NO. 94679-5

SUPREME COURT
OF THE STATE OF WASHINGTON

JUDITH MARGARITA REYES,
on her own behalf and on behalf of the Estate of Jose Luis Reyes, Deceased, and on behalf of her minor children, Erik (n/m/n) Reyes (dob: 3/12/98) and Leslie Maria Reyes (dob: 6/23/99);

Petitioner,

v.

YAKIMA HEALTH DISTRICT,
a public entity in the State of Washington; CHRISTOPHER SPITTERS, M.D.; JOHN DOES NOS. 1-20;

Respondents.

RESPONDENTS CHRISTOPHER SPITTERS, M.D.'S AND YAKIMA HEALTH DISTRICT'S JOINT ANSWER TO PETITIONER'S MOTION FOR DISCRETIONARY REVIEW

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I. IDENTITY OF RESPONDENTS

The answering parties are Respondents Yakima Health District (hereinafter "YHD") and Christopher Spitters, MD (hereinafter "Dr. Spitters").

II. REASONS WHY REVIEW SHOULD BE DENIED

Despite Petitioner's contentions, the Court of Appeals' Decision in this matter was consistent with prior Washington State appellate court decisions. Petitioner has also failed identify the specific basis under RAP 13.4(b) upon which her Petition for Review relies.

Petitioner seeks discretionary review of the Court of Appeals' finding that her medical expert Rosa Martinez, MD's declaration was insufficient to support her medical negligence claim. However, Petitioner had failed to demonstrate a legitimate basis for review of that issue under RAP 13(b)(1) or (2). Specifically, she has failed to provide any evidence that the Court of Appeals failed to follow previous Court of Appeals and Supreme Court decisions regarding necessary expert support for medical negligence claims.

Petitioner also argues for the first time that *res ipsa loquitur* applies. This, however, is not a proper basis for review for two reasons: (1) the doctrine of *res ipsa loquitur* was raised for the first time on appeal and is therefore not an appealable issue and (2) *res ipsa loquitur* applies

only to a specific set of factual circumstances in medical negligence cases, which are nothing like this case.

Finally, Petitioner argues, again for the first time on appeal, that Respondents violated Mr. Reyes' due process rights by treating his tuberculosis. However, Petitioner fails to demonstrate how Respondents' medical care violated Mr. Reyes' due process rights, or even identify which due process rights (procedural or substantive) were violated.

III. COUNTER-STATEMENT OF THE CASE

A. Factual History

Dr. Spitters is an infectious disease specialist certified by the American Board of Preventive Medicine and serves as the Local Health Officer for Respondent YHD, a local health district. CP 29.

In 2009, Petitioner's husband, Mr. Reyes, presented to Rizwana Kahn, MD at the Yakima Chest Clinic complaining of intermittent chest pain. CP 149. Following a concerning chest x-ray, he underwent a bronchoscopy on April 20, 2010. CP 153. Mr. Reyes's sputum sample tested positive for tuberculosis. CP 144; 146; A1-A3. The Yakima Valley Memorial Hospital Microbiology Lab reported these results to the Washington Department of Health ("DOH") and YHD. CP 144; 146; A1-A3. Additional sputum samples analyzed by the DOH's Public Health

Laboratory cultured positive for tuberculosis. CP 155-158; 216-219; A4-A11.

On May 25, 2010, Mr. Reyes began tuberculosis treatment at YHD, where he was prescribed a four drug combination of isoniazid, rifampin, ethambutol, and pyrazinamide. CP 7; 159; 213. As his treatment progressed he was repeatedly asked to present to YHD for liver function testing. After six weeks, Mr. Reyes finally presented to YHD on July 8, 2010. CP 211. His results showed low liver function levels, so Dr. Devika Singh immediately instructed Nurse Hansen, the YHD nurse caring for Mr. Reyes, to hold Mr. Reyes' medication and have him return to YHD for more testing. CP 211. Nurse Hansen also contacted Dr. Spitters and told him about Mr. Reyes. CP 211.

Dr. Spitters reviewed Mr. Reyes' medical records and called him, leaving a message in English and Spanish and asking for Mr. Reyes to call back immediately. CP 211. Dr. Spitters also told Nurse Hansen to continue to hold Mr. Reyes' medication and to send him to the Emergency Room (ER). CP 212. Dr. Spitters reached Mr. Reyes via phone on July 15, 2010, at which point Mr. Reyes admitted that he had been experiencing fatigue and nausea for several weeks and that he had been drinking alcohol while taking his tuberculosis medications. CP 213. Mr. Reyes had been previously warned that drinking while on his tuberculosis

medication could increase his risk of a drug induced liver injury. CP 211. Dr. Spitters directed Mr. Reyes to go to the ER, but Mr. Reyes refused. CP 213. Dr. Spitters diagnosed Mr. Reyes with a drug induced liver injury and asked him to come back for additional testing. CP 213-214.

On July 16, 2010, Mr. Reyes presented to YHD for liver function testing, which was somewhat improved. CP 215. Dr. Spitters examined Mr. Reyes in the YHD clinic on July 21, 2010. CP 215-219. Dr. Spitters also connected Mr. Reyes with the hepatology department at the University of Washington to treat Mr. Reyes' liver injury. CP 221; 224-225. Sadly, Mr. Reyes' condition declined, and he passed away at the University of Washington on August 6, 2010. CP 226.

B. Procedural History – Trial Court

Petitioner filed this lawsuit individually and on behalf of her two minor children and Mr. Reyes' estate on October 3, 2014. CP 4. On December 2, 2014, Dr. Spitters filed a Motion for Summary Judgment on the statute of limitations, which the trial court denied. 5/5 RP 13:1-8. Thereafter, Dr. Spitters filed a Motion to Dismiss for Failure to Comply with Discovery (which was later stricken) and a Motion for Summary Judgment re Lack of Experts. CP 398-410; 460-462. On April 27, 2015 Petitioner filed her first declaration from Dr. Martinez in response to Dr. Spitters' Motion for Summary Judgment re Lack of Experts. CP 108-113.

In reply Dr. Spitters argued that Dr. Martinez' declaration was insufficient to establish a *prima facie* claim of medical negligence. CP 108-116.

On May 5, 2015, the trial court dismissed Petitioner's medical negligence claims, explaining:

> Look, I take this very seriously, because this is the nail in the coffin, and it sounds like Mr. Reyes suffered a horrible death, but at this point we don't have any facts to establish what the causation is, what the standard of care is, whether Dr. Martinez is qualified to reach these conclusory statements that she makes, and I agree with Mr. Kerley. You don't need a whole lot, but you need more than is here...
>
> She indicates that they violated the standard of care but she doesn't indicate anywhere that she's aware of the protocols in this State for the diagnosis and treatment of tuberculosis, which apparently they believe that he had.
>
> She indicates that she studied the medical records, doesn't say what records... There's just so many ambiguities here. I think this declaration is very deficient.

5/5 RP 44: 13-20; 45:12-18; 46:3-5. On May 11, 2015, Dr. Spitters filed his Motion for Summary Judgment re Tort of Outrage, asking the trial court to dismiss Petitioner's remaining claim. CP 195-206. YHD filed a similar motion on Petitioner's remaining claims and a Motion for Summary Judgment to dismiss Petitioner's wrongful death claims on the statute of limitations. CP 261-266. Dr. Spitters joined YHD's motion to dismiss the wrongful death claims. CP 272-275.

On May 18, 2015, Petitioner filed a Motion for Reconsideration of the trial court's May 5, 2015 decision to dismiss her medical negligence claim. CP 228. Petitioner attached a second declaration from Dr. Martinez to the Motion for Reconsideration. CP 229-231. In response, Dr. Spitters argued that Petitioner's Motion for Reconsideration was untimely and deficient under CR 59 because it failed to state any facts or law upon which it was based. CP 237; 240. Respondents also noted that Dr. Martinez' second declaration still failed to support a medical negligence claim because it did not sufficiently articulate the standard of care as it applied to Dr. Spitters and/or YHD, how Dr. Spitters and/or YHD violated the standard of care, and any causal connection between Dr. Spitters' care and Mr. Reyes' injury. CP 238-240.

At the July 15, 2015 hearing, the trial court agreed with Dr. Spitters and YHD, declining to consider Petitioner's untimely Motion for Reconsideration or Dr. Martinez' deficient second declaration. 7/15 RP 21:20-22:7. However, the trial court recognized that the second declaration was still deficient because Dr. Martinez' legal conclusion that Dr. Spitters and YHD violated the standard of care did not sufficiently articulate the standard of care required of Dr. Spitters and YHD or explain how each respondent failed to follow it. 7/15 RP 38:12-39:16.

The trial court also granted Dr. Spitters' Motion for Summary Judgment re Tort of Outrage and YHD's two motions. 7/15 RP 40:22-41:5. The trial court dismissed Petitioner's wrongful death claims, brought individually and on behalf of her two children, on the independent basis that they were barred by the three year statute of limitations for wrongful death claims. 7/15 RP 11:8-18.

C. Procedural History – Court of Appeals

Petitioner appealed the trial court's dismissal of her claims to the Court of Appeals. In its unpublished February 14, 2017 opinion, the Court of Appeals upheld the trial court's summary judgment dismissal of Petitioner's claims. *Reyes v. Yakima Health Dist.*, 197 Wn. App. 1072 (2017). The Court of Appeals reviewed the summary judgment dismissal *de novo*, first holding that the medical negligence claim was properly dismissed because Dr. Martiez' declaration failed to create an issue of fact. *Id.* at *3. Specifically, the declaration "failed to identify the discreet conduct" of Respondents that violated the standard of care and "also failed to declare the applicable standard." *Id.* at *4. The Court of Appeals did not address the issue of causation.

The Court of Appeals also upheld the trial court's dismissal of Petitioner's tort of outrage claim. The Court of Appeals declined to address whether a patient may recover for outrage despite the provisions

of Chapter 7.70 RCW because, as a threshold matter, Respondents' conduct was not outrageous as a matter of law. *Id.* at *5. The Court of Appeals analyzed Petitioner's claim in the context of Washington tuberculosis law, recognizing that a health district is statutorily required to maintain a tuberculosis treatment program and that a local health officer holds the authority to order a patient to submit for treatment. *Id.* at *6. It recognized that some records contained a diagnosis of tuberculosis and that Respondents reasonably believed that Mr. Reyes had tuberculosis. Therefore, they had an obligation to treat him and prevent the disease's spread to others. This treatment was neither extreme nor outrageous. *Id.* Finally, the Court of Appeals upheld the dismissal of Petitioner's wrongful death claim because it had upheld the dismissal of Petitioner's underlying claims (medical negligence and the tort of outrage). *Id.* at *7.

Petitioner filed a Motion for Reconsideration, which the Court of Appeals denied. This Petition followed.

IV. ARGUMENT

Petitioner has raised three issues in her Petition: (1) whether the Court of Appeals erred in finding that Dr. Martinez' declaration was insufficient to support a *prima facie* claim of medical negligence, (2) whether the Court of Appeals erred in dismissing all of her claims under

the doctrine of *res ipsa loquitur*, and (3) whether the Court of Appeals erred in dismissing her claims under the principle of due process.

A. Petitioner has failed to demonstrate a legitimate basis for discretionary review of the Court of Appeals holding that Dr. Martinez' declaration was insufficient to support a *prima facie* medical negligence claim.

A petition for review will only be accepted by the Supreme Court in specific instances:

> (1) If the decision of the Court of Appeals is in conflict with a decision of the Supreme Court; or
> (2) If the decision of the Court of Appeals is in conflict with a published decision of the Court of Appeals; or
> (3) If a significant question of law under the Constitution of the State of Washington or of the United States is involved; or
> (4) If the petition involves an issue of substantial public interest that should be determined by the Supreme Court.

RAP 13.4(b).

Nowhere in her brief does petitioner set forth the legal basis that would permit discretionary review, most likely because there is none. Rather, Petitioner argues that the Court of Appeals must accept, by mere fact of its existence, that Dr. Martinez' declaration is sufficient to establish a *prima facie* medical negligence claim. She further argues that the Court of Appeals weighed the "credibility" of Dr. Martinez' declaration as opposed to whether it met the requirements set forth by this Court and the Courts of Appeals. This is procedurally and legally incorrect.

The Court of Appeals reviewed the trial court's summary judgment dismissal of Petitioner's medical negligence claim *de novo*. It upheld dismissal for two reasons: (1) Dr. Martinez' declaration failed to identify the Respondents' discreet conduct that violated the standard of care, and (2) her declaration failed to declare the applicable standard of care that applied to each respondent in this case. The Court of Appeals cited well established precedent that requires a medical expert to articulate both the specific standard of care as it applies to each medical defendant and explain the discreet conduct that actually violated that standard of care in order to survive summary judgment. *See, e.g. Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 341 P.3d 261 (2014); *Douglas v. Bussabarger*, 73 Wn.2d 476, 438 P.2d 829 (1968); *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 851 P.2d 689 (1993); *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 226, 770 P.2d 182 (1989). Because Dr. Martinez' declaration failed to meet both of these requirements, summary judgment was appropriate. Petitioner has failed to articulate any basis for discretionary review of these findings under RAP 13.4(b), and her petition should be denied.

B. Petitioner is not entitled to discretionary review of the Court of Appeals' decision under the doctrine of *res ipsa loquitur*.

Petitioner raises for the first time the argument that her claims should not have been dismissed due to the doctrine of *res ipsa loquitur*. However, this is not a sufficient basis for discretionary review. With limited exception, this Court does not consider legal issues not raised or briefed in the Court of Appeals. *State v. Halstien*, 122 Wn.2d 109, 130, 857 P.2d 270 (1993) ("An issue not raised or briefed in the Court of Appeals will not be considered by this court."). These exceptions are as follows:

> (a) Errors Raised for First Time on Review. The appellate court may refuse to review any claim of error which was not raised in the trial court. However, a party may raise the following claimed errors for the first time in the appellate court: (1) lack of trial court jurisdiction, (2) failure to establish facts upon which relief can be granted, and (3) manifest error affecting a constitutional right.

RAP 2.5(a). The doctrine of *res ipsa loquitur* does not fall into the limited exception of RAP 2.5(a). Petitioner is not permitted to assert this argument for the first time on appeal.

Even if the Court were to allow discretionary review of whether *res ipsa loquitur* applies here, discretionary review would be pointless because *res ipsa loquitur* does not apply to this case and would not have prevented the trial court from dismissing Petitioner's claims.

> The doctrine of res ipsa loquitur spares the plaintiff the requirement of proving specific acts of negligence in cases where a plaintiff asserts that he or she suffered injury, **the cause of which cannot be fully explained, and the injury is of a type that would not ordinarily result if the defendant were not negligent.** In such cases the jury is permitted to infer negligence. The doctrine permits the inference of negligence on the basis that the evidence of the cause of the injury is practically accessible to the defendant but inaccessible to the injured person.

Pacheco v. Ames, 149 Wn.2d 431, 436, 69 P.3d 324 (2003) (internal citations omitted) (emphasis added) (allowing a *res ipsa loquitur* instruction where the defendant physician allegedly operated on the wrong side of the plaintiff's mouth). *Res ipsa loquitur* is applicable only when the evidence shows,

> (1) the accident or occurrence producing the injury is of a kind which ordinarily does not happen in the absence of someone's negligence, (2) the injuries are caused by an agency or instrumentality within the exclusive control of the defendant, and (3) the injury-causing accident or occurrence is not due to any voluntary action or contribution on the part of the plaintiff.

Id. at 436 (internal citations omitted). In a medical negligence cases, this includes cases where,

> (1) When the act causing the injury is so palpably negligent that it may be inferred as a matter of law, i.e., leaving foreign objects, sponges, scissors, etc., in the body, or amputation of a wrong member; (2) when the general experience and observation of mankind teaches that the result would not be expected without negligence; and (3) when proof by experts in an esoteric field creates an inference that negligence caused the injuries.

Id. at 438-9 (internal citations omitted).

Not only was *res ipsa loquitur* not raised at the trial court or Court of Appeals, but it does not apply to this claim. First, the cause of Mr. Reyes' liver injury is not in dispute; he had a drug induced liver injury. Second, Petitioner has demonstrated no evidence that drug induced liver injuries do not happen absent negligence. To the contrary, a medical provider may prescribe commonly used tuberculosis medications within the standard of care, and the patient may still become injured even absent any negligence on the part of the provider.

Most importantly, Dr. Spitters and YHD did not have complete control of Mr. Reyes. Mr. Reyes was an outpatient who decided when and if he showed up for treatment and testing to monitor his liver function. After beginning treatment, Mr. Reyes chose not to comply with regular liver function testing. Once he finally presented for testing and was diagnosed with a drug induced liver injury, Mr. Reyes chose to wait another week to seek medical care. Moreover, Mr. Reyes admitted to drinking while on his medications, something over which Respondents had no control and which may have caused or contributed to his injury. Dr. Spitters and YHD did not have exclusive control over Mr. Reyes, which is fatal to Petitioner's new *res ipsa loquetur* claim.

C. This Court should deny discretionary review of Petitioner's new due process claim.

Petitioner's Petition for Discretionary Review raises a due process claim for the first time in this litigation. Specifically, Petitioner argues that Mr. Reyes' due process rights under the Fourteenth Amendment of the U.S. Constitution and Article 1, § 3 of the Washington Constitution were violated when YHD medical staff required him to take medications to treat his tuberculosis. However, Petitioner has failed to demonstrate how YHD actually breached Mr. Reyes's due process rights. Similarly, petitioner has failed to explain how Dr. Spitters, who became involved in Mr. Reyes' care after his injury occurred, violated Mr. Reyes' due process rights. Petitioner's claim is without merit and should not be afforded discretionary review.

1. Petitioner has failed to articulate a legitimate basis for discretionary review of her new due process claim.

RAP 2.5(a)(3) provides a limited exception to the rule that new arguments cannot be raised on appeal where an the alleged error is a manifest error affecting a constitutional right. RAP 2.5(a)(3).

> Because RAP 2.5(a)(3) is an exception to the general rule that parties cannot raise new arguments on appeal, we construe the exception narrowly by requiring the asserted error to be (1) manifest and (2) truly of constitutional magnitude.

State v. WWJ Corp., 138 Wn.2d 595, 602, 980 P.2d 1257 (1999) (internal citations omitted) (applying the RAP 2.5(a)(3) exception to civil cases).

> [A]n alleged error is manifest only if it results in a concrete detriment to the claimant's constitutional rights, and the claimed error rests upon a plausible argument that is supported by the record. To determine whether a newly claimed constitutional error is supported by a plausible argument, the court must preview the merits of the claimed constitutional error to see if the argument has a likelihood of succeeding.

Id. at 603. In other words, "Appellate courts will not waste their judicial resources to render definitive rulings on newly raised constitutional claims when those claims have no chance of succeeding on the merits." *Id.*

To recover for a substantive due process claim, "the plaintiff must identify a property right, show that the state has deprived him or her of that right, and show that the deprivation occurred without due process." *Durland v. San Juan Cty.*, 182 Wn.2d 55, 340 P.3d 191 (2014). To recover for a procedural due process claim, Petitioner must show that that Mr. Reyes was deprived of some sort of fair hearing, which requires "notice; an opportunity to be heard or defend before a competent tribunal in an orderly proceeding adapted to the nature of the case; an opportunity to known the claims of opposing parties and to meet them; and a reasonable time for preparation of one's case." *Cuddy v. State, Dep't of Pub. Assistance*, 74 Wn.2d 17, 19, 442 P.2d 617 (1968).

While a constitutional claim can be raised for the first time on discretionary review, Petitioner's claim does not fit within this narrow exception and should be denied review. Petitioner's brief both fails to identify which type of due process claim she alleges (substantive or procedural), or how Dr. Spitters and YHD actually violated Mr. Reyes' due process rights. Petitioner's due process claim has no chance of surviving at the trial court level and fails to illustrate a manifest error of constitutional magnitude. Thus, discretionary review on this basis should be denied.

2. Petitioner's due process claim is not supported by the record.

Petitioner's due process claim is not supported by the record. Petitioner's claim appears to be based on the idea that Mr. Reyes never had tuberculosis and that both Respondents forced him to ingest drugs to treat it even though they knew or should have known he never had tuberculosis. This is factually incorrect, and Petitioner's brief cites no support of these allegations in the record. To the contrary, the record shows that Mr. Reyes was diagnosed with tuberculosis by positive sputum culture at Yakima Memorial Hospital and that the Washington State DOH Laboratory also grew positive tuberculosis from his sputum. CP 144; 146; 155-158; 216-219; A1-A11. Mr. Reyes was prescribed medications to treat the tuberculosis by YHD medical providers in accordance with the

Washington statutes that govern tuberculosis treatment. Dr. Spitters did not begin care until he was contacted by YHD staff on July 8, 2010, after Mr. Reyes' liver injury occurred. As the Court of Appeals recognized in its analysis of Petitioner's tort of outrage claim, Respondents reasonably believed that Mr. Reyes had tuberculosis, and they followed the statutes that govern local health districts and local health officers in their treatment of tuberculosis. The record does not support a due process claim.

3. Petitioner has failed to articulate a legal basis for her due process claim.

Petitioner has failed to articulate any legitimate legal basis for a procedural or substantive due process claim. To the contrary, Respondents' care was consistent with the Washington statutes governing tuberculosis treatment, RCW 70.28.005 and WAC 246-170 *et. seq.*, which do not provide a basis for petitioner's due process claim in this case.

Substantive due process requires that civil commitment laws be narrowly tailored to serve a compelling government interest. *Matter of Det. of M.W. v. Dep't of Soc. & Health Servs.*, 185 Wn.2d 633, 649, 374 P.3d 1123 (2016) (holding that former RCW 71.05.320(3)(c)(ii) satisfied both substantive and procedural due process). Procedural due process requires that the government provide proper notice and the opportunity to

be heard when it seeks to deprive an individual of a protected interest. *Id.* at 653.

In Washington, each county local health officer "is responsible for the control of tuberculosis within a jurisdiction." WAC 246-170-021. "Each local health department shall assure the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis..." WAC 246-170-031(1). In enacting the laws governing tuberculosis testing and treatment, the Washington legislature recognized that tuberculosis is a "is a life-threatening airborne disease" and that the increasing number of cases per year poses a serious health risk requiring public health intervention. WAC 246-170-002(1)(a). Therefore,

> In order to limit the spread of tuberculosis, it is essential that individuals who have the disease are diagnosed and treated before they infect others... A person with infectious tuberculosis who does not voluntarily submit to appropriate testing, treatment, or infection control methods poses an unreasonable risk of spreading the disease to those who come into the infectious person's proximity.

WAC 246-170-002(1)(b)-(c). The local health officer is required to make a reasonable effort to obtain voluntary compliance with tuberculosis testing and treatment. WAC 246-170-051(1). However, if the local health officer suspects non-compliance, then he or she may ask the court for an order compelling involuntary detention and treatment. *Id.* WAC 246-170-

055 affords patients due process prior to involuntary detention for treatment:

> (1) A hearing on the petition for detention filed under WAC 246-170-051 shall be conducted in superior court within seventy-two hours after initial detention, excluding weekends and holidays. The local health officer shall have the burden of proving the allegations set forth in the petition by a preponderance of the evidence. The person named in the petition shall have the right to cross-examine witnesses, present evidence, and be represented by an attorney at any hearing held on the petition. If the person is indigent and requests appointment of legal counsel, legal counsel shall be appointed at public expense at least twenty-four hours prior to the superior court hearing.

WAC 246-170-055(1).

Here, Mr. Reyes was never involuntary detained because he was initially compliant with his testing and treatment. Petitioner alleges that when Mr. Reyes later became non-compliant, YHD staff threatened to detain him if he remained non-compliant. However, YHD's threat to follow Washington's law governing involuntary detention for tuberculosis does not amount to depriving Mr. Reyes of a constitutionally protected right. Moreover, in RCW 70.28.005 and WAC 246-170 *et. seq.* the Washington legislature clearly identified a compelling government interest (protecting the public from a tuberculosis epidemic) and set forth a narrowly tailored process to achieve its goals. Mr. Reyes' substantive due process rights were not violated in this case.

Similarly, the facts of this case never necessitated a hearing for detention and treatment, meaning that Petitioner has no procedural due process claim. Moreover, WAC 246-170-055 explicitly sets forth procedural due process protections that would have been afforded to Mr. Reyes. Had involuntary detention become necessary, Respondents would have followed the process set forth in WAC 246-170-055 to ensure that Mr. Reyes was afforded due process.

The facts of this case do not rise to the level of a substantive or procedural due process violation. Petitioner cites no case law to support her due process claim and offers the Court no other basis to assert a new constitutional claim on appeal. Thus, discretionary review of Petitioner's due process claim should be denied.

V. CONCLUSION

For the foregoing reasons Respondents respectfully request that the Court deny Petitioner's Petition for Discretionary review.

DATED this 14th day of July, 2017, at Seattle, Washington.

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VI. CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that the following is true and correct:

That on the date signed below, I caused to be served in the manner indicated a true and accurate copy of the foregoing, RESPONDENTS CHRISTOPHER SPITTERS, M.D.'S AND YAKIMA HEALTH DISTRICT'S JOINT ANSWER TO PETITIONER'S MOTION FOR DISCRETIONARY REVIEW, by the method indicated below and addressed to the following:

Counsel for Petitioner J.J. Sandlin, Esq. Sandlin Law Firm, P.S. PO Box 1707 Prosser, WA 98350 jj@sandlinlawfirm.com	☐ U.S. Mail ☐ Hand Delivery ☐ Facsimile	☐ Overnight ☑ E-mail/E-Service ☐ Messenger

Counsel for Respondent Yakima Health District Christopher J. Kerley, Esq. Evans, Craven & Lackie, P.S. 818 W. Riverside, Ste. 250 Spokane, WA 99201-0910 ckerley@ecl-law.com	☐ U.S. Mail ☐ Hand Delivery ☐ Facsimile	☐ Overnight ☑ E-mail/E-Service ☐ Messenger

Signed this 14 day of July, 2017, at Seattle, Washington.

Elizabeth Mitchell
Legal Assistant to John C. Graffe and
Michelle S. Taft

VII. APPENDIX A

Positive AFB Report Form

Reporting Lab: Yakima Valley Memorial Hospital
Microbiology Lab
2811 Tieton Drive
Yakima, WA 98902
509-249-5382

Requesting Doctor's Name: Khanh Pitzman
Address: 2nd Nelson Ave
Yakima, WA
Phone #: 509 - 575-7693

Source of Specimen: Branch Wash-Rinse
Date of Collection: 4-30-10
Date Received: 4-30-10
Accession #: T8546
AFB Smear Result: [redacted]
AFB Culture Result: [redacted]

Patient Information
Name: [redacted]
Gender: M
Date of Birth: [redacted]
Address: [redacted]
Telephone: [redacted]

Other information of epidemiological value:

This information faxed to DOH TB Program 360-236-3405 on 5/18 at 1450

This information faxed to YHD 249-6628 on 5/18 at 1450

Send copy of this form with specimen to Infection Control.
Place original copy in Send out book.
Microbiology/Mycobacteriology/Positive AFB Report Form

Microbiology Results

Time of report: 07/06/2010 14:33

Name: [redacted]

Date of birth: [redacted]

Sex: [redacted]

SSN:

HMO ID: 310300

Hospital ID: 0

Location: YAKVAL

SCANNED AUG 2 2012

M62836 Collection D/T: 04/28/2010 1846 Receive D/T:

SENT/D: 03/19/2010 1846

Transport Time: 085.5 hours

Requisition NO:

Order Location: YAKVAL

AP Diagnosis:

AP Comment:

Attending Phys: KHAN,KIZHAKA (Consult)

AFB Susceptibility		
Specimen Description	Organism From culture	(1266) HV
Special Requests	None	(1265) HV
Culture	Mycobacterium tuberculosis complex identification by sequence analysis : This is a reportable organism under WAC 246-101. Please report to State Health Dept. TB Control at (360) 236 3397 within 48 hours. Further susceptibility results to follow. - Previously issued as a Final Report on: 6/10/10	(2609) HV
Report Status	...	
Sensitivity		
Organism	Mycobacterium tuberculosis complex identification by sequence analysis : This is a reportable organism under WAC 246-101. Please report to State Health Dept. TB Control at (360) 236 3397 within 48 hours. Further susceptibility results to follow.	(2609) HV
Sensitivity Type	AFB Sensitivity, MGIT	(2609) HV
Streptomycin (1 ug/mL)	Sensitive	(2609) HV
Isoniazid (0.1 ug/mL)	Sensitive	(2609) HV
Rifampin (1 ug/mL)	Sensitive	(2609) HV
Ethambutol (5 ug/ml)	Sensitive	(2609) HV

Susceptibility Color Code	
	SUSCEPTIBLE
	INTERMEDIATE
	RESISTANT
	NO RESULTS
	NO INTERPRETATION

PZA pending

~~Noted~~ CS

No plans 07/16/10

END OF REPORT

Please forward to YHD TB WTRL. Fax 509 249 ~~658~~ 6632.

nc

33697 2-000000146

900080
17418

Washington State Department of Health
TB section

Harborview Medical Center
325 Ninth Avenue
Seattle WA
Phone: USA

FINAL REPORT

SCANNED
AUG 3 2010

Mycobacteriology Laboratory Results

For Patient: [redacted]

Seattle WA 98104
County: King
Patient ID: [redacted]
Birth Date: [redacted] Age: [redacted] Years [redacted]
Submitting Lab: WA2836 2506 Physician:
TB Lab #: 10001606 PHL Tracking #: WA0082694
Test Reason: Reference Date Collected: 04-20-2010
Specimen Site: Unknown Topography Date Received: 06-17-2010
Specimen Source: Unknown/Unspecified

Microscopy Report

Test	Result	Performed by	Date
AFB Smear	Not provided	HARBORVIEW	06-18-2010

Culture Report

Test	Result	Performed by	Date
Conclusion - 1	Mycobacterium tuberculosis complex		
HARBORVIEW 05-21-2010			

Susceptibility Report - 1st Line of Drugs

Test	Result	Performed by	Date
MGIT Streptomycin (SM) 1.0	Sensitive	HARBORVIEW	06-18-2010
MGIT Isoniazid (INH) 0.1	Sensitive	HARBORVIEW	06-18-2010
MGIT Rifampin (RIF) 1.0	Sensitive	HARBORVIEW	06-18-2010
MGIT Ethambutol (EMB) 5.0	Sensitive	HARBORVIEW	06-18-2010
Pyrazinamide 100	Results to follow AM090303		
06-18-2010			

Lab Comments Report

033) Primary submitter: Yakima Valley Hospital Lab 06-18-2010
146) PHL receipt date used due to lack of information provided by

33697 2-000000148

05/21/2010 18:19 UNIVERSITY OF WASHINGTON MEDICAL CENTER INTERIM REPORT
INCLUDING LABORATORIES AT UWMC, HMC AND SCCA PAGE 1
DAP 84637-01, 84637-16, 84637-19, 84637-30, 84637-36, 84653-01

Name: [redacted] Age: [redacted] Sex: M *** PATIENT ***
Pt #: [redacted] Loc: YAKVAL *** DISCHARGED ***
Acct: 0 Dr: KHAN,RIZWANA (YAKVAL)

MICRO COLL: 04/20/2010 UNKNOWN REC: 05/19/2010 18:48 PHYS: KHAN,RIZWANA (YAKVAL)

AFB Smearing
Specimen Description Pure Culture (UW)
Special Requests None (UW)
Culture Mycobacterium tuberculosis complex This is a reportable (UW) —
organism under WAC 246-101. Please report to State Health
Dept. TB Control at (360) 236 3597 within 48 hours.
FINDINGS REVIEWED BY PATHOLOGIST.
Telephoned with read back to: Heather at Yakima Valley
Hospital Lab, 1215 05/21/10

Report Status ...

[redacted]

T.C: 215 Message left. 5-7-10

Reported 5-21-10

SCANNED AUG 8 2012

[redacted]

33697 2-000000155

Washington State Department of Health
Health
Public Health Laboratories

State of Washington
Department of Health
Public Health Laboratories
1610 NE 150th Street, PO Box 550501
Shoreline, WA 98155-9701
Phone: (206) 418-5473
Fax: (206) 418-5545

REDACTED

Yakima Health District
Attn: TB Control
1210 Ahtanum Ridge Drive
Union Gap WA 98903

Phone: 509-249-6532
Fax: 509-249-6632

Final Report

Mycobacteriology Laboratory Results

For Patient:	[redacted]	Physician:	Dr. Singh
		TB Lab #:	16000404
		PHL Tracking #:	WA0082431
County:	[redacted]	Date Collected:	06/07/2010
Patient ID:		Date Received:	06/08/2010
Birth Date:	[redacted] Age: [redacted]	Test Reason:	Diagnostic
Sex:		Specimen Site:	Lung, NOS
		Specimen Source:	Sputum
Submitting Lab#:		Primary Submitter:	

Microscopy Report

Test	Result	Performed by	Date
AFB Smear	AFB Not Found (fluorochrome stain). Report to follow	CMV	6/10/2010

Culture Report

	Performed by	Date
Mycobacterium tuberculosis complex	ZKI	8/2/2010
102) 1 colony(s) isolated at 8 weeks.		8/2/2010
112) Previous positive. See WA Lab #16001365		

Lab Comments Report

815) This specimen was noted to be watery during processing. Watery samples are often caused by the collection of postnasal fluid or saliva instead of sputum. Please note the proper procedure for collection of sputum specimens for AFB (See instructions with specimen kits). 6/10/2010

Washington State Department of Health
Public Health Laboratories

State of Washington
Department of Health
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1610 NE 150th Street, PO Box 359901
Shoreline, WA 98155-9701
Phone: (206) 418-5473
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RETACTED

Yakima Health District
Attn: TB Control
1210 Ahtanum Ridge Drive
Union Gap WA 98903

Phone: 509-249-6532
Fax: 509-249-6632

Final Report

Mycobacteriology Laboratory Results

For Patient: [redacted]
County:
Patient ID :
Birth Date: Age
Sex :
Submitting Lab#:

Physician: Dr. Singh
TB Lab #: 10001365
PHL Tracking #: WA0082036
Date Collected: 05/25/2010
Date Received: 05/27/2010
Test Reason: Diagnostic
Specimen Site: Lung, NOS
Specimen Source: Sputum
Primary Submitter:

Microscopy Report

Test	Result	Performed by	Date
AFB Smear	AFB Not Found (fluorochrome stain). Report to follow	ZKJ	5/28/2010

Culture Report

		Performed by	Date
	Mycobacterium tuberculosis complex	CAL	6/24/2010
102)	2 colony(s) isolated at 4 weeks		6/24/2010

SCANNED AUG 8 2012

Printed On: 11/23/2010

33697 2-000000157

State of Washington
Department of Health
Public Health Laboratories
1610 NE 150th Street, PO Box 550501
Shoreline, WA 98155-9701
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REDACTED

Yakima Health District
Attn: TB Control
1210 Ahtanum Ridge Drive
Union Gap WA 98903

Phone: 509-249-6532
Fax: 509-249-6632

Final Report

Mycobacteriology Laboratory Result

For Patient: [redacted]
County:
Patient ID :
Birth Date: Age: [redacted]
Sex :
Submitting Lab#:

Physician: Dr. Singh
TB Lab #: 10001366
PHL Tracking #: WA0082037
Date Collected: 05/26/2010
Date Received: 05/27/2010
Test Reason: Diagnostic
Specimen Site: Lung, NOS
Specimen Source: Sputum
Primary Submitter:

Microscopy Report

Test	Result	Performed by	Date
AFB Smear	AFB Not Found (Smear/culture discordant). Report to follow	ZKI	5/28/2010

Culture Report

		Performed by	Date
	Mycobacterium tuberculosis complex	CAL	6/24/2010
191) MGIT positive at four weeks.			6/24/2010

Lab Comments Report

015) This specimen was noted to be watery during processing. Watery samples are often caused by the collection of postnasal fluid or saliva instead of sputum. Please note the proper procedure for collection of sputum specimens for AFB (See instructions with specimen kits). 5/27/2010

SCANNED AUG 3 2012

Printed On: 11/23/2010

33697 2-000000158

Yakima Health District
1210 Ahtanum Ridge Drive
Union Gap, WA 98903
Phone (509) 575-4040
Fax (509) 575-7894

July 22, 2010

[redacted]

1-hour office visit yesterday, July 21, with [redacted] in follow-up for severe drug-induced liver injury, presumably secondary to anti-tuberculosis therapy.

Background from my review yesterday of [redacted] YHD TB record:
[redacted] was evaluated through a 1993 YHD contact investigation centered around a relative with active TB. At that time he was diagnosed with old inactive TB (RUL fibrotic opacity per Dr. Atwood's interpretation [image not available]; sputum AFB smears and cultures negative x3). [redacted] 1993 record indicated a regular alcohol intake of a six-pack or two on weekends. It appears that [redacted] was started on isoniazid, being dispensed a single month's supply, but he did not continue therapy and apparently was lost to follow-up.

In late 2009 began a series of clinical and radiographic evaluations through outside providers for a non-resolving multi-lobar pneumonia. This was radiographically characterized on serial chest CTs (December 3, 2009, and January 12, 2010) by a persistent fibronodular right apical infiltrate and loculated right pleural effusion, along with somewhat improved right superior segment (lower lobe), right middle lobe and left lower lobe opacities. Also noted on the initial diagnostic CT report was multifocal hypoattenuation suggestive of fatty liver; the radiologist's report indicated that this finding had improved on the follow-up CT. On or about April 20, 2010, Mr. Reyes underwent bronchoscopic examination by Dr. Khan. A plain PA CXR done at that time showed persistent right apical infiltrate and smaller right effusion. The BAL fluid collected was AFB smear-negative, but yielded *M. tuberculosis* complex in culture. The isolate was later shown to be sensitive to all first line agents (INH/RIF/PZA/EMB/STREP).

[redacted] was referred by his diagnosing pulmonologist (Rizwana Khan, MD) to YHD for treatment. A follow-up plain PA CXR obtained May 25 showed less right apical opacity and an essentially stable right pleural effusion. On or about May 25 he was started on INH/RIF/PZA/EMB and B6 at weight-standardized doses by DOT given daily M-F (no weekends). In his contemporary history provided to both outside providers and YHD, [redacted] initially indicated that he had stopped alcohol ingestion a month or two prior to the TB diagnosis, but later he indicated to YHD staff that he may have had a couple of beers on weekends. Baseline hepatic function was essentially normal (total bilirubin was slightly above the normal range at 1.6mg/dl). Hematocrit was 40 with an MCV of 92. WBC, platelets and differential were normal. Sputum was collected x3 at that time; these were AFB sputum- and culture-negative. HIV serology was negative. A follow-up plain chest film at that time showed findings similar to those mentioned above from the CTs.

In mid-June, after two weeks of daily therapy, his treatment was temporarily changed to twice-weekly as a trial of a more mutually convenient regimen. However, he reported gastro-intestinal complaints that caused his treatment to revert to daily dosing. In late June and early July, [redacted] missed a

string of DOT days, and was also reported by the TB nurse as being delinquent in submitting blood for monitoring of tolerance (i.e., CMP, CBC). After repeated efforts by YHD staff to ensure submission of a blood, a July 8 specimen was ultimately collected and submitted, demonstrating an ALT of approximately 600, AST ~1100, total bilirubin ~2.5. TB medications were held and a series of events documented in previous notes ensued attempting to motivate [redacted] to report to an emergency room for an inpatient evaluation. These attempts were finally successful on July 16 or 17. At that time his ALT had risen to ~1400, AST ~2000, and total bilirubin ~25. Total anti-HAV was positive but IgM was negative (immune); HBsAg was also negative. When I spoke with his evaluating gastroenterologist (Gilbert Ong, MD) on or about July 17, his INR was reportedly about 2 and ammonia was also slightly elevated. Dr. Ong concurred with the diagnosis of severe drug induced liver injury and developed an outpatient follow-up plan that is ongoing. Follow-up bloodwork collected yesterday demonstrated AST ~900, ALT ~800, and total bilirubin still up ~23. Albumin is down to 2.5 from 3.4 a week ago.

Interval History

[redacted] presented on time to meet with me. He speaks and understands English fluently by my assessment and there is no language barrier in bilateral communication of complex social and technical information. Upon specific questioning, he says that his energy level is about 60% improved since medications were held (60 on a scale of 0 [at his worst on the day meds were stopped] to 100 [normal for him]). He is eating lots of fruits and yoghurt but still has occasional bouts of anorexia and fatigue. He is working supervising manual laborers constructing and repairing apple crates at multiple sites. He reports that this mostly involves driving around Yakima Valley, which his wife often helps him with. He denies nausea, vomiting, headache, diarrhea, clay colored stools (stools are "normal brown color"), bleeding gums, easy bruising, or other bleeding phenomena. He now reports to me that back around mid-June he began to feel fatigued and often had to lay down on the couch and close his eyes during the day; this was not usual for him. This continued until medications were stopped. He reports that he does not drink alcohol. He asks if YHD or I can be of assistance in dealing with the medical bills associated with his hospitalization. He reports that his wife and family are concerned and that he didn't bring his wife along for the visit because he doesn't want to worry her. When I asked him what she would ask if she were here, he said that she would ask how this happened and what will happen in the future as a result.

Focused exam:

- BP 110/65, P 76 and reg, R 18, afebrile
- No acute distress, well dressed and well groomed
- Icterus noted on sclerae and areas of skin not exposed to sun (e.g., axilla)
- No cervical adenopathy
- Lungs clear to auscultation bilaterally
- Regular heart rate and rhythm w/o murmur, rub or gallop
- Abdomen soft and non tender. Liver edge palpable but not tender at right costal margin. No palpable splenomegaly.
- Extremities without edema or injury.
- Skin normal except for jaundice. No ecchymoses or petechiae. Multiple tattoos noted.
- Speech, language, cognitive function and gross sensorimotor function intact

Labs as set forth above. Also note that a sputum AFB smear of July 2 is negative with AFB culture pending.

Impression:

1. Severe drug induced liver injury with guarded prognosis. Hepatitis A excluded, hepatitis B unlikely, hepatitis C apparently not tested. Whether alcohol ingestion contributed to this is difficult to determine. Transaminases appear to have peaked and now are coming down (50% since last exam about 5 days ago), suggesting a slowing of hepatocyte death, and his reported clinical improvement over the two weeks since treatment was interrupted is also cause for hope. Persistent hyperbilirubinemia and falling albumin are concerning, however, regarding his organ reserve for detoxification and synthetic function. The recent past history of fatigue that he reports to me today and is inconsistent with the reports made to YHD staff of not feeling ill after the July 8 blood draw, as well as with his report to me when I spoke with him for the first time on or about July 16. Regardless, the liver injury appears to have progressed to this severity as a result of the roughly three week interval between the now-reported onset of fatigue in mid-June and the interruption of therapy following discovery of elevated transaminases in early July.

   Although the declining transaminases might imply improvement, as would his recent clinical history of feeling improved and eating reasonably well, the falling albumin is concerning regarding his liver function. With [redacted] present in the room, I called Dr. Ong's office on speaker phone to arrange for the July 23 follow-up blood testing Dr. Ong had planned on (CMP, CBC, PT/INR, ammonia). For completeness' sake, anti-HBc IgM and anti-HCV testing should be also be pursued to definitively rule out viral hepatitis as a primary or contributing cause.

   During that call, Dr. Ong's nurse (Michelle) also arranged for a follow-up appointment on August 17 (10:30 AM). I printed this information by hand and gave it to [redacted] along with a card bearing my name and cell phone number to call if problems arise. If Friday's bloodwork shows continued decline of synthetic function, we may need to arrange for his follow-up with Dr. Ong to be expedited. Meanwhile, I defer to Dr. Ong on the most appropriate setting for observation and management, diet, and activity.

2. Partially treated, fully sensitive, non-cavitary, smear-negative pulmonary TB after six weeks of effective therapy. [redacted] does not pose an imminent infection control concern. In that respect, it would be advisable to obtain another PA/LAT chest radiograph and collect a sputum sample once per week for surveillance purposes while anti-TB therapy remains interrupted. Further plans for anti-TB therapy with alternative agents are deferred indefinitely until his acute liver injury is stabilized or there is a return of culture positivity or clinical evidence of TB to compel treatment sooner.

Patient Counseling

I explained fully my understanding of the sequence of events that led his current status as set forth above. Specifically, there was a roughly three week gap between the now-reported onset of fatigue in mid-June and the interruption of therapy following detection of elevated transaminases in early July. I expressed that I am sorry for the pain, suffering and worry he and his family are experiencing as a

result. I also expressed guarded hope for continued clinical improvement but inability to assure him that he is out of danger and the reality that many patients with this type of liver injury end up not recovering spontaneously, going into liver failure, and/or requiring a liver transplant. I strongly encouraged him to continue to stay alcohol free, to avoid working and rest as much as possible, and to follow-up with Dr. Ong for blood testing on Friday, July 23 (he will go to the 11th Avenue PAML office, as arranged with Michelle at Dr. Ong's office). I instructed him of the importance of reporting immediately for care if bleeding phenomena occur. I offered to help fill out any forms or write any letters that may be needed to reconcile his hospital bills and asked him to forward such requests through YHD staff. I encouraged him to include his wife in a telephone call or office visit with me so that I can directly address her concerns, if he is so willing. Finally, I arranged to meet with him again next Wednesday, July 28, at 11AM at YHD.

Orders:

1. No TB treatment until further notice.
2. Please work with Dr. Ong's office to ensure that anti-HCV and anti-HBc IgM testing are added to his next blood draw for CMP, CBC, differential, PT/INR, and ammonia.
3. Obtain PA/LAT CXR when next feasible.
4. Collect or ensure collection of one sputum specimen weekly for AFB smear and culture until further notice.

CSpitters and CSpitters

Chris Spitters, MD

C: Gilbert Ong, MD (Tel 509 834 6043; Fax 509 248 4831)
Rizwana Khan, MD
Devika Singh, MD

33697 2-000000219

Last Update: 1/24/95

Chapter 246-170 WAC

TUBERCULOSIS—PREVENTION, TREATMENT, AND CONTROL

Complete Chapter | Show Dispositions

WAC Sections

WAC 246-170-002

Findings and purpose.

(1) The board of health finds that:

(a) Pulmonary tuberculosis is a life-threatening airborne disease that can be casually transmitted without significant interaction with an infectious person. Tuberculosis has reemerged as an epidemic disease nationally, and though Washington state is not in an epidemic yet, the increasing number of cases in Washington state each year clearly demonstrate that absent timely and effective public health intervention in individual cases, the residents of the state of Washington are at risk of being infected by tuberculosis.

(b) In order to limit the spread of tuberculosis, it is essential that individuals who have the disease are diagnosed and treated before they infect others. Diagnosis requires a variety of methodologies including skin tests, X rays, and laboratory analysis of sputum samples.

(c) A person with infectious tuberculosis who does not voluntarily submit to appropriate testing, treatment, or infection control methods poses an unreasonable risk of spreading the disease to those who come into the infectious person's proximity.

(d) Although the recommended course of treatment for tuberculosis varies somewhat from one individual to another, at a minimum, effective treatment requires a long-term regimen of multiple drug therapy. Some drugs are effective with some individuals but not others. The development of the appropriate course of treatment for any one individual may require trying different combinations of drugs and repeated drug susceptibility testing. The course of treatment may require as long as several years to complete.

(e) A person who begins a course of treatment for tuberculosis and fails to follow the recommended course through to completion is highly likely to relapse at some point into infectious tuberculosis. The person will most likely then be infected with what is known as multiple drug resistant tuberculosis, which is more virulent, more difficult to treat, and more likely to result in fatality. A person who is infectious with multiple drug resistant tuberculosis poses a significant risk of transmitting multiple drug resistant tuberculosis to other persons, unless appropriate treatment and infection control methods are followed.

(f) Multiple drug resistant tuberculosis is a significant element in the epidemic that is being encountered nation-wide, and effective public health interventions are necessary to prevent that epidemic from developing in or spreading to Washington state.

(2) The following rules are adopted for the purpose of establishing standards necessary to protect the public health by:

(a) Assuring the diagnosis, treatment, and prevention of tuberculosis; and

(b) Assuring that the highest priority is given to providing appropriate individualized preventive and curative treatment in the least restrictive setting.

[Statutory Authority: ESB 6158 and chapter **70.28** RCW. WSR 95-04-035, § 246-170-002, filed 1/24/95, effective 1/24/95.]

WAC 246-170-021

Responsibility of local health officers.

Each county, city-county and district health officer is responsible for the control of tuberculosis within a jurisdiction. Each health officer shall act as or shall designate a physician to act as tuberculosis control officer. This individual shall coordinate all aspects of the prevention, treatment, and control program.

[Statutory Authority: ESB 6158 and chapter **70.28** RCW. WSR 95-04-035, § 246-170-021, filed 1/24/95, effective 1/24/95.]

WAC 246-170-031

Local health department responsibilities.

(1) Each local health department shall assure the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis. Services shall include:

(a) Prevention and screening, with emphasis on screening of high risk populations;

(b) Diagnosis and monitoring, including laboratory and radiology;

(c) Individualized treatment planning consistent with American Thoracic Society/Centers for Disease Control and Prevention statements based on the least restrictive measures necessary to assure appropriate treatment; and

(d) Case management.

(2) In the absence of third party reimbursement, the local health department shall assure the provision of inpatient or outpatient care, including DOT/DOPT and case management.

(3) Each local health department shall maintain a register of all diagnosed or suspected cases of tuberculosis. In addition, each local health department shall also maintain a register of individuals to whom that health department is providing preventive therapy. Quarterly status reports on suspected and diagnosed cases shall be furnished to the department of health tuberculosis control program.

(4) A physician knowledgeable in the diagnosis and treatment of tuberculosis approved by the department shall be available to provide review of diagnoses, plans of management and, if appropriate, discharge from inpatient facilities.

(5) Sufficient nursing, clerical, and other appropriate personnel shall be provided to furnish supervision of preventive and outpatient treatment, surveillance, suspect evaluation, epidemiologic investigation, and contact workup.

[Statutory Authority: ESB 6158 and chapter **70.28** RCW. WSR 95-04-035, § 246-170-031, filed 1/24/95, effective 1/24/95.]

WAC 246-170-051

Procedures for involuntary testing, treatment, and detention.

(1) A local health officer shall make reasonable efforts to obtain voluntary compliance with requests for examination, testing, and treatment prior to initiating the procedures for involuntary detention.

(2) If the local health officer has reason to believe that:

(a) A person is a suspected case, and that the person has failed to comply with a documented request from a health care practitioner or the local health officer to submit to examination and testing;

(b) A person with confirmed tuberculosis is failing to comply with an individual treatment plan approved by the local health officer;

(c) A person who is either a suspected or confirmed case and is failing to comply with infection control directives issued by the local health officer; or

(d) A person is a suspected or confirmed case of tuberculosis based upon generally accepted standards of medical and public health science. A local health officer shall investigate and evaluate the factual basis supporting his or her "reason to believe";

then the health officer may detain the person, cause the person to be detained by written order, or petition the superior court *ex parte* for an order to take the person into emergency detention for testing or treatment, or both. The period of detention shall not exceed seventy-two hours, excluding weekends and holidays.

(3) At the time of detention the person detained shall be given the following written notice:

NOTICE: You have the right to a superior court hearing within seventy-two hours of detention, excluding holidays and weekends. You have the right to legal counsel. If you are unable to afford legal counsel, then counsel will be appointed for you at government expense and you should request the appointment of counsel at this time. If you currently have legal counsel, then you have an opportunity to contact that counsel for assistance.

You have a right to contest the facts alleged against you, to cross-examine witnesses, and to present evidence and witnesses on your behalf.

You have a right to appeal any decision made by the court.

You may be given appropriate TB medications only on your informed consent, or pursuant to a court order.

(4) If a person is involuntarily detained under this section, within one judicial day of initial detention, the local health officer shall file with the superior court in the county of detention a petition for detention. A petition filed under this section shall specify:

(a) The basis for the local health officer's belief that the respondent is either a suspected or confirmed case; including the name, address and phone numbers of whom the health officer expects to testify in support of the petition for detention and identification of any and all medical tests and records relied upon by the local health officer;

(b) The specific actions taken by the local health officer to obtain voluntary compliance by the respondent with recommended examination and testing or treatment, as the case may be;

(c) The nature and duration of further detention or other court-ordered action that the local health officer believes is necessary in order to assure that the respondent is appropriately tested or treated;

(d) The basis for believing that further detention or other court-ordered action is necessary to protect the public health; and

(e) Other information the local health officer believes is pertinent to the proper resolution of the petition.

(5) Service on respondent. The health officer shall serve a copy of the petition on the individual named therein at the time of the detention. If the person informs the health officer that he or she is represented by legal counsel, service on such counsel shall be made by delivering a copy of the petition to the attorney's office no later than the time of filing the petition with the superior court.

[Statutory Authority: ESB 6158 and chapter **70.28** RCW. WSR 95-04-035, § 246-170-051, filed 1/24/95, effective 1/24/95.]

WAC 246-170-055

Due process proceedings.

(1) A hearing on the petition for detention filed under WAC **246-170-051** shall be conducted in superior court within seventy-two hours after initial detention, excluding weekends and holidays. The local health officer shall have the burden of proving the allegations set forth in the petition by a preponderance of the evidence. The person named in the petition shall have the right to cross-examine witnesses, present evidence, and be represented by an attorney at any hearing held on the petition. If the person is indigent and requests appointment of legal counsel, legal counsel shall be appointed at public expense at least twenty-four hours prior to the superior court hearing.

(2) At the conclusion of the hearing, the court shall consider the evidence, the action taken by the health officer to secure voluntary compliance by the patient, and the purpose and intent of the public health laws, including this chapter, and may take one of the following actions:

(a) If the court finds that the respondent is a suspected case, the court may enter an order requiring that the person be subjected to further examination, testing, and treatment as specified in the court's order. If the court finds that further detention of the respondent is necessary in order to assure that the examination, testing, and treatment occurs, or to protect the public health the court may order that the respondent be detained for an additional period not to exceed forty-five days. The results of testing conducted under this chapter shall be provided to the court and the person detained or his or her legal counsel as soon as they are available to the local health officer. The court may then conduct an additional hearing to determine whether the person is a confirmed case and, if so, whether further measures are necessary to protect the public health pursuant to (b) or (c) of this subsection.

(b) If the court finds that the person is a confirmed case, that further measures less restrictive than detention of the respondent are necessary to assure that appropriate treatment is implemented and that imposition of less restrictive measures will be sufficient to protect the public health, the court may enter an order setting forth such measures and ordering the respondent to comply with the measures.

(c) If the court finds that the person is a confirmed case, that further detention of the respondent is necessary to protect the public health, and that imposition of less restrictive measures will not be sufficient to protect the public health, the court may order that the respondent be detained and treated for an additional period not to exceed forty-five days.

(d) If the court finds that there is insufficient evidence to support the petition for detention, then the court shall immediately release the person detained.

(3) A person detained under this chapter may be released prior to the expiration of the court-ordered detention if the health officer or the court finds that less restrictive measures are sufficient to protect the public health. The court may impose such conditions on the release of the person as the court finds are necessary to protect the public health. A person detained under this chapter may also petition the court for release based upon new evidence or a change in circumstances.

(4) The court may extend a period of court-ordered detention for additional periods not to exceed one hundred eighty days each following a hearing as described in WAC **246-170-051** and this section, if the court finds that the requirements of subsection (2)(a), (b), or (c) of this section have been met and if the court finds that further detention is necessary to assure that appropriate treatment is implemented, and that imposition of less restrictive measures are not sufficient to protect the public health. As an alternative to extending the period of detention, if the court finds after hearing that further measures less restrictive than detention are necessary to assure that appropriate treatment is continued, and that imposition of less restrictive measures will be sufficient to protect the public health, the court may enter an order setting forth the measures and ordering the respondent to comply.

(5) In the event that a person has been released from detention prior to completion of the prescribed course of treatment and fails to comply with the prescribed course of treatment, the health officer where that individual is found may detain that person, and any court having jurisdiction of the person may order

the person detained for an additional period or periods, not to exceed one hundred eighty days each, as the court finds necessary to protect the public health.

(6) If a person has been detained in a county other than the county in which the court that originally ordered the detention is located, venue of the proceedings may remain in the original county, or may be transferred to the county of detention. Change in venue may be sought either by the local health officer in the original county or in the county of detention, or by the person detained. Except as otherwise agreed between the original health officer and the health officer in the county of detention, the original health officer retains jurisdiction over the detained person, including financial responsibility for costs incurred in implementing and continuing the detention.

(7) Court orders entered under this chapter shall be entered only after a hearing at which the respondent is accorded the same rights as at the initial hearing on the petition for detention.

(8)(a) When a court order for detention is issued, the transporting law enforcement agency and the receiving facility shall be informed of the infectious TB status of the person for disease control and the protection of the health of the staff, other offenders and the public. Such information shall be made available prior to the transport.

(b) Whenever disclosure is made pursuant to this subsection, it shall be accompanied by a statement in writing which includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it except as authorized by state law."

(c) Transporting agencies and/or receiving facilities shall establish and implement policies and procedures that maintain confidentiality related to the detained person's medical information as defined in this subsection and state law.

[Statutory Authority: ESB 6158 and chapter **70.28** RCW. WSR 95-04-035, § 246-170-055, filed 1/24/95, effective 1/24/95.]

JOHNSON GRAFFE KEAY MONIZ & WICK

July 14, 2017 - 1:16 PM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	94679-5
Appellate Court Case Title:	Judith Margarita Reyes, et al. v. Yakima Health District, et al.
Superior Court Case Number:	14-2-03342-6

The following documents have been uploaded:

- 946795_Answer_Reply_20170714130850SC459557_2629.pdf
  This File Contains:
  Answer/Reply - Answer to Petition for Review
  The Original File Name was Respondents Spitters' and YHD's Joint Answer to Petitioner's Motion for Discretionary Review with Attachments.pdf

A copy of the uploaded files will be sent to:

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