IN THE COURT OF APPEALS FOR THE STATE OF WASHINGTON

DIVISION ONE

NICHOLE POLETTI, as executor of the estate of Sherri Poletti, deceased,	)	No. 63568-9-I
	)	No. 62818-6-I
Appellant,	)	
	)	DIVISION ONE
v.	)	
	)	UNPUBLISHED OPINION
OVERLAKE HOSPITAL MEDICAL CENTER and KING COUNTY,	)	
	)	
Respondents.	)	
	)	
	)	FILED: May 24, 2010

Appelwick, J. — Poletti appeals the dismissal on summary judgment of her suit arising from the death of her mother, Sherri Poletti, in a car accident hours after her discharge from the hospital. Poletti sued Overlake, alleging it was grossly negligent in discharging her mentally ill mother without insisting on an involuntary civil commitment evaluation by a King County designated mental health professional. She also sued King County, alleging it was grossly negligent in treating Overlake's request as a consult and failing to perform an evaluation. Genuine issues of material fact exist as to each respondent. We reverse and remand.

FACTS

Sherri Poletti (Ms. Poletti) was diagnosed with bipolar disorder in 2001. On December 30, 2006, Ms. Poletti went to the Swedish Medical Center/Ballard emergency room, complaining of sores around her eyes, which did not exist. She subsequently admitted she was bipolar, off medications, and increasingly paranoid.

She believed she was being followed by people who were after her and had been driving around Washington, Oregon, and Canada for the last five days and nights trying to evade them. She had suicidal thoughts and had attempted suicide. The note from Swedish states in part:

> [Patient] says she has been increasingly paranoid and believes that people are following her, reading her thoughts, and are against her. She says she left her home in Ballard on Christmas and traveled to Oregon and then to Canada "to get away from people who are after me." [Patient] says she has been desperate and has been thinking of suicide by taking [overdose]. She reports taking [an overdose] of Lithum [sic] recently but told no one. "I'm so scared . . . I'm so tired of it."
>
> Veg[itative] Symptoms: [Patient] reports not sleeping for past several nights. She has been driving since 12/25 and returned to Seattle yesterday.

Swedish referred Ms. Poletti to Overlake Hospital Medical Center.

Ms. Poletti arrived at Overlake early in the morning of December 31, 2006. She was placed on close observation every thirty minutes. Hospital records show she was observed from 2:00 a.m. until 9:00 a.m., during which time she laid awake in bed until 6:00 a.m. and slept intermittently thereafter.

According to the attending nurse's progress notes of 4:00 a.m., Ms. Poletti admitted that she was having hallucinations, but she refused to divulge their content. She was refusing antipsychotic medications. She was assessed as "[g]uarded, paranoid refusing treatment at this time." The nurse noted that Ms. Poletti's "good faith status [is] in question as she had left Swedish, Prov[idence] recently [against medical advice]." At 8:30 a.m., Ms. Poletti told the nurse she had blisters around her eyes. However, her skin was clear.

Dr. Kalen Koenig was the evaluating physician at Overlake that day. His

handwritten chart note at 1:00 p.m. indicates that Ms. Poletti had stopped taking her psychiatric medication two weeks before. Ms. Poletti stated to Dr. Koenig, "I get manic and don't know what I'm doing" and "people can follow me using my tooth." She refused to talk about her hallucinations and denied having delusions at the moment. She admitted to Dr. Koenig that she had taken an overdose of lithium one month before and also that she "held knife to [her] throat" at some unspecified time.

Dr. Koenig dictated a detailed assessment of Ms. Poletti at 4:16 p.m., which was transcribed at 6:50 p.m. Dr. Koenig indicated that Ms. Poletti "does endorse current delusions." She acknowledged that she was fearful that others might harm her and that she had ongoing suicidal thoughts with thoughts of overdosing. She admitted that "she overdosed on lithium a month ago but did not seek treatment or tell anyone and describes that she held a knife to her throat earlier in the year and considered stabbing herself . . . ."

Dr. Koenig assessed that Ms. Poletti was "endorsing suicidal ideation and paranoia. The patient has a long history of poor compliance with psychiatric care frequently stopping her medications. . . . Sherri is continuing to decline medications. . . ." Dr. Koenig and the treatment team decided to give Ms. Poletti one day to adjust to the inpatient unit and for the treatment team to develop rapport with her. During that time, they "would again encourage the patient to consider psychiatric medications. If the patient persists in not taking psychiatric mediations she will be referred to the mental health professional [MHP] for an involuntary assessment." Dr. Koenig stated Ms Poletti "is felt currently to meet MHP criteria [for detention] due to psychosis and suicidal ideation with a recent suicide attempt and a lack of compliance

with voluntary care." Dr. Koenig recommended that she "continue to be closely monitored."

At 5:00 p.m., Dr. Koenig left duty. At about 6:30 p.m., Ms. Poletti indicated that she wanted to leave. Psychiatric nurse Elaine Short proceeded to assess Ms. Poletti's mental status. Nurse Short knew that Dr. Koenig had evaluated Poletti and she had his chart notes. However, she did not have the evaluation he had dictated less than two hours before, as it was not yet transcribed.

According to Nurse Short, she purposefully structured the conversation with Ms. Poletti to allow her to assess whether she had any paranoid delusions or hallucinations, her potential for self-harm, and whether she was capable of and had a plan to care for herself upon discharge. Ms. Poletti was "very tense and guarded." She reported that she was, "'[C]leaned out' from her medication and her mind is clear and she is ready for [discharge]." She stated that "her earlier fears that someone could or would harm her are gone." She also stated that she was not responding to auditory hallucinations and that she would not injure herself. According to Nurse Short, Ms. Poletti did not exhibit nonverbal behavior that suggested that she was disorganized in her thought process or psychotic. She also advised Nurse Short of her plan once she left the hospital, which included taking a cab to get home and a doctor's appointment on January 12, 2007, for follow up psychiatric care. Nurse Short did not try to assess whether Ms. Poletti was going to resume the driving behavior preceding her visit to Swedish.

Nurse Short attempted to persuade Ms. Poletti to stay and receive further care. However, in her professional opinion, Ms. Poletti did not meet the criteria for

involuntary commitment. Nevertheless, according to Nurse Short, "there was something that triggered me to ask Dr. Mathiasen, who was my consulting, first, if he wanted a mental health evaluation before discharge." Dr. Mathiasen ordered that she request a mental health evaluation.

At 6:45 p.m. on December 31, 2006, Nurse Short spoke with King County Designated Mental Health Professional (DMHP) Joseph Militello by telephone. Nurse Short relayed that Ms. Poletti had presented to Swedish the evening before with suicidal thoughts, paranoia, and auditory hallucinations. She did not, however, inform Militello about the nature of Ms. Poletti's hallucinations and delusions, about her suicide attempt about a month before, or the fact that Ms. Poletti had been driving aimlessly for the five days and nights prior to presenting to Swedish, trying to elude people who were following her through her tooth.

Nurse Short also told Militello that Ms. Poletti had slept most of the day while at Overlake, and that when she woke up, she reported she felt better and requested to be discharged.[1] According to Militello's investigation summary, Nurse Short reported that Ms. Poletti "denied being suicidal and evidenced no overt [signs or symptoms] of [paranoid ideation], other delusions, or hallucinations. She was organized and able to form/express plans for getting herself home from the hospital." That Ms. Poletti had plans to take a cab home was significant to Militello, because it evidenced that she was thinking about and planning for the future. According to Militello's summary, Nurse

[1] There are no hospital records showing whether Ms. Poletti was observed after 9:00 a.m. Nurse Short explained that another nurse reported to her that Ms. Poletti slept most of the day and that "[t]hey did not document it, . . . that does not mean they did not check her."

Short was "aware that [Ms. Poletti] is not currently giving any indication of imminent dangerousness or [grave disability], but she has concerns that [the patient] may be getting hypomanic." At his turn, Militello informed Nurse Short that King County DMHPs had evaluated Ms. Poletti about two weeks before and did not detain her.

Based on Ms. Poletti's symptoms, as presented by Nurse Short, and his knowledge of Ms. Poletti's past history with King County DMHPs, Militello informed Nurse Short that he would not involuntarily commit Ms. Poletti. Militello and Nurse Short then agreed to consider the call a "consultation." Militello summarized thusly his input henceforth:

> I validate [Ms. Short's] assessment re: the apparent lack of issues of imminent dangerousness to self or [grave disability] in how [patient] is currently presenting at [Overlake], and I point out that if [patient], as [Nurse Short] expects she will, presents to MHPs as she is currently presenting, we would not have evidence to detain due to lack of evidence of imminent dangerousness or [grave disability]. . . . [Nurse Short] is not making referral for MHP eval[uation] at this time; she thanks me for the consultation.

Nurse Short returned to Ms. Poletti. Nurse Short knew that Ms. Poletti had not resumed taking her medication. She advised Ms. Poletti in general terms about the risks of discharge against medical advice, but did not warn her about the risk of driving. Nurse Short knew that there was a high probability that someone who has been having hallucinations but is not taking their antipsychotic medication will continue to have hallucinations, and that auditory hallucinations could impair driving, depending on their severity.

Overlake then discharged Poletti against medical advice. Ms. Poletti took a taxi home. She then got into her car and started driving. She was wearing sweatpants,

was driving in socks but not shoes, and had food and other personal items in the car. She was not wearing her seatbelt. At a curve in the road, while driving in Thurston County, the car drifted over onto to the right shoulder of the road. Ms. Poletti attempted to correct the drift, but overcorrected to the left. The car crossed the other lane, hit a rocky embankment, and rolled. Ms. Poletti was ejected from the vehicle. She died at the scene of the accident, at 11:10 p.m. The toxicology report indicated no alcohol or drugs were present in Ms. Poletti's system.[2] Both the investigating officer and the coroner ruled the death an accident.

Nichole Poletti (Poletti), an adult daughter and executor of Ms. Poletti's estate, sued Overlake and King County for wrongful death. She alleged they were negligent in discharging Ms. Poletti without performing an evaluation for the purpose of involuntary civil commitment.

The defendants moved for summary judgment. Overlake argued lack of expert medical testimony on the standard of care, and lack of evidence on proximate cause. Poletti responded by submitting the declaration of Bruce Olson, Ph. D., a psychologist, and identifying facts which allegedly create an issue of fact as to proximate cause. Overlake moved to strike Olson's declaration. It also argued that proximate cause could not be established, because Militello's decision interrupted the causal chain. Poletti submitted an additional declaration, of Christian Harris, M.D. The court denied the motion to strike, but granted Overlake summary judgment, relying on both grounds

[2] A negative test was for: opiates, cocaine, amphetamines, PCP, marijuana, methadone propoxyphene, benzodiazepines, barbiturates, and tricyclic antidepressants. Present in the blood was caffeine, lithium, and dextromethorphan.

argued.

King County argued the lack of a duty toward Ms. Poletti, because Nurse Short had concluded Ms. Poletti did not meet the criteria for involuntary commitment, and therefore there was no referral for an evaluation. Poletti responded that a genuine issue of fact exists as to both whether King County owed Ms. Poletti a duty and to proximate cause. Poletti submitted a second declaration of psychologist Bruce Olson. King County's reply addressed the issue of duty exclusively. The court reasoned that, because there were no grounds to refer Ms. Poletti to a DMHP for an evaluation and Overlake did not refer her for an evaluation, Militello had no duty to Ms. Poletti. The court also concluded there is no genuine issue of material fact on proximate cause. Summary judgment dismissing all claims was granted. Poletti appeals both orders.

ANALYSIS

I. Standard of Review

We review summary judgment orders de novo.[3] When reviewing an order of summary judgment, we engage in the same inquiry as the trial court, considering the facts and all reasonable inferences from the facts in the light most favorable to the nonmoving party.[4] Summary judgment is proper only when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law.[5] Evidentiary decisions made in conjunction with an order on summary judgment are also reviewed de novo.[6]

II. The Involuntary Treatment Act[7]—Relevant Provisions

[3] Hadley v. Maxwell, 144 Wn.2d 306, 310, 27 P.3d 600 (2001).
[4] Right-Price Recreation, LLC v. Connells Prairie Cmty. Council, 146 Wn.2d 370, 381, 46 P.3d 789 (2002).
[5] CR 56(c).
[6] Folsom v. Burger King, 135 Wn.2d 658, 663, 958 P.2d 301 (1998).

The involuntary treatment act (ITA) was enacted, among others things, for the purpose of providing prompt evaluation and timely and appropriate treatment of persons with serious mental disorders, and providing continuity of care for persons with serious mental disorders.[8] To further these purposes, a person voluntarily admitted for inpatient treatment and who may be suffering from a mental illness, may be denied discharge in order to be evaluated by the county's DMHP.[9] RCW 71.05.050 provides the process to be employed:

> Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request. . . . PROVIDED HOWEVER, That if the professional staff of any . . . hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a mental disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the *county designated mental health professional of such person's condition to enable the *county designated mental health professional to authorize such person being further held in custody or transported to an evaluation and treatment center pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day . . . .

Acting on the information received from hospital professional staff, and after conducting an evaluation that generally includes a DMHP personally interviewing the patient, the DMHP may file a petition for an initial 72-hour detention if his or her evaluation confirms that person is gravely disabled or presents a likelihood of serious harm.[10] RCW 71.05.150 states:

> When a designated mental health professional receives information alleging that a person, as a result of a mental disorder: (i) Presents a likelihood of serious harm; or (ii) is gravely disabled; the designated mental health professional may, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of any person

[7] Chapter 71.05 RCW.
[8] RCW 71.05.010(2), (4).
[9] RCW 71.05.050.
[10] RCW 71.05.150.

> providing information to initiate detention, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention. Before filing the petition, the designated mental health professional must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility or in a crisis stabilization unit.

Mental health professionals, including hospital professional staff and DMHPs, are immune from tort liability in the performance of their duties "with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence."[11] Bad faith implies acting with tainted o fraudulent motives.[12] Gross negligence is "'negligence substantially and appreciably greater than ordinary negligence.'"[13]

Poletti argues that her mother died as a result of gross negligence by Overlake and King County in discharging their duties under the ITA. Specifically, Poletti argues that Overlake, through Nurse Short, was grossly negligent in failing to follow the on-call physician's order to request an evaluation, in failing to provide the DMHP with accurate and complete information regarding Ms. Poletti's mental health history and her then-current condition, and in failing to follow Overlake's protocol for discharge against medical advice. Poletti also argues that King County, through DMHP Militello, was grossly negligent in persuading Nurse Short to agree to a consult, or, in the alternative, in performing an evaluation over the phone, without personally interviewing Ms. Poletti.

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[11] RCW 71.05.120; see also Spencer v. King County, 39 Wn. App. 201, 204–05, 692 P.2d 874 (1984), overruled on other grounds by Frost v. City of Walla Walla, 106 Wn.2d 669, 724 P.2d 1017 (1986).
[12] Spencer, 39 Wn. App. at 208.
[13] Id. at 206 (quoting Nist v. Tudor, 67 Wn.2d 322, 331, 407 P.2d 798 (1965)).

III. Summary Judgment

In order to maintain a medical negligence action, a plaintiff must prove duty, breach, damages, and causation.[14] Specifically, the plaintiff must prove that the defendant health care provider "failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances" and "[s]uch failure was a proximate cause of the injury complained of."[15] Expert medical testimony is generally required to establish the standard of care and to prove causation in a medical negligence action.[16]

A defendant moving for summary judgment in a medical negligence claim has the initial burden to show the absence of an issue of material fact or that the plaintiff lacks competent evidence to support an essential element of her case.[17] If the defendant meets his burden by showing that the plaintiff lacks evidence to support his case, the burden shifts to the plaintiff to produce evidence sufficient to support a reasonable inference that the defendant was negligent.[18]

Here, the court held that Poletti failed to present competent expert testimony as to the standard of care applicable to Nurse Short and breach of that standard by the hospital. It held that there is insufficient evidence King County owed Ms. Poletti a duty, and that there is insufficient evidence that the defendants' acts and omissions

[14] Colwell v. Holy Family Hosp., 104 Wn. App. 606, 611, 15 P.3d 210 (2001).
[15] RCW 7.70.040(1), (2); Davies v. Holy Family Hosp., 144 Wn. App. 483, 492, 183 P.3d 283 (2008).
[16] Guile v. Ballard Cmty. Hosp., 70 Wn. App. 18, 25, 851 P.2d 689 (1993).
[17] Seybold v. Neu, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001); Guile, 70 Wn. App. at 23.
[18] Seybold, 105 Wn. App at 676.

proximately caused Ms. Poletti's death. We address each issue in turn.

A. Competent Expert Testimony

In response to summary judgment motions brought by Overlake and King County, Poletti submitted the declarations of Bruce Olson, Ph. D., a psychologist, and G. Christian Harris, M.D., a psychiatrist.

Olson had worked as a DMHP for Snohomish County between 1981 and 1985, and has been a contract clinician/consultant to Snohomish County's ITA program since 1984. It is undisputed that Olson is qualified to testify as an expert on the standard of care and breach thereof by King County, through DMHP Militello. It is also undisputed that Olson's opinion that Militello was grossly negligent in telling Nurse Short that Ms. Poletti was not detainable, without personally interviewing Ms. Poletti, creates an issue of fact as to whether Militello violated the applicable standard of care.

Overlake objected to Olson's testimony on the standard of care applicable to Nurse Short because he is not a medical doctor, but a psychologist. Indeed, the standard of care required of professional practitioners "must be established by the testimony of experts who practice in the same field."[19] In a medical malpractice action, this generally means that "a practitioner of one school of medicine is not competent to testify as an expert . . . against a practitioner of another school of medicine."[20]

Poletti contends that Olson is competent to testify as both he and Nurse Short are mental health professionals, as they are defined by the ITA.[21]

[19] McKee v. Am. Home Prods. Corp., 113 Wn.2d 701, 706, 782 P.2d 1045 (1989).
[20] Miller v. Peterson, 42 Wn. App. 822, 831, 714 P.2d 695 (1986). Thus, a pharmacist may not define the standard of care for a physician, Young v. Key Pharms., Inc., 112 Wn.2d 216, 229, 770 P.2d 182 (1989), and a physician may not do so for a pharmacist, McKee, 113 Wn.2d at 706–07.

Both a DMHP and a hospital psychiatric nurse qualify as "professional person[s]" under the ITA and a DMHP may be, among other things, a psychologist or a psychiatric nurse.[22] In discharging their duties, such mental health professionals are called to assess whether a patient presents, "as a result of a mental disorder, an imminent likelihood of serious harm, or is gravely disabled."[23] But, the fact that these professionals operate with the same concepts does not mean they have similar duties under the ITA or that the same standard of care applies to them all. Hospital psychiatric nurses may be responsible for assessing a patient in order to decide whether a request for an evaluation is warranted;[24] they do so within the structure of a hospital, and are subject to the hospital rules. DMHPs actually perform the evaluations once there is a referral and may petition the court for involuntary civil commitment if their evaluations confirm that the legal requirements are present.[25] In other words, the work of a DMHP usually starts where the work of a psychiatric nurse stops. Their only point of convergence is the referral or request for evaluation.[26]

As Overlake aptly points out, physicians, pharmacists, nurses, physical

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[21] Overlake contends that Poletti raised this argument for the first time on appeal. The record shows she raised it in the trial court in her response to Overlake's motion to strike.

[22] See RCW 71.05.020 (11), (25), (28), (31).

[23] See RCW 71.05.050, .150.

[24] See RCW 71.05.050.

[25] See RCW 71.05.150.

[26] By this we don't mean to imply that DMHPs and hospital psychiatric nurses stop interacting once a referral is made. As part of the evaluation, a DMHP must investigate and evaluate the specific facts alleged and must assess the credibility of any person providing information about the patient. See RCW 71.05.150. In most cases, the hospital psychiatric nurse who made the referral will therefore be interviewed by the DMHP. However, it is our understanding that at that phase, the nurse's role shifts from making an independent assessment of the patient to facilitating the DMHP's evaluation.

therapists, etc., all qualify as "health care provider[s]" for the purposes of chapter 7.70 RCW (which governs medical malpractice lawsuits). However, this has never been interpreted to mean that a general "health care provider" standard of care applies to all of them. Similarly here, we decline to hold that a general "mental health professional" standard of care applies to all such professionals under the ITA.

Nothing in Olson's curriculum vitae or declaration allows us to conclude that he is familiar with the standard of care of a hospital psychiatric nurse in discharging her duties under the ITA or otherwise. The court did not err in holding Olson was not qualified to testify as to the standard of care applicable to Nurse Short.

The court did not find similar problems with Dr. Harris's qualifications. Overlake nevertheless challenges his qualifications, because his declaration does not include any information showing that he has sufficient knowledge or experience to qualify him to testify on the standard of care for an inpatient psychiatric nurse like Nurse Short.[27]

Affidavits made in support of, or in opposition to, a motion for summary judgment must affirmatively show that the affiant is competent to testify to the matters therein.[28] A physician may generally testify regarding a nurse's standard of care.[29] Usually, this requires that the physician have "education, medical training, or supervisory experience that could demonstrate his familiarity with the standard of care" applicable to nurses.[30] Ultimately, "[i]t is the scope of a witness's knowledge and not artificial classification by

[27] We address Overlake's argument, despite its failure to cross-appeal, because an appellate court may affirm a summary judgment order on any basis supported by the record. Davies, 144 Wn. App. at 491.
[28] CR 56(e); Davies, 144 Wn. App. at 493.
[29] Hall v. Sacred Heart Med. Ctr., 100 Wn. App. 53, 60, 995 P.2d 621 (2000).
[30] Davies, 144 Wn. App. at 495.

professional title that governs the threshold question of admissibility of expert medical testimony in a malpractice case."[31]

Dr. Harris' declaration addressed whether Nurse Short was deficient in fulfilling her duties under the ITA. He asserted she was by failing to follow Dr. Mathiasen's order to request an evaluation, in providing Militello with an incomplete and inaccurate mental health history and then-current condition of Ms. Poletti, and in failing to follow Overlake's protocol for discharging patients against medical advice.

As to the last issue, we agree that Dr. Harris's failure to reference any hospital experience renders him incompetent to testify that failure to follow the hospital's protocol for discharging patients against medical advice represents a breach of the standard of care applicable to a hospital psychiatric nurse. But, Dr. Harris did establish that he is qualified to testify as to the other issues. As a psychiatrist who has had professional responsibility for doing evaluations on many individuals, in both civil and criminal matters, Dr. Harris is familiar with what the standard of care required of psychiatrists and psychiatric nurses. He is competent to testify about whether or not Nurse Short should have followed the doctor's order to seek an evaluation. He is also competent to evaluate the adequacy of the information relayed to a DMHP, when making a referral for an evaluation. We hold that Dr. Harris was qualified to testify as an expert on these issues.

In granting summary judgment, the court found Dr. Harris's declaration unsatisfactory, because he did not cite to the standard of care for a nurse in Nurse Short's position and how she breached it.

[31] Eng v. Klein, 127 Wn. App. 171, 172, 110 P.3d 844 (2005).

An explicit enunciation of the standard of care, while desirable, is not required where the declaration clearly identifies the facts supporting the witness's opinion that the defendant breached the standard of care.[32] Although Dr. Harris did not articulate the standard of care, he stated that Nurse Short was grossly negligent in failing to provide a complete and accurate mental health history and then-current condition of Ms. Poletti. He also identified the facts supporting his opinion: Nurse Short did not confer with Dr. Koenig. She did not read his dictated assessment of Ms. Poletti. No hospital records verify that Ms. Poletti was watched the hours before she requested to be discharged, despite Dr. Koenig's orders that she be closely monitored every 30 minutes. Dr. Mathiason ordered that a referral be made for a mental health evaluation. Dr. Harris's declaration is sufficient.

We hold the trial court erred in concluding that Poletti did not put forward competent expert testimony on the standard of care applicable to a hospital psychiatric nurse when making a referral and on breach of that standard of care.

B. Duty

It is undisputed that Overlake owed Ms. Poletti a duty. King County, however, successfully argued that it owed no duty to Ms. Poletti, because there were no grounds for a referral and Overlake did not refer Ms. Poletti for an evaluation. These are factual issues that may be decided on summary judgment only "'when reasonable minds could reach but one conclusion from the evidence presented.'"[33]

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[32] See Morton v. McFall, 128 Wn. App. 245, 254–55, 115 P.3d 1023 (2005).

[33] Van Dinter v. City of Kennewick, 121 Wn.2d 38, 47, 846 P.2d 522 (1993) (quoting Cent. Wash. Bank v. Mendelson-Zeller, Inc., 113 Wn.2d 346, 353, 779 P.2d 697 (1989)).

1. Grounds for Referral

The staff at a private hospital may detain any patient for evaluation by a DMHP, despite that patient's request for release, if the staff "regards" a patient as presenting, as a result of a mental disorder, an imminent likelihood of serious harm, or is gravely disabled.[34] "Gravely disabled" means,

> [A] condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety. . . .[35]

"Likelihood of serious harm" means, among other things, "A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself."[36] "Imminent" means, "[T]he state or condition of being likely to occur at any moment or near at hand, rather than distant or remote."[37]

Poletti argues her mother was both gravely disabled and presenting an imminent likelihood of serious harm. She points out that Ms. Poletti had a documented history of treatment for mental illness, including a history of refusing to take medication. Ms. Poletti had stopped taking her antipsychotic medication two weeks prior to reporting to Swedish, and then to Overlake. Before that, she had been driving aimlessly throughout Washington, Oregon, and Canada for five days and nights without sleeping, in an

[34] RCW 71.05.050.
[35] RCW 71.05.020(17).
[36] RCW 71.05.020(23)(a).
[37] RCW 71.05.020(20).

attempt to elude people she thought were after her and were following her using her tooth. She had auditory hallucinations and displayed paranoid and suicidal ideation. Ms. Poletti continued to refuse medication while at Overlake. According to Dr. Koenig's dictated assessment, she was "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."

King County argues that Dr. Koenig's assessment was stale, as about six hours passed before Ms. Poletti requested to be discharged. It contends the requirement of imminent likelihood of serious harm means that only the current mental status of the patient matters. The court found Dr. Koenig's assessment was not yet current and relied on his statement that "[i]f patient continues to decline medication on 01/01/2007, the treatment team will *consider* referring the patient to the mental health professionals for an involuntary assessment versus administratively discharging the patient." (Emphasis added.)

It is undisputed that, by the time she requested to be discharged, Ms. Poletti had not resumed taking her antipsychotic medication. Although Ms. Poletti denied any intention to harm herself, Nurse Short knew that Ms. Poletti's good faith status was in question. Ms. Poletti had repeatedly left hospitals against medical advice. Ms. Poletti had otherwise admitted while at Overlake that she had suicidal thoughts and had attempted suicide about a month before. Nurse Short also knew there was a high probability that someone who has been having hallucinations, but is not taking their antipsychotic medication, will continue to have hallucinations. Less than six hours passed between her assessment by Dr. Koenig and the time of her discharge. Nothing

in the record indicates that anything had changed in Ms. Poletti's condition, except for Nurse Short's opinion to the contrary. A jury could find that Dr. Koenig's assessment was not stale.

Further, Dr. Koenig's decision to postpone a decision on whether to contact King County DMHP was consistent with the treatment plan he developed for Ms. Poletti, which allowed one day for her to adjust to the inpatient unit and for the treatment team to establish a rapport with her. Dr. Koenig's assessment is otherwise clear that Ms. Poletti met the criteria for a referral at that time. Based on all these facts, we hold that a jury may find that Ms. Poletti presented an imminent likelihood of serious harm.

The facts also create an issue as to whether Ms. Poletti was gravely disabled. She had not slept for five days and nights prior to her admission at Overlake, and it is unclear whether she slept while there. As long as she was refusing to take her antipsychotic medication, there was a high probability that her hallucinations would continue. Ms. Poletti had slept only several hours in 5 to 6 days and nights. She had been driving aimlessly most of that time. She was led by auditory hallucinations and delusions that she was being followed through her tooth. A jury may conclude that she was exhibiting a failure to provide for her essential human needs of health and safety.[38] A jury may also conclude that Ms. Poletti was in danger of serious physical harm, because of her behavior.[39]

The court erred in holding there was no issue of fact as to whether Ms. Poletti met the criteria for involuntary commitment.

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[38] See RCW 71.05.020(17).
[39] See id.

2. Referral for Evaluation

We also hold the court erred in holding there was no issue of fact as to whether there was a referral for an evaluation. Nurse Short testified in her deposition:

> Q. And you didn't ask for such an evaluation, did you?
> A. That's what we did when we called the MHPs.
> Q. Well, are you aware of the fact that the mental health professionals have indicated that you did not ask for an evaluation?
> A. Okay, during the conversation it was termed—you know, it was a moderate conversation. So I give the symptoms of why I'm concerned about the patient and during that conversation he said we have recently seen this patient and I will not be detaining her. And so then he said do you want to consider this a consultation?
> So my response was if you know you're not going to detain her, you know, and we really did not have criteria for a detention, so I said then we can consider it a consultation if you clearly know you're not going to detain her.

Mr. Militello characterized the decision to not do an evaluation as, "[A] collaborative process. Ultimately the decision to request an evaluation rests with the hospital in this case. Had she asked us to evaluate Ms. Poletti, we would have."

The inference from the quoted testimony, construed favorably to Poletti, is that Nurse Short initially requested an evaluation. A further inference is that she was persuaded to settle for a consultation based, at least in part, on Militello's statement that he would not detain Ms. Poletti. We hold that there is a genuine issue of fact as to whether a referral for an evaluation was made. The trial court erred in holding otherwise.

C. Proximate Cause.

Proximate cause is generally a question of fact.[40] Proximate cause has two elements—cause in fact (but-for cause) and legal causation (legal policy).[41] "A

[40] Hertog v. City of Seattle, 138 Wn.2d 265, 275, 979 P.2d 400 (1999).

proximate cause is one that in natural and continuous sequence, unbroken by an independent cause, produces the injury complained of and without which the ultimate injury would not have occurred."[42]

The plaintiff need not establish causation by direct and positive evidence.[43] She need only show by "a chain of circumstances from which the ultimate fact required is reasonably and naturally inferable."[44] But, evidence establishing proximate cause must rise above speculation, conjecture, or mere possibility.[45] A jury is not permitted to speculate on how an accident or injury occurred when causation is based solely on circumstantial evidence and there is nothing more substantial to proceed on than competing theories with the defendant liable under one but not the other.[46]

Overlake focuses on Poletti's concessions that she does not know for sure what caused Ms. Poletti's accident to argue that Poletti lacks proof on causation and relies on mere speculation. But, these alleged concessions must be viewed in context. In her deposition, Poletti was asked to "speculate" as to the causes of her mother's accident. Poletti said her "[B]est guesses is [sic] either she was so tired and she fell asleep and woke up and overcorrected and hit right into the rock culvert, or she purposefully hit the rock culvert because she wanted to kill herself." Similarly, at the summary judgment hearing Poletti's attorney stated, "We will never know if this individual intended to go off the road, fell asleep at the wheel, or had hallucinations that

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[41] Schooley v. Pinch's Deli Mkt., Inc., 134 Wn.2d 468, 478, 951 P.2d 749 (1998).
[42] Attwood v. Albertson's Food Ctrs., Inc., 92 Wn. App. 326, 330, 966 P.2d 351 (1998).
[43] Id. at 331.
[44] Id.
[45] Reese v. Stroh, 128 Wn.2d 300, 309, 907 P.2d 282 (1995).
[46] Sanchez v. Haddix, 95 Wn.2d 593, 599, 627 P.2d 1312 (1981).

prevented her from seeing where she was driving." That Poletti declined to settle on one single theory on causation does not defeat her claim. She has consistently argued that Ms. Poletti was gravely disabled by reason of her mental illness and lack of sleep during the several days and nights before her death, and/or in imminent likelihood of serious harm because of her delusions, hallucinations, and suicidal ideation, and recent suicide attempt. This case is distinguishable from those cases where the plaintiff relies on circumstantial evidence consistent with competing theories, with the defendant liable under one, but not the other. Here, the defendants could be found liable under either theory.

Overlake next contends there is no issue of fact on proximate cause, because the investigating officer concluded the accident was caused by Ms. Poletti apparently falling asleep, and that the coroner, who had been made aware of Ms. Poletti's mental illness, determined that the cause of death was traffic accident.

We note that the investigating officer's conclusion supports one of Poletti's alternative arguments, while the coroner's conclusion is not particularly helpful. More importantly, the toxicology report confirmed that Ms. Poletti had not resumed taking her antipsychotic medication. In Mr. Olson's opinion,[47] it was reasonably foreseeable by anyone who would have evaluated Ms. Poletti that she would continue to drive upon discharge, given her behavior before her visit at Swedish. It was also reasonably foreseeable that Ms. Poletti would continue to have hallucinations. She had reported hallucinations while at Swedish and Overlake and was refusing to take her

[47] This opinion is included in the second declaration of Olson, submitted after the court issued its summary judgment order in favor of Overlake. There was no challenge to Olson's competency to testify as to causation.

antipsychotic medication. A reasonably foreseeable risk of very serious harm existed as to Ms. Poletti, and others, if Ms. Poletti was discharged and allowed to drive. Olson concluded that had Overlake held Ms. Poletti for an evaluation and had Militello not told Nurse Short that Ms. Poletti was not subject to involuntary detention without interviewing her, she would not have been driving that night and would not have died.

This evidence, seen in the light most favorable to Poletti, creates an issue of fact as to whether there is cause in fact between the discharge without an evaluation and Ms. Poletti's death. The evidence is also sufficient to create an issue of fact as to legal cause. Unlike in other cases, here there are not "too many gaps in the chain of factual causation to warrant submission of that issue to the fact finder."[48]

Finally, Overlake contends that, as it is concerned, the causal chain was interrupted by Militello's decision that Ms. Poletti did not meet the criteria for involuntary commitment. As such, Overlake's argument goes, even if it had required Militello to evaluate Ms. Poletti in person, there would have been no difference in her outcome.

Overlake relies on Militello's deposition testimony that he "stands by [his] statement" and that Ms. Poletti's scenario was "not a commitment scenario." But, Militello also explained that if he were doing an evaluation, he "would be assessing not just her symptoms, but the credibility of her reporting . . . . That's why we don't make decisions over the phone. We need that contact." Further, as explained earlier, Poletti contends that Nurse Short did not provide Militello with complete and accurate

[48] Walters v. Hampton, 14 Wn. App. 548, 555, 543 P.2d 648 (1975) (submission of issue of causation to the jury not warranted where a high degree of speculation was necessary to conclude that some sort of prosecutorial action by the police against shooter in 1970 would have prevented plaintiff's injuries at shooter's hands in 1972).

information about Ms. Poletti's recent mental health history and then-current condition. Whether Militello would still have concluded that Ms. Poletti was undetainable with all relevant information available and after personally interviewing Ms. Poletti, is certainly an issue that cannot be decided on summary judgment. Moreover, as King County correctly points out, had Nurse Short insisted on an evaluation, as ordered by Dr. Mathiason, Overlake could have detained Ms. Poletti until the evaluation was performed, but not later than the next judicial day.[49]

The court erred in holding there is no issue of material fact as to causation.

We reverse the grant of summary judgment and remand for further proceedings.

Appelwick, J.

WE CONCUR:

Leach, A.C.J.

Scheivelbein, J.

[49] See RCW 71.05.050.