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NO. 63568-9

COURT OF APPEALS, DIVISION ONE  
STATE OF WASHINGTON

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

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NICHOLE POLETTI,

*Appellant,*

vs.

OVERLAKE HOSPITAL MEDICAL CENTER, and KING COUNTY

*Respondent.*

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Consolidated Reply Brief of Appellant

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## I. INTRODUCTION

Appellant Nichole Poletti submits this consolidated Reply Brief in response to the briefs filed by both Respondent Overlake Hospital Medical Center (“Overlake”) and by King County. Appellant seeks reversal of the orders granting summary judgment to defendants King County and Overlake Hospital Medical Center and remand of the case for further proceedings.

Defendants Overlake and King County persist in making unpersuasive technical arguments instead of focusing on the real issues in the case. Defendants are collectively responsible for carrying out the duties set forth in the civil commitment statute, RCW 71.05.050. Although not directly addressed by Overlake in its Brief, it had the statutory authority to detain Sherri Poletti for up to *six hours* pending a mental health evaluation by King County. Overlake should have ordered a commitment evaluation and had the right to hold Poletti for up to six hours to get the examination done. Overlake is liable for failing to do so.

The facts are that Overlake did attempt to obtain an examination by calling King County, although it is also a fact that Overlake through nurse Short failed to convey critical information to King County. But once Overlake made that call (which was a “referral” no matter what the appellees called it), the King County Designated Mental Health

Professional (“CDMHP”) should have come out and performed an evaluation of Sherri Poletti. Instead, King County, through Joseph Militello, its CDMHP, performed an evaluation over the phone and then told nurse Short of Overlake in no uncertain terms that he would not commit Poletti based on the information nurse Short had provided.

It was New Years Eve, and perhaps Mr. Militello did not want to make the trip to Overlake to see Sherri Poletti. But by his own admission, it is inappropriate for a CDMHP to make a commitment decision without seeing the patient. Defendants concede that nurse Short and Mr. Militello talked about Sherri Poletti for over 20 minutes. And it was only at the end of that conversation when Mr. Militello told nurse Short that he would not commit Sherri Poletti that Overlake “stopped” considering detention.

The civil commitment statutes exist both to protect the rights of the mentally ill and to protect public safety. Both Overlake and King County failed to discharge their duty consistent with these objectives. Neither Overlake nor King County can seriously contend that Sherri Poletti should have been driving a car in her condition on New Year’s Eve, December 31, 2006.

She was, at the time of her discharge, gravely disabled, and presented an imminent risk of harm to herself and others, a fact borne out by her death in a one car accident only a few hours after discharge. Both

Overlake and King County were aware that for the week before admission she had been driving aimlessly throughout Washington, Oregon and Canada, in the belief that she was being followed by tracking her tooth, without rest and without her anti-psychotic medication.

Overlake and King County relied in their determination that Poletti did not pose a risk of harm to herself or others on the fact that Poletti told nurse Short that she was going to take a cab home. Indeed, both Overlake and King County now argue that the fact that Poletti was taking a cab was a key feature in the plan for her to get home *safely*.

And yet, while it seems obvious, neither Overlake nor King County considered that it was probable that Poletti would take a cab home, get back in her car, and resume exactly the same dangerous behavior (driving aimlessly while exhausted and in the belief that she was being tracked by her tooth) that she had exhibited in the prior week.

At the time of Poletti's discharge, the following are the operative facts which bear upon the question of whether she presented a danger to herself and others and whether she was gravely disabled.

- Sherri Poletti was evaluated at Overlake at 1:00 pm the day of discharge by a physician (Dr. Koenig) who determined that she "currently" met the criteria for detention. CP 127.

- Sherri Poletti was continuing to refuse to take her anti-psychotic medications while at Overlake. CP 127.
- Sherri Poletti had reported at Overlake at 8:30 am the day of discharge that she had “sores” around her eyes which was a delusion because she did not have any sores. CP 123.
- Sherri Poletti had a documented history of treatment for mental illness including a history of refusing to take medication. CP 119, 127.
- Sherri Poletti had not slept for several days at the time of her admission to Overlake. CP 119.
- Sherri Poletti had—for five days before her admission to Overlake—been *driving* aimlessly throughout Washington, Oregon, and Canada in a sleep-deprived attempt to elude people who she thought were after her. CP 119.
- Sherri Poletti and was having thoughts of suicide while at Overlake. CP 119, 127.
- Sherri Poletti believed that the people who were after her could follow her using her tooth. CP 125.
- Sherri Poletti would more likely than not continue to have the same type of hallucinations and delusions as she had

been having the week before admission to Overlake as long as she avoided her medication. CP 140.

Defendants should have concluded that if she was going to get in a car, Poletti plainly posed an “imminent likelihood of serious harm” to herself and others and was “gravely disabled” and should not be driving a car at the time of discharge. No reasonable person with knowledge of her condition would have ridden as her passenger if she was driving. No reasonable person, knowing of her mental condition, would voluntarily choose to be travelling on the same road with her. And Overlake discharged her only because she was taking a cab home. Both defendants are liable for their failure to carry out the duties set forth in RCW 71.05.050.

Both Overlake and King County argue that Sherri Poletti’s one car accident four hours after her discharge from Overlake was “just an accident” and that there is no causal link between the accident and Overlake’s decision to discharge her AMA. Again, defendants exalt form over substance. Causation can be established by circumstantial evidence, and there is no shortage of that evidence here.

Neither Overlake nor King County point to any mechanical defect with the Poletti vehicle, nor can they point to any road defect— so the accident is plainly related to operator error. Overlake notes that the

investigating officer determined that Poletti fell asleep, which a jury could easily conclude was a result of her ongoing sleepless battle with her psychotic episodes. In other words, Overlake's argument that the likely cause of the accident was that she fell asleep is hardly exculpatory. To the contrary, a reasonable jury could easily conclude Overlake should not have discharged Poletti in part because she was simply too physically exhausted from her psychotic episodes to drive and was for that reason "gravely disabled".

Alternatively, a reasonable jury could conclude that Sherri Poletti died because she was suffering delusions and thought she was being followed because people were tracking her tooth, a mental condition which impaired her driving. In that regard, Overlake conceded that her delusions were more likely than not to continue as long as she was not medicated. Again, because Sherri Poletti was likely to suffer hallucinations, it is self evident that she should not have been driving, and that she presented an imminent risk of harm both to herself, and to any other drivers in proximity to her. It is incomprehensible that Overlake or King County would think it acceptable for her to get back behind the wheel of a car, and yet neither considered that it was probable that Sherri would do just that, considering that she had a five day history of driving while exhausted, unmedicated and delusional.

In short, defendants proximate cause arguments fail because a jury could easily conclude based on the totality of the evidence before the Court that Sherri Poletti's death was not the result of a mere accident, but rather that a proximate cause of her death was the appellees' failure to implement the provisions of RCW 71.05.050, involuntarily detain her, and thereby keep her from driving in an impaired condition, exhausted, delusional and unmedicated.

Finally, defendants ignore that their duty was to protect not only Sherri Poletti but also the public. Only Sherri Poletti was killed on New Year's Eve. But had there been an oncoming car when she crossed the centerline, the tragedy could have been much worse. The point is that she was gravely disabled, should never have been driving and was an imminent danger to herself. Defendants should have held Poletti for a commitment examination on New Year's Eve. Instead, Overlake and King County combined to release her, she went home, got in her car, and four hours later she was dead.

## II. REPLY ARGUMENT

### A. Overlake Breached Its Duty When It Discharged Sherri Poletti On New Year's Eve, 2006.

#### 1. Overlake Misstates the Applicable Legal Standards.

Overlake implies throughout its brief that only King County could involuntarily detain Sherri Poletti and that when Sherri Poletti told nurse Short she wanted to leave Overlake, nurse Short had little choice in the matter. Overlake Brief at 5, 6, 10.

But Overlake plainly misstates its duty under the civil commitment statute. As pointed out by King County in its brief, in the first instance, it is the professional staff of a private agency or hospital that have the legal authority to detain a voluntarily admitted patient *for up to six hours* pending investigation through the hospital's referral to a CDMHP. RCW 71.05.050; *see also* King County Brief at 4.

When Overlake learned that Sherri Poletti wanted to leave, even though she was not taking her medications, Overlake did not, as it now argues, simply have to let her go. Rather, Overlake had not only the right, but the duty, to ask for an evaluation by King County, and to hold Sherri Poletti for up to six hours while that was done.<sup>1</sup>

## **2. Overlake Grossly Mishandled Sherri Poletti's Discharge.**

Even Overlake concedes that it would have been in Sherri Poletti's best interest to stay at Overlake to receive treatment, including working

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<sup>1</sup> Overlake now argues that nurse Short "attempted to persuade Ms. Poletti to stay," but that "nurse Short cannot force a patient to stay in the hospital." Overlake Brief at 5. Overlake is simply wrong. It had the legal authority to detain Sherri Poletti for up to six hours pending an evaluation, and that is exactly what it should have done.

with her medications and receiving psychiatric support. Overlake Brief at 5-6.

Overlake's decision to discharge Sherri Poletti against medical advice rather than holding her for an evaluation had tragic and avoidable consequences.

Overlake admitted Sherri Poletti early in the morning of December 31, 2006 and discharged her shortly after 7 p.m. that night. Remarkably, the only doctor at Overlake who examined Sherri Poletti while she was at Overlake on December 31, 2006 was Dr. Kelen Koenig. Dr. Koenig thought that Poletti should be evaluated if she did not start taking her medication and that she "*currently* met the commitment standards". CP 127 (emphasis added).

Overlake attempts to ignore this critical evidence and does not even discuss until page 38 of its Brief the undisputed fact that Dr. Koenig saw Poletti on December 31, 2006 and determined that she "currently" met the test for civil commitment.<sup>2</sup>

Overlake now argues that Dr. Koenig's opinion would not have mattered anyway because he could not make the determination to commit Ms. Poletti. Overlake Brief at 38. But Overlake is wrong on that score as

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<sup>2</sup> Overlake ignores other critical evidence of Poletti's condition as well. For example, Poletti reported sores around her eyes at 8:30 AM on the day of discharge. CP 123. Plainly this was a delusion. Similarly, on admission, Poletti was noted to be paranoid. CP 123.

well because Dr. Koenig would have been well within the statutory authority granted to hospitals to refer her to King County for evaluation and to order her held for six hours pending an evaluation.<sup>3</sup>

Of course, Dr. Koenig did not make an order for six hour detention to hold Sherri Poletti pending an evaluation, because he was never called by nurse Short and told that Sherri Poletti wanted to leave, which is just one of Overlake's many acts of negligence involving Poletti's discharge. CP at 137.

Overlake fails in its Brief to explain why nurse Short did not call Dr. Koenig to discuss Poletti's request for discharge. Moreover, despite the risk that Poletti might seek a discharge, Overlake fails to explain in its Brief why it did not have a system in place to notify and provide nurse Short with access to Dr. Koenig's report which was still in dictation, given that the report contained key information indicating that Poletti met the criteria for civil commitment.<sup>4</sup> Incredibly, the opinion of the only

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<sup>3</sup> Dr. Koenig's note indicates that Poletti "endorses paranoia and suicidal ideation;" that she acknowledged "bi-polar disorder and psychosis, but is resistant to taking medications" and continuing to decline taking them. CP 222-223. Because of that, Dr. Koenig concluded that Poletti then met "MHP criteria due to psychosis and suicidal ideation with a recent suicide attempt". CP at 223. Poletti reported that she "does endorse current delusions, "people can follow me using my tooth,..." CP 220.

<sup>4</sup> The transcription of Dr. Koenig's report was completed at 6.50 p.m. on December 31. CP 225. Dr. Koenig left duty at 5.00 p.m. that day. CP 137. nurse Short failed to track down the report in which Dr. Koenig stated that Poletti "currently meet[s] MHP criteria due to psychosis and suicidal ideation..." CP 223, and therefore did not reveal Dr.

physician to actually examine Sherri Poletti on the day of discharge was ignored, with tragic results.<sup>5</sup>

Overlake concedes that nurse Short did not review Dr. Koenig's report, but suggests that nurse Short conducted her own examination and that she thought the criteria for commitment were not met.<sup>6</sup> But the truth is that Nurse short was unsure of what to do, which is why, when Sherri Poletti requested discharge, nurse Short asked the on call physician what to do. Again Overlake's Brief ignores this important evidence as well: *nurse Short was told by the attending physician to get an evaluation.* CP 137.

Nurse Short then got on the phone with the CDMHP, Joseph Militello and conversed for over 20 minutes. Nurse Short had not made

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Koenig's evaluation to the CDMHP. Moreover, Overlake does not explain why, by the time of nurse Short's discharge note at 7.15 p.m., she had not reviewed Dr. Koenig's now transcribed examination report which was completed twenty five minutes earlier. Nurse Short testified that she "was not aware" that Dr. Koenig wanted Poletti to be evaluated by a CDMHP. Short dep. At 57:4-8, CP 57. A jury could easily conclude that both she and King County would have acted differently had they reviewed the contents of Dr. Koenig's transcribed report.

<sup>5</sup> Overlake also argues that Dr. Koenig's evaluation was not "current" when Sherri Poletti requested discharge. But Overlake fails to demonstrate what had changed between the time of the Koenig evaluation and the request for discharge. Overlake presents no evidence that Sherri Poletti resumed her medications, provides no record support for the claim that Poletti got significant sleep, and even nurse Short admitted that Poletti was more likely than not going to continue to hallucinate if she did not resume her medication. CP 140.

<sup>6</sup> It also seems obvious that had nurse Short looked at Dr. Koenig's report, she would have called him and/or brought the report to either the attending physician, the CDMPH or both. It is hard to imagine that Mr. Militello would have cavalierly dismissed commitment of Poletti if confronted by the Koenig report.

up her mind about whether Poletti met the criteria for commitment before the call to Militello as King County now claims. King County Brief at 12. Rather, nurse Short was instructed to call the CDMPH at the order of her superior, and nurse Short dropped the idea of commitment only after CDMPH Militello told her in no uncertain terms that he would not commit Poletti.<sup>7</sup>

Overlake also argues that nurse Short evaluated Sherri Poletti in a manner “purposefully structured” to determine whether Sherri Poletti posed a threat to herself or others. Overlake Brief at 5. But, among other things, nurse Short claims to have been impressed with Sherri Poletti’s “plan once she left the hospital, *which included taking a cab to get home safely....*” Overlake Brief at 6.

Overlake was aware that before admission, Poletti had been driving aimlessly for five days, hallucinating, with suicidal ideation, and off her medication. Overlake’s decision to discharge Poletti AMA appears to be based largely on the belief that because she was taking a cab home, Poletti posed no threat of imminent harm because she would not be driving. Indeed, Overlake’s indifference to the risk that Poletti would

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<sup>7</sup> Nurse Short and Dr. Mathiasen, the doctor on duty, discussed Ms. Poletti’s mental status and Dr. Koenig’s earlier evaluation of Ms. Poletti. CP 137. As the end of that discussion, Dr. Mathiasen directed nurse Short to call the CDMHP, Mr. Militello, for an evaluation. CP 137.

drive was such that Overlake and nurse Short failed to even provide the warnings about driving that would have been required under Overlake's policy for discharge AMA. CP 138-39.

**3. Overlake's Claim That The Expert Opinions Offered By Plaintiffs Were Insufficient Should Be Rejected.**

Overlake's Motion for Summary Judgment in the trial court rested in large measure on the technical claim that plaintiff's experts testimony should be excluded for lack of foundation. Plaintiff proffered the testimony of Dr. Bruce Olson, Ph.D., a psychologist *and former CDMHP for Snohomish County*, to testify on the standard of care required of Elaine Short, R.N., while fulfilling her duties as a "mental health professional" or a "professional person" as defined at RCW 71.05.020(25) and RCW 71.05.020(28), respectively. Plaintiff also submitted the declaration of Dr. G. Christian Harris, Ph.D., a psychiatrist, for the same purpose.

Overlake continues to argue Dr. Olson is not qualified to testify as to nurse Short's duties as a mental health professional as defined in RCW 71.05 *et. seq.* Overlake does not dispute that Dr. Olson is familiar with the procedures relevant to civil commitment under the statute, and Overlake cannot seriously contend that Dr. Olson lacks that knowledge of how mental health professionals should perform in satisfying the statute since he has served as a Snohomish CDMHP.

Instead, Overlake argues that there is a distinction between nurse Short's title and license as a Psychiatric Nurse and Plaintiff's experts, who are doctors. In particular, Overlake relies on *Davies v. Holy Family Hospital*, 144 Wn.App. 483, 183 P.3d 283 (2008) to support its argument that plaintiff's experts were not qualified to testify. However, when taken in the context of nurse Short's actions relative to Ms. Poletti, *Davies* stands for the opposite proposition— that because Plaintiff's experts Olson and Harris were both “mental health professionals” under RCW 71.05 *et. seq.*, they were qualified to testify on the standard of care for a mental health professional.

*Davies* goes further to say that “a physician with a medical degree will ordinarily be qualified to express an opinion with respect to any medical question, including areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the...problem at issue in the action.” *Davies*, 144 Wn.App. at 494 (citing *White v. Kent Med. Ctr., Inc.*, 61 Wn.App. 163, 173, 810 P.2d 4 (1991)). Dr. Harris is a medical doctor who has experience in professional evaluation. By the same reasoning, Dr. Olson, as a former CDMHP, obviously has the requisite expertise to demonstrate familiarity with nurse Short's duties under the statute.

Moreover, the facts of both *Davies* and *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 770 P.2d 182 (1989), also relied on by Overlake, are inapposite. *Davies* involved a radiologist opining on a nurse's response to a patient's internal bleeding. *Davies*, 144 Wn.App. at 488, 183 P.3d at 286. *Young* involved a pharmacologist opining on a doctor's actions. *Young*, 112 Wn.2d at 232-33, 770 P.2d at 191. Here, Olson and Harris are both mental health professionals opining on another mental health professional in connection with the proper steps to follow for a civil commitment evaluation. Overlake's suggestion in particular that Dr. Olson, who has actually worked as a CDMHP, lacks the knowledge to opine on nurse Short's actions under the statute is unfounded.<sup>8</sup>

Overlake mischaracterizes the issues with regard to nurse Short's duties pertinent to this case. Overlake claims that what is at issue are her general duties as a psychiatric nurse. Overlake concedes that, as a psychiatric nurse, she is "concerned with the scientific application of principles of care related to the prevention of illness and care during illness." Overlake Brief at 12. But nurse Short's "prevention of illness" or general treatment of Ms. Poletti is not the issue Dr. Olson is testifying about. Rather, the issue that Dr. Olson addressed is nurse Short's duties

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<sup>8</sup> While Overlake attempts to color this fact as a "new argument" raised on appeal, in his February 13, 2009 declaration Dr. Olson clearly states "I have...worked as a county designated mental health professional, as that term is defined in RCW Chapter 71.05."

under RCW 71.05 *et. seq.*, specifically her failure to procure an evaluation under the six hour rule allowed to secure an evaluation under RCW 71.05.050. Dr. Olson is certainly qualified to testify to nurse Short's duties as a mental health professional under RCW 71.05, and any argument by Overlake about that testimony fairly goes to weight, but not admissibility.

**B. King County's Attempt To Gloss Over The Factual Issues Concerning Its Involvement In the Decision to Release Sherri Poletti Should Be Rejected.**

King County concedes that Overlake's nurse Short had a phone conversation with King County Designated Mental Health Professional Joseph Militello before Overlake released Poletti AMA.

King County argues as a *factual contention* that in an exercise of her "independent professional judgment, nurse Short did not consider Ms. Poletti detainable under the required legal criteria of RCW 71.05 when the discharge occurred." King County Brief at 2.

King County then argues that it had no duty to Ms. Poletti because nurse Short only engaged in a "consultation" but did not make a "referral," that a "referral" is a term of art triggering King County's duty,<sup>9</sup> and that

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<sup>9</sup> King County contradicts the legal position taken by Overlake, and points out, correctly, that, "only professional staff of a private agency or hospital has the legal authority to detain a voluntarily admitted patient like Ms. Poletti pending investigation through the hospital's referral to a CDMHP." King County Brief at 1, #4.

“no duty was owed [by the County] because the undisputed evidence was that **in nurse Short’s independent professional opinion, Ms. Poletti did not meet the statutory criteria...to detain and make a referral.**” King County Brief at 12. (emphasis added).

But there are distinct factual issues precluding King County’s argument for purposes of summary judgment. King County ignores the evidence in the record that nurse Short initially called the CDMHP for an “evaluation” after she spoke with the on-duty psychiatrist at Overlake, Dr. Mathiasen, who indicated that she should request an evaluation and “[t]hat’s what we did when we called the MHP’s.” Short Depo. at 14:19-20; 21-24, CP 55. (Emphasis added).

King County concedes that nurse Short’s conversation with the CDMHP, Mr. Militello, lasted “maybe 20 minutes or so.” Militello dep. at 92:8-9, CP 80. And while King County claims that nurse Short had independently determined that Ms. Poletti did not meet the criteria for involuntary detention *before* the call, the facts indicate quite the opposite.<sup>10</sup>

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<sup>10</sup> King County’s claim that nurse Short had her mind made up before she called King County is disputed not only by plaintiff but also by Overlake. *See e.g.* Overlake Brief at 6.

As nurse Short testified:

I called the mental health professionals saying there are concerns. These are what we're seeing, and the comment back is we do not have enough criteria to detain her. We will not detain her. *So that's where we stopped.* (CP 68) (emphasis added).

King County did not properly act on the referral. Indeed, Militello set the bar for the standard of care in his own deposition when he testified that it is inappropriate to make detention decisions over the phone. Militello dep. At 98:8-9, CP 86. Were he to make an evaluation, he would be *assessing credibility* and because of that a personal examination is required. *Id.* at p. 99:17-19, CP 87. (emphasis added)

But despite his own testimony that it was improper to do so, the fact is that Militello did make a commitment decision over the phone and his notes of his conversation with nurse Short confirm that fact: “I **validate Elaine’s [Short] assessment** in how pt. is currently presenting at OMC, and I point out that if pt., as Elaine expects she will, presents to MHPs as she is currently presenting, we would not have evidence to detain...” CP 88. (emphasis added).

C. **Defendants Causation Argument Should Be Rejected Because There Was Substantial Circumstantial Evidence To Support the Element of Proximate Cause To Go To A Jury.**

Defendants argue that Plaintiff raised insufficient evidence to show that Defendants’ actions caused the death of Ms. Poletti. Defendants’

ignore the substantial evidence raised by Plaintiffs, especially when such evidence is considered in a light most favorable to Plaintiffs, and when considered relative to the lack of any other evidence of the cause of the crash. Proximate cause is a question of fact, and may only be determined as a matter of law if “reasonable minds cannot differ.” *Hertog ex rel. S.A.H. v. City of Seattle*, 138 Wn.2d 265, 275, 979 P.2d 400, 406 (1999) (citing *Sherman v. State*, 128 Wn.2d 164, 183, 905 P.2d 355 (1995)).

“Plaintiff need not establish causation by direct and positive evidence, but only by a chain of circumstances from which the ultimate fact required is reasonably and naturally inferable.” *Attwood v. Albertson’s Food Centers, Inc.*, 92 Wn.App. 326, 331, 966 P.2d 351, 353, (1998). Proximate cause may be proven by circumstantial evidence. *Ripley v. Lanzer*, 215 P.3d 1020, 1026 (2009). Causation must not be mere speculation, but “must be based on circumstances from which the ultimate fact required is reasonably and naturally inferable.” *Conrad ex. Rel. Conrad v. Alderwood Manor*, 119 Wn.App. 275, 281, 78 P.3d 177, 181 (2003).

Contrary to Defendants’ assertions, ample evidence exists in the record which would lead a reasonable person to believe that Ms. Poletti’s accident was caused by her impaired condition, and, consequently, the defendants’ collective negligence.

Defendants cite no evidence in the police investigation of mechanical failure nor was there any evidence that adverse weather played any role in Poletti's death.<sup>11</sup> It also appears from the police report that where Poletti was driving the road was "straight and level" and that she was 'going straight ahead" when she failed to take a slight turn to the right. CP 31, 33.<sup>12</sup> The responding police officer concluded that, based on the evidence at the scene, the cause of the accident was that the driver probably fell asleep. CP 31, 33.

This conclusion does not exculpate Overlake. Overlake was aware that Poletti was likely to drive while hallucinating for days on end, endangering her life in the process. Overlake was aware that Poletti had not slept in days. The reasonable inference is that Poletti, "gravely disabled" and also suffering from lack of sleep, fell asleep, went off the road, was startled and over-corrected in the other direction causing the crash.

Alternately, one could reasonably infer that the accident was caused by Poletti's delusional attempts to evade the people who were after her. Overlake was aware that Poletti had been hallucinatory prior to admission to the hospital, and that such hallucinations were likely to

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<sup>11</sup> The police report, CP 31-33, states that the road surface was dry and that it was overcast. See boxes 1 and 2, left side of CP 31, and glossary to same, CP 33.

<sup>12</sup> See police report at boxes 6, left side of CP 31, and box 29, right side of CP 31 and glossary to same, CP 33.

continue. nurse Short acknowledged in her deposition testimony that Poletti was not taking anti-psychotic medications, a point observed by Dr. Koenig a few hours before Poletti's discharge AMA. Short dep. at 50:21-23, CP 140. She further testified:

Q. If they're not on medication, isn't it likely that they're going to have hallucinations again?

A. Most people who present having auditory hallucinations, if gone untreated, probably they're not going to go away unless it's sleep deprivation or a particular thing....

Q. Isn't there a high probability if someone has been having hallucinations and they aren't on their antipsychotic medication, that they will continue to have hallucinations?

A. Probably.

Short dep. At 53:8-54:1, CP 140-141.

In short, Overlake knew at the time of discharge, that Poletti was not taking her medications, and therefore would likely continue to have hallucinations. Overlake discharged Sherri Poletti even though she was hallucinatory, was likely to remain so, had been driving around for days, was sleep deprived and off her medications. Defendants offer no other possible cause of the accident, and a juror could easily find more likely than not that the failure to detain Poletti was a proximate cause of her death.

### **III. CONCLUSION**

For the above reasons, Appellant requests that the orders granting summary judgment to defendants King County and Overlake Hospital

Medical Center be reversed and that the case e remanded for further proceedings.

Dated at Seattle this 25<sup>th</sup> day of November, 2009.

**PETERSON YOUNG PUTRA**



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Michael A. Goldfarb, WSBA No. 13492  
Of Attorneys for Plaintiff

CERTIFICATE OF SERVICE

THE UNDERSIGNED, under penalty of perjury under the laws of the State of Washington, certifies that on the 25<sup>th</sup> day of November, 2009, she sent by ABC Messenger for same day delivery, addressed as follows:

Court of Appeals of the State of Washington  
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Documents sent:

1. Reply Brief of Appellant

SIGNED in Seattle, Washington this 25<sup>th</sup> day of November, 2009.

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Dana Vizzare