 Wn.2d 201, 205-06, 432 P.2d 541 (1967); 16 DAVID K. DEWOLF, WASHINGTON PRACTICE: TORT LAW AND PRACTICE § 7:3 (4th ed. 2013)

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(characterizing RCW 4.24.010 as one of “five statutes in Washington that govern wrongful death actions”). “It is not a survival action pursuing the ‘surviving’ rights of the decedent child, but is a separate, independent action brought by [a] father on his own behalf for recovery of his own personal loss—the anguish and sorrow experienced by a parent who suffers the wrongful death of a child.” *Moen v. Hanson*, 85 Wn.2d 597, 598-99, 537 P.2d 266 (1975) (action by father for death of a child whom his wife was due to deliver in 30 days; both mother and child were killed as the result of an automobile accident).

Unlike most states, Washington’s wrongful death statutes do not contain an express statute of limitation. *White v. Johns-Manville Corp.*, 103 Wn.2d 344, 348, 693 P.2d 687 (1985) (citing S. SPEISER, RECOVERY FOR WRONGFUL DEATH § 11:8 (2d ed. 1975)). Instead, actions for wrongful death have long been held to be subject to the three-year limitations period provided by RCW 4.16.080(2) for “injury to the person or rights of another, not hereinafter enumerated.” *Atchison v. Great W. Malting Co.*, 161 Wn.2d 372, 377, 166 P.3d 662 (2007) (“The statute of limitations for a wrongful death action in Washington is three years.”) (citing RCW 4.16.080(2); *Beal v. City of Seattle*, 134 Wn.2d 769, 776, 954 P.2d 237 (1998); *Bader v. State*, 43 Wn. App. 223, 227, 716 P.2d 925 (1986); *Dodson v. Cont’l Can Co.*, 159 Wash. 589, 294 P. 265 (1930)). Like the statute creating an action for death of a child, the statute prescribing the limitations period generally applicable to torts predates statehood. See LAWS OF 1854, § 4, at 363.

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A wrongful death action accrues, and the time for filing begins, at the time of death.

Atchison, 161 Wn.2d at 378-79.

The Fast's position is that with enactment in 1976 of Substitute H.B. 1470, entitled "Civil Recompense and Claims—Medical Malpractice," Laws of 1976, ch. 56, the limitations period that applied to the statutory action for the death of a child changed, if the cause of the child's death was medical malpractice. They point to language in the bill that the legislature was "modify[ing] . . . certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care" provided after the effective date of the act. RCW 4.16.350 was amended to include parallel language, stating that it prescribes the limitations period for any civil action for damages "for injury occurring as a result of health care." LAWS OF 1976, ch. 56, §§ 1, 6. The Fast's argue that "injury" should be interpreted as having a broad meaning—a meaning broad enough to include the loss of a child.

The same argument about the breadth of "injury" in the two health care statutes was presented and rejected 25 years ago by Division II of our court in *Wills, supra*. In that case, the personal representative of Cheri Skye's estate filed an action for wrongful death against Ms. Skye's physician, alleging that he had been negligent in treating her. *Id.* at 758. The trial court was persuaded to apply the health care statute of limitations, RCW 4.16.350, and measured the three-year limitation period from the date of Ms.

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Skye's last visit with the physician. *Id.* at 759. Because the last visit occurred more than three years before the personal representative filed the complaint, the trial court dismissed the action on the grounds that it was time barred. *Id.*

On appeal, the *Wills* court identified the issue before it as "whether the medical malpractice statute of limitations, RCW 4.16.350, which measures the period from the act or omission causing the injury, embraces a wrongful death claim based on medical malpractice." *Id.* at 760. In the court's view, the issue of statutory construction came down to "whether 'damages for injury' should be interpreted broadly to apply to injury to statutory beneficiaries in a wrongful death claim or should be limited to injury suffered by the patient." *Id.* at 761.

The court first observed that the new chapter 7.70 RCW created by the 1976 legislation "is primarily concerned with various aspects of claims involving personal injuries of the patient," and that "[t]here is nothing to suggest that the limitation of actions for medical malpractice embraces a claim for wrongful death." *Id.* at 762. It next reasoned that the statute of limitations for wrongful death actions must apply, because otherwise "we would have the situation where such a claim could be barred even before death triggers accrual of the right to bring the action." *Id.* The court concluded, "Such a result seems to us illogical and unjust." *Id.*

Finally, the court noted that "[i]f the Legislature had intended to include wrongful death claims within these limited periods it could have done so by so limiting such

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actions for damages for injury, or death, as a result of health care.” *Id.* at 763. Because it had not done so, the court concluded “that the three-year limitation period of RCW 4.16.080(2), measured from the date of death, applies to this claim for wrongful death based on the alleged medical malpractice of Dr. Kirkpatrick.” *Id.*

While the *Fasts* ask us to reject the reasoning of Division Two in *Wills*, we find it to be sound. A wrongful death claim, whether under RCW 4.20.010, the wrongful death provision applicable in *Wills* or RCW 4.24.010, the provision that applies here, is not one to recover for physical injury to a plaintiff but to recover for a different type of loss.

While it is true that “injury” can have a broader meaning of “harm” or “damage,” it is noteworthy that RCW 4.16.350 and RCW 7.70.010 both speak of “civil actions . . . for damages for injury occurring as a result of health care.” RCW 7.70.010 (emphasis added). The broad concept of injury is captured by the word “damages,” leaving the word “injury” to describe the particular type of damage—injury suffered by the patient—to which the provisions apply. ~~To read the term “injury” more broadly, extending the scope of the health care statutes to “damages for damage or harm occurring as a result of health care” could capture, e.g., a tortious interference claim between health care providers.~~ We agree with Division Two’s interpretation of the 1976 legislation as more narrowly focused.

20/11

Equally if not more importantly, *Wills* has answered the question of which statute of limitations applies to actions for a wrongful death caused by medical malpractice for a

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quarter century. While the Fast's argue that the *Wills* court's interpretation of the statutes contravened legislative intent, the legislature has never acted to alter the result in *Wills* even though it has amended either RCW 4.16.350 or RCW 7.70.010 on four separate occasions since 1990. See LAWS OF 2006, ch. 8, § 302 and LAWS OF 2011, ch. 336, § 88 (amending RCW 4.16.350); LAWS OF 1993, ch. 492, § 420 and LAWS OF 1996, ch. 270, § 1 (amending RCW 7.70.010). At some point legislative acquiescence in a judicial interpretation of a statute is assumed. *City of Federal Way v. Koenig*, 167 Wn.2d 341, 352, 217 P.3d 1172 (2009) (Korsmo, J. Pro Tem., concurring).

The trial court correctly applied the general tort statute of limitations to the Fast's claim under RCW 4.24.010.

II. A local government entity that fails to comply with RCW 4.96.020(3) is precluded from raising a defense of nonpresentment of a pre-filing notice of claim.

The trial court dismissed the claim for damages for injury suffered by Ms. Fast based on the failure of the Fast's to present a tort claim to the hospital, a local government entity, at least 60 days before filing suit.

In chapter 4.96 RCW, the legislature has waived the sovereign immunity of local government entities and their officers, employees or volunteers, but it has required that “[f]iling a claim for damages within the time allowed by law shall be a condition precedent to the commencement of any action claiming damages.” After the tort claim is presented to the entity, the plaintiff must wait until 60 days have elapsed before

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commencing a lawsuit against the government entity. RCW 4.96.020(4). “The purpose of this claim is ‘to allow government entities time to investigate, evaluate, and settle claims’ before they are sued.” *Renner v. City of Marysville*, 168 Wn.2d 540, 545, 230 P.3d 569 (2010) (quoting *Medina v. Pub. Util. Dist. No. 1 of Benton County*, 147 Wn.2d 303, 310, 53 P.3d 993 (2002)).

The parties do not dispute that the hospital is a local governmental entity and that chapter 4.96 RCW applies. It is also undisputed that the Fasts failed to present a tort claim form to the hospital before bringing suit. The standard tort claim form document that the Fasts did file with the superior court was served on the defendants after the lawsuit was commenced. The Fasts argue, however, that the hospital is not eligible to assert a defense under chapter 4.96 RCW because of its own failure to comply with a statutory requirement that it make available both a tort claim form and instructions on how the form is to be presented. At issue are changes made to chapter 4.96 RCW in 2009.

Under the 2009 changes, claims for damages must be presented on the standard tort claim form that is maintained by the risk management division of the Washington State office of financial management, except for local government entities who elect to prepare a claim form of their own, in which case the local form may be used. RCW 4.96.020(3). In addition,

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Local governmental entities shall make available the standard tort claim form described in this section with instructions on how the form is to be presented and the name, address, and business hours of the agent of the local governmental entity.

RCW 4.96.020(3)(c). RCW 4.96.020(2) provides that “[t]he failure of a local governmental entity to comply with the requirements of this section precludes that local governmental entity from raising a defense under this chapter.”

In opposing summary judgment, the Fast presented the declaration of their lawyer stating he had been unable to locate a tort claim form or instructions on the hospital’s website, and that he had placed a phone call to the hospital inquiring about a tort claim form and was unable to obtain any information—this, despite his call having been transferred to three different employees. They presented the declaration of a private investigator who had traveled to the hospital and questioned hospital employees about obtaining a form or instructions; he was not provided with any form or information other than the suggestion that he contact an attorney of his own choice. Finally, they presented the deposition testimony of the hospital’s designated agent conceding that she was aware that there was a new statutory requirement to provide a form and instructions but that the hospital was not yet in compliance.

The defendants argue that “[t]he fact that [the hospital] does not have the form on

its website does not bar it from raising the defense.” Br. of Resp’t at 25.² But while the Fasts’ lawyer testified that the hospital’s website was one place he looked for the form, the Fasts do not argue that the form had to be available on the hospital’s website. They argue, consistent with the plain language of RCW 4.96.020(3)(c), that the hospital was required to “make available the standard tort claim form . . . with instructions on how the form is to be presented and the name, address, and business hours of the agent of the local governmental entity.”

Alternatively, the defendants argue that “[i]t is apparent from the context of the statute that this bar [on raising failure to file a claim form as a defense] relates solely to the failure to designate an agent for service.” *Id.* at 26. We do not find this to be apparent at all.

Here again, our interpretation of a statutory amendment presents a question of law, as to which review is *de novo*. *Myles*, 170 Wn. App. at 530. Our fundamental objective in interpreting a statute is to ascertain and carry out the legislature’s intent. *Arborwood Idaho, LLC v. City of Kennewick*, 151 Wn.2d 359, 367, 89 P.3d 217 (2004). If the

² In a memorandum decision by the trial court, it found that the hospital complied with the requirements of RCW 4.96.020(3) because “there was a standard form available on line”—presumably referring to the standard tort claim form made available for claims against Washington State addressed to the state department of enterprise services in Olympia. CP at 1235. The defendants do not advance this argument on appeal and understandably so; the fact that the State has made the form available does not satisfy the hospital’s direct responsibility under RCW 4.96.020(3) to make the form and instructions available itself.

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statute's meaning is plain on its face, we must give effect to that plain meaning as an expression of legislative intent. *Dep't of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 9-10, 43 P.3d 4 (2002). Only if a statute remains ambiguous after a plain meaning analysis may we resort to external sources or interpretive aids, such as canons of construction, case law, or legislative history. *Jongeward v. BNSF Ry. Co.*, 174 Wn.2d 586, 600, 278 P.3d 157 (2012); *State ex rel. Citizens Against Tolls v. Murphy*, 151 Wn.2d 226, 242-43, 88 P.3d 375 (2004).

“Section,” “chapter,” “title,” and “subsection” are surely among the words whose meaning in our revised code is most plain. In 1951, the Washington legislature enacted and designated a “Revised Code of Washington.” LAWS OF 1951, ch. 5, § 2, *codified as* RCW 1.04.010. It adopted a numbering system at the same time and provided for it to be followed as new chapters or sections were added as a result of laws thereafter enacted. “Sections” are numbered according to the plan generally used in the 1950 supplement, using the number of the title, the number of the chapter, and a section part of the number (*e.g.*, .020), which is initially made up of three digits and constitutes a true decimal. RCW 1.04.014; RCW Titles Preface.

The entire text of chapter 4.96 RCW is included in an appendix to this opinion. Use of the terms “this section,” “this chapter,” and “this subsection,” as well as reference to particular subsections, are highlighted. Setting aside for a moment the use of “this

section” in RCW 4.96.020(2), the use of those words in the chapter is consistent in every case with their meaning provided by chapter 1.04 RCW.

For example, the use of “this section” in RCW 4.96.020(1) and RCW 4.96.020(5) must refer to all of RCW 4.96.020 because the only substantive import of those subsections is to describe the scope and construction of other subsections.

As a further example, RCW 4.96.020(3) speaks of “(c) of this subsection,” thereby designating itself as a subsection, not a section. Similarly, RCW 4.96.041(4) speaks of “subsection (1) of this section,” thereby designating RCW 4.96.041 as a section and RCW 4.96.041(1) as a subsection.

RCW 4.96.020(4) speaks of actions “subject to the claim filing requirements of this section” but itself includes no claim filing requirements, hence “this section” necessarily refers to RCW 4.96.020.

It is true that if we ignored chapter 1.04 RCW and the other uses of “section” and “subsection” in chapter 4.96 and other chapters of our revised code, then we could read “this section” as used in RCW 4.96.020(2) to mean .020(2) of the chapter without the provision becoming incoherent. But we do not ignore how the words are used elsewhere in the chapter and the revised code. The plain meaning of a statute “is discerned from all that the Legislature has said in the statute and related statutes which disclose legislative intent about the provision in question.” *Campbell & Gwinn*, 146 Wn.2d at 11.

The defendants make two other arguments as to why this plain meaning of “this section” cannot be correct. They first point to *Mavis v. King County Public Hospital No. 2*, 159 Wn. App. 639, 648-49, 248 P.3d 558 (2011), the only decision to address the meaning of RCW 4.96.020(2), which they argue describes subsection (2) as creating only two requirements: to appoint an agent, and to record his or her identity with the county auditor. While it is true that subsection (2) of RCW 4.96.020 imposes only those two requirements, it is beside the point, since the requirement to make a form and instructions available is imposed by subsection (3) of RCW 4.96.020 (which was enacted after the presentation of the claim that was at issue in *Mavis*). What is important is that in addition to including two requirements of its own, subsection (2) also provides that a local government entity’s failure to comply with the requirements of the *section* prevents it from raising a defense under the chapter. This is recognized by language in *Mavis* that directly undercuts the hospital’s argument—*Mavis* states that “[l]ocal government entities must strictly comply with *RCW 4.96.020* in order to raise a defense under the statute.” *Id.* at 646 (citing RCW 4.96.020(2)) (emphasis added).

The defendants’ second argument points to the fact that subparagraph (c) of RCW 4.96.020(3) permits a local government entity to prepare its own tort claim form and subparagraph (d) of the subsection provides that if the local government’s form fails to require the information provided in section RCW 4.96.020 or misidentifies the agent with whom the form is to be filed, then the local government is deemed to have waived any

defense arising from the forgone information or a misguided filing. From this, the hospital argues that subparagraph (d) must provide the exclusive remedy for a failure to comply with subsection RCW 4.96.020(3).

This argument, too, is unpersuasive. What RCW 4.96.020(3)(c) does is permit local governments to create their own forms requiring less information than that provided by the standard form maintained by the risk management division of the office of financial management—in other words, it *permits* them to “fail[] to require the information specified in this section”: it permits them to fail to provide the information specified in RCW 4.96.020(3)(a). *See* the introductory language of RCW 4.96.020(3) (“all claims for damage[] must be presented on the standard tort claim form . . . *except as allowed under (c) of this subsection*” (emphasis added)). For that “failure” only—a *permitted* failure—the local government is not entirely denied a defense under the chapter but is only held to the deficiencies of its form.

To read the section as the hospital does would lead to an absurd result: if the local government prepared a form falling short of the contents of the standard form and made it available with instructions, then a claimant completing the local government’s form could pursue her claim and the local government would be held to the deficiencies of its form. But if the government even more egregiously failed to make available *any* form or instructions, then it could raise a defense that would bar a cause of action by a claimant whose ability to file a form was hampered by its violation of the statute. Statutes are

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construed in a manner that avoids unlikely, absurd or strained consequences. *Kilian v. Atkinson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002).

Given our conclusion that the hospital is not eligible to raise the defense of the Fasts' failure to present a prefiling notice of claim, we need not reach their arguments that they substantially complied with the requirements of chapter 4.96 RCW or that the prefiling notice of claim requirement is unconstitutional.

III. Attorney fees

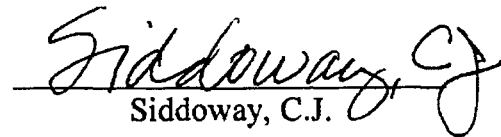
The Fasts request attorney fees and costs incurred on appeal under RAP 18.1. The rule provides for attorney fees “[i]f applicable law grants to a party the right to recover reasonable attorney fees or expenses on review.” The Fasts do not identify applicable law under which they would be entitled to such an award. “Merely citing to RAP 18.1 is insufficient for an award of fees.” *Faulkner v. Racquetwood Vill. Condo. Ass’n*, 106 Wn. App. 483, 487, 23 P.3d 1135 (2001). Their request for fees is denied.

We affirm dismissal of the Fasts' claim under RCW 4.24.010, reverse the trial

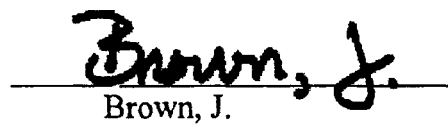
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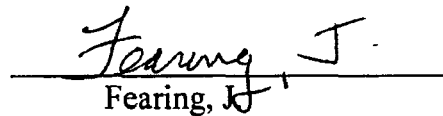
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court's dismissal of their claim for Ms. Fast's injuries, and remand for further proceedings consistent with this opinion.


Siddoway, C.J.

WE CONCUR:


Brown, J.


Fearing, J.

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Appendix

APPENDIX

4.96.010

Tortious conduct of local governmental entities — Liability for damages.

(1) All local governmental entities, whether acting in a governmental or proprietary capacity, shall be liable for damages arising out of their tortious conduct, or the tortious conduct of their past or present officers, employees, or volunteers while performing or in good faith purporting to perform their official duties, to the same extent as if they were a private person or corporation. Filing a claim for damages within the time allowed by law shall be a condition precedent to the commencement of any action claiming damages. The laws specifying the content for such claims shall be liberally construed so that substantial compliance therewith will be deemed satisfactory.

(2) Unless the context clearly requires otherwise, for the purposes of this chapter, “local governmental entity” means a county, city, town, special district, municipal corporation as defined in RCW 39.50.010, quasi-municipal corporation, any joint municipal utility services authority, any entity created by public agencies under RCW 39.34.030, or public hospital.

(3) For the purposes of this chapter, “volunteer” is defined according to RCW 51.12.035.

4.96.020

Tortious conduct of local governmental entities and their agents — Claims — Presentment and filing — Contents.

(1) The provisions of this section apply to claims for damages against all local governmental entities and their officers, employees, or volunteers, acting in such capacity.

(2) The governing body of each local governmental entity shall appoint an agent to receive any claim for damages made under this chapter. The identity of the agent and the address where he or she may be reached during the normal business hours of the local governmental entity are public records and shall be recorded with the auditor of the county in which the entity is located. All claims for damages against a local governmental entity, or against any local governmental entity’s officers, employees, or

volunteers, acting in such capacity, shall be presented to the agent within the applicable period of limitations within which an action must be commenced. A claim is deemed presented when the claim form is delivered in person or is received by the agent by regular mail, registered mail, or certified mail, with return receipt requested, to the agent or other person designated to accept delivery at the agent's office. The failure of a local governmental entity to comply with the requirements of **this section** precludes that local governmental entity from raising a defense under **this chapter**.

(3) For claims for damages presented after July 26, 2009, all claims for damages must be presented on the standard tort claim form that is maintained by the risk management division of the office of financial management, except as allowed under (c) of **this subsection**. The standard tort claim form must be posted on the office of financial management's web site.

(a) The standard tort claim form must, at a minimum, require the following information:

- (i) The claimant's name, date of birth, and contact information;
- (ii) A description of the conduct and the circumstances that brought about the injury or damage;
- (iii) A description of the injury or damage;
- (iv) A statement of the time and place that the injury or damage occurred;
- (v) A listing of the names of all persons involved and contact information, if known;
- (vi) A statement of the amount of damages claimed; and
- (vii) A statement of the actual residence of the claimant at the time of presenting the claim and at the time the claim arose.

(b) The standard tort claim form must be signed either:

- (i) By the claimant, verifying the claim;
 - (ii) Pursuant to a written power of attorney, by the attorney in fact for the claimant;
 - (iii) By an attorney admitted to practice in Washington state on the claimant's behalf;
- or
- (iv) By a court-approved guardian or guardian ad litem on behalf of the claimant.

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(c) Local governmental entities shall make available the standard tort claim form described in **this section** with instructions on how the form is to be presented and the name, address, and business hours of the agent of the local governmental entity. If a local governmental entity chooses to also make available its own tort claim form in lieu of the standard tort claim form, the form:

(i) May require additional information beyond what is specified under **this section**, but the local governmental entity may not deny a claim because of the claimant's failure to provide that additional information;

(ii) Must not require the claimant's social security number; and

(iii) Must include instructions on how the form is to be presented and the name, address, and business hours of the agent of the local governmental entity appointed to receive the claim.

(d) If any claim form provided by the local governmental entity fails to require the information specified in **this section**, or incorrectly lists the agent with whom the claim is to be filed, the local governmental entity is deemed to have waived any defense related to the failure to provide that specific information or to present the claim to the proper designated agent.

(e) Presenting either the standard tort claim form or the local government tort claim form satisfies the requirements of this chapter.

(f) The amount of damages stated on the claim form is not admissible at trial.

(4) No action subject to the claim filing requirements of **this section** shall be commenced against any local governmental entity, or against any local governmental entity's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct until sixty calendar days have elapsed after the claim has first been presented to the agent of the governing body thereof. The applicable period of limitations within which an action must be commenced shall be tolled during the sixty calendar day period. For the purposes of the applicable period of limitations, an action commenced within five court days after the sixty calendar day period has elapsed is deemed to have been presented on the first day after the sixty calendar day period elapsed.

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(5) With respect to the content of claims under **this section** and all procedural requirements in **this section**, **this section** must be liberally construed so that substantial compliance will be deemed satisfactory.

4.96.041

Action or proceeding against officer, employee, or volunteer of local governmental entity — Payment of damages and expenses of defense.

(1) Whenever an action or proceeding for damages is brought against any past or present officer, employee, or volunteer of a local governmental entity of this state, arising from acts or omissions while performing or in good faith purporting to perform his or her official duties, such officer, employee, or volunteer may request the local governmental entity to authorize the defense of the action or proceeding at the expense of the local governmental entity.

(2) If the legislative authority of the local governmental entity, or the local governmental entity using a procedure created by ordinance or resolution, finds that the acts or omissions of the officer, employee, or volunteer were, or in good faith purported to be, within the scope of his or her official duties, the request shall be granted. If the request is granted, the necessary expenses of defending the action or proceeding shall be paid by the local governmental entity. Any monetary judgment against the officer, employee, or volunteer shall be paid on approval of the legislative authority of the local governmental entity or by a procedure for approval created by ordinance or resolution.

(3) The necessary expenses of defending an elective officer of the local governmental entity in a judicial hearing to determine the sufficiency of a recall charge as provided in *RCW 29.82.023 shall be paid by the local governmental entity if the officer requests such defense and approval is granted by both the legislative authority of the local governmental entity and the attorney representing the local governmental entity. The expenses paid by the local governmental entity may include costs associated with an appeal of the decision rendered by the superior court concerning the sufficiency of the recall charge.

(4) When an officer, employee, or volunteer of the local governmental entity has been represented at the expense of the local governmental entity under **subsection (1)** of **this section** and the court hearing the action has found that the officer, employee, or volunteer was acting within the scope of his or her official duties, and a judgment has been entered against the officer, employee, or volunteer under chapter 4.96 RCW or 42 U.S.C. Sec.

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1981 et seq., thereafter the judgment creditor shall seek satisfaction for nonpunitive damages only from the local governmental entity, and judgment for nonpunitive damages shall not become a lien upon any property of such officer, employee, or volunteer. The legislative authority of a local governmental entity may, pursuant to a procedure created by ordinance or resolution, agree to pay an award for punitive damages.

(Reviser's note omitted.)

4.96.050

Bond not required.

No bond is required of any local governmental entity for any purpose in any case in any of the courts of the state of Washington and all local governmental entities shall be, on proper showing, entitled to any orders, injunctions, and writs of whatever nature without bond, notwithstanding the provisions of any existing statute requiring that bonds be furnished by private parties.

FILED
JULY 28, 2015
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

COURT OF APPEALS, DIVISION III, STATE OF WASHINGTON

SHANE FAST, JAMIE FAST, the marital
community comprised thereof, ROBERT
DALTON FAST, and the estate thereof,

Appellants,

v.

KENNEWICK PUBLIC HOSPITAL
DISTRICT d/b/a KENNEWICK
GENERAL HOSPITAL and d/b/a MID-
COLUMBIA WOMEN'S HEALTH
CENTER, a Washington public hospital
district organized as a government entity,
municipal or quasi-municipal corporation;
ADAM T. SMITH, D.O., individually and
for the marital community with spouse or
registered domestic partner Jane Doe
Smith; GREGORY SCHROFF, M.D.,
individually and for the marital
community with spouse or registered
domestic partner Jane Doe Smith; and
DOES 1 through 50,

Respondents.

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ORDER GRANTING IN PART
MOTION FOR
RECONSIDERATION
AND AMENDING OPINION

THE COURT has considered Appellant's motion for reconsideration and the answer thereto, and is of the opinion the motion should be granted in part. Therefore,

IT IS ORDERED, the motion for reconsideration of this court's decision of June 2, 2015, is hereby granted in part with the opinion to be amended accordingly.

IT IS FURTHER ORDERED the opinion filed June 2, 2015, is amended as follows:

The second paragraph on page 11 is amended to read:

While the Fast's ask us to reject the reasoning of Division Two in *Wills*, we find it to be sound. A wrongful death claim, whether under RCW 4.20.010, the wrongful death provision applicable in *Wills* or RCW 4.24.010, the provision that applies here, is not one to recover for physical injury to a plaintiff but to recover for a different type of loss. While it is true that "injury" can have a broader meaning of "harm" or "damage," it is noteworthy that RCW 4.16.350 and RCW 7.70.010 both speak of "civil actions . . . for damages for injury occurring as a result of health care." RCW 7.70.010 (emphasis added). The broad concept of injury is captured by the word "damages," leaving the word "injury" to describe the particular type of damage—injury suffered by the patient—to which the provisions apply. We agree with Division Two's interpretation of the 1976 legislation as more narrowly focused.




The motion for reconsideration is otherwise denied.

DATED: July 28, 2015

PANEL: Judges Siddoway, Brown, Fearing

FOR THE COURT:


LAUREL H. SIDDOWAY, Chief Judge

APPENDIX B
Laws of 2006 ch. 8

(1) The provisions of this chapter do not apply with respect to the nonhighway use of diesel fuel, or aircraft fuel as defined in RCW 82.42.010(5), by a farm fuel user. Fuel used for space or water heating for human habitation is not exempt under this section.

(2) The definitions in section 1 of this act apply to this section.

NEW SECTION. **Sec. 3.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

Passed by the House March 3, 2006.

Passed by the Senate March 3, 2006.

Approved by the Governor March 6, 2006.

Filed in Office of Secretary of State March 6, 2006.

CHAPTER 8

[Second Substitute House Bill 2292]

MEDICAL MALPRACTICE

AN ACT Relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees; amending RCW 5.64.010, 4.24.260, 18.71.015, 18.130.160, 43.70.075, 43.70.510, 42.56.400, 48.18.290, 48.18.2901, 48.18.100, 48.18.103, 48.19.043, 48.19.060, 4.16.190, 7.70.100, and 7.70.080; reenacting and amending RCW 42.17.310 and 69.41.010; reenacting RCW 4.16.350; adding new sections to chapter 7.70 RCW; adding a new section to chapter 48.18 RCW; adding a new chapter to Title 70 RCW; adding a new chapter to Title 48 RCW; adding a new chapter to Title 7 RCW; creating new sections; prescribing penalties; providing an effective date; and providing an expiration date.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. **Sec. 1.** The legislature finds that access to safe, affordable health care is one of the most important issues facing the citizens of Washington state. The legislature further finds that the rising cost of medical malpractice insurance has caused some physicians, particularly those in high-risk specialties such as obstetrics and emergency room practice, to be unavailable when and where the citizens need them the most. The answers to these problems are varied and complex, requiring comprehensive solutions that encourage patient safety practices, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient for all the participants.

It is the intent of the legislature to prioritize patient safety and the prevention of medical errors above all other considerations as legal changes are made to address the problem of high malpractice insurance premiums. Thousands of patients are injured each year as a result of medical errors, many of which can be avoided by supporting health care providers, facilities, and carriers in their efforts to reduce the incidence of those mistakes. It is also the legislature's intent to provide incentives to settle cases before resorting to court, and to provide the option of a more fair, efficient, and streamlined alternative to trials for those for whom settlement negotiations do not work. Finally, it is the intent of the legislature to provide the insurance commissioner with the tools and information necessary to regulate medical malpractice insurance rates and policies so that they are fair to both the insurers and the insured.

PART I - PATIENT SAFETY

Encouraging Patient Safety Through Communications With Patients

Sec. 101. RCW 5.64.010 and 1975-'76 2nd ex.s. c 56 s 3 are each amended to read as follows:

(1) In any civil action against a health care provider for personal injuries which is based upon alleged professional negligence ~~((and which is against:~~

~~(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;~~

~~(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or~~

~~(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;)), or in any arbitration or mediation proceeding related to such civil action, evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible ~~((to prove liability for the injury)).~~~~

(2)(a) In a civil action against a health care provider for personal injuries that is based upon alleged professional negligence, or in any arbitration or mediation proceeding related to such civil action, a statement, affirmation, gesture, or conduct identified in (b) of this subsection is not admissible as evidence if:

(i) It was conveyed by a health care provider to the injured person, or to a person specified in RCW 7.70.065 (1)(a) or (2)(a) within thirty days of the act or omission that is the basis for the allegation of professional negligence or within thirty days of the time the health care provider discovered the act or omission that is the basis for the allegation of professional negligence, whichever period expires later; and

(ii) It relates to the discomfort, pain, suffering, injury, or death of the injured person as the result of the alleged professional negligence.

(b) (a) of this subsection applies to:

(i) Any statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence; or

(ii) Any statement or affirmation regarding remedial actions that may be taken to address the act or omission that is the basis for the allegation of negligence.

**Encouraging Reports of Unprofessional Conduct or Lack of
Capacity to Practice Safely**

Sec. 102. RCW 4.24.260 and 1994 sp.s. c 9 s 701 are each amended to read as follows:

~~((Physicians licensed under chapter 18.71 RCW, dentists licensed under chapter 18.32 RCW, and pharmacists licensed under chapter 18.64 RCW))~~ Any member of a health profession listed under RCW 18.130.040 who, in good faith, makes a report, files charges, or presents evidence against another member of ((their) a health profession based on the claimed ((incompetency or gross misconduct)) unprofessional conduct as provided in RCW 18.130.180 or inability to practice with reasonable skill and safety to consumers by reason of any physical or mental condition as provided in RCW 18.130.170 of such person before the ((medical quality assurance commission established under chapter 18.71 RCW, in a proceeding under chapter 18.32 RCW, or to the board of pharmacy under RCW 18.64.160)) agency, board, or commission responsible for disciplinary activities for the person's profession under chapter 18.130 RCW, shall be immune from civil action for damages arising out of such activities. A person prevailing upon the good faith defense provided for in this section is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission Consumer Membership

Sec. 103. RCW 18.71.015 and 1999 c 366 s 4 are each amended to read as follows:

The Washington state medical quality assurance commission is established, consisting of thirteen individuals licensed to practice medicine in the state of Washington under this chapter, two individuals who are licensed as physician assistants under chapter 18.71A RCW, and ~~((four))~~ six individuals who are members of the public. At least two of the public members shall not be from the health care industry. Each congressional district now existing or hereafter created in the state must be represented by at least one physician member of the commission. The terms of office of members of the commission are not affected by changes in congressional district boundaries. Public members of the commission may not be a member of any other health care licensing board or commission, or have a fiduciary obligation to a facility rendering health services regulated by the commission, or have a material or financial interest in the rendering of health services regulated by the commission.

The members of the commission shall be appointed by the governor. Members of the initial commission may be appointed to staggered terms of one to four years, and thereafter all terms of appointment shall be for four years. The governor shall consider such physician and physician assistant members who are recommended for appointment by the appropriate professional associations in the state. In appointing the initial members of the commission, it is the intent of the legislature that, to the extent possible, the existing members of the board of medical examiners and medical disciplinary board repealed under section 336, chapter 9, Laws of 1994 sp. sess. be appointed to the commission. No member may serve more than two consecutive full terms. Each member shall hold office until a successor is appointed.

Each member of the commission must be a citizen of the United States, must be an actual resident of this state, and, if a physician, must have been licensed to practice medicine in this state for at least five years.

The commission shall meet as soon as practicable after appointment and elect officers each year. Meetings shall be held at least four times a year and at such place as the commission determines and at such other times and places as the commission deems necessary. A majority of the commission members appointed and serving constitutes a quorum for the transaction of commission business.

The affirmative vote of a majority of a quorum of the commission is required to carry any motion or resolution, to adopt any rule, or to pass any measure. The commission may appoint panels consisting of at least three members. A quorum for the transaction of any business by a panel is a minimum of three members. A majority vote of a quorum of the panel is required to transact business delegated to it by the commission.

Each member of the commission shall be compensated in accordance with RCW 43.03.265 and in addition thereto shall be reimbursed for travel expenses incurred in carrying out the duties of the commission in accordance with RCW 43.03.050 and 43.03.060. Any such expenses shall be paid from funds appropriated to the department of health.

Whenever the governor is satisfied that a member of a commission has been guilty of neglect of duty, misconduct, or malfeasance or misfeasance in office, the governor shall file with the secretary of state a statement of the causes for and the order of removal from office, and the secretary shall forthwith send a certified copy of the statement of causes and order of removal to the last known post office address of the member.

Vacancies in the membership of the commission shall be filled for the unexpired term by appointment by the governor.

The members of the commission are immune from suit in an action, civil or criminal, based on its disciplinary proceedings or other official acts performed in good faith as members of the commission.

Whenever the workload of the commission requires, the commission may request that the secretary appoint pro tempore members of the commission. When serving, pro tempore members of the commission have all of the powers, duties, and immunities, and are entitled to all of the emoluments, including travel expenses, of regularly appointed members of the commission.

Health Care Provider Discipline

Sec. 104. RCW 18.130.160 and 2001 c 195 s 1 are each amended to read as follows:

Upon a finding, after hearing, that a license holder or applicant has committed unprofessional conduct or is unable to practice with reasonable skill and safety due to a physical or mental condition, the disciplining authority may consider the imposition of sanctions, taking into account any prior findings of fact under RCW 18.130.110, any stipulations to informal disposition under RCW 18.130.172, and any action taken by other in-state or out-of-state disciplining authorities, and issue an order providing for one or any combination of the following:

- (1) Revocation of the license;
- (2) Suspension of the license for a fixed or indefinite term;
- (3) Restriction or limitation of the practice;
- (4) Requiring the satisfactory completion of a specific program of remedial education or treatment;
- (5) The monitoring of the practice by a supervisor approved by the disciplining authority;
- (6) Censure or reprimand;
- (7) Compliance with conditions of probation for a designated period of time;
- (8) Payment of a fine for each violation of this chapter, not to exceed five thousand dollars per violation. Funds received shall be placed in the health professions account;
- (9) Denial of the license request;
- (10) Corrective action;
- (11) Refund of fees billed to and collected from the consumer;
- (12) A surrender of the practitioner's license in lieu of other sanctions, which must be reported to the federal data bank.

Any of the actions under this section may be totally or partly stayed by the disciplining authority. In determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder or applicant. All costs associated with compliance with orders issued under this section are the obligation of the license holder or applicant.

The licensee or applicant may enter into a stipulated disposition of charges that includes one or more of the sanctions of this section, but only after a statement of charges has been issued and the licensee has been afforded the opportunity for a hearing and has elected on the record to forego such a hearing. The stipulation shall either contain one or more specific findings of unprofessional conduct or inability to practice, or a statement by the licensee acknowledging that evidence is sufficient to justify one or more specified findings of unprofessional conduct or inability to practice. The stipulation entered into pursuant to this subsection shall be considered formal disciplinary action for all purposes.

Increasing Patient Safety Through Disclosure and Analysis of Adverse Events

NEW SECTION. **Sec. 105.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adverse health event" or "adverse event" means the list of serious reportable events adopted by the national quality forum in 2002, in its consensus report on serious reportable events in health care. The department shall update the list, through adoption of rules, as subsequent changes are made by the national quality forum. The term does not include an incident.

(2) "Ambulatory surgical facility" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not

requiring hospitalization, whether or not the facility is certified under Title XVIII of the federal social security act.

(3) "Childbirth center" means a facility licensed under chapter 18.46 RCW.

(4) "Correctional medical facility" means a part or unit of a correctional facility operated by the department of corrections under chapter 72.10 RCW that provides medical services for lengths of stay in excess of twenty-four hours to offenders.

(5) "Department" means the department of health.

(6) "Health care worker" means an employee, independent contractor, licensee, or other individual who is directly involved in the delivery of health services in a medical facility.

(7) "Hospital" means a facility licensed under chapter 70.41 RCW.

(8) "Incident" means an event, occurrence, or situation involving the clinical care of a patient in a medical facility that:

(a) Results in unanticipated injury to a patient that is not related to the natural course of the patient's illness or underlying condition and does not constitute an adverse event; or

(b) Could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

"Incident" does not include an adverse event.

(9) "Independent entity" means that entity that the department of health contracts with under section 108 of this act to receive notifications and reports of adverse events and incidents, and carry out the activities specified in section 108 of this act.

(10) "Medical facility" means a childbirth center, hospital, psychiatric hospital, or correctional medical facility. An ambulatory surgical facility shall be considered a medical facility for purposes of this chapter upon the effective date of any requirement for state registration or licensure of ambulatory surgical facilities.

(11) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.

NEW SECTION. Sec. 106. (1) The legislature intends to establish an adverse health events and incident reporting system that is designed to facilitate quality improvement in the health care system, improve patient safety and decrease medical errors in a nonpunitive manner. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(2) Each medical facility shall notify the department of health regarding the occurrence of any adverse event and file a subsequent report as provided in this section. Notification must be submitted to the department within forty-eight hours of confirmation by the medical facility that an adverse event has occurred. A subsequent report must be submitted to the department within forty-five days after confirmation by the medical facility that an adverse event has occurred. The notification and report shall be submitted to the department using the internet-based system established under section 108(2) of this act.

(3) The notification and report shall be filed in a format specified by the department after consultation with medical facilities and the independent entity. The format shall identify the facility, but shall not include any identifying information for any of the health care professionals, facility employees, or

patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

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

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

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

NEW SECTION. Sec. 107. (1) The department shall:

(a) Receive and investigate, where necessary, notifications and reports of adverse events, including root cause analyses and corrective action plans submitted as part of reports, and communicate to individual facilities the department's conclusions, if any, regarding an adverse event reported by a facility; and

(b) Adopt rules as necessary to implement this chapter.

(2) The department may enforce the reporting requirements of section 106 of this act using their existing enforcement authority provided in chapter 18.46 RCW for childbirth centers, chapter 70.41 RCW for hospitals, and chapter 71.12 RCW for psychiatric hospitals.

NEW SECTION. Sec. 108. (1) The department shall contract with a qualified, independent entity to receive notifications and reports of adverse events and incidents, and carry out the activities specified in this section. In establishing qualifications for, and choosing the independent entity, the department shall strongly consider the patient safety organization criteria included in the federal patient safety and quality improvement act of 2005, P.L. 109-41, and any regulations adopted to implement this chapter.

(2) The independent entity shall:

(a) In collaboration with the department of health, establish an internet-based system for medical facilities and the health care workers of a medical facility to submit notifications and reports of adverse events and incidents, which shall be accessible twenty-four hours a day, seven days a week. The system shall be a portal to report both adverse events and incidents, and notifications and reports of adverse events shall be immediately transmitted to the department. The system shall be a secure system that protects the confidentiality of personal health information and provider and facility specific

information submitted in notifications and reports, including appropriate encryption and an accurate means of authenticating the identify of users of the system;

(b) Collect, analyze, and evaluate data regarding notifications and reports of adverse events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of the state;

(c) Develop recommendations for changes in health care practices and procedures, which may be instituted for the purpose of reducing the number or severity of adverse events and incidents;

(d) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce adverse events or incidents;

(e) Issue recommendations to medical facilities on a facility-specific or on a statewide basis regarding changes, trends, and improvements in health care practices and procedures for the purpose of reducing the number and severity of adverse events or incidents. Prior to issuing recommendations, consideration shall be given to the following factors: Expectation of improved quality of care, implementation feasibility, other relevant implementation practices, and the cost impact to patients, payers, and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on a publicly accessible web site. The recommendations made to medical facilities under this section shall not be considered mandatory for licensure purposes unless they are adopted by the department as rules pursuant to chapter 34.05 RCW; and

(f) Monitor implementation of reporting systems addressing adverse events or their equivalent in other states and make recommendations to the governor and the legislature as necessary for modifications to this chapter to keep the system as nearly consistent as possible with similar systems in other states.

(3) The independent entity shall report no later than January 1, 2008, and annually thereafter to the governor and the legislature on the activities under this chapter in the preceding year. The report shall include:

(a) The number of adverse events and incidents reported by medical facilities on a geographical basis and their outcomes;

(b) The information derived from the data collected, including any recognized trends concerning patient safety; and

(c) Recommendations for statutory or regulatory changes that may help improve patient safety in the state.

The annual report shall be made available for public inspection and shall be posted on the department's and the independent entity's web site.

(4) The independent entity shall conduct all activities under this section in a manner that preserves the confidentiality of facilities, documents, materials, or information made confidential by section 110 of this act.

(5) Medical facilities and health care workers may report incidents to the independent entity. The report shall be filed in a format specified by the independent entity, after consultation with the department and medical facilities, and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department or a disciplinary authority if a licensed practitioner has committed

unprofessional conduct as defined in RCW 18.130.180. The protections of RCW 43.70.075 apply to reports of incidents that are submitted in good faith by employees of medical facilities.

Sec. 109. RCW 43.70.075 and 1995 c 265 s 19 are each amended to read as follows:

(1) The identity of a whistleblower who complains, in good faith, to the department of health about the improper quality of care by a health care provider, or in a health care facility, as defined in RCW 43.72.010, or who submits a notification or report of an adverse event or an incident, in good faith, to the department of health under section 106 of this act or to the independent entity under section 108 of this act, shall remain confidential. The provisions of RCW 4.24.500 through 4.24.520, providing certain protections to persons who communicate to government agencies, shall apply to complaints and notifications or reports of adverse events or incidents filed under this section. The identity of the whistleblower shall remain confidential unless the department determines that the complaint or notification or report of the adverse event or incident was not made in good faith. An employee who is a whistleblower, as defined in this section, and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW.

(2)(a) "Improper quality of care" means any practice, procedure, action, or failure to act that violates any state law or rule of the applicable state health licensing authority under Title 18 or chapters 70.41, 70.96A, 70.127, 70.175, 71.05, 71.12, and 71.24 RCW, and enforced by the department of health. Each health disciplinary authority as defined in RCW 18.130.040 may, with consultation and interdisciplinary coordination provided by the state department of health, adopt rules defining accepted standards of practice for their profession that shall further define improper quality of care. Improper quality of care shall not include good faith personnel actions related to employee performance or actions taken according to established terms and conditions of employment.

(b) "Reprisal or retaliatory action" means but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct pursuant to Title 18 RCW; letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; and a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower.

(c) "Whistleblower" means a consumer, employee, or health care professional who in good faith reports alleged quality of care concerns to the department of health.

(3) Nothing in this section prohibits a health care facility from making any decision exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(4) The department shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under Title 18 RCW for health professionals or health care facilities.

NEW SECTION. Sec. 110. (1) When a notification or report of an adverse event or incident under section 106 or 108 of this act is made by or through a coordinated quality improvement program under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee for the purpose of preparing a notification or report of an adverse event or incident, and the notification or report itself, shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh) and 42.56.360(1)(c).

(2) When a notification or report of an adverse event or incident made by a health care worker under section 106 or 108 of this act uses information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200 or a peer review committee under RCW 4.24.250, the notification or report itself and the information or documents used for the purpose of preparing the notification or report, shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh) and 42.56.360(1)(c).

Sec. 111. RCW 42.17.310 and 2005 c 424 s 16, 2005 c 349 s 1, 2005 c 312 s 6, 2005 c 284 s 1, 2005 c 172 s 13, and 2005 c 33 s 4 are each reenacted and amended to read as follows:

(1) The following are exempt from public inspection and copying:

(a) Personal information in any files maintained for students in public schools, patients or clients of public institutions or public health agencies, or welfare recipients.

(b) Personal information in files maintained for employees, appointees, or elected officials of any public agency to the extent that disclosure would violate their right to privacy.

(c) Information required of any taxpayer in connection with the assessment or collection of any tax if the disclosure of the information to other persons would (i) be prohibited to such persons by RCW 84.08.210, 82.32.330, 84.40.020, or 84.40.340 or (ii) violate the taxpayer's right to privacy or result in unfair competitive disadvantage to the taxpayer.

(d) Specific intelligence information and specific investigative records compiled by investigative, law enforcement, and penology agencies, and state agencies vested with the responsibility to discipline members of any profession, the nondisclosure of which is essential to effective law enforcement or for the protection of any person's right to privacy.

(e) Information revealing the identity of persons who are witnesses to or victims of crime or who file complaints with investigative, law enforcement, or penology agencies, other than the public disclosure commission, if disclosure would endanger any person's life, physical safety, or property. If at the time a complaint is filed the complainant, victim or witness indicates a desire for disclosure or nondisclosure, such desire shall govern. However, all complaints filed with the public disclosure commission about any elected official or candidate for public office must be made in writing and signed by the complainant under oath.

(f) Test questions, scoring keys, and other examination data used to administer a license, employment, or academic examination.

(g) Except as provided by chapter 8.26 RCW, the contents of real estate appraisals, made for or by any agency relative to the acquisition or sale of property, until the project or prospective sale is abandoned or until such time as all of the property has been acquired or the property to which the sale appraisal relates is sold, but in no event shall disclosure be denied for more than three years after the appraisal.

(h) Valuable formulae, designs, drawings, computer source code or object code, and research data obtained by any agency within five years of the request for disclosure when disclosure would produce private gain and public loss.

(i) Preliminary drafts, notes, recommendations, and intra-agency memorandums in which opinions are expressed or policies formulated or recommended except that a specific record shall not be exempt when publicly cited by an agency in connection with any agency action.

(j) Records which are relevant to a controversy to which an agency is a party but which records would not be available to another party under the rules of pretrial discovery for causes pending in the superior courts.

(k) Records, maps, or other information identifying the location of archaeological sites in order to avoid the looting or depredation of such sites.

(l) Any library record, the primary purpose of which is to maintain control of library materials, or to gain access to information, which discloses or could be used to disclose the identity of a library user.

(m) Financial information supplied by or on behalf of a person, firm, or corporation for the purpose of qualifying to submit a bid or proposal for (i) a ferry system construction or repair contract as required by RCW 47.60.680 through 47.60.750 or (ii) highway construction or improvement as required by RCW 47.28.070.

(n) Railroad company contracts filed prior to July 28, 1991, with the utilities and transportation commission under RCW 81.34.070, except that the summaries of the contracts are open to public inspection and copying as otherwise provided by this chapter.

(o) Financial and commercial information and records supplied by private persons pertaining to export services provided pursuant to chapter 43.163 RCW and chapter 53.31 RCW, and by persons pertaining to export projects pursuant to RCW 43.23.035.

(p) Financial disclosures filed by private vocational schools under chapters 28B.85 and 28C.10 RCW.

(q) Records filed with the utilities and transportation commission or attorney general under RCW 80.04.095 that a court has determined are confidential under RCW 80.04.095.

(r) Financial and commercial information and records supplied by businesses or individuals during application for loans or program services provided by chapters 43.163, 43.160, 43.330, and 43.168 RCW, or during application for economic development loans or program services provided by any local agency.

(s) Membership lists or lists of members or owners of interests of units in timeshare projects, subdivisions, camping resorts, condominiums, land developments, or common-interest communities affiliated with such projects, regulated by the department of licensing, in the files or possession of the department.

(t) All applications for public employment, including the names of applicants, resumes, and other related materials submitted with respect to an applicant.

(u) The residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, and emergency contact information of employees or volunteers of a public agency, and the names, dates of birth, residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, and emergency contact information of dependents of employees or volunteers of a public agency, which are held by any public agency in personnel records, public employment related records, or volunteer rosters, or are included in any mailing list of employees or volunteers of any public agency. For purposes of this subsection, "employees" includes independent provider home care workers as defined in RCW 74.39A.240.

(v) The residential addresses and residential telephone numbers of the customers of a public utility contained in the records or lists held by the public utility of which they are customers, except that this information may be released to the division of child support or the agency or firm providing child support enforcement for another state under Title IV-D of the federal social security act, for the establishment, enforcement, or modification of a support order.

(w)(i) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health, except this exemption does not apply to requests made directly to the department from federal, state, and local agencies of government, and national and state licensing, credentialing, investigatory, disciplinary, and examination organizations; (ii) the current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department, if the provider requests that this information be withheld from public inspection and copying, and provides to the department an accurate alternate or business address and business telephone number. On or after January 1, 1995, the current residential address and residential telephone number of a health care provider governed under RCW 18.130.040 maintained in the files of the department shall automatically be withheld from public inspection and copying unless the provider specifically requests the information be released, and except as provided for under RCW 42.17.260(9).

(x) Information obtained by the board of pharmacy as provided in RCW 69.45.090.

(y) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420.

(z) Financial information, business plans, examination reports, and any information produced or obtained in evaluating or examining a business and industrial development corporation organized or seeking certification under chapter 31.24 RCW.

(aa) Financial and commercial information supplied to the state investment board by any person when the information relates to the investment of public trust or retirement funds and when disclosure would result in loss to such funds or in private loss to the providers of this information.

(bb) Financial and valuable trade information under RCW 51.36.120.

(cc) Client records maintained by an agency that is a domestic violence program as defined in RCW 70.123.020 or 70.123.075 or a rape crisis center as defined in RCW 70.125.030.

(dd) Information that identifies a person who, while an agency employee: (i) Seeks advice, under an informal process established by the employing agency, in order to ascertain his or her rights in connection with a possible unfair practice under chapter 49.60 RCW against the person; and (ii) requests his or her identity or any identifying information not be disclosed.

(ee) Investigative records compiled by an employing agency conducting a current investigation of a possible unfair practice under chapter 49.60 RCW or of a possible violation of other federal, state, or local laws prohibiting discrimination in employment.

(ff) Business related information protected from public inspection and copying under RCW 15.86.110.

(gg) Financial, commercial, operations, and technical and research information and data submitted to or obtained by the clean Washington center in applications for, or delivery of, program services under chapter 70.95H RCW.

(hh) Information and documents created specifically for, and collected and maintained by, a quality improvement committee pursuant to RCW 43.70.510 or 70.41.200, by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, and notifications or reports of adverse events or incidents made under section 106 or 108 of this act, regardless of which agency is in possession of the information and documents.

(ii) Personal information in files maintained in a data base created under RCW 43.07.360.

(jj) Financial and commercial information requested by the public stadium authority from any person or organization that leases or uses the stadium and exhibition center as defined in RCW 36.102.010.

(kk) Names of individuals residing in emergency or transitional housing that are furnished to the department of revenue or a county assessor in order to substantiate a claim for property tax exemption under RCW 84.36.043.

(ll) The names, residential addresses, residential telephone numbers, and other individually identifiable records held by an agency in relation to a vanpool, carpool, or other ride-sharing program or service. However, these records may be disclosed to other persons who apply for ride-matching services and who need that information in order to identify potential riders or drivers with whom to share rides.

(mm) The personally identifying information of current or former participants or applicants in a paratransit or other transit service operated for the benefit of persons with disabilities or elderly persons.

(nn) The personally identifying information of persons who acquire and use transit passes and other fare payment media including, but not limited to, stored value smart cards and magnetic strip cards, except that an agency may disclose this information to a person, employer, educational institution, or other entity that is responsible, in whole or in part, for payment of the cost of acquiring or using a transit pass or other fare payment media, or to the news media when reporting on public transportation or public safety. This information may also be

disclosed at the agency's discretion to governmental agencies or groups concerned with public transportation or public safety.

(oo) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310. If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this section as exempt from disclosure. If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality.

(pp) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110.

(qq) Financial and commercial information supplied by or on behalf of a person, firm, corporation, or entity under chapter 28B.95 RCW relating to the purchase or sale of tuition units and contracts for the purchase of multiple tuition units.

(rr) Any records of investigative reports prepared by any state, county, municipal, or other law enforcement agency pertaining to sex offenses contained in chapter 9A.44 RCW or sexually violent offenses as defined in RCW 71.09.020, which have been transferred to the Washington association of sheriffs and police chiefs for permanent electronic retention and retrieval pursuant to RCW 40.14.070(2)(b).

(ss) Credit card numbers, debit card numbers, electronic check numbers, card expiration dates, or bank or other financial account numbers, except when disclosure is expressly required by or governed by other law.

(tt) Financial information, including but not limited to account numbers and values, and other identification numbers supplied by or on behalf of a person, firm, corporation, limited liability company, partnership, or other entity related to an application for a horse racing license submitted pursuant to RCW 67.16.260(1)(b), liquor license, gambling license, or lottery retail license.

(uu) Records maintained by the employment security department and subject to chapter 50.13 RCW if provided to another individual or organization for operational, research, or evaluation purposes.

(vv) Individually identifiable information received by the work force training and education coordinating board for research or evaluation purposes.

(ww) Those portions of records assembled, prepared, or maintained to prevent, mitigate, or respond to criminal terrorist acts, which are acts that significantly disrupt the conduct of government or of the general civilian population of the state or the United States and that manifest an extreme indifference to human life, the public disclosure of which would have a substantial likelihood of threatening public safety, consisting of:

(i) Specific and unique vulnerability assessments or specific and unique response or deployment plans, including compiled underlying data collected in

preparation of or essential to the assessments, or to the response or deployment plans; and

(ii) Records not subject to public disclosure under federal law that are shared by federal or international agencies, and information prepared from national security briefings provided to state or local government officials related to domestic preparedness for acts of terrorism.

(xx) Commercial fishing catch data from logbooks required to be provided to the department of fish and wildlife under RCW 77.12.047, when the data identifies specific catch location, timing, or methodology and the release of which would result in unfair competitive disadvantage to the commercial fisher providing the catch data. However, this information may be released to government agencies concerned with the management of fish and wildlife resources.

(yy) Sensitive wildlife data obtained by the department of fish and wildlife. However, sensitive wildlife data may be released to government agencies concerned with the management of fish and wildlife resources. Sensitive wildlife data includes:

(i) The nesting sites or specific locations of endangered species designated under RCW 77.12.020, or threatened or sensitive species classified by rule of the department of fish and wildlife;

(ii) Radio frequencies used in, or locational data generated by, telemetry studies; or

(iii) Other location data that could compromise the viability of a specific fish or wildlife population, and where at least one of the following criteria are met:

(A) The species has a known commercial or black market value;

(B) There is a history of malicious take of that species; or

(C) There is a known demand to visit, take, or disturb, and the species behavior or ecology renders it especially vulnerable or the species has an extremely limited distribution and concentration.

(zz) The personally identifying information of persons who acquire recreational licenses under RCW 77.32.010 or commercial licenses under chapter 77.65 or 77.70 RCW, except name, address of contact used by the department, and type of license, endorsement, or tag. However, the department of fish and wildlife may disclose personally identifying information to:

(i) Government agencies concerned with the management of fish and wildlife resources;

(ii) The department of social and health services, child support division, and to the department of licensing in order to implement RCW 77.32.014 and 46.20.291; and

(iii) Law enforcement agencies for the purpose of firearm possession enforcement under RCW 9.41.040.

(aaa)(i) Discharge papers of a veteran of the armed forces of the United States filed at the office of the county auditor before July 1, 2002, that have not been commingled with other recorded documents. These records will be available only to the veteran, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding that veteran's general power of attorney, or to anyone else designated in writing by that veteran to receive the records.

(ii) Discharge papers of a veteran of the armed forces of the United States filed at the office of the county auditor before July 1, 2002, that have been commingled with other records, if the veteran has recorded a "request for exemption from public disclosure of discharge papers" with the county auditor. If such a request has been recorded, these records may be released only to the veteran filing the papers, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding the veteran's general power of attorney, or anyone else designated in writing by the veteran to receive the records.

(iii) Discharge papers of a veteran filed at the office of the county auditor after June 30, 2002, are not public records, but will be available only to the veteran, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding the veteran's general power of attorney, or anyone else designated in writing by the veteran to receive the records.

(iv) For the purposes of this subsection (1)(aaa), next of kin of deceased veterans have the same rights to full access to the record. Next of kin are the veteran's widow or widower who has not remarried, son, daughter, father, mother, brother, and sister.

(bbb) Those portions of records containing specific and unique vulnerability assessments or specific and unique emergency and escape response plans at a city, county, or state adult or juvenile correctional facility, the public disclosure of which would have a substantial likelihood of threatening the security of a city, county, or state adult or juvenile correctional facility or any individual's safety.

(ccc) Information compiled by school districts or schools in the development of their comprehensive safe school plans pursuant to RCW 28A.320.125, to the extent that they identify specific vulnerabilities of school districts and each individual school.

(ddd) Information regarding the infrastructure and security of computer and telecommunications networks, consisting of security passwords, security access codes and programs, access codes for secure software applications, security and service recovery plans, security risk assessments, and security test results to the extent that they identify specific system vulnerabilities.

(eee) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW.

(fff) Proprietary data, trade secrets, or other information that relates to: (i) A vendor's unique methods of conducting business; (ii) data unique to the product or services of the vendor; or (iii) determining prices or rates to be charged for services, submitted by any vendor to the department of social and health services for purposes of the development, acquisition, or implementation of state purchased health care as defined in RCW 41.05.011.

(ggg) The personally identifying information of persons who acquire and use transponders or other technology to facilitate payment of tolls. This information may be disclosed in aggregate form as long as the data does not contain any personally identifying information. For these purposes aggregate

data may include the census tract of the account holder as long as any individual personally identifying information is not released. Personally identifying information may be released to law enforcement agencies only for toll enforcement purposes. Personally identifying information may be released to law enforcement agencies for other purposes only if the request is accompanied by a court order.

(hhh) Financial, commercial, operations, and technical and research information and data submitted to or obtained by the life sciences discovery fund authority in applications for, or delivery of, grants under chapter 43.350 RCW, to the extent that such information, if revealed, would reasonably be expected to result in private loss to the providers of this information.

(iii) Records of mediation communications that are privileged under chapter 7.07 RCW.

(2) Except for information described in subsection (1)(c)(i) of this section and confidential income data exempted from public inspection pursuant to RCW 84.40.020, the exemptions of this section are inapplicable to the extent that information, the disclosure of which would violate personal privacy or vital governmental interests, can be deleted from the specific records sought. No exemption may be construed to permit the nondisclosure of statistical information not descriptive of any readily identifiable person or persons.

(3) Inspection or copying of any specific records exempt under the provisions of this section may be permitted if the superior court in the county in which the record is maintained finds, after a hearing with notice thereof to every person in interest and the agency, that the exemption of such records is clearly unnecessary to protect any individual's right of privacy or any vital governmental function.

(4) Agency responses refusing, in whole or in part, inspection of any public record shall include a statement of the specific exemption authorizing the withholding of the record (or part) and a brief explanation of how the exemption applies to the record withheld.

Sec. 112. RCW 42.56.360 and 2005 c 274 s 416 are each amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, and notifications or reports of adverse events or incidents made under section 106 or 108 of this act, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in

connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170; and

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1).

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Coordinated Quality Improvement Programs

Sec. 113. RCW 43.70.510 and 2004 c 145 s 2 are each amended to read as follows:

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by

licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of five or more providers may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200. For purposes of this section, a health care provider group may be a consortium of providers consisting of five or more providers in total. All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that, in substantial good faith, shares information or documents with one or more other programs, committees, or boards under subsection (6) of this section is not subject to an action for civil damages or other relief as a result of the activity or its consequences. For the purposes of this section, sharing information is presumed to be in substantial good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created,

collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 70.41.200 or a peer review committee under RCW 4.24.250, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program or a peer review committee under RCW 4.24.250 and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Prescription Legibility

NEW SECTION. **Sec. 114.** The legislature finds that prescription drug errors occur because the pharmacist or nurse cannot read the prescription from the physician or other provider with prescriptive authority. The legislature further finds that legible prescriptions can prevent these errors.

Sec. 115. RCW 69.41.010 and 2003 c 257 s 2 and 2003 c 140 s 11 are each reenacted and amended to read as follows:

As used in this chapter, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Administer" means the direct application of a legend drug whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by:

(a) A practitioner; or

(b) The patient or research subject at the direction of the practitioner.

(2) "Community-based care settings" include: Community residential programs for the developmentally disabled, certified by the department of social

and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and boarding homes licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(3) "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a legend drug, whether or not there is an agency relationship.

(4) "Department" means the department of health.

(5) "Dispense" means the interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(6) "Dispenser" means a practitioner who dispenses.

(7) "Distribute" means to deliver other than by administering or dispensing a legend drug.

(8) "Distributor" means a person who distributes.

(9) "Drug" means:

(a) Substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, or any supplement to any of them;

(b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals;

(c) Substances (other than food, minerals or vitamins) intended to affect the structure or any function of the body of man or animals; and

(d) Substances intended for use as a component of any article specified in (a), (b), or (c) of this subsection. It does not include devices or their components, parts, or accessories.

(10) "Electronic communication of prescription information" means the communication of prescription information by computer, or the transmission of an exact visual image of a prescription by facsimile, or other electronic means for original prescription information or prescription refill information for a legend drug between an authorized practitioner and a pharmacy or the transfer of prescription information for a legend drug from one pharmacy to another pharmacy.

(11) "In-home care settings" include an individual's place of temporary and permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings.

(12) "Legend drugs" means any drugs which are required by state law or regulation of the state board of pharmacy to be dispensed on prescription only or are restricted to use by practitioners only.

(13) "Legible prescription" means a prescription or medication order issued by a practitioner that is capable of being read and understood by the pharmacist filling the prescription or the nurse or other practitioner implementing the medication order. A prescription must be hand printed, typewritten, or electronically generated.

(14) "Medication assistance" means assistance rendered by a nonpractitioner to an individual residing in a community-based care setting or in-home care setting to facilitate the individual's self-administration of a legend drug or controlled substance. It includes reminding or coaching the individual,

handing the medication container to the individual, opening the individual's medication container, using an enabler, or placing the medication in the individual's hand, and such other means of medication assistance as defined by rule adopted by the department. A nonpractitioner may help in the preparation of legend drugs or controlled substances for self-administration where a practitioner has determined and communicated orally or by written direction that such medication preparation assistance is necessary and appropriate. Medication assistance shall not include assistance with intravenous medications or injectable medications, except prefilled insulin syringes.

(15) "Person" means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(16) "Practitioner" means:

(a) A physician under chapter 18.71 RCW, an osteopathic physician or an osteopathic physician and surgeon under chapter 18.57 RCW, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW, an optometrist under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010, an osteopathic physician assistant under chapter 18.57A RCW, a physician assistant under chapter 18.71A RCW, a naturopath licensed under chapter 18.36A RCW, a pharmacist under chapter 18.64 RCW, or, when acting under the required supervision of a dentist licensed under chapter 18.32 RCW, a dental hygienist licensed under chapter 18.29 RCW;

(b) A pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a legend drug in the course of professional practice or research in this state; and

(c) A physician licensed to practice medicine and surgery or a physician licensed to practice osteopathic medicine and surgery in any state, or province of Canada, which shares a common border with the state of Washington.

(17) "Secretary" means the secretary of health or the secretary's designee.

PART II - INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting

NEW SECTION. **Sec. 201.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for monetary damages for injury or death caused by medical malpractice, and a voluntary indemnity payment for injury or death caused by medical malpractice made in the absence of a demand for monetary damages.

(2) "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.

(3) "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility, or provider. A claim may be closed with or without an indemnity payment to a claimant.

(4) "Commissioner" means the insurance commissioner.

(5) "Economic damages" has the same meaning as in RCW 4.56.250(1)(a).

(6) "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients, and includes entities described in RCW 7.70.020(3).

(7) "Health care provider" or "provider" has the same meaning as in RCW 7.70.020 (1) and (2).

(8) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

(d) An unauthorized insurer that provides surplus lines coverage.

(9) "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services that is actionable under chapter 7.70 RCW.

(10) "Noneconomic damages" has the same meaning as in RCW 4.56.250(1)(b).

(11) "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice.

NEW SECTION. Sec. 202. (1) For claims closed on or after January 1, 2008:

(a) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report each medical malpractice closed claim to the commissioner.

(b) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include, but are not limited to, situations in which the:

(i) Facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(ii) Claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(iii) Annual aggregate coverage limits had been exhausted by other claim payments.

(2) Beginning in 2009, reports required under subsection (1) of this section must be filed by March 1st, and include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years. The commissioner may adopt rules that require insuring entities, self-insurers, facilities, or providers to file closed claim data electronically.

(3) The commissioner may impose a fine of up to two hundred fifty dollars per day against any insuring entity that violates the requirements of this section.

(4) The department of health, department of licensing or department of social and health services may require a provider or facility to take corrective action to assure compliance with the requirements of this section.

NEW SECTION. Sec. 203. Reports required under section 202 of this act must contain the following information in a form and coding protocol prescribed by the commissioner that, to the extent possible and still fulfill the purposes of this chapter, are consistent with the format for data reported to the national practitioner data bank:

- (1) Claim and incident identifiers, including:
 - (a) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility, or provider; and
 - (b) An incident identifier if companion claims have been made by a claimant. For the purposes of this section, "companion claims" are separate claims involving the same incident of medical malpractice made against other providers or facilities;
- (2) The medical specialty of the provider who was primarily responsible for the incident of medical malpractice that led to the claim;
- (3) The type of health care facility where the medical malpractice incident occurred;
- (4) The primary location within a facility where the medical malpractice incident occurred;
- (5) The geographic location, by city and county, where the medical malpractice incident occurred;
- (6) The injured person's sex and age on the incident date;
- (7) The severity of malpractice injury using the national practitioner data bank severity scale;
- (8) The dates of:
 - (a) The incident that was the proximate cause of the claim;
 - (b) Notice to the insuring entity, self-insurer, facility, or provider;
 - (c) Suit, if filed;
 - (d) Final indemnity payment, if any; and
 - (e) Final action by the insuring entity, self-insurer, facility, or provider to close the claim;
- (9) Settlement information that identifies the timing and final method of claim disposition, including:
 - (a) Claims settled by the parties;
 - (b) Claims disposed of by a court, including the date disposed; or
 - (c) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial, and other common dispute resolution methods; and
 - (d) Whether the settlement occurred before or after trial, if a trial occurred;
- (10) Specific information about the indemnity payments and defense expenses, as follows:
 - (a) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:
 - (i) The total verdict or judgment;
 - (ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
 - (iii) Economic damages;
 - (iv) Noneconomic damages; and

(v) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(b) For claims that do not result in a verdict or judgment that itemizes damages:

- (i) The total amount of the settlement;
- (ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
- (iii) Paid and estimated economic damages; and
- (iv) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses;

(11) The reason for the medical malpractice claim. The reporting entity must use the same allegation group and act or omission codes used for mandatory reporting to the national practitioner data bank; and

(12) Any other claim-related data the commissioner determines to be necessary to monitor the medical malpractice marketplace, if such data are reported:

- (a) To the national practitioner data bank; or
- (b) Voluntarily by members of the physician insurers association of America as part of the association's data-sharing project.

NEW SECTION. Sec. 204. The commissioner must prepare aggregate statistical summaries of closed claims based on data submitted under section 202 of this act.

(1) At a minimum, the commissioner must summarize data by calendar year and calendar/incident year. The commissioner may also decide to display data in other ways if the commissioner:

- (a) Protects information as required under section 206(2) of this act; and
 - (b) Exempts from disclosure data described in RCW 42.56.400(11).
- (2) The summaries must be available by April 30th of each year, unless the commissioner notifies legislative committees by March 15th that data are not available and informs the committees when the summaries will be completed.
- (3) Information included in an individual closed claim report submitted by an insuring entity, self-insurer, provider, or facility under this chapter is confidential and exempt from public disclosure, and the commissioner must not make these data available to the public.

NEW SECTION. Sec. 205. Beginning in 2010, the commissioner must prepare an annual report that summarizes and analyzes the closed claim reports for medical malpractice filed under sections 202 and 209 of this act and the annual financial reports filed by authorized insurers writing medical malpractice insurance in this state. The commissioner must complete the report by June 30th, unless the commissioner notifies legislative committees by June 1st that data are not available and informs the committees when the summaries will be completed.

- (1) The report must include:
- (a) An analysis of reported closed claims from prior years for which data are collected. The analysis must show:
 - (i) Trends in the frequency and severity of claim payments;
 - (ii) A comparison of economic and noneconomic damages;

(iii) A distribution of allocated loss adjustment expenses and other legal expenses;

(iv) The types of medical malpractice for which claims have been paid; and

(v) Any other information the commissioner finds relevant to trends in medical malpractice closed claims if the commissioner:

(A) Protects information as required under section 206(2) of this act; and

(B) Exempts from disclosure data described in RCW 42.56.400(11);

(b) An analysis of the medical malpractice insurance market in Washington state, including:

(i) An analysis of the financial reports of the authorized insurers with a combined market share of at least ninety percent of direct written medical malpractice premium in Washington state for the prior calendar year;

(ii) A loss ratio analysis of medical malpractice insurance written in Washington state; and

(iii) A profitability analysis of the authorized insurers with a combined market share of at least ninety percent of direct written medical malpractice premium in Washington state for the prior calendar year;

(c) A comparison of loss ratios and the profitability of medical malpractice insurance in Washington state to other states based on financial reports filed with the national association of insurance commissioners and any other source of information the commissioner deems relevant; and

(d) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior calendar year, including an analysis of the trend of direct incurred losses as compared to prior years.

(2) The commissioner must post reports required by this section on the internet no later than thirty days after they are due.

(3) The commissioner may adopt rules that require insuring entities and self-insurers required to report under section 202 of this act and subsection (1)(a) of this section to report data related to:

(a) The frequency and severity of closed claims for the reporting period; and

(b) Any other closed claim information that helps the commissioner monitor losses and claim development patterns in the Washington state medical malpractice insurance market.

NEW SECTION. Sec. 206. The commissioner must adopt all rules needed to implement this chapter. The rules must:

(1) Identify which insuring entity or self-insurer has the primary obligation to report a closed claim when more than one insuring entity or self-insurer is providing medical malpractice liability coverage to a single health care provider or a single health care facility that has been named in a claim;

(2) Protect information that, alone or in combination with other data, could result in the ability to identify a claimant, health care provider, health care facility, or self-insurer involved in a particular claim or collection of claims; and

(3) Specify standards and methods for the reporting by claimants, insuring entities, self-insurers, facilities, and providers.

NEW SECTION. Sec. 207. (1) If the national association of insurance commissioners adopts revised model statistical reporting standards for medical malpractice insurance, the commissioner must analyze the new reporting standards and report this information to the legislature, as follows:

(a) An analysis of any differences between the model reporting standards and:

- (i) Sections 201 through 206 of this act; and
- (ii) Any statistical plans that the commissioner has adopted under RCW 48.19.370; and
- (b) Recommendations, if any, about legislative changes necessary to implement the model reporting standards.

(2) The commissioner must submit the report required under subsection (1) of this section to the following legislative committees by the first day of December in the year after the national association of insurance commissioners adopts new model medical malpractice reporting standards:

- (a) The house of representatives committees on health care; financial institutions and insurance; and judiciary; and
- (b) The senate committees on health and long-term care; financial institutions, housing and consumer protection; and judiciary.

NEW SECTION. Sec. 208. This chapter does not amend or modify the statistical reporting requirements that apply to insurers under RCW 48.19.370.

NEW SECTION. Sec. 209. A new section is added to chapter 7.70 RCW to read as follows:

(1) As used in this section:

- (a) "Claim" has the same meaning as in section 201(1) of this act.
- (b) "Claimant" has the same meaning as in section 201(2) of this act.
- (c) "Commissioner" has the same meaning as in section 201(4) of this act.
- (d) "Medical malpractice" has the same meaning as in section 201(9) of this act.

act.

(2)(a) For claims settled or otherwise disposed of on or after January 1, 2008, the claimant or his or her attorney must report data to the commissioner if any action filed under this chapter results in a final:

- (i) Judgment in any amount;
- (ii) Settlement or payment in any amount; or
- (iii) Disposition resulting in no indemnity payment.

(b) As used in this subsection, "data" means:

(i) The date of the incident of medical malpractice that was the principal cause of the action;

(ii) The principal county in which the incident of medical malpractice occurred;

(iii) The date of suit, if filed;

(iv) The injured person's sex and age on the incident date; and

(v) Specific information about the disposition, judgment, or settlement, including:

(A) The date and amount of any judgment or settlement;

(B) Court costs;

(C) Attorneys' fees; and

(D) Costs of expert witnesses.

Sec. 210. RCW 42.56.400 and 2005 c 274 s 420 are each amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of all viators regulated by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Information gathered under chapter 19.85 RCW or RCW 34.05.328 that can be identified to a particular business;

(7) Examination reports and information obtained by the department of financial institutions from banks under RCW 30.04.075, from savings banks under RCW 32.04.220, from savings and loan associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, all of which is confidential and privileged information;

(8) Information provided to the insurance commissioner under RCW 48.110.040(3);

(9) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged; ~~((and))~~

(10) Confidential proprietary and trade secret information provided to the commissioner under RCW 48.31C.020 through 48.31C.050 and 48.31C.070; and

(11) Data filed under sections 202, 203, 205, and 209 of this act that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in section 201(2) of this act.

(b) "Health care facility" has the same meaning as in section 201(6) of this act.

(c) "Health care provider" has the same meaning as in section 201(7) of this act.

(d) "Insuring entity" has the same meaning as in section 201(8) of this act.

(e) "Self-insurer" has the same meaning as in section 201(11) of this act.

Underwriting Standards

NEW SECTION. Sec. 211. A new section is added to chapter 48.18 RCW to read as follows:

- (1) For the purposes of this section:
- (a) "Affiliate" has the same meaning as in RCW 48.31B.005(1).
 - (b) "Claim" means a demand for monetary damages by a claimant.
 - (c) "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.
 - (d) "Tier" has the same meaning as in RCW 48.18.545(1)(h).
 - (e) "Underwrite" or "underwriting" means the process of selecting, rejecting, or pricing a risk, and includes each of these activities:
 - (i) Evaluation, selection, and classification of risk, including placing a risk with an affiliate insurer that has higher rates and/or rating plan components that will result in higher premiums;
 - (ii) Application of classification plans, rates, rating rules, and rating tiers to an insured risk; and
 - (iii) Determining eligibility for:
 - (A) Insurance coverage provisions;
 - (B) Higher policy limits; or
 - (C) Premium payment plans.
- (2) During each underwriting process, an insurer may consider the following factors only in combination with other substantive underwriting factors:
- (a) An insured has inquired about the nature or scope of coverage under a medical malpractice insurance policy;
 - (b) An insured has notified their insurer about an incident that may be covered under the terms of their medical malpractice insurance policy, and that incident does not result in a claim; or
 - (c) A claim made against an insured was closed by the insurer without payment. An insurer may consider the effect of multiple claims if they have a significant effect on the insured's risk profile.
- (3) If any underwriting activity related to the insured's risk profile results in higher premiums as described under subsection (1)(e) (i) and (ii) of this section or reduced coverage as described under subsection (1)(e)(iii) of this section, the insurer must provide written notice to the insured, in clear and simple language, that describes the significant risk factors which led to the underwriting action. The commissioner must adopt rules that define the components of a risk profile that require notice under this subsection.

Sec. 212. RCW 48.18.290 and 1997 c 85 s 1 are each amended to read as follows:

- (1) Cancellation by the insurer of any policy which by its terms is cancellable at the option of the insurer, or of any binder based on such policy which does not contain a clearly stated expiration date, may be effected as to any interest only upon compliance with the following:
- (a) ~~((Written notice of such cancellation, accompanied by the actual reason therefor, must be actually delivered or mailed to the named insured not less than forty five days prior to the effective date of the cancellation except for cancellation of insurance policies for nonpayment of premiums, which notice shall be not less than ten days prior to such date and except for cancellation of fire insurance policies under chapter 48.53 RCW, which notice shall not be less than five days prior to such date;))~~ For all insurance policies other than medical

malpractice insurance policies or fire insurance policies canceled under RCW 48.53.040:

(i) The insurer must deliver or mail written notice of cancellation to the named insured at least forty-five days before the effective date of the cancellation; and

(ii) The cancellation notice must include the insurer's actual reason for canceling the policy.

(b) For medical malpractice insurance policies:

(i) The insurer must deliver or mail written notice of the cancellation to the named insured at least ninety days before the effective date of the cancellation; and

(ii) The cancellation notice must include the insurer's actual reason for canceling the policy and describe the significant risk factors that led to the insurer's underwriting action, as defined under section 211(1)(e) of this act.

(c) If an insurer cancels a policy described under (a) or (b) of this subsection for nonpayment of premium, the insurer must deliver or mail the cancellation notice to the named insured at least ten days before the effective date of the cancellation.

(d) If an insurer cancels a fire insurance policy under RCW 48.53.040, the insurer must deliver or mail the cancellation notice to the named insured at least five days before the effective date of the cancellation.

(e) Like notice must also be so delivered or mailed to each mortgagee, pledgee, or other person shown by the policy to have an interest in any loss which may occur thereunder. For purposes of this subsection (1)(~~(b)~~) (e), "delivered" includes electronic transmittal, facsimile, or personal delivery.

(2) The mailing of any such notice shall be effected by depositing it in a sealed envelope, directed to the addressee at his or her last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States post office. The insurer shall retain in its records any such item so mailed, together with its envelope, which was returned by the post office upon failure to find, or deliver the mailing to, the addressee.

(3) The affidavit of the individual making or supervising such a mailing, shall constitute prima facie evidence of such facts of the mailing as are therein affirmed.

(4) The portion of any premium paid to the insurer on account of the policy, unearned because of the cancellation and in amount as computed on the pro rata basis, must be actually paid to the insured or other person entitled thereto as shown by the policy or by any endorsement thereon, or be mailed to the insured or such person as soon as possible, and no later than forty-five days after the date of notice of cancellation to the insured for homeowners', dwelling fire, and private passenger auto. Any such payment may be made by cash, or by check, bank draft, or money order.

(5) This section shall not apply to contracts of life or disability insurance without provision for cancellation prior to the date to which premiums have been paid, or to contracts of insurance procured under the provisions of chapter 48.15 RCW.

Sec. 213. RCW 48.18.2901 and 2002 c 347 s 1 are each amended to read as follows:

(1) Each insurer ~~((shall be required to))~~ must renew any ~~((contract of))~~ insurance policy subject to RCW 48.18.290 unless one of the following situations exists:

~~((The insurer gives the named insured at least forty-five days' notice in writing as provided for in RCW 48.18.290, that it proposes to refuse to renew the insurance contract upon its expiration date; and sets forth in that writing the actual reason for refusing to renew))~~ (i) For all insurance policies subject to RCW 48.18.290(1)(a):

(A) The insurer must deliver or mail written notice of nonrenewal to the named insured at least forty-five days before the expiration date of the policy; and

(B) The notice must include the insurer's actual reason for refusing to renew the policy.

(ii) For medical malpractice insurance policies subject to RCW 48.18.290(1)(b):

(A) The insurer must deliver or mail written notice of the nonrenewal to the named insured at least ninety days before the expiration date of the policy; and

(B) The notice must include the insurer's actual reason for refusing to renew the policy and describe the significant risk factors that led to the insurer's underwriting action, as defined under section 211(1)(e) of this act;

(b) At least twenty days prior to its expiration date, the insurer has communicated, either directly or through its agent, its willingness to renew in writing to the named insured and has included in that writing a statement of the amount of the premium or portion thereof required to be paid by the insured to renew the policy, and the insured fails to discharge when due his or her obligation in connection with the payment of such premium or portion thereof;

(c) The insured has procured equivalent coverage prior to the expiration of the policy period;

(d) The contract is evidenced by a written binder containing a clearly stated expiration date which has expired according to its terms; or

(e) The contract clearly states that it is not renewable, and is for a specific line, subclassification, or type of coverage that is not offered on a renewable basis. This subsection (1)(e) does not restrict the authority of the insurance commissioner under this code.

(2) Any insurer failing to include in the notice required by subsection (1)(b) of this section the amount of any increased premium resulting from a change of rates and an explanation of any change in the contract provisions shall renew the policy if so required by that subsection according to the rates and contract provisions applicable to the expiring policy. However, renewal based on the rates and contract provisions applicable to the expiring policy shall not prevent the insurer from making changes in the rates and/or contract provisions of the policy once during the term of its renewal after at least twenty days' advance notice of such change has been given to the named insured.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal, or with respect to cancellation of fire policies under chapter 48.53 RCW.

(4) "Renewal" or "to renew" means the issuance and delivery by an insurer of a contract of insurance replacing at the end of the contract period a contract of

insurance previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a contract beyond its policy period or term. However, (a) any contract of insurance with a policy period or term of six months or less whether or not made continuous for successive terms upon the payment of additional premiums shall for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295 be considered as if written for a policy period or term of six months; and (b) any policy written for a term longer than one year or any policy with no fixed expiration date, shall, for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295, be considered as if written for successive policy periods or terms of one year.

(5) A midterm blanket reduction in rate, approved by the commissioner, for medical malpractice insurance shall not be considered a renewal for purposes of this section.

Prior Approval of Medical Malpractice Insurance Rates

Sec. 214. RCW 48.18.100 and 2005 c 223 s 8 are each amended to read as follows:

(1) No insurance policy form or application form where written application is required and is to be attached to the policy, or printed life or disability rider or endorsement form may be issued, delivered, or used unless it has been filed with and approved by the commissioner. This section does not apply to:

- (a) Surety bond forms;
- (b) Forms filed under RCW 48.18.103;
- (c) Forms exempted from filing requirements by the commissioner under RCW 48.18.103;
- (d) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject; or
- (e) Contracts of insurance procured under the provisions of chapter 48.15 RCW.

(2) Every such filing containing a certification, in a form approved by the commissioner, by either the chief executive officer of the insurer or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW and Title 284 of the Washington Administrative Code, may be used by the insurer immediately after filing with the commissioner. The commissioner may order an insurer to cease using a certified form upon the grounds set forth in RCW 48.18.110. This subsection does not apply to certain types of policy forms designated by the commissioner by rule.

(3) Except as provided in RCW 48.18.103, every filing that does not contain a certification pursuant to subsection (2) of this section must be made not less than thirty days in advance of issuance, delivery, or use. At the expiration of the thirty days, the filed form shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner. The commissioner may extend by not more than an additional fifteen days the period within which he or she may affirmatively approve or disapprove any form, by giving notice of the extension before expiration of the initial thirty-day period. At the expiration of the period that has been extended, and in the absence of prior affirmative approval or disapproval, the form shall be deemed approved.

The commissioner may withdraw any approval at any time for cause. By approval of any form for immediate use, the commissioner may waive any unexpired portion of the initial thirty-day waiting period.

(4) The commissioner's order disapproving any form or withdrawing a previous approval must state the grounds for disapproval.

(5) No form may knowingly be issued or delivered as to which the commissioner's approval does not then exist.

(6) The commissioner may, by rule, exempt from the requirements of this section any class or type of insurance policy forms if filing and approval is not desirable or necessary for the protection of the public.

(7) Every member or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization. Deviations from the organization are permitted only when filed with the commissioner in accordance with this chapter.

(8) Medical malpractice insurance form filings are subject to the provisions of this section.

Sec. 215. RCW 48.18.103 and 2005 c 223 s 9 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for forms.

(2) Commercial property casualty policies may be issued prior to filing the forms.

(3) All commercial property casualty forms must be filed with the commissioner within thirty days after an insurer issues any policy using them. This subsection does not apply to:

(a) Types or classes of forms that the commissioner exempts from filing by rule; and

(b) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject.

(4) If, within thirty days after a commercial property casualty form has been filed, the commissioner finds that the form does not meet the requirements of this chapter, the commissioner shall disapprove the form and give notice to the insurer or rating organization that made the filing, specifying how the form fails to meet the requirements and stating when, within a reasonable period thereafter, the form shall be deemed no longer effective. The commissioner may extend the time for review an additional fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(5) Upon a final determination of a disapproval of a policy form under subsection (4) of this section, the insurer must amend any previously issued disapproved form by endorsement to comply with the commissioner's disapproval.

(6) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance.

(7) Except as provided in subsection (5) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(8) Every member or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization. An insurer may deviate from forms filed on its behalf by an organization only if the insurer files the forms with the commissioner in accordance with this chapter.

(9) In the event a hearing is held on the actions of the commissioner under subsection (4) of this section, the burden of proof shall be on the commissioner.

Sec. 216. RCW 48.19.043 and 2003 c 248 s 7 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for rates.

(2) Notwithstanding the provisions of RCW 48.19.040(1), commercial property casualty policies may be issued prior to filing the rates. All commercial property casualty rates shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty rate has been filed, the commissioner finds that the rate does not meet the requirements of this chapter, the commissioner shall disapprove the filing and give notice to the insurer or rating organization that made the filing, specifying how the filing fails to meet the requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a rate filing under subsection (3) of this section, the insurer shall issue an endorsement changing the rate to comply with the commissioner's disapproval from the date the rate is no longer effective.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof is on the commissioner.

Sec. 217. RCW 48.19.060 and 1997 c 428 s 4 are each amended to read as follows:

(1) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this chapter.

(2) Except as provided in RCW 48.19.070 and 48.19.043:

(a) No such filing shall become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if he or she

gives notice within such waiting period to the insurer or rating organization which made the filing that he or she needs such additional time for the consideration of the filing. The commissioner may, upon application and for cause shown, waive such waiting period or part thereof as to a filing that he or she has not disapproved.

(b) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

(3) Medical malpractice insurance rate filings are subject to the provisions of this section.

PART III - HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose

NEW SECTION. Sec. 301. The purpose of this section and section 302 of this act is to respond to the court's decision in *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998), by expressly stating the legislature's rationale for the eight-year statute of repose in RCW 4.16.350.

The legislature recognizes that the eight-year statute of repose alone may not solve the crisis in the medical insurance industry. However, to the extent that the eight-year statute of repose has an effect on medical malpractice insurance, that effect will tend to reduce rather than increase the cost of malpractice insurance.

Whether or not the statute of repose has the actual effect of reducing insurance costs, the legislature finds it will provide protection against claims, however few, that are stale, based on untrustworthy evidence, or that place undue burdens on defendants.

In accordance with the court's opinion in *DeYoung*, the legislature further finds that compelling even one defendant to answer a stale claim is a substantial wrong, and setting an outer limit to the operation of the discovery rule is an appropriate aim.

The legislature further finds that an eight-year statute of repose is a reasonable time period in light of the need to balance the interests of injured plaintiffs and the health care industry.

The legislature intends to reenact RCW 4.16.350 with respect to the eight-year statute of repose and specifically set forth for the court the legislature's legitimate rationale for adopting the eight-year statute of repose. The legislature further intends that the eight-year statute of repose reenacted by section 302 of this act be applied to actions commenced on or after the effective date of this section.

Sec. 302. RCW 4.16.350 and 1998 c 147 s 1 are each reenacted to read as follows:

Any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976 against:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's

assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;

based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be commenced more than eight years after said act or omission: PROVIDED, That the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, until the date the patient or the patient's representative has actual knowledge of the act of fraud or concealment, or of the presence of the foreign body; the patient or the patient's representative has one year from the date of the actual knowledge in which to commence a civil action for damages.

For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.

For purposes of this section, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years.

This section does not apply to a civil action based on intentional conduct brought against those individuals or entities specified in this section by a person for recovery of damages for injury occurring as a result of childhood sexual abuse as defined in RCW 4.16.340(5).

Sec. 303. RCW 4.16.190 and 1993 c 232 s 1 are each amended to read as follows:

(1) Unless otherwise provided in this section, if a person entitled to bring an action mentioned in this chapter, except for a penalty or forfeiture, or against a sheriff or other officer, for an escape, be at the time the cause of action accrued either under the age of eighteen years, or incompetent or disabled to such a degree that he or she cannot understand the nature of the proceedings, such incompetency or disability as determined according to chapter 11.88 RCW, or

imprisoned on a criminal charge prior to sentencing, the time of such disability shall not be a part of the time limited for the commencement of action.

(2) Subsection (1) of this section with respect to a person under the age of eighteen years does not apply to the time limited for the commencement of an action under RCW 4.16.350.

Certificate of Merit

NEW SECTION. Sec. 304. A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action against an individual health care provider under this chapter for personal injury or wrongful death in which the injury is alleged to have been caused by an act or omission that violates the accepted standard of care, the plaintiff must file a certificate of merit at the time of commencing the action. If the action is commenced within forty-five days prior to the expiration of the applicable statute of limitations, the plaintiff must file the certificate of merit no later than forty-five days after commencing the action.

(2) The certificate of merit must be executed by a health care provider who meets the qualifications of an expert in the action. If there is more than one defendant in the action, the person commencing the action must file a certificate of merit for each defendant.

(3) The certificate of merit must contain a statement that the person executing the certificate of merit believes, based on the information known at the time of executing the certificate of merit, that there is a reasonable probability that the defendant's conduct did not follow the accepted standard of care required to be exercised by the defendant.

(4) Upon motion of the plaintiff, the court may grant an additional period of time to file the certificate of merit, not to exceed ninety days, if the court finds there is good cause for the extension.

(5)(a) Failure to file a certificate of merit that complies with the requirements of this section is grounds for dismissal of the case.

(b) If a case is dismissed for failure to file a certificate of merit that complies with the requirements of this section, the filing of the claim against the health care provider shall not be used against the health care provider in professional liability insurance rate setting, personal credit history, or professional licensing and credentialing.

Voluntary Arbitration

NEW SECTION. Sec. 305. This chapter applies to any cause of action for damages for personal injury or wrongful death based on alleged professional negligence in the provision of health care where all parties to the action have agreed to submit the dispute to arbitration under this chapter in accordance with the requirements of section 306 of this act.

NEW SECTION. Sec. 306. (1) Parties in an action covered under section 305 of this act may elect to submit the dispute to arbitration under this chapter in accordance with the requirements in this section.

(a) A claimant may elect to submit the dispute to arbitration under this chapter by including such election in the complaint filed at the commencement

of the action. A defendant may elect to submit the dispute to arbitration under this chapter by including such election in the defendant's answer to the complaint. The dispute will be submitted to arbitration under this chapter only if all parties to the action elect to submit the dispute to arbitration.

(b) If the parties do not initially elect to submit the dispute to arbitration in accordance with (a) of this subsection, the parties may make such an election at any time during the pendency of the action by filing a stipulation with the court in which all parties to the action agree to submit the dispute to arbitration under this chapter.

(2) A party that does not initially elect to submit a dispute to arbitration under this chapter must file a declaration with the court that meets the following requirements:

(a) In the case of a claimant, the declaration must be filed at the time of commencing the action and must state that the attorney representing the claimant presented the claimant with a copy of the provisions of this chapter before commencing the action and that the claimant elected not to submit the dispute to arbitration under this chapter; and

(b) In the case of a defendant, the declaration must be filed at the time of filing the answer and must state that the attorney representing the defendant presented the defendant with a copy of the provisions of this chapter before filing the defendant's answer and that the defendant elected not to submit the dispute to arbitration under this chapter.

NEW SECTION. Sec. 307. (1) An arbitrator shall be selected by agreement of the parties no later than forty-five days after: (a) The date all defendants elected arbitration in the answer where the parties elected arbitration in the initial complaint and answer; or (b) the date of the stipulation where the parties agreed to enter into arbitration after the commencement of the action through a stipulation filed with the court. The parties may agree to select more than one arbitrator to conduct the arbitration.

(2) If the parties are unable to agree to an arbitrator by the time specified in subsection (1) of this section, each side may submit the names of three arbitrators to the court, and the court shall select an arbitrator from among the submitted names within fifteen days of being notified that the parties are unable to agree to an arbitrator. If none of the parties submit any names of potential arbitrators, the court shall select an arbitrator.

NEW SECTION. Sec. 308. The arbitrator may conduct the arbitration in such manner as the arbitrator considers appropriate so as to aid in the fair and expeditious disposition of the proceeding subject to the requirements of this section and section 309 of this act.

(1)(a) Except as provided in (b) of this subsection, each party is entitled to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert.

(b) Where there are multiple parties on one side, the arbitrator shall determine the number of experts that are allowed based on the minimum number of experts necessary to ensure a fair and economic resolution of the action.

(2)(a) Unless the arbitrator determines that exceptional circumstances require additional discovery, each party is entitled to the following discovery from any other party:

- (i) Twenty-five interrogatories, including subparts;
- (ii) Ten requests for admission; and
- (iii) In accordance with applicable court rules:
 - (A) Requests for production of documents and things, and for entry upon land for inspection and other purposes; and
 - (B) Requests for physical and mental examinations of persons.
- (b) The parties shall be entitled to the following depositions:
 - (i) Depositions of parties and any expert that a party expects to call as a witness. Except by order of the arbitrator for good cause shown, the length of the deposition of a party or an expert witness shall be limited to four hours.
 - (ii) Depositions of other witnesses. Unless the arbitrator determines that exceptional circumstances require additional depositions, the total number of depositions of persons who are not parties or expert witnesses is limited to five depositions per side, each of which may last no longer than two hours in length. In the deposition of a fact witness, each side is entitled to examine for one hour of the deposition.
- (3) An arbitrator may issue a subpoena for the attendance of a witness and for the production of records and other evidence at any hearing and may administer oaths. A subpoena must be served in the manner for service of subpoenas in a civil action and, upon motion to the court by a party to the arbitration proceeding or the arbitrator, enforced in the manner for enforcement of subpoenas in a civil action.

NEW SECTION. Sec. 309. (1) An arbitration under this chapter shall be conducted according to the time frames specified in this section. The time frames provided in this section run from the date all defendants have agreed to arbitration in their answers where the parties elected arbitration in the initial complaint and answer, and from the date of the execution of the stipulation where the parties agreed to enter into arbitration after the commencement of the action through a stipulation filed with the court. The arbitrator shall issue a case scheduling order in every case specifying the dates by which the requirements of (b) through (f) of this subsection must be completed.

- (a) Within forty-five days, the claimant shall provide stipulations for all relevant medical records to the defendants.
- (b) Within one hundred twenty days, the claimant shall disclose to the defendants the names and curriculum vitae or other documentation of qualifications of any expert the claimant expects to call as a witness.
- (c) Within one hundred forty days, each defendant shall disclose to the claimants the names and curriculum vitae or other documentation of qualifications of any expert the defendant expects to call as a witness.
- (d) Within one hundred sixty days, each party shall disclose to the other parties the name and curriculum vitae or other documentation of qualifications of any rebuttal expert the party expects to call as a witness.
- (e) Within two hundred forty days, all discovery shall be completed.
- (f) Within two hundred seventy days, the arbitration hearing shall commence subject to the limited authority of the arbitrator to extend this deadline under subsection (2) of this section.

(2) It is the express public policy of the legislature that arbitration hearings under this chapter be commenced no later than twelve months after the parties elect to submit the dispute to arbitration. The arbitrator may grant a continuance

of the commencement of the arbitration hearing to a date more than twelve months after the parties elect to submit the dispute to arbitration only where a party shows that exceptional circumstances create an undue and unavoidable hardship on the party.

NEW SECTION. Sec. 310. (1) The arbitrator shall issue a decision in writing and signed by the arbitrator within fourteen days after the completion of the arbitration hearing and shall promptly deliver a copy of the decision to each of the parties or their attorneys.

(2) The arbitrator may not make an award of damages under this chapter that exceeds one million dollars for both economic and noneconomic damages.

(3) The arbitrator may not make an award of damages under this chapter under a theory of ostensible agency liability.

(4) With or without the request of a party, the arbitrator shall review the reasonableness of each party's attorneys' fees taking into account the factors enumerated in RCW 4.24.005.

(5) The fees and expenses of the arbitrator shall be paid by the nonprevailing parties.

NEW SECTION. Sec. 311. After a party to the arbitration proceeding receives notice of a decision, the party may file a motion with the court for a judgment in accordance with the decision, at which time the court shall issue such a judgment unless the decision is modified, corrected, or vacated as provided in section 312 of this act.

NEW SECTION. Sec. 312. There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal of the arbitrator's decision is limited to the bases for appeal provided in RCW 7.04A.230(1) (a) through (d) and 7.04A.240, or equivalent provisions in a successor statute.

NEW SECTION. Sec. 313. The provisions of chapter 7.04A RCW do not apply to arbitrations conducted under this chapter except to the extent specifically provided in this chapter.

Mandatory Mediation

Sec. 314. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) No action based upon a health care provider's professional negligence may be commenced unless the defendant has been given at least ninety days' notice of the intention to commence the action. If the notice is served within ninety days of the expiration of the applicable statute of limitations, the time for the commencement of the action must be extended ninety days from the service of the notice.

(2) The provisions of subsection (1) of this section are not applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name.

(3) After the filing of the ninety-day presuit notice, and before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care provided after July 1, 1993, shall be subject to mandatory mediation prior to trial except as provided in subsection (6) of this section.

~~((2))~~ (4) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. ~~The ((rules shall)) implementation contemplates the adoption of rules by the supreme court which will require mandatory mediation without exception unless subsection (6) of this section applies. The rules on mandatory mediation shall~~ address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held;

(f) A means by which mediation of an action under this chapter may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(g) Any other matters deemed necessary by the court.

~~((3))~~ (5) Mediators shall not impose discovery schedules upon the parties.

~~(6) The mandatory mediation requirement of subsection (4) of this section does not apply to an action subject to mandatory arbitration under chapter 7.06 RCW or to an action in which the parties have agreed, subsequent to the arisal of the claim, to submit the claim to arbitration under chapter 7.04A or 7.— (sections 305 through 313 of this act) RCW.~~

~~(7) The implementation also contemplates the adoption of a rule by the supreme court for procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section.~~

Collateral Sources

Sec. 315. RCW 7.70.080 and 1975-'76 2nd ex.s. c 56 s 13 are each amended to read as follows:

Any party may present evidence to the trier of fact that the ~~((patient)) plaintiff~~ has already been compensated for the injury complained of from any source except the assets of the ~~((patient, his)) plaintiff, the plaintiff's representative, or ((his)) the plaintiff's immediate family((, — or insurancee purchased with such assets)).~~ In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. ~~((Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee.))~~ Compensation as used in this section shall mean payment of money or other property to or on behalf of the

((patient)) plaintiff, rendering of services to the ((patient)) plaintiff free of charge to the ((patient)) plaintiff, or indemnification of expenses incurred by or on behalf of the ((patient)) plaintiff. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

Preventing Frivolous Lawsuits

NEW SECTION. Sec. 316. A new section is added to chapter 7.70 RCW to read as follows:

In any action under this section, an attorney that has drafted, or assisted in drafting and filing an action, counterclaim, cross-claim, third-party claim, or a defense to a claim, upon signature and filing, certifies that to the best of the party's or attorney's knowledge, information, and belief, formed after reasonable inquiry it is not frivolous, and is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause frivolous litigation. If an action is signed and filed in violation of this rule, the court, upon motion or upon its own initiative, may impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the action, counterclaim, cross-claim, third-party claim, or a defense to a claim, including a reasonable attorney fee. The procedures governing the enforcement of RCW 4.84.185 shall apply to this section.

PART IV - MISCELLANEOUS PROVISIONS

NEW SECTION. Sec. 401. Part headings and subheadings used in this act are not any part of the law.

NEW SECTION. Sec. 402. (1) Sections 105 through 108 and 110 of this act constitute a new chapter in Title 70 RCW.

(2) Sections 201 through 208 of this act constitute a new chapter in Title 48 RCW.

(3) Sections 305 through 313 of this act constitute a new chapter in Title 7 RCW.

NEW SECTION. Sec. 403. Sections 211, 212, and 213 of this act apply to insurance policies issued or renewed on or after January 1, 2007.

NEW SECTION. Sec. 404. Section 111 of this act expires July 1, 2006.

NEW SECTION. Sec. 405. Sections 112 and 210 of this act take effect July 1, 2006.

NEW SECTION. Sec. 406. If specific funding for the purposes of sections 105 through 112 of this act, referencing sections 105 through 112 of this act by bill or chapter number and section numbers, is not provided by June 30, 2006, in the omnibus appropriations act, sections 105 through 112 of this act are null and void.

NEW SECTION. Sec. 407. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Passed by the House February 28, 2006.

Passed by the Senate February 22, 2006.

Approved by the Governor March 6, 2006.

Filed in Office of Secretary of State March 6, 2006.

CHAPTER 9

[Substitute House Bill 2333]

HOME CARE AGENCY WORKERS

AN ACT Relating to parity for home care agency workers; adding a new section to chapter 74.39A RCW; creating a new section; providing an effective date; and providing an expiration date.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. A new section is added to chapter 74.39A RCW to read as follows:

(1) The department shall create a formula that converts the cost of the increase in wages and benefits negotiated and funded in the contract for individual providers of home care services pursuant to RCW 74.39A.270 and 74.39A.300, into a per-hour amount, excluding those benefits defined in subsection (2) of this section. That per-hour amount shall be added to the statewide home care agency vendor rate and shall be used exclusively for improving the wages and benefits of home care agency workers who provide direct care. The formula shall account for:

(a) All types of wages, benefits, and compensation negotiated and funded each biennium, including but not limited to:

- (i) Regular wages;
- (ii) Benefit pay, such as vacation, sick, and holiday pay;
- (iii) Taxes on wages/benefit pay; and
- (iv) Mileage; and

(b) The increase in the average cost of worker's compensation for home care agencies and application of the increases identified in (a) of this subsection to all hours required to be paid, including travel time, of direct service workers under the wage and hour laws and associated employer taxes.

(2) The contribution rate for health care benefits, including but not limited to medical, dental, and vision benefits, for eligible agency home care workers shall be paid by the department to home care agencies at the same rate as negotiated and funded in the collective bargaining agreement for individual providers of home care services.

NEW SECTION. Sec. 2. For the fiscal year ending June 30, 2007, the per-hour amount added to the home care agency vendor rate pursuant to section 1(1)(a) of this act shall be limited to the cost of: (1) A \$0.02 per-hour increase in wages, plus the employer share of unemployment and social security taxes on the amount of the increase; and (2) the cost of annual leave benefits negotiated and funded for individual providers of home care services. This section expires June 30, 2007.

NEW SECTION. Sec. 3. This act takes effect July 1, 2006.

CERTIFICATE OF SERVICE

I hereby certify that on this day, I caused a true and complete copy of the following document(s) to be served on the following persons in the manner indicated below:

**TABLE OF AUTHORITIES
To Petition for Review, Case No. 31509-6-III**

TO:

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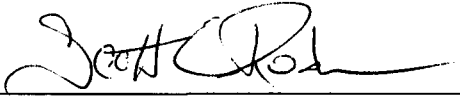
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DATED this 28th Day of August, 2015



Scott E. Rodgers, WSBA No. 41368
Rodriguez Interiano Hanson & Rodgers PLLC
Attorneys for Plaintiffs

AUG 31 2015

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

CERTIFICATE OF SERVICE

I hereby certify that on this day, I caused a true and complete copy of the following document(s) to be served on the following persons in the manner indicated below:

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PETITION FOR REVIEW Washington State Supreme Court
Case No. 31509-6-III

TO: **SEP - 3 2015**

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Original plus one copy

Ronald R. Carpenter
Clerk

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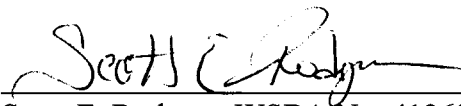
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DATED this 27TH Day of August, 2015



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