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No. 67821-3-I

COURT OF APPEALS
OF THE STATE OF WASHINGTON, DIVISION I

NICOLE POLETTI, as the Executor of the Estate of Sherri Poletti, Deceased,
Plaintiff/Respondent,

v.

OVERLAKE HOSPITAL MEDICAL CENTER,

Defendant/Petitioner,

and KING COUNTY,

Defendant.

BRIEF OF RESPONDENT NICOLE POLETTI

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BRIEF OF RESPONDENT

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I. INTRODUCTION

This wrongful death action arises out of Overlake Hospital Medical Center's ("Overlake's") complete, and ultimately fatal, failure to properly treat Sherri Poletti.¹ In Overlake's own words, it "failed tremendously" in its substandard care of Ms. Poletti. (CP 714) Accordingly, the trial court properly entered partial summary judgment denying Overlake statutory immunity under the Involuntary Treatment Act, RCW 71.05.120, ("ITA") and finding that Overlake breached the standard of care owed to Ms. Poletti.

Overlake concedes that Ms. Poletti, who suffered from bipolar disorder, was admitted to Overlake in a delusional, paranoid, and suicidal state after driving aimlessly without sleep or medication for nearly a week.² Overlake acknowledged the severity of Ms. Poletti's condition when it admitted her into its inpatient unit—a "crisis stabilization" facility that is reserved for patients who cannot be treated on an outpatient basis—and Ms. Poletti's attending physician quickly concluded that she was not fit to be released. Nonetheless, Overlake's staff committed a series of

¹ This is the second time this matter has been before this Court. Many of the key facts are addressed in the Court's earlier decision, *Poletti v. Overlake Hosp. Med. Ctr.*, No. 63568-9-1, 2010 WL 2028750 (May 24, 2010) (CP 720-744).

² Overlake concedes Sherri Poletti's delusional condition, including that she was off her medications, had been driving since December 25 and had not slept for several nights. (Overlake Brief at 4).

grave mistakes that resulted in both the on-call physician and the MHP being utterly misinformed as to Ms. Poletti's condition—including but not limited to the staff's failure to inform the on-call physician and MHP of the diagnosis and order of the attending physician (who was the on-call physician's superior) that Ms. Poletti *met the detention criteria*. As a result of these grave mistakes, Overlake's on-call physician was misled and ultimately discharged Ms. Poletti on the evening of December 31, 2006 (New Years Eve)—while still off her medications and less than 24 hours after she was admitted to Overlake. Once discharged, Ms. Poletti almost immediately resumed her delusional driving, fell asleep at the wheel, and died in a single-car crash that night.

Shortly before this case was scheduled for trial, the parties stipulated to stay the case and resolve, via summary judgment motions, the question of whether Overlake is entitled to statutory immunity under the ITA. This issue is significant because a plaintiff must prove gross negligence if ITA immunity applies, but only ordinary negligence if it does not.

After hearing both parties' arguments, the trial court agreed with Plaintiff that ITA immunity does not apply, and then granted partial summary judgment against Overlake on liability based on un rebutted evidence that Overlake breached the standard of care. The parties had

stipulated that the trial court's ruling would be presented to this Court for discretionary review pursuant to RAP 2.3(b)(4), and this Court granted review on that basis.

The trial court's summary judgment order should be affirmed for three reasons. First, Overlake is not entitled to ITA immunity, and the evidence at summary judgment abundantly supported a finding of liability against Overlake under the ordinary negligence standard. Second, even if the ITA immunized the physician's discretionary decision to discharge Ms. Poletti, it certainly did not immunize the negligent treatment and diagnosis that Overlake provided. Third, even if the ITA applies, the evidence at summary judgment also established Overlake's liability under the gross negligence standard.³ As described below, Overlake, primarily, through Nurse Elaine Short, committed multiple acts of negligence (and gross negligence) that provide overwhelming and un rebutted evidence more than sufficient to sustain the trial court's order.

To begin with, Overlake continues to misconstrue the limited immunity available under the Involuntary Treatment Act. Overlake not only ignores the rule that statutory immunity in derogation of common law

³ Since the trial court's ruling may be sustained on any ground, this Court may affirm without reaching the ITA immunity issue by finding that Plaintiff's un rebutted showing at summary judgment established that Overlake was grossly negligent.

is narrowly construed, but further ignores the text of the ITA which provides immunity only “for performing duties pursuant to this chapter.” There is only *one act* that a hospital can take pursuant to the ITA—the hospital “may detain [the patient] for sufficient time to notify the county designated mental health professional” (“MHP”) so that the MHP may conduct an in-person evaluation. RCW 71.05.050. The ITA simply provides corresponding immunity in the event a hospital like Overlake detains a patient until the patient can be seen by the MHP.

To be clear, the ITA provides immunity only where (1) the hospital determines that the patient meets the criteria for detention, and (2) the hospital detains the patient temporarily pending an MHP evaluation. In other words, the ITA provides immunity for the only act authorized by the ITA—temporary detention—but nothing more.

Here, Overlake’s treatment of Sherri Poletti did not implicate the ITA because Overlake did not “detain” her. Overlake implicitly conceded the narrow scope of the ITA and that “detention” was required, which is why a few days before trial Overlake began claiming (contrary to its long-stated position) that it had “detained” Ms. Poletti. But Overlake’s last minute attempt to shoehorn itself into the ITA failed at the trial court because there was no evidence at all of any “detention,” and any claim of

detention was directly at odds with Overlake's prior written statements to both the trial and appellate court that she was never "detained."

Second, even if Overlake's broad reading of the ITA immunity were adopted, at most only the discretionary detention decision would be immunized, but Overlake cannot seriously suggest that the ongoing negligence that began with the failure to monitor shortly after admission is also immunized. Overlake's position throughout this case (even when it started claiming "detention," and even now) is that it never regarded Ms. Poletti as "detainable." If, as Overlake now claims, the ITA applies to treatment decisions where the hospital does not regard the patient as meeting the detention criteria, then there is no end to the application of ITA immunity, and a hospital could argue that any treatment and/or failure to diagnose the patient that ultimately led to discharge without detention for an ITA evaluation was immune under the ITA.

In particular, Overlake is required by several provisions of state law to implement procedures that establish the standard of care for its psychiatric practice. *See, e.g.*, WAC 246-320-136. Overlake concedes it implemented policies and procedures that set the standard of care, including procedures that address what the standard of care requires for a psychiatric patient that is to be discharged "against medical advice" ("AMA"). If Overlake can claim blanket ITA immunity for voluntarily

treating Ms. Poletti and consequently does not have to meet the standard of care set forth in those statutorily mandated standard-of-care policies, then the narrow immunity in the ITA would swallow the entire standard of care applicable to in-patient psychiatry, rendering those policies and the controlling law moot.

Some examples from this case prove the point. Overlake has admitted, through its 30(b)(6) representative, a series of negligent acts, the first being a failure to monitor Sherri Poletti every half hour as required by Overlake procedure. Overlake's failure to monitor began several hours after admission, and well before any discussion of AMA discharge. Yet, under Overlake's expansive reading of the ITA, Overlake asks this Court to rule that its failure to monitor Sherri Poletti was covered by the ITA, and subject to the gross negligence standard. In addition, here two different Overlake psychiatrists gave an order that Sherri Poletti be referred for an MHP evaluation. Overlake's Dr. Koenig did so in his evaluation report after spending an hour with Sherri Poletti. ("If the patient persists in not taking psychiatric medications she *will* be referred to the mental health professional for an involuntary assessment. The patient is felt currently to meet MHP criteria. . . ") (CP 623) (emphasis added). Later, Dr. Mathiasen, the on-call psychiatrist working from home, gave Nurse Short an order to obtain an MHP evaluation. Nurse Short flatly

disobeyed these instructions, first by negligently failing to obtain and read Dr. Koenig's report and second by simply ignoring Dr. Mathiasen's order. Overlake's claim that Nurse Short's admitted negligence in treating Sherri Poletti should be immunized goes far beyond the purpose of the limited immunity afforded by the ITA.

Similarly, Nurse Short negligently failed to properly warn Ms. Poletti of the risks of discharge, an error that took place *after* the decision to discharge was made. However broadly Overlake would like to read the Act, it cannot possibly immunize Overlake's negligence committed *after* Overlake declined to apply the ITA.

Finally, although the trial court properly determined the scope of the ITA, there was also substantial, unrebutted evidence of Overlake's negligence—and gross negligence—sufficient to sustain the trial court decision even under a gross negligence standard.

II. STATEMENT OF THE CASE

A. Factual History

Sherri Poletti was a 58-year-old mother of three who suffered from bipolar disorder. (CP 574). On or about Christmas Day 2006, she began driving without sleep and off her medications through Washington, Oregon and Canada. *Id.* Late on the night of December 30, 2006,

desperate, exhausted and suicidal, Sherri Poletti voluntarily went to the Swedish Ballard Emergency Department. *Id.* The Swedish Ballard staff observed that Ms. Poletti was complaining of sores around her eyes that did not exist; that she had paranoid thoughts about people reading her mind and following her; that her aimless driving was intended “to get away from people who are after me;” that she had recently attempted suicide by overdosing on lithium; that she was considering another suicide attempt; and that she reported “not sleeping for past several nights.” *Id.* Ms. Poletti also explicitly told a nurse that she could not be trusted to give accurate information about how she was feeling: “when you are bipolar you don’t want to go off your meds, and you don’t want to tell anyone when you are having bad thoughts.” (CP 577).

Swedish Ballard recommended immediate inpatient treatment and Ms. Poletti agreed to voluntary admission. Because Swedish lacked a bed for Ms. Poletti, it referred and transported her to Overlake, where she was admitted by Dr. Kelan Koenig. (CP 592).

Overlake’s Policy and Procedure for admission to its psychiatric unit requires that the patient have an acute psychiatric condition that cannot be treated on an outpatient basis. (CP 582). Overlake concedes that Ms. Poletti met its admission criteria, and, indeed, Overlake’s experts

concede she met the criteria for ITA involuntary detention upon admission to Overlake. (CP 586; 590).

Overlake physically admitted Ms. Poletti at about 1:00 a.m. on December 31, 2006. Overlake's records demonstrate that, during the morning of December 31, Ms. Poletti was still delusional, paranoid, depressed and suicidal. (CP 592-96). Overlake also documented that she had a sleep disturbance ongoing for 3 months, that she could not fall asleep or stay asleep and that she was getting 2-4 hours of sleep a night. (CP 596). At 4:00 a.m. on December 31, Overlake's progress notes indicate Ms. Poletti was refusing medications and that her "good faith status [was] in question." (CP 598).

One Overlake policy, which sets a standard of care for the psychiatric unit, requires "close monitoring" of patients every 30 minutes until that schedule is changed by a physician. (CP 602-04). But Overlake only complied until 9:00 a.m., at which point close monitoring inexplicably stopped. (CP 614).

Dr. Koeing, the head of Overlake's psychiatric unit, was assigned as Ms. Poletti's "attending physician." At about noon on December 31, Dr. Koenig spent an hour or more performing a detailed psychiatric evaluation of Ms. Poletti. This was the only in-person evaluation that Ms. Poletti would receive from a physician while at Overlake.

At 4:32 p.m., Dr. Koenig dictated a six page evaluation summary, which noted that Ms. Poletti was off her medications, that she endorsed paranoid delusions including that “people can follow me using my tooth,” that she was “fearful that others may harm her,” that “*she has ongoing suicidal thoughts*,” that she had previously overdosed on lithium, and that “she held a knife to her throat earlier in the year and considered stabbing herself.” (CP 620-25) (emphasis added). Dr. Koenig also performed a Global Assessment of Function, and Ms. Poletti scored 20-25 out of 100 (CP 624), a score indicating serious impairment of behavior, judgment, and ability to function outside of a hospital setting (CP 617). In addition to the excerpts that Overlake selectively includes in its brief, Dr. Koenig’s assessment also included this critical determination:

If the patient persists in not taking psychiatric medications *she will be referred to the mental health professional for an involuntary assessment*. The patient is felt currently to meet MHP criteria due to psychosis and suicidal ideation with a recent suicide attempt and a lack of compliance with voluntary care. (CP 623) (emphasis added).

Dr. Koenig ordered continued close monitoring, but that order too was not followed. As a result, Overlake admitted that “we have a gap in a pretty significant period of time where no one has anything - - where no one knows anything about this patient.” (CP 572).

Overlake had a nursing shift change at 2:30 p.m., and charge nurse Elaine Short came on duty. Nurse Short had had no prior contact with Ms. Poletti. Dr. Koenig went home at about 5:00 p.m. Another Overlake psychiatrist, Dr. Patrick Mathiasen, was the “on call” physician, but was not physically present at Overlake, and never met or even spoke with Ms. Poletti. (CP 607).

Shortly after Dr. Koenig left, Nurse Short was advised that Ms. Poletti was seeking discharge. At that point, Nurse Short became subject to another Overlake policy, which requires that “Patients in need of further psychiatric (inpatient) treatment, but who . . . do not consent to treatment, *will* be referred to the County Designated Mental Health Professional for immediate evaluation.” (CP 627-28) (emphasis added).

Overlake had already failed to monitor Sherri Poletti, so there was a dearth of information about her condition since she had been seen by Dr. Koenig at lunchtime. Nurse Short and Overlake then committed a series of additional negligent acts leading to Overlake’s failure to obtain an MHP evaluation and instead its discharge of Sherri Poletti.

First, Nurse Short was aware that Dr. Koenig’s detailed evaluation report was in dictation. But as Overlake admits, she violated the standard of care by making no effort to obtain the report or to “stall” the patient for additional time to get it, even though Overlake nurses are trained to do so

if necessary. (CP 570). As a result, no one making treatment decisions about Ms. Poletti knew that Dr. Koenig had determined that she met the commitment criteria as of 4:30 p.m., when Dr. Koenig dictated his report.

Second, without the benefit of Dr. Koenig's report, and without a thorough review of the chart, Nurse Short asked Ms. Poletti a few questions (CP 631-32), and reached the conclusion—directly contrary to that of Dr. Koenig—that Ms. Poletti was not detainable. (CP 634; 636). However, as this Court previously found, “[n]othing in the record indicates that anything had changed in Ms. Poletti's condition” since Dr. Koenig's diagnosis, “except for Nurse Short's opinion to the contrary.” (CP 738).

Third, Nurse Short then called Dr. Mathiasen, the “on call” physician. Dr. Mathiasen had not seen Ms. Poletti, had not reviewed her chart and was dealing with the question of how to proceed by phone. Because Nurse Short had not taken basic steps to learn the facts of Ms. Poletti's condition, she did not tell Dr. Mathiasen about her history of sleep disorder and sleepless driving, nor did she convey Dr. Koenig's detailed evaluation and conclusion that Ms. Poletti met the ITA detention criteria. Overlake agrees that the failure to communicate Dr. Koenig's findings to Dr. Mathiasen was a breach of the standard of care. (CP 557)

Contrary to Overlake's incomplete account, Dr. Mathiasen did more than merely "speak" with Nurse Short. As this Court noted in its last opinion, even with the incomplete history he was provided, Dr. Mathiasen did not believe Ms. Poletti should leave Overlake and gave a verbal *order* to Nurse Short to call the MHP to request an "evaluation" (CP 724).⁴ Nurse Short's duty, which she breached, was simply to follow Dr. Mathiasen's order, and the Overlake policy, by obtaining an evaluation from the MHPs. (CP 627-28; 710).

Fourth, however, Nurse Short again violated the standard of care when she failed to follow that order and the Overlake policy requiring a referral to the MHPs. Nurse Short called Joseph Militello, the on-duty King County MHP. But instead of obtaining an evaluation, Nurse Short engaged in a speculative "consultation," which is not a procedure countenanced by the ITA.⁵ Still worse, Nurse Short substituted her own judgment for Dr. Mathiasen's, and told Mr. Militello that *she* did not believe Ms. Poletti met the criteria for detention. (CP 634). Nurse Short also told Mr. Militello that Ms. Poletti had slept most of the day, which

⁴ "Evaluation" is a term of art under MHP procedures, and means an in-person investigation by the MHP to assess detainability. When a health care provider requests an evaluation, by law the MHPs cannot refuse. (CP 859).

⁵ Jean Robertson, the 30(b)(6) representative for King County, admitted that "the Involuntary Treatment Act does not talk about consultations." (CP 857).

Overlake now agrees was “irresponsible” given that there was no close monitoring and Overlake’s chart did not support that statement. (CP 567). As this Court previously noted and as Overlake has admitted, Nurse Short also failed to tell Mr. Militello other essential information, including that Sherri Poletti was off her medications, had been driving through Oregon, Washington and Canada in a delusional and psychotic state without sleep to get away from people she thought were following her, that there had been a recent suicide attempt, and that Dr. Koenig had evaluated the patient and concluded she was detainable. (CP 724; 648-51). Nurse Short also did not tell the MHP that Dr. Mathiasen had ordered Nurse Short to get an “evaluation.”

Based on the inaccurate and incomplete account that Nurse Short presented, Mr. Militello agreed that, in the hypothetical event that he performed an in-person evaluation, she would not be detained on those facts.

Fifth, Nurse Short then called Dr. Mathiasen again and told him erroneously that King County would not detain Ms. Poletti. In fact, King County never makes detention determinations on the phone, and Mr. Militello only gave a hypothetical response (a “consultation,” not an “evaluation”) about what might happen if he saw what Nurse Short was reporting. On the strength of Nurse Short’s representation to Dr.

Mathiasen that Ms. Poletti would not be detained, Dr. Mathiasen did not insist on a face-to-face evaluation. (CP 610). Dr. Mathiasen has testified that if he had been told that King County had no position on whether Ms. Poletti was detainable, than “it is more likely than not” that he would have insisted on a full MHP evaluation. (CP 611-12).

Sixth, at 7:10 p.m. on New Year’s Eve, Nurse Short discharged Sherri Poletti against Medical Advice pursuant to Dr. Mathiasen’s discharge order. When an AMA discharge is requested, Overlake policies require that staff confer with the patient; that the nurse’s supervisor be notified and involved; that the staff attempt to have a physician speak directly with the patient; and that the staff fully explain the risks before discharging a patient AMA. (CP 641-42). Overlake concedes that Nurse Short breached this policy by failing to adequately explain the risks to Ms. Poletti (including the risks of driving in her condition), by not involving her supervisor, and by failing to make efforts to involve a physician to speak directly to Ms. Poletti. (CP 554-55; 561; 565-66; 568). Instead, Ms. Poletti signed a form and left Overlake in a taxi, alone. She returned to Ballard, got in her car and resumed driving. About 11:00 PM she fell asleep at the wheel on a two lane highway near Olympia and died in the ensuing single-car accident. (CP 716).

B. Overlake's Admitted Breaches of the Standard of Care

The record before the trial court contained overwhelming evidence of negligence and more, a stunning lack of care—most of it coming in the form of the damning testimony of Overlake's own 30(b)(6) witness, Barbara Berkau.

Ms. Berkau, in addition to serving as Overlake's designated 30(b)(6) witness, is Overlake's Director of Nursing Operations, is Nurse Short's superior, and is a member of the committee charged with writing Overlake's policies (CP 550-51). At her deposition, Ms. Berkau confirmed that Overlake "failed tremendously" in its treatment of Ms. Poletti. (CP 714). Specifically, Ms. Berkau admitted:

- That the failure of Nurse Short to review the records from Swedish Ballard Emergency that were delivered to Overlake when Sherri Poletti was admitted was a breach of the standard of care. (CP 569).
- That the failure of the nurses on duty prior to Nurse Short to monitor and document Sherri Poletti in response to the monitoring orders was a breach of the standard of care (CP 572).
- That Nurse Short's failure to obtain Dr. Koenig's dictated report before speaking with Dr. Mathiasen was a breach of the standard of care. (CP 557).
- That Nurse Short's failure to document the risks of discharge with Sherri Poletti was a breach of the standard of care. (CP 558-59).
- That Nurse Short's statement made to King County MHP Joseph Militello, that Sherri Poletti had slept most of the day, was not supported by the Overlake chart, was "*irresponsible*" and was a breach of the standard of care. (CP 567) (emphasis added).

- That Nurse Short's failure to attempt to stall Sherri Poletti from seeking discharge in order to get additional information, including Dr. Koenig's report, was a breach of the standard of care. (CP 570-71).
- That Nurse Short's failure to notify her Clinical Manager, as required by Overlake's Policies and Procedures, was a breach of the standard of care. (CP 555-56)
- That Dr. Mathiasen's failure to personally discuss the risks of discharge with Sherri Poletti, even though he was available to do so, was a breach of Overlake's Policies and Procedures and a breach of the standard of care. (CP 565-66).
- That the failure of any Overlake staff person, including Nurse Short, to take any steps to encourage Sherri Poletti to speak with her physician before discharge was a breach of Overlake's Policies and Procedures and a breach of the standard of care. (CP 554; 568).
- That the failure of Overlake's staff to develop a plan for post-discharge safety was a breach of the standard of care. (CP 563-64).

Ms. Berkau also admitted that, in violation of Overlake's AMA discharge policy and in another "clear breach of the standard of care," Nurse Short failed to properly inform Poletti of the risks of the treatment option (immediate discharge) that Ms. Poletti was seeking. (CP 558-59). Specifically, Nurse Short failed to disclose the risks of driving, the risk of isolation at a holiday time; the risk of her sleep disturbance; the risk of going off of her medication; and the risk of injury to herself. (CP 560-

62).⁶ Finally, Plaintiff presented un rebutted expert testimony that the failure by Nurse Short to follow the physician's order was negligent and grossly negligent. (CP 704).

Finally, it is also undisputed that Nurse Short failed to follow the Overlake policy (required by the WAC) requiring that “[p]atients in need of further psychiatric (inpatient) treatment, but who . . . do not consent to treatment, *will* be referred to the County Designated Mental Health Professional for immediate evaluation.”) (CP 627-28) (emphasis added). As discussed below, Overlake's only defense to its failure to adhere to this policy is to now claim that its own policy is unlawful.

C. Procedural History

Plaintiff filed this lawsuit on March 4, 2008 against both Overlake and King County (who has subsequently settled). The complaint alleged gross negligence against the county but ordinary negligence against Overlake. (CP 9-10). Overlake asserted the ITA immunity provision in its sixth affirmative defense. (CP 17).

Early in the case, both defendants moved for summary judgment, claiming that Plaintiff lacked expert testimony to establish a duty and could not prove causation. The trial court granted summary judgment for

⁶ Ms. Berkau, in other words, admitted to all the facts necessary to establish liability on a theory of informed consent.

the defendants (CP 21-26), and Plaintiff appealed. The Court of Appeals reversed on May 24, 2010.⁷ Contrary to Overlake's account, the Court of Appeals did not rule on, or even address, the question of whether the ITA immunity provision applied to Overlake.⁸ Instead, the court only noted that Plaintiff was *alleging* conduct amounting to gross negligence, and held that Plaintiff had adequate expert testimony to take those allegations to a jury. (CP 729; 734-35).

As the case progressed toward trial, the question of ITA immunity became a central issue. Overlake apparently came to realize that its claim to immunity was tenuous at best, because it had never discharged a duty under the ITA. Thus, beginning with its opposition to Plaintiff's motions *in limine*, filed just a few days before trial was scheduled, Overlake abandoned its previous position that it did not—and could not—detain Ms. Poletti because its staff had not regarded her as detainable. Instead, Overlake now argued that Nurse Short “detained” Ms. Poletti under the ITA because she was not discharged immediately upon request. However,

⁷ *Poletti v. Overlake Hosp. Med. Ctr.*, No. 63568-9-1, 2010 WL 2028750 (May 24, 2010) (CP 720-44).

⁸ Plaintiff's appellate brief specifically noted that the question of whether Overlake possessed ITA immunity “was not developed or argued,” because the issue was “not pertinent to this appeal.” (Appellant's brief, No. 63568-9-1, Sept. 8, 2009, at 1 n. 1.)

no medical records, nor any witness testimony, suggested that Nurse Short took any action to detain or confine Ms. Poletti in any way. (CP 681-83).

Shortly before trial, the parties agreed it would be wasteful to try the case while it was uncertain what standard of negligence applied to Overlake. Therefore, the parties stipulated to an order staying the trial to allow the parties to address the ITA immunity issue through summary judgment motions. (CP 399-400). Plaintiff moved for partial summary judgment, alleging (1) that Overlake was not entitled to the ITA's immunity provision, and (2) that Nurse Short's failure to follow Overlake policy breached the standard of care as a matter of law. (CP 514-38). Plaintiff supported its motion with a gamut of evidence showing Overlake's extreme negligence, including the testimony of Ms. Berkau (CP 547-572), that of Plaintiff's expert Dr. Csaba Hegyvary (CP 714), and Overlake's own policies (CP 602-04; 627-28; 644-45).

Overlake simultaneously moved for summary judgment, arguing (1) that it was entitled to ITA immunity, and (2) that Plaintiff could not demonstrate gross negligence. (CP 401-415). In its briefing Overlake continued to make unsupported factual claims that Nurse Short "detained" Ms. Poletti. Plaintiff moved to strike the detention allegations as factually groundless. (CP 785-95). However, Overlake failed to raise any evidence showing that it had acted with due care.

At the summary judgment hearing on September 2, 2011, Judge Barnett sustained Plaintiff's objection to Overlake's detention argument, holding that Overlake lacked any evidence to support its allegations. (CP 905-08). Judge Barnett also concurred with Plaintiff that, because Overlake had never exercised any duties pursuant to the ITA, it was not entitled to the Act's immunity provision, meaning the ordinary negligence standard of medical malpractice would apply. (CP 909-10). Finally, Judge Barnett ruled that since state regulations required Overlake to develop policies that set the standard of care, Nurse Short's undeniable violation of the Overlake policy requiring a referral for psychiatric patients in need of but refusing treatment was un rebutted evidence of a breach of the standard of care, which entitled Plaintiff to summary judgment on liability. *Id.*

Overlake then sought discretionary review pursuant to the parties' stipulation, but also on the unfounded argument that the trial court's ruling was clearly erroneous. Commissioner Neel granted the petition for discretionary review pursuant to the stipulation only.

III. ARGUMENT

Overlake is subject to the ordinary negligence standard just like every hospital in Washington. RCW 7.70.030; WPI 105.02.01. Hospitals

also owe an independent duty of care to their patients, including the “duty to exercise reasonable care to adopt policies and procedures for health care provided to its patients.” WPI 105.02.02. Overlake has the burden of establishing the defense of ITA immunity. It cannot meet that burden as addressed below. But even if the ITA applies to Overlake’s misconduct, the evidence at summary judgment amply established Overlake’s liability under the gross negligence standard.

A. Overlake Failed to Carry the Burden to Establish Entitlement to ITA Immunity

The trial court correctly concluded that Overlake is not entitled to immunity under the Involuntary Treatment Act for the simple reason that it never undertook any involuntary treatment actions. The ITA expressly limits the grant of immunity to “duties pursuant to” the rest of the Act. RCW 71.05.120. And the *only* ITA duty a hospital may undertake is detaining a patient pending the arrival of an MHP. Having not performed any ITA duties, Overlake cannot avail itself of ITA immunity. Overlake apparently recognized this when it suddenly began making claims that Nurse Short detained Ms. Poletti, a groundless position that the trial court rejected and that Overlake has apparently abandoned on appeal.

Two threshold points underscore the trial court’s decision. First, statutory immunity is an affirmative defense, and it was Overlake’s burden

to demonstrate the immunity provision applies. *See Rideau v. Cort Furniture Rental*, 110 Wn. App. 301, 304, 39 P.3d 1006, 1007 (2002) (“The burden of avoiding liability . . . [is on] the party attempting to gain the benefits of statutory immunity from common law suit”).

Second, because the immunity provision is in derogation of the common law of negligence, it must be narrowly construed. *See Matthews v. Elk Pioneer Days*, 64 Wn. App. 433, 437, 824 P.2d 541, 543 (1992) (immunity provision “is in derogation of the common law rules of liability of landowners and occupiers. Statutes in derogation of the common law are *strictly construed* and no intent to change that law will be found unless it appears with clarity.”) (emphasis in original).

Overlake’s argument, that its discharge of a voluntary psychiatric patient should be subject to a gross negligence standard, misconstrues the ITA in several critical respects.

1. The ITA Expressly Limits Immunity to ITA Duties

Overlake consistently ignores the fact that the ITA only provides a defense against “liability for performing *duties pursuant to this chapter.*” RCW 71.05.120 (emphasis added). Since Overlake never undertook any such duty, it cannot find refuge under the ITA.

The Act imposes very different duties on different classes of actors (for example, hospitals, county MHPs, courts, state officials, commitment

facilities, and others), and the scope of immunity granted to each kind of actor depends on the scope of that actor's duties.⁹ In the case of a hospital like Overlake, the ITA only contemplates one duty: if a hospital "regards" a patient as meeting the detention criteria, it may detain the patient for a limited time until an MHP can evaluate the patient and determine whether further action is necessary. RCW 71.05.050.

Caselaw confirms that, to act under the ITA, a hospital must do at least two things: it must regard a patient as detainable, and must temporarily detain (*i.e.*, confine or restrain) a patient pending the arrival of an MHP. For example, in *Detention of C.W.*, the state Supreme Court confirmed that, even when a hospital has confined a patient, the procedures set out in the ITA do not begin until the moment when its staff regards the patient as detainable. *In re Det. of C.W.*, 147 Wn.2d 259, 53 P.3d 979 (2002) (so-called "pre-detention restraint" before hospital regards patient as detainable does not trigger ITA's six-hour time limit).

Here, there is some ambiguity as to whether Overlake "regarded" Ms. Poletti as detainable.¹⁰ But the distinction is immaterial because, as

⁹ In its first opinion, this Court noted that "the fact that these professionals [MHPs and psychiatric nurses] operate with the same concepts *does not mean that they have similar duties* under the ITA." (CP 732) (emphasis added).

¹⁰ Overlake continues to make the false claim that Nurse Short, who never regarded Ms. Poletti as detainable, was the real decision-maker. On the other hand, both Dr. Koenig and Dr. Mathiasen gave orders to obtain an MHP evaluation.

Overlake appears now to concede, it never detained Ms. Poletti and thus never undertook an ITA duty. The trial court correctly struck Overlake's claim that it detained Ms. Poletti as factually unsupported, and correctly held that neither the "consultation" call nor Ms. Poletti's discharge from voluntary care was not a "duty pursuant to" the ITA. Since it performed no ITA duties, Overlake's claim to immunity naturally fails.

2. Release of a Voluntary Patient is Not an ITA Duty

Overlake argues that the release of a voluntary psychiatric patient is always an ITA act that gives rise to immunity. These arguments would not only lead to the unwarranted outcome of immunizing virtually all of psychiatric medicine (as discussed further *infra*); they are also based on a misreading of the language and context of the statute.

Overlake first claims that every time it hospital releases a voluntary patient, it implicitly makes a decision not to detain that patient, and therefore earns ITA immunity. But Overlake's selective reading ignores that only ITA duties are immune. Some other actors, such as MHPs, are charged under the ITA with making involuntary treatment decisions. Thus, if an MHP is summoned under the ITA, evaluates a patient and decides not to detain, that decision is immunized because that decision was made by virtue of the MHP's statutory authority. But the same is not true for a hospital, because the decision to discharge a

voluntary patient is made within the hospital's role as a medical provider rather than as an ITA agent.

Overlake next argues is that it performed an ITA duty when it discharged Ms. Poletti upon her request. But as Overlake acknowledges, the obligation to release a patient stems not from the ITA, but from the fundamental principle that people normally cannot be held against their will—a principle embodied in constitutional due process, the tort of false imprisonment, etc. *See Jensen v. Lane County*, 312 F.3d 1145, 1147 (9th Cir. 2002) (“In general, due process precludes the involuntary hospitalization of a person who is not both mentally ill and a danger to one's self or others.”). Since this basic legal obligation is not a duty imposed by the ITA, it is not enough to trigger the liability exemption.

In sum, when a hospital discharges a patient but never initiates the procedure set out in the ITA, it has not undertaken a “duty pursuant to” the Act and there is nothing to immunize.

3. The ITA Term “Discharge” Does Not Apply to Voluntary Psychiatric Treatment

In another attempt to connect its actions to the ITA, Overlake grossly distorts the meaning of the ITA's defined term “discharge.” Overlake concedes that it did not “release” Ms. Poletti for ITA purposes, because it never held legal authority over her, but nevertheless claims to

have “discharged” her by terminating its medical relationship. However, within the Act, the term “discharge” was never meant to refer the discharge of a voluntary patient who was never detained, and Overlake’s attempt to shoehorn its way into the immunity provision fails.

The legislative history makes clear that within the ITA, the term “discharge” refers only to the discharge of patients who have *already been held* under the Act. The bill report for the 1987 amendment, which added “evaluation and treatment facilities” to the list of protected entities, explained that such facilities “are not civilly or criminally liable for the good faith *release of persons held under* the Involuntary Treatment Act, Chapter 71.05 RCW, if the release was done without gross negligence.” S. Bill Report, SSB 6048 (Wash. 1987) (emphasis added).

Overlake’s claim that the term “discharge” may apply to voluntary hospitalization, even though “release” applies only to ITA detention, is also flatly contradicted by legislative history. Prior to 2000, the immunity provision only included legal terms such as “release” (*i.e.* the termination of a commitment order¹¹), and not medical terms such as “discharge.” When the Legislature added “discharge” and other medical terms, it explained that this change was *not* meant to extend the scope of the Act. S.

¹¹ RCW 71.05.020(37).

Bill Report, HB 2520 (Wash. 2000) (“This is a technical bill and makes no substantive changes.”) Instead, the change was made to distinguish (primarily for billing purposes) between legal and medical terminology used for patients who were *already* being involuntarily treated under the ITA. See F. Bill Report, HB 2520 (Wash. 2000) (Describing bill as “Changing terminology in the *release from commitment* of persons *in mental treatment facilities*,” and noting that “[t]he definitions and uses of legal and medical terms involving individuals *served in state mental hospitals* are made consistent.”) (emphasis added).

Nowhere in the amendments, nor the legislative history, did the Legislature indicate that it intended to radically broaden the scope of the ITA to include immunity for the discharge of voluntary psychiatric patients who had never been involuntarily detained.

4. Overlake Cannot Justify Its Erroneous Interpretation on Public Policy Grounds

Finally, Overlake fails to establish a policy rationale for its misconstruction of the ITA. Overlake argues that the trial court’s interpretation of the Act would offer more protection for treatment providers who detain than those who did not. (It should come as little surprise that the *Involuntary Treatment* Act applies differently based on whether providers engage in involuntary treatment). But beyond merely

noting this asymmetry exists, Overlake fails to show that it is contrary to the Legislature's intent or otherwise undesirable from a public policy standpoint.

On the contrary, there is a significant policy interest in encouraging providers, via the grant of ITA immunity, to request ITA evaluations when they believe the criteria are met, even when that requires a temporary detention. This limited immunity encourages hospitals to have patients seen by MHPs who are both specially trained and authorized by state law to make treatment decisions, so it makes sense for the law to create incentives in favor of involving MHPs in questionable cases.

This narrow construction of hospital immunity under the ITA is also justified by the asymmetric nature of the risks involved in a hospital's detention decision. If a hospital decides to call an MHP, the only prospective harm is a few hours' detention pending the MHP's arrival. On the other hand, erroneously discharging a detainable patient poses a truly grave risk to that patient and others in the community, as the tragic outcome of this case demonstrates. An immunity scheme that favors evaluation in questionable cases and immunizes the hospital for doing so makes sense. Immunizing a hospital for negligently treating a psychiatric inpatient and then discharging them does not.

Finally, because MHPs only act through the ITA and are accordingly immunized regardless of the decision they make, the asymmetry Overlake complains of only exists at the first brief stage of the detention process. Thus, while involuntary detention is always a serious matter, it makes a great deal of sense for the Legislature to tailor a statutory scheme that encourages hospitals to involve the ITA professionals in ITA treatment decisions.

B. Even if the Decision to Discharge Were Covered by the ITA, Overlake's Other Negligent Acts Are Not

Overlake repeatedly argues that Nurse Short's alleged "decision" to discharge Sherri Poletti should be immunized by the ITA.¹² However, Nurse Short committed multiple negligent acts quite apart from Dr. Mathiasen's ultimate decision to discharge Ms. Poletti.¹³ By claiming that it deserves ITA immunity for the entirety of Plaintiff's allegations, Overlake implicitly argues that the liability exemption must cover everything that occurred while Sherri Poletti was under its care.

¹² In truth, Dr. Mathiasen, not Nurse Short, gave the discharge order.

¹³ For example, Nurse Short failed to take reasonable steps to acquire Dr. Koenig's evaluation, which Overlake admits was a violation of the standard of care. (CP 570-71). And she "irresponsibly" told Militello that Ms. Poletti had slept when there was no documentation of that claim, another admitted violation of the standard of care. (CP 567).

But even if the ITA immunized the Overlake's discretionary act of choosing whether to detain or discharge Ms. Poletti, there is no suggestion in either the letter or the spirit of the act that that immunity should extend to Overlake's negligent performance of its ordinary medical duties to diagnose and treat Ms. Poletti. Thus, it goes much too far for Overlake to claim that immunity for that *decision* extends to cover all of the negligence that happened while Ms. Poletti was at Overlake—even those acts that occurred in the ordinary course of her medical treatment, and especially those that occurred after the discharge decision was made.

If the ITA actually immunized a hospital for the entire course of treatment of a psychiatric patient, just because involuntary commitment proceedings were *considered but never initiated*, the ITA would essentially impose a gross negligence standard over the entire course of the patient's treatment. There is, of course, no suggestion that the Legislature intended the ITA to reach any such result. Thus, even if this Court should find that the decision to discharge Ms. Poletti was within the scope of ITA immunity, it should nonetheless hold that Overlake's other negligent acts remain subject to the ordinary medical malpractice standard of regular negligence.

1. The Language of the ITA Limits Immunity to Involuntary Care Decisions, Not Negligently Performed Treatment

The plain wording of the statute precludes a blanket grant of immunity for all treatment of a patient who is later subject to the ITA. As Overlake repeats time and time again, the ITA confers immunity “for performing duties pursuant to this chapter [the Involuntary Treatment Act] with regard to the *decision* of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment.” RCW 71.05.120 (emphasis added). Putting aside the fact that Overlake does not meet the Act’s “duty pursuant to this chapter” requirement, the provision does *not* say that all previous or later treatment of a patient discharged or released is covered. At most, it only immunizes the decision as to detention, and reading it as broadly as Overlake urges would contradict the maxim that immunity provisions should be construed narrowly. *Matthews*, 64 Wn. App. at 437.

A California court articulated this very principle in *Gonzalez v. Paradise Valley Hospital*, 111 Cal. App. 4th 735, 737-38, 3 Cal. Rptr. 3d 903, 904-05 (2003). In that case, a mental patient was shot by police after escaping from a facility where he was kept on an involuntary 72-hour hold. The patient’s parents sued for wrongful death, on the grounds that the hospital failed to keep the patient properly secured. *Id.* at 738. The hospital claimed immunity under Section 5278, California’s equivalent to

the ITA, arguing that “any negligence committed during a legal 72-hour hold is within section 5278's scope of immunity.” *Id.* at 740. The court, however, narrowly construed the scope of immunity:

The protected conduct is confined to the exercise of statutory authority to detain, evaluate and treat against the patient's wishes, and ***does not extend to the manner in which evaluation and treatment are carried out.*** In other words, liability arising from negligent evaluation or treatment is not liability arising from the “exercis[e of] this authority in accordance with the law.”

Id. at 741-42 (citation omitted) (emphasis added). The same conclusion is compelled here. Nurse Short’s failure to provide competent treatment while Ms. Poletti was a voluntary patient cannot be immunized simply because a detention decision was made (or, in reality, merely contemplated). Similarly, Nurse Short’s failure to follow the standard of care while discharging Ms. Poletti—such as her failure to warn her patient of the dangers of discharge—is not subsumed into immunity for the discharge decision itself.¹⁴

2. Overlake’s Overbroad Interpretation is Contradicted by Caselaw on Analogous Immunity Rules

The ITA should be construed in accordance with Washington caselaw applying a very narrow scope to similar immunity doctrines. The involuntary treatment authority vested in the MHPs and health care

¹⁴ See sections B.3 and C.2 *infra* regarding informed consent.

providers under the ITA is essentially a judicial one: the power to deprive patients of their personal liberty. The delegation of this quasi-judicial authority under the ITA stems from the reality that it would be impractical for a judge to participate in emergency detention decisions where time is of the essence. See *In re Harris*, 98 Wn.2d 276, 654 P.2d 109 (1982) (due process requires that a magistrate approve non-emergency detentions, but not emergency ones). It follows that the immunity granted by the ITA has similar limitations to the common law of immunity for other professionals acting in a quasi-judicial function.

Judicial immunity exists to promote “independent and impartial decision making” by ensuring that officials “can administer justice without fear of personal consequences.” *Taggart v. State*, 118 Wn.2d 195, 203-04, 822 P.2d 243, 247 (1992). “Judicial immunity also extends to governmental agencies and executive branch officials performing quasi-judicial functions,” but *only* where “administrative action is functionally comparable to judicial action.” *Id.* at 204-05. When examining other grants of immunity, derived both from the common law and from statutes, courts have ruled that immunity only covers decisions of a judicial nature, not ordinary job duties by a professional who sometimes exercises such powers.

In *Taggart*, the Washington Supreme Court held that “parole officers are entitled to quasi-judicial immunity only for those functions they perform that are an integral part of a judicial or quasi-judicial proceeding. . . . But when the officer takes purely supervisory or administrative actions, no such protection arises.” *Id.* at 213. For example, an officer’s failure to conduct progress checks or drug tests on probationers is not immunized, even though those actions might have informed a quasi-judicial parole decision.

The same analysis has been applied to another statutory immunity provision implicating the mental health field. In *Webb v. Neuroeducation, Inc., P.C.*, 121 Wn. App. 336, 340, 121 P.3d 417, 418 (2004), a psychologist was accused of inducing a patient to make false accusations of abuse, and consequently reporting the “abuse” to CPS. The court noted that the psychologist would not be entitled to immunity under a provision for reporters of child abuse,¹⁵ because that provision only covered the final decision to report the abuse:

¹⁵ “Any person participating in good faith in the making of a report pursuant to this chapter or testifying as to alleged child abuse or negligence in a judicial proceeding shall in doing so be immune from any liability arising out of such reporting or testifying.” RCW 26.44.060. The similarities between this statute and the ITA immunity provision are readily apparent. Both statutes include the qualifier “pursuant to this chapter,” and both confer immunity only for a final action—the decision to admit, discharge, detain, etc., and the reporting or testimony on child abuse, respectively.

The child abuse reporting statute, RCW 26.44.060, immunizes those who report suspected child abuse to the authorities from suits based on adverse consequences of reporting. But RCW 26.44.060 ***does not provide immunity from negligent treatment or investigation giving rise to the report.***

Id. at 348 (emphasis added). Just as the psychologist in *Webb* could not obtain “immunity from negligent treatment or investigation giving rise to the report,” Overlake cannot obtain immunity under the ITA for negligent investigation and treatment simply because it preceded an alleged involuntary treatment decision.¹⁶

3. Overlake’s Reading Would Rewrite the Standard of Care for Psychiatric Medicine

Third, Overlake’s interpretation would effectively alter the standard of care for much of psychiatric medicine to gross negligence, which is clearly far beyond the Legislature’s intent. Overlake’s argument amounts to a claim that a hospital in the process of discharging of a voluntary psychiatric inpatient can invoke the ITA merely by considering an MHP evaluation, and can thereby immunize the entire course of treatment of a patient. If that were the case, since hospitals explicitly or implicitly make decisions on whether to “admit,” “discharge,” and

¹⁶ See also *Babcock v. State*, 116 Wn.2d 596, 612, 809 P.2d 143, 152 (1991)) (because “a caseworker’s investigation of a child abuse complaint is not a quasi-prosecutorial act, we cannot extend the prosecutor’s immunity to the caseworker’s investigation of a foster care placement”).

“detain” every psychiatric patient, every aspect of patient care would be subsumed into ITA immunity. For all practical purposes, this interpretation would provide a gross negligence standard for all psychiatric treatment by a hospital. The Legislature did not intend that result.

Washington’s medical malpractice statute covers all civil actions arising out of health care, RCW 7.70.010, and requires health care providers follow “the accepted standard of care,” RCW 7.70.40. There is no suggestion in the medical malpractice statute, nor the case law interpreting it, that the field of mental health care should be held to a lesser standard of gross negligence. As the *Webb* court succinctly concluded:

Washington law imposes a duty upon mental health professionals to perform according to the standards of care expected of every health professional. If immunity from liability is to be conferred upon therapists for failing to adhere to a professional standard of care . . . it is for the legislature to confer, not the courts.

Webb, 121 Wn. App. at 350. The California court in *Gonzalez* made a similar declaration:

The interpretation of section 5278 the defendants urge is contrary to its language, and would undermine a purpose of the Legislature in enacting the LPS Act, protection of mentally ill persons. Any intent of the Legislature to confer an immunity that would deny involuntarily detained

persons redress for injuries caused by evaluation or treatment falling below the standard of professional care should be expressly stated.

Gonzalez, 111 Cal. App. 4th at 742.

In fact, far from declaring that psychiatric providers need only exercise “slight care” on behalf of some of society’s most vulnerable members, Washington has enacted a regulatory system that imposes many duties of care on psychiatric care providers. Of note, several regulations require providers to develop policies and procedures that set the standard of care. These include:

- WAC 246-320-136: Licensed hospitals must establish policies and procedures that define the standard of care for specialty services, including psychiatry.
- WAC 246-320-271: If providing psychiatric services, hospitals must “use hospital policies and procedures which define standards of practice.”
- WAC 246-322-035: Private psychiatric hospitals must develop policies and procedures governing many aspects of patient care.
- WAC 277-865-0547: For involuntary treatment programs, the medical record must contain documentation of a plan for discharge, documentation of the course of treatment, etc.¹⁷

¹⁷ Note that WAC 277-865-0547 imposes specific obligations on hospitals even in involuntary treatment scenarios. If the ITA does not absolve hospitals from adherence to the standard of care while treating involuntary patients, then *a fortiori* it does not apply to the treatment of voluntary patients like Ms. Poletti.

It stretches credulity to suggest that all of these regulations, and the hospital policies they require, are strictly aspirational in nature, and that hospitals are under no enforceable obligation to adhere to them. Yet, under Overlake's interpretation, a hospital need only suggest that it considered detaining a patient pursuant to the ITA (or, at most, conducted a perfunctory consultation with the county MHPs) to convert the entire course of a patient's treatment to the gross negligence standard. If psychiatric care is really to be governed only by the obligation to exercise "slight care," rather than the standards applied to every other medical field and required by a carefully developed system of regulations, the Legislature would certainly have made that intent more clear.

4. The ITA Clearly Does Not Excuse Overlake's Failure to Warn and to Obtain Informed Consent

As discussed above, Overlake admits that, *after* Dr. Mathiasen gave the discharge order, Nurse Short negligently failed to adequately warn Ms. Poletti of the risks of discharge. At that point, any ITA decision was a *fair accompli*, but Overlake still owed Sherri Poletti its normal duty to meet the standard of care in carrying out that discharge, which including providing warnings as to the failure to seek treatment. (CP 560-62). Even if the ITA was read so broadly as to immunize the alleged discharge decision *and* all of the negligent diagnosis and treatment that led

to that decision, there is no conceivable reason why that immunity should extend to negligent acts that took place after that decision was made.

For the same reasons, Overlake is liable on an informed consent theory because Nurse Short wholly failed to advise Ms. Poletti as to the risks of the treatment decision (AMA discharge) that she was seeking. If Overlake were right and Sherri Poletti did not meet the detention criteria, it still owed her a duty to warn of the decision not to seek treatment—a duty arising both under Overlake’s discharge policy and by statute (CP 644-45) (“the risks of leaving are explained by the staff to the patient”); RCW 7.70.030(3); *see also* WPI 105.04 (health care provider “has a duty to inform a patient of all material facts, including risks and alternatives, that a reasonably prudent patient would need in order to make an informed decision”); *Gates v. Jensen*, 92 Wn.2d 246, 251, 595 P.3d 919, 922 (1979) (“The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. . . The physician's duty of disclosure arises, therefore, whenever the doctor becomes aware of an abnormality which may indicate risk of danger.”)

Whether the warning would be effective is judged by what a “reasonably prudent person” would do, not what Sherri Poletti would do. WPI 105.04; *Backlund v. Univ. of Washington*, 137 Wn.2d 651, 664, 975 P.2d 950, 957 (1999). By definition, no reasonable person would agree to

be discharged AMA on New Year' Eve, let alone off their medications and no reasonable person would drive in that condition. And again, this failure—which was committed by Nurse Short in her ordinary capacity as a nurse, after all involuntary treatment issues were over and done with—cannot possibly be subsumed into the ITA's grant of immunity for ITA *decisions*.

Thus, at a bare a minimum, Plaintiff is entitled to proceed under a regular negligence standard for all negligent acts other than Dr. Mathiasen's order to discharge Ms. Poletti and further to proceed on an informed consent theory.

C. The Trial Court Correctly Granted Partial Summary Judgment on Liability and that Judgment Can and Should be Sustained.

A trial court's ruling may be sustained, "on any correct ground, even though that ground was not considered by the trial court." *Gontmakher v. City of Bellevue*, 120 Wn. App. 365, 370, 85 P.3d 926, 929 (2004). Here, the trial court not only confirmed that Overlake is subject to the ordinary medical standard of care—it also granted a judgment for Plaintiff on liability based on Nurse Short's undisputed breach of an Overlake policy requiring her to refer Ms. Poletti for an MHP evaluation. That ruling was in accord with the undisputed facts on summary judgment and should be sustained.

Moreover, the entire judgment can, if the Court chooses, be sustained without the necessity of reaching the ITA issues at all. *See Margola Associates v. City of Seattle*, 121 Wn.2d 625, 645 n. 7, 854 P.2d 23, 35 (1993) (“We decline to address their arguments, which go beyond what is necessary to decide the narrow facial takings challenge posed in this case.”). Even when ITA immunity applies, a provider is still liable if it acts with gross negligence. RCW 71.05.120. This Court can, and should, find that the un rebutted evidence submitted on summary judgment shows that Nurse Short’s actions were grossly negligent—*i.e.*, that on several occasions she gave “substantially appreciably less than the quantum of care inhering in ordinary negligence.” *Nist v. Tudor*, 67 Wn.2d 322, 331, 407 P.2d 798, 804 (1965). Should it reach this conclusion, the Court may affirm the summary judgment order without reaching the broader and more complex issue of whether ITA immunity applies.

Overlake did not dispute, and in most cases admitted, the many acts of negligence established by Plaintiff in the summary judgment record. Those same undisputed acts also sound in gross negligence, so the Court may sustain the summary judgment ruling on any one of several theories.

Overlake has previously attempted to defend Nurse Short's glaring failures by arguing that they are counterbalanced by other actions where Nurse Short allegedly showed due care, so that, as a whole, Nurse Short was less than grossly negligent in her overall treatment of Ms. Poletti. However, this argument is legally flawed: a particular negligent act is never mitigated because the actor has otherwise been careful or competent. *See Shielee v. Hill*, , 47 Wn.2d 362, 367, 287 P.2d 479, 481 (1955)) ("If defendant's servants were not negligent at the time plaintiff sustained the injuries of which he complains, it was wholly immaterial how habitually and recklessly negligent they might have been prior thereto; or, if they were negligent then, how careful and prudent they had previously been.").

In other words, a defendant is not entitled to "average out" the negligent act that caused the harm against other, less culpable acts. For example, if a motorist made a grossly negligent maneuver and got into an accident, it would be no defense to claim that she had been driving safely until the accident, so that "on average" she was merely ordinarily negligent that day. Rather, a single act of gross negligence is enough to establish liability regardless of the ITA immunity question. And, as detailed below, Nurse Short's multiple and grievous breaches of the

standard of care are more than sufficient for a finding of both negligence and gross negligence.

1. Nurse Short’s Failure to Follow the Policy Requiring an MHP Referral Supports the Trial Court’s Order.

The trial court’s liability ruling was based on the Overlake policy requiring that “[p]atients in need of further psychiatric (inpatient) treatment, but who . . . do not consent to treatment, *will* be referred¹⁸ to the County Designated Mental Health Professional for immediate evaluation.” (CP 627-28) (emphasis added). Overlake has not disputed that Ms. Poletti was “in need of further treatment,” which is inherent in the concept of AMA discharge. (CP 535). Overlake has also not disputed that an ITA evaluation (which the MHPs could not refuse to respond to) was not actually made.

a. *Overlake Cannot Evade Its Own Policy on Illegality Grounds*

Overlake’s latest argument is that the referral policy is void, or did not impose any obligations in this case, because it conflicts with a hospital’s constitutional and ITA duties to release voluntary psychiatric patients on demand. As a threshold matter, Overlake waived this

¹⁸ “Referral” is another term of art under the ITA, and connotes a request for evaluation that results in an in-person visit by an MHP. (Resp. App at 53) (“It’s not a referral until they ask for the person to be seen.”)

argument because it did not raise it before the trial court, nor in its motion for discretionary review. RAP 2.5(a); *see Lindblad v. Boeing Co.*, 108 Wn. App. 198, 207, 31 P.3d 1, 5 (2001) (“We will not review an issue, theory, argument, or claim of error not presented at the trial court level.”). Similarly, as discussed in greater depth below, this argument is foreclosed by Overlake’s admission that its policies set the standard of care. Plaintiff relied on those admissions in its preparation for trial, and would be prejudiced if Overlake were allowed to abandon its previously admitted position.

Overlake’s new argument is not only untimely, but fails on substantive grounds as well. The policy and the controlling law are not necessarily at odds, particularly under the facts in this case. First, Overlake’s inpatient facility is reserved for patients with conditions too serious to treat on an outpatient basis (CP 582). Therefore, whenever Overlake recommends against discharge, it makes a determination that that the patient would not be safe if released into the community. It seems unlikely that Overlake would make that determination without also having a good faith belief that a patient might meet the ITA commitment criteria.

Furthermore, in this particular case, the discrepancy Overlake complains of simply does not exist. Both Dr. Koenig and Dr. Mathiasen believed that Ms. Poletti should have been referred for an ITA evaluation

rather than discharged. Under those circumstances, Overlake would certainly have been within its legal rights to detain Ms. Poletti.¹⁹ In other words, nothing in the ITA or the constitution prevented Nurse Short from being able to follow the policy. Overlake's self-serving argument that its own policy should be rejected in its entirety, simply because it *might* run counter to the ITA under some hypothetical facts not before this Court, should be rejected out of hand.²⁰

b. The Policy Breach Established Liability as a Matter of Law

Contrary to Overlake's protestations, in the context of this case Nurse Short's breach of the policy provided irrefutable evidence of negligence, so that the Court correctly granted summary judgment as a matter of law.

As the trial court observed, the Washington Administrative Code requires licensed hospitals to "[a]dopt and implement policies and procedures which *define standards of care* for each specialty service,"

¹⁹ It is less than clear whether Overlake as a corporate entity "regarded" Ms. Poletti as detainable at the time of the decision to call Mr. Militello, since Drs. Koenig and Mathiasen did, but Nurse Short presumably did not. However, given the orders of both physicians, Overlake cannot claim with a straight face that it would have been unconstitutional for Overlake to detain Ms. Poletti for an evaluation.

²⁰ Overlake's argument is analogous to a "facial" challenge to the validity of a statute, but such a challenge "must be rejected if there are any circumstances where the statute can constitutionally be applied." *Lummi Indian Nation v. State*, 170 Wn.2d 247, 258, 241 P.3d 1220, 1227 (2010) (citation omitted.) (citation omitted).

including psychiatry. WAC 246-320-136 (emphasis added); *see also* WAC 246-320-271 (“If providing psychiatric services, hospitals must: . . . Use hospital policies and procedures *which define standards of practice.*”) (emphasis added). The state Supreme Court has confirmed that, in medical malpractice actions, the “standards of care to which a hospital should be held may be defined by the accreditation standards of the Joint Commission on Accreditation of Hospitals and the hospital's own bylaws.” *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160, 1164 (1991).

Perhaps even more importantly, Overlake, through its 30(b)(6) witness, admitted that its Policies and Procedures establish the standard of care. (CP 552). Overlake also conceded that these standards are intended “to make it very clear for a nurse in med surge to understand how to proceed with this process.” (CP 553).

To summarize, Overlake admits that the policy set the standard of care, and that Nurse Short did not follow that policy.²¹ It follows as a matter of simple logic that Overlake admits to a breach of the standard of care. Against this backdrop, the trial court was correct to recognize that there is nothing left to try—Overlake was negligent as a matter of law.

²¹ As discussed above, Overlake’s only excuse is the fallacious argument that the policy might be trumped by the ITA or constitutional due process rights.

c. *Summary Judgment Was Also Proper Because Plaintiff's Evidence of Negligence Went Unrebutted*

Overlake has argued that a policy violation does not establish negligence *per se*. But even if a policy violation were only “evidence” of negligence, that distinction would be irrelevant to the trial court’s ruling because Plaintiff’s evidence actually went unrebutted.

After Plaintiff raised evidence of negligence on its motion for summary judgment, Overlake was required to bring its own evidence in opposition. *Seven Gables Corp. v. MGM/UA Entm't Co.*, 106 Wn.2d 1, 13 721 P.2d 1, 7 (1986) (“A nonmoving party in a summary judgment may not rely on speculation [or] argumentative assertions that unresolved factual issues remain . . . the nonmoving party must set forth specific facts that sufficiently rebut the moving party's contentions and disclose that a genuine issue as to a material fact exists.”).

In its summary judgment opposition brief, Overlake only made the irrelevant argument that a policy violation could not establish negligence as a matter of law, and vaguely claimed that it “has put forth expert testimony that the standard of care has was complied with.” Yet, despite its summary judgment burden, Overlake failed to attach any evidence, such as expert testimony, showing that the specific act in question—Nurse Short’s failure to make an MHP referral as required by hospital policy and Dr. Mathiasen’s order—was not negligent.

Thus, since Plaintiff's evidence of negligence went un rebutted, the trial court was required to grant summary judgment. See *Seven Gables*, 106 Wn.2d at 12-13 ("the adverse party must set forth specific facts showing there is a genuine issue for trial or have the summary judgment, if appropriate, entered against them"). And since this Court may only consider the materials brought before the trial court in the summary judgment briefing, the same conclusion is compelled here. RAP 9.12 ("On review of an order granting or denying a motion for summary judgment the appellate court will consider only evidence and issues called to the attention of the trial court.").

2. Additional Unrebutted Evidence of Negligence and Gross Negligence Also Supports the Trial Court Order

This Court may also affirm the trial court's finding based on the unrebutted laundry list of other standard of care violations that Ms. Berkau, Overlake's 30(b)(6) representative, admitted to. (See pp. 15-16). At nearly every step of the way, and even after it made the discharge decision it claim was immunized, Overlake failed to provide the level of care required by its own policies, the WACs governing psychiatric practice, and the statutory and common law of medical negligence. Ms. Berkau's summary admission, that based on the record Overlake "failed tremendously" (CP 714) illustrates the fact that Overlake's performance

fell “substantially or appreciably less than the quantum of car inhering in ordinary negligence,” and therefore rises to the level of gross negligence. *Nist*, 67 Wn.2d at 322.

Finally, this court may affirm based on the un rebutted testimony of Plaintiff’s expert, Dr. Csaba Hegyvary (the only on-point expert testimony in the summary judgment record), that Overlake was both ordinarily and grossly negligent. (CP 714).

IV. CONCLUSION

For the reasons discussed above, the trial court’s ruling was proper and should be affirmed in its entirety. With liability established, this Court should remand for a trial on causation and damages.

RESPECTFULLY SUBMITTED this 9th day of May, 2012.

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CERTIFICATE OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington that on May 9, 2012, a copy of this document was sent for service on the following persons:

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