

APPEALS
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COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

NO. 34817-9-II

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

DARWIN BRAME, et al.,
Appellants,

v.

WESTERN STATE HOSPITAL, an Agency of the State of Washington,
Respondent.

BRIEF OF APPELLANT

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ORIGINAL

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A. Assignments of Error

Appellants assign error to the Superior Court's granting of Defendant/Respondent's Motion for Summary Judgment because there are genuine issues of material fact in dispute.

The two significant material facts in this case are whether or not the employer knew with certainty that employees would be injured and whether or not they failed to act on that knowledge.

A material fact is one upon which the outcome of litigation depends in whole or in part. *Anica v. Wal-Mart Stores, Inc.*, 120 Wash. App. 481, 84 P.3d 1231 (2004).

B. Statement of the Case

Appellants are all Western State Hospital ("WSH") employees ("Staff") who were injured on the job, by patients who are at WSH because they are a danger to themselves or others and are criminals from the jail, while caring for WSH patients. CP 110.

1. WSH had knowledge.

WSH knew for certain that staff would continue to be injured by a patient. They knew for certain these injuries would occur based on the

historical data. CP 110. WSH knew of prior assaults. Their own statistical records compiled the number of patients to staff injuries per ward/ per month/ per year for the years from 2003 through March 2005. CP 110. WSH, CEO, head officials and management (“management team”) were given numerous reports that stated that the wards were inadequately staffed and the dangerous conditions and injuries were a result of such inadequacy. CP 111. The declaration of Appellants’ expert concluded that administration of WSH knew for a certainty that staff would be assaulted by patients based on historical data. CP 111.

Prior Assaults:

Reports were filled out by staff when they had concerns about the ward conditions. There were three reports: Short Staffing Report; Understaffed Dangerous Ward Condition; and Staff Injured Dangerous Ward Report. CP 111.

Short Staffing Reports:

According to WSH’s own statistical records, from the year 2003 through 2005, a minimum of thirteen injuries to staff by patients had been reported every month. Each year the number of injuries per month increased. In 2003, there were 161 patients to staff injuries reported. In

2004, there were 209 patient to staff injuries. In 2005, there were 93 patients to staff injuries reported from January through March. CP 111.

From 2002 through 2004, staff members filled out and submitted to their supervisors 37 Short Staffing Reports. This is a report that staff fills out to report a shortage of staff (inadequate staff to safely carry out their assignments) based on their professional judgment and the Johnson Model Acuity System. CP 111, 112.

The standard WSH and its staff used to determine the number of staff needed to be scheduled per ward for the given day (shift) was the Johnson Model standard. CP 113. Although this standard was used and was still in use by WSH to determine their staffing needs it was not properly followed by WSH or its managers when doing their scheduling. CP 113. It was not properly followed because it was not understood by the staff members and they were not properly trained to use it. CP 113. The head nurses were aware that there was a misunderstanding regarding the use of the Johnson Model amongst the staff members, however, nothing was done to resolve the misunderstanding. CP 113.

Understaffed Dangerous Ward Reports:

From 2002 through 2005, there were 219 Understaffed Dangerous

Ward Reports submitted by staff to the ward manager. CP 114. These reports were submitted when staff had concerns about understaffed wards. The reports indicate the lack of staff/patient ratio based on Johnson Model. The concerns are passed on to the Ward and/or Nurse supervisor. CP 113. The original understaffed report is given to the supervisor and copies are forwarded to the CEO, Medical Director, CFS Unit Manager, Psychiatric Nurse Executive, Lead Psychiatric Nurse Executive, Lead Psychiatrist, Ward Manager, RN4 (nurse supervisor), Safety Office, Union Office and Area Representatives. CP 114.

Staff Injured Today Dangerous Ward Report:

From January 2004 through August 2004 there were eleven Staff Injured Today Dangerous Ward Reports (“Staff Injured Report”) submitted by staff to the Ward Program Manager and/or nurse supervisor. This report is submitted when a staff injury has occurred on a ward where there was an inadequate number of staff assigned to that ward. The standard used to determine the inadequacy was the Johnson Model. An explanation of the events leading up to the injury; the patient’s behavioral history, and other comments are generally included in the report. CP 114.

In 1999, an Assault Review Team (ART) was established by WSH

in response to the numerous assaults that were being perpetrated by the patients to staff and to the no tolerance policy regarding such injuries set by the Director of Washington State Mental Health Division. The purpose of ART was to review and submit recommendations concerning the reduction of assaults against staff by patients. Numerous recommendations were made to reduce the staff injuries; such as: an adequate safe staff/patient ratio; an increase in communication among and within shifts; placing staff safety as an institutional priority; an effective assault reduction/prevention program; and others. CP 115, 116.

WSH did not implement any of the recommendations that resulted from the study. CP 116.

2. WSH failed to act.

WSH knew for certain that patients were going to assault and injure staff. It had a duty to act and prevent such assaults to staff. It failed to act by not providing adequate training to staff in defending themselves against assaults and not implementing any changes to prevent assaults. Rather, WSH implemented a non-violence/no restraint policy that resulted in an increase to staff injury. CP 116.

Inadequate training.

WSH did not provide adequate training to its staff. Staff received a minimal amount of training in preventing assaults. A two hour assault prevention training session during orientation and a Patients Assault Residents Training (“PART”) training was the most they had. CP 116, 117. The PART training consisted of a no hands/ no restraints (whether chemical or physical unless approved by doctor’s orders) training when dealing with assaultive, aggressive, or combative patients. CP 117.

A substantial cause of the staff being assaulted by the patients was the lack of training provided by WSH to the staff. Appellants received between fifteen minutes to two hours of training during their employment. Duration of their employments was at a minimum of two years. CP 117.

The current CEO of WSH, Doctor Andrew Phillips, who has been in the position since January 2004 took no action to prevent assaults on staff by patients. He had knowledge of these assaults but failed to prevent or reduce the assaults. He did not review the 1999 survey report prepared by ART. He testified that he believed that staff had a right to defend themselves if being attacked, but he implemented a non-violence initiative which required zero use of restraint and seclusion. CP 118.

Doctor Klein, the medical director at WSH had been employed by

WSH since 1985. His role is to oversee the procedures/ policies and standards of practice that are in place. He had knowledge that staff is assaulted by patients. He stated that he believed that patients will assault staff unless there was substantial change. Doctor Klein was the chair of the Assessment Subcommittee. CP 119.

Doctor Gage, the supervising psychiatrist at the Center for Forensic Services (CFS), stated that he did not know of any other initiative besides non-violent /no restraint/ no seclusion, that have been implemented by WSH to reduce risk of harm to staff by patients. CP 120.

Doctor Rick Mehlman, PHD, Center Director for CFS stated that he had not read the PART manual and he did not know what the training required the staff to do when being assaulted. CP 120.

Teckna Riley, a nurse manager in the CFS building, stated that the Johson's acuity model (Johnson Model) was a clinical too to determine what was going on with the patients. She did not keep records of staff assaults. CP 120.

Teresita Cueva, a nurse manager in CFS unit, was responsible for both patient care and staffing responsibilities, such as to have an adequate mix of staff on all wards. She oversees the RN3s who are the first line

supervisor on the ward which included overseeing how they did their scheduling. She was never asked what could been done to reduce assaults on staff. CP 120, CP 121.

C. Argument

Whether or not the employer (Western State Hospital) is liable to its employees for its failure to protect them from assaults at the hands of others.

Washington State's Industrial Insurance Act (IIA), Title 51 RCW, provides the exclusive remedy for an employee's work related injuries. RCW 51.04.010; RCW 51.32.010. An exception to the exclusive remedy, however, arises when the employer deliberately injures an employee. Under RCW 51.24.020, "[i]f injury results to a worker from the deliberate intention of his or her employer to produce such injury, the worker or beneficiary of the worker shall have the privilege to take under this title and also have cause of action against the employer as if this title had not been enacted, for any damages in excess of compensation and benefits paid or payable under this title." RCW 51.24.020. (Emphasis added).

Deliberate intention has been held by the courts to mean the employer had actual knowledge that an injury was certain to occur and

willfully disregarded that knowledge. *Birklid v. Boeing*, 127 Wash. 2d 853, 856, 904 P.2d 278 (1995); *Vallandigham v. Clover Park School District No. 400*, 154 Wash. 2d 16, 20, 109 P.3d 805 (2005).

Washington's IIA was the product of grand compromise in 1911. Injured workers were given a swift, no-fault compensation system for injuries on the job and employers were given immunity from civil suits by workers. At the same time, however, employers who deliberately injured their employees would not enjoy the immunity from suits. *Birklid v. Boeing*, 127 Wash. 2d 853, 859, 904 P.2d 278 (1995).

The courts have continuously interpreted RCW 51.24.020 to find an exception to the Worker's Compensation Act in cases of assault and battery by the employer or its agent against an employee. *Birklid v. Boeing*, 127 Wash. 2d at 862. In *Birklid*, Boeing factory workers sued their employer based on exposure to toxic fumes. *Birklid v. Boeing*, 127 Wash. 2d at 856. Boeing knew the fumes made its employees ill, but denied their request for improved ventilation. *Birklid v. Boeing*, 127 Wash. 2d at 856. The Court held that the employees had demonstrated facts sufficient to justify a jury in finding a deliberate intention by Boeing to injure them. *Birklid v. Boeing*, 127 Wash. 2d at 873. The Court

articulated a clearer definition of “deliberate intention” and what constituted “deliberate intention.” The Court held that the phrase “deliberate intention” in RCW 51.24.020 meant the employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge

Respondent WSH knew that their employees would be injured to certainty.

An exception to the exclusive remedy under IIA requires deliberate intention by the employer to injure or cause injury to the employee. RCW 51.24.020. In 1995, our Supreme Court defined the “deliberate intention” to mean that an employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge.

Prior to the *Birklid* case the court found “deliberate intention” only when there had been a physical assault by one worker against another.

Birklid at 862.

In our case, there has been an ongoing history of assaultive incidents between staff and patients. A study was held to determine what could be done to protect and predict assaultive conduct by patients to staff. The study was extensive and came up with multiple recommendations as

to how to solve the problem of staff being injured by patients. The preamble to the study recognized the assaults upon staff by patients was unacceptable and would have to be reduced to zero. Additionally, WSH has kept records of the assaults by patients upon staff. Based upon those statistics kept by the Respondent WSH, the employees have produced a declaration by an expert witness that the hospital knew with certainty that the patients would assault the staff. This ongoing incidence of assaultive conduct provides the basis of knowledge.

WSH had a duty to protect its employees from injuries by patients.

In *Bishop v. Miche*, 137 Wash. 2d 518, 973 P.2d 465 (1999), the court found that the question of the governmental entity's duty to prevent a third person from doing harm to another exists when a governmental entity has taken charge of the third person and knows or should have known of the danger posed by the third person.

Here, each of the persons who assaulted staff are criminals or person who are a danger to themselves or others. Those who are there because of a court order to determine their competency are persons who have been accused of committing violent crimes.

WSH had an obligation to protect third persons from the criminal

acts of another. In *Peterson v. State*, 100 Wash. 2d 421, 426, 671 P.2d 230, 236 (1983), the court noted that there was a duty to control when a special relationship exists between the actor and the third person and that imposes a duty upon the actor to control the third person's conduct or where a special relationship exists between the actor and the other that gives the other the right to protection.

An employee can look to an employer for a duty to protect. Here, in our case, a special relationship exists between the inmate and the hospital. The existence of the duty and causation are questions for the jury. The question for the jury is, did the hospital make little or no effort to protect its employees from being assaulted at the hands of their charges, the patients. It is a supervisory duty and when that fails the traditional assault and battery exception to the Worker's Compensation Act exists. *Taggart v. State*, 118 Wash. 2d 195, 822 P.2d 243 (1992).

At the time of acts complained of by the employees in this matter, each Appellants- employees was a staff person at WSH. Each of the persons who assaulted the staff persons were patients within the hospital. Washington courts have recognized the creation of a duty by creating the "special relationship" rule. A duty arises where (a) a special relation exists

between the defendant and a third person which imposes a duty upon the defendant to control the third person's conduct; or (b) a special relation exists between the defendant and the other which gives the other a right to protection. *Niece v. Elmview Group Home*, 131 Wash. 2d 39, 44, 929 P.2d 420 (1997); *Peterson v. State*, 100 Wash. 2d 421, 426, 671 P.2d 230 (1983).

The Appellants-employees' negligence claim in this matter involve both types of special relationships. WSH owes a duty to the Appellants to protect them from being injured where the injury is reasonably foreseeable. Based on their statistics, it was clearly foreseeable that assaults would occur on a regular basis by patients upon staff. There was no intervening cause which would break the causal action in this case and WSH is liable for those injuries. *Bishop v. Miche*, 137 Wash. 2d at 518; *Taggart v. State*, 118 Wash. 2d at 195.

- b. Respondent WSH disregarded the knowledge that would be injured by patients.

Prior to Dr. Phillips arriving at the hospital as the administrator, the study was done at the request of the administration for state hospitals to determine how and what would need to be done to protect the staff from

the violent staff and how to reduce staff injuries. The study was extensive and came up with multiple suggestions and resolutions to provide the staff with more protection from the violent patients. The cost analysis was done for those remedial measures. None of those measures were followed or implemented. Dr. Phillips neither read the study nor attempted to create a committee or a group or an individual or an ombudsman for the purposes of protecting the staff from these violent persons. The only training the staff received was their initial PART (patient assault resident training) training when they were new employees.

In *Vallandigham*, supra, two special education instructors sued the school district for injuries caused by a handicapped student who had a history of aggression. The Court rejected the Plaintiffs' theory that the school willfully disregarded its actual knowledge by failing to take effective remedial measures to prevent the injuries. The school was in the process of taking steps to correct or protect the teacher. *Vallandigham* at 20.

Respondent WSH's approach is similar to that found in *Hope v. Larry's Market*, 108 Wash. App. 185, 195, 29 P.3d 1268 (2001) where the plaintiff was able to produce evidence sufficient to challenge the

correctness or effectiveness of the employers remedial measures. If the remedial measures were ineffective, the “willful disregard” prong is met. Here, in that WSH took no remedial measures, it is clear that they willfully disregarded all of the proof and evidence before them that employees would be injured. This is proven by an increase of incidents of patient assaults upon staff.

Willful disregard is also demonstrated by Dr. Phillips when he testified he wanted the stay to be a pleasant experience for the patients who were criminals and that he did not want to do anything to upset them. These persons, to a large degree, who are assaulting the staff at WSH are criminals who have been sent to WSH for the purpose of determining whether or not they can aid their attorneys in their defense or whether or not they are criminally insane. Many are the same persons who were housed at the Pierce County Jail. The Pierce County Jail also keeps records of the assaults by inmates upon the staff. As can be seen by that record, assaults upon staff by inmates are rare. Assaultive conduct by these criminals is not allowed in the jail atmosphere.

E. Conclusion

The deliberate intention exception is applicable because the

employer WSH had knowledge that injury (assaults on staff) occurred and would continue to occur but they willfully disregarded and failed to act upon such knowledge. Thus, the element of deliberate intention in the exception under RCW 51.24.020 is met.

Respectfully submitted this 21 day of July, 2006.


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DECLARATION OF MAILING

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that on the below date, I mailed or caused delivery of a true copy of the foregoing to:

at the regular office or residence thereof.

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DATED this 21st day of July, 2006
at Tacoma, Washington.

Lisa D. Hollis
LISA D. HOLLIS, Paralegal

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