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No. 96998-1

Court of Appeals No. 50336-1-II

IN THE SUPREME COURT FOR
THE STATE OF WASHINGTON

GERALDINE IVERSON,
as personal representative of BESSIE RITTER,

Respondent,

v.

PRESTIGE CARE, INC. and
NORTHWEST COUNTRY PLACE, INC.,

Petitioners.

ANSWER TO PETITION FOR REVIEW

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INTRODUCTION

Respondent Geraldine Iverson, PR for the Estate of Bessie Ritter, asks this Court to deny review in ***Iverson v. Prestige Care, Inc.***, No. 50336-I-II (Wash. Ct. App. Jan. 3, 2019).[1] Bessie Ritter died after suffering severe constipation for 10 days. The defendant nursing facility was under orders to monitor her bowel movements, to take corrective action, and to call a doctor if problems persisted. The facility did nothing.

A highly qualified, Board Certified Gastroenterologist, Teresa Brentnall, opined to a reasonable medical certainty that the facility's neglect caused Ms. Ritter's death. The facility nonetheless sought summary judgment on the theory that Dr. Brentnall's opinion was insufficient to establish causation. The trial court struck her opinion under ***Frye*** and granted summary judgment. The Court of Appeals correctly reversed under ***Anderson v. Akzo Nobel Coatings, Inc.***, 172 Wn.2d 593, 260 P.3d 857 (2011). ***L.M. v. Hamilton***, 193 Wn.2d 113, 436 P.3d 803 (2019) is not to the contrary. A competent differential diagnosis is not subject to ***Frye***. Review is unwarranted.

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[1] The Court of Appeals granted Iverson's motion for reconsideration and struck its erroneous footnotes 3 and 6. Iverson attaches the corrected opinion and that order as App. A.

FACTS RELEVANT TO ANSWER[2]

A. Iverson alleged that NCPI's failure to properly monitor and care for her mother, Bessie Ritter, caused her death.

Geraldine Iverson is Bessie Ritter's daughter, and the Personal Representative of her Estate. CP 1. In late July 2014, Ms. Ritter was admitted to a nursing home owned and operated by the petitioners, Prestige Care, Inc. and Northwest Country Place, Inc. (collectively, "NCPI" or "facility"). CP 1-2, 8. Iverson alleges that facility staff failed to monitor Ms. Ritter's bowel movements, and failed to act on her lack of bowel movements, for an extended period in August 2014. CP 2. This failure led to Ms. Ritter's hospitalization and death in September 2014. *Id*.

B. During a difficult discovery process in which the trial court repeatedly compelled discovery from the facility, NCPI sought summary judgment.

Discovery was difficult. The trial court repeatedly compelled NCPI to answer interrogatories and to produce documents, and even continued the trial as a result. CP 26-28, 53-56, 79-81. The court also had to compel depositions. CP 90-91. On February 6, 2017, Iverson brought a motion to enforce the order compelling depositions and for sanctions. CP 98-108.

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[2] Iverson agrees with the Court of Appeals' statement of the facts. More specifics, and citations, are provided here.

On February 17, 2017, with Iverson's motion to enforce pending, NCPI sought summary judgment on causation. CP 336-54. It sought to dismiss both of Iverson's claims - negligence and violation of Washington's Vulnerable Adults Act. CP 336-37. As discussed below, the facility essentially argued that Iverson's expert could not establish causation due to ***Frye***.[3] CP 339-50.

C. Iverson responded to the summary judgment motion with a doctor's expert testimony that – to a reasonable medical probability – NCPI caused Ms. Ritter's death.

In response to the summary judgment motion, Iverson presented the Declaration of Teresa Brentnall, M.D. CP 481-562.[4] Dr. Brentnall is Board-Certified in Gastroenterology, which she has practiced for 20 years. CP 481; *see also* CP 489-99. She is familiar with the standard of care for treating patients like Ms. Ritter (CP 482):

> Regardless of whether the patient is in a rehab center, hospital, or skilled nursing facility, the standard of care applicable to her requires that her care facility address the documented failure to have a bowel movement and follow doctor's orders in connection with the failure to have a bowel movement. The standard of care requires administration of medication in accordance with doctor's orders and follow-up to ensure that the medication is effective.

[3] ***Frye v. United States***, 293 F. 1013 (D.C. Cir. 1923).

[4] Dr. Brentnall's declaration (without Exhibits) is attached as App. B.

Dr. Brentnall reviewed “records from [the facility] for the admission beginning July 25, 2014[,] and records from Providence Centralia Hospital, including records from the admissions of August 19, 2014, and [of] September 1, 2014.” CP 482. Dr. Brentnall found that “Ms. Ritter was readmitted to [the facility] from Providence Centralia Hospital on 8/22/14 at 6:50 p.m. and was discharged back to Providence Centralia Hospital on 9/1/14 at 6:25 p.m.” *Id*.

Facility records show “Ms. Ritter did not have any bowel movements during this . . . 10 days.” *Id*. (citing CP 501-02).[5] Yet Ms. Ritter already “suffered from constipation following her discharge back to the facility on 8/22/14”. CP 483 (citing CP 509-10).[6] “That Ms. Ritter went without a bowel movement . . . between 8/22/14 and 9/1/14 is further confirmed by the presence of residual oral contrast [dye] noted on the 9/1/14 imaging study.” *Id*. “The contrast was administered on 8/19/14 and should have passed from her system in 5 days.” *Id*. The Sitz Marker test, commonly used to measure bowel transit, “is considered abnormal if the radio-opaque markers consumed in the test have not cleared the body within 5 days.” *Id.*

[5] The vitals report is attached as App. C.

[6] These hospital records are attached as App. D.

(citing CP 512-14). “It is grossly abnormal for the oral contrast not to have cleared Ms. Ritter’s system between 8/19/14 and 9/1/14.” *Id*.

The objective evidence of severe constipation “is strong and includes not just the facility’s own medical record, but also the condition of the patient and the imaging of her abdomen when she was admitted to [the hospital] on 9/1/14.” CP 483-84. Authoritative guidelines from the American Gastroenterological Association further support this diagnosis. CP 484 (quoting CP 516-22).

Medical records further show that “the facility did not do anything to address Ms. Ritter’s constipation until the evening of 8/30/14, when for the first time she was given Milk of Magnesia.” CP 482-83 (citing CP 504).[7] The facility also “did not follow the physician orders set forth on [App. D] and referencing the ‘HBP,’” which the doctor understood as “the House Bowel Program or Constipation Management Protocol.” CP 483 (citing CP 506-07).[8]

As a result of these failures, the facility breached the Constipation Management Protocol and physician orders, and thus the standard of care, by the following omissions (CP 483, paragraphing added):

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[7] This medication administration record is attached as App. E.

[8] This constipation management protocol is attached as App. F.

> (1) not administering docusate sodium after more than one day without a bowel movement;
>
> (2) not administering Milk of Magnesium after three days without a bowel movement;
>
> (3) not giving Ms. Ritter a suppository after three days and one shift without a bowel movement; [and]
>
> (4) not calling the physician after having no results from these medications.
>
> These breaches were repeated daily during the time period between 8/23/14 and 8/30/14, when Ms. Ritter was finally given medication for constipation.

Dr. Brentnall opined that these breaches caused Ms. Ritter's death. CP 484-85. To a reasonable medical certainty, "the untreated constipation of Bessie Ritter during the period between 8/22/14 and 9/1/14 led to her development of a cecal volvulus." CP 484. "Cecal volvulus is a twisting of the colon." *Id*. "Ms. Ritter's colon likely twisted as a result of the ten day period of constipation at" the facility. *Id*.

Dr. Brentnall's opinion is "supported by known facts regarding the anatomy of the colon and by the presence of a 'large amount of stool' in the colon in the imaging study of 9/1/14." *Id*. That "large amount of stool causes the colon to distend and interferes with muscle function." *Id*. "The colonic distension from constipated stool decreases capillary blood flow, leads to decreased colonic motility (atony), increases the risk of torsion of the colon, and likely led to the

twisting of Ms. Ritter's cecum." *Id*. This "was avoidable and preventable through the implementation of the Constipation Management Protocol ordered by the doctors." *Id*.

Indeed, patients "with constipation are 7 times more likely to develop volvulus." CP 485 (citing CP 524-33, 535-44). Groups especially vulnerable include chronically ill patients with decreased ambulatory capacity like Ms. Ritter. *Id*. "This process is likely what led to Ms. Ritter's cecal volvulus." *Id*.

Dr. Brentnall's opinion is based on her differential diagnosis:

> Differential diagnosis is the method used in medicine to determine the cause of an illness. The method involves using information such as symptoms, patient history, and medical knowledge to determine the cause of an illness. The clinician applies known facts and clinical experience to narrow the possible causes of an illness and determine the likely cause.
>
> I have used this method to form the opinions contained in this declaration. Differential diagnosis is well accepted in the scientific community and is used every day by thousands of physicians throughout the country.
>
> Through the process of differential diagnosis, it is in my opinion more likely than not, that the untreated constipation of Bessie Ritter during the period between 8/22/14 and 9/1/14 led to her development of a cecal volvulus.
>
> . . .
>
> I have considered the events that led to the cecal volvulus that was the immediate cause of Ms. Ritter's demise, and on a more probable than not basis, the ten day period of untreated constipation and resulting heavy stool burden were the

> proximate causes of the twisting of the cecum and [of] Mrs. Ritter's demise.

CP 484-85 (paragraphing altered for readability). Dr. Brentnall's differential diagnosis is also supported by medical literature. CP 485-86 (citing CP 524-33).

In sum, there "is little question that the twisting of the cecum was the immediate cause of Ms. Ritter's death," which was "treatable and avoidable." CP 486 (citing CP 546-47,[9] 549[10]). Ms. Ritter's prior episode of constipation at the facility, which completely resolved with the use of laxatives, supports this analysis. *Id*. By following the doctor's orders, NCPI would have prevented Ms. Ritter's death. *Id*.

D. Notwithstanding Dr. Brentnall's medical opinion, the trial court granted summary judgment on causation.

The trial court granted summary judgment on causation. CP 764-65. It denied Iverson's reconsideration motion explaining in detail why this Court's ***Anderson*** decision precludes summary judgment here. CP 745-51; 757. It entered a final judgment, and a supplemental judgment. CP 743-44, 758-60. Iverson timely appealed. CP 761-68.

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[9] The hospital "Discharge Summary" is attached as App. G.

[10] The death certificate is attached as App. H.

REASONS THIS COURT SHOULD DENY REVIEW

A. The decision is correctly based on a close application of ***Anderson***: ***Frye*** does not apply to the widely recognized diagnostic modality, differential diagnosis.

Anderson holds that ***Frye*** "is not implicated if the theory and the methodology relied upon and used by the expert to reach an opinion on causation is generally accepted by the relevant scientific community." ***Anderson***, 172 Wn.2d at 597. When the theory and methodology are widely accepted, "the evidence is admissible under ***Frye***, without separately requiring widespread acceptance of the plaintiff's theory of causation." *Id.* at 609.

"Many medical opinions on causation are based upon differential diagnoses." *Id.* at 610. As Dr. Brentnall explained, differential diagnosis "is the method used in medicine to determine the cause of an illness." CP 484. This method "involves using information such as symptoms, patient history, and medical knowledge to determine the cause of an illness." *Id.* The doctor "applies known facts and clinical experience to narrow the possible causes of an illness and determine the likely cause." *Id*. Dr. Brentnall used this scientific methodology to reach her causation opinion, to a reasonable degree of medical probability. CP 484, 486.

Differential diagnosis has been generally accepted in the scientific community since at least Hippocrates (460-370 B.C.), though examples may exist in the Babylonian Esagil-kin-apli (fl. 1069-1046 B.C.), and in the writings of Imhotep (2630-2611 B.C.).[11] Therefore, ***Frye*** is not implicated where, as here, a causation opinion is not based on novel science. ***Anderson***, 172 Wn.2d at 611.

Rather, a physician "may base a conclusion about causation through a process of ruling out potential causes with due consideration to temporal factors, such as events and the onset of symptoms." *Id*. at 610. This is because many "expert medical opinions are pure opinions and are based on experience and training rather than scientific data." *Id*. (emphases added). This Court requires "only that 'medical expert testimony . . . be based upon a reasonable degree of medical certainty' or probability." *Id*. (quoting ***McLaughlin v. Cooke***, 112 Wn.2d 829, 836, 774 P.2d 1171 (1989)).

In ***Anderson***, plaintiffs relied on a doctor who opined, "within a reasonable degree of medical certainty, as to the cause of [the child's] malformations as being in utero workplace exposure." *Id*. Much like Dr. Brentnall here, that doctor based his opinion on the

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[11] *See generally* https://en.wikipedia.org/wiki/differential_diagnosis and /medical_diagnosis)

child's medical records, documents from the defendant, and his own experience and training. *Id*. at 603-04. This included "work he himself did" and reported in a medical journal. *Id*. at 604. But his coauthor, testifying for the defense, opined that this journal article "does not establish the existence of a causal relation between exposure to organic solvents and birth defects." *Id*. at 604-05.[12] Indeed, the *plaintiff*'s expert admitted, "we don't have enough research, you're absolutely right," the state of the science is "evolving." *Id*. at 605.

The defendant in ***Anderson*** thus argued – like the facility here – that the causal theory must be "generally accepted" (*id*.):

> it is not enough "to argue, therefore, that expert opinion testimony is admissible solely because it is based on accepted scientific techniques. Not only the technique used to accumulate scientific data or information, but also the theory of causation arrived at, must be 'generally accepted' in the scientific community." [Emphasis added.]

As here, the ***Anderson*** trial court agreed. *Id*.

But this Court disagreed (*id*. at 609):

> This court has consistently found that if the science and methods are widely accepted in the relevant scientific community, the evidence is admissible under ***Frye***, without separately requiring widespread acceptance of the plaintiff's theory of causation. *See, e.g.*, [***State v.***]***Gregory***, 158 Wn.2d [759,] 829[, 147 P.3d 1201 (2006)]; [***State v.***]***Copeland***, 130 Wn.2d [244,] 255[, 922 P.3d 1304 (1996)]; ***Reese***[***v. Stroh***],

[12] In a significant footnote, this Court noted that the journal study was designed only to show correlation, not causation. 172 Wn.2d at 605 n.3.

> 128 Wn.2d [300,] 309[, 907 P.2d 282 (1995)]; [***State v.***] ***Cauthron***, 120 Wn.2d [879,] 887[, 846 P.2d 502 (1993)]. [Emphasis added.]

And as the Court of Appeals said in ***Reese***, there is nothing "mystical" about a jury evaluating pure medical opinions (*id*.):

> We do not find that lack of statistical support fatal to Dr. Fallat's causation opinion. Such support is required neither by ER 702, ER 703, nor by our case law. Rather, medical expert testimony must be based upon a "reasonable degree of medical certainty." [Citations omitted.]
>
> . . .
>
> Dr. Fallat's proposed testimony, based on the information known to the medical profession at the time of Plaintiff's treatment, "is the type of information jurors and their physicians rely on in their everyday lives to make decisions about health care. There is nothing mystical about it, and jurors are perfectly capable of determining what weight to give this kind of expert testimony." ***Reese*** [***v. Stroh***], 74 Wn. App. [550,]565[, 874 P.2d 200 (1994)].

Indeed, the "absence of 'a statistically significant basis' for the expert's opinion that the plaintiff would have benefited from the Prolastin therapy <u>neither implicated ***Frye***</u> nor rendered the proffered testimony inadmissible." 172 Wn.2d at 610 (citing ***Reese***, 128 Wn.2d at 305, 307) (emphasis added). This is because many "expert medical opinions <u>are pure opinions</u> and are based on experience and training <u>rather than scientific data</u>." *Id*. (emphases added). Indeed, many "<u>medical opinions on causation are based upon differential diagnoses</u>." *Id.* (emphasis added).

These holdings are dispositive here. But ***Anderson*** went on to expressly reject the "ever more nuanced argument" that "to satisfy ***Frye***, Anderson must establish that the specific causal connection between the specific toxic organic solvents to which she was exposed and the specific polymicrogyria birth defect is generally accepted in the scientific community." *Id*. at 611. If one accepts such arguments, "virtually all opinions based upon scientific data could be argued to be within some part of the scientific twilight zone." *Id*.

Unfortunately, the facility led this trial court into that twilight zone – and left it there. After failing to cite ***Anderson*** in its moving papers, the facility argued in reply that the above holdings were merely *dicta*. RP 16. On the contrary, they are central to the disposition of the ***Frye*** issue, as they were in ***Reese*** and other cases ***Anderson*** cites, which support Iverson. And the central point of ***Anderson*** is that the "***Frye*** test is implicated only where the opinion offered is based upon novel science." 172 Wn.2d at 611 (citing ***Reese***, 128 Wn.2d at 306). "It applies where either the theory and technique or the method of arriving at the data relied upon is so novel that it is not generally accepted by the relevant scientific community." *Id*. It has no application where, as here, a doctor opines on causation based on her own differential diagnosis.

Nonetheless, there is nothing “novel” about the “theory” that constipation may cause a cecal volvus. On the contrary, people with constipation are ***seven times more likely*** to suffer one. CP 485 (citing CP 524-33, 535-44). And people like Ms. Ritter, who are bed-ridden and constipated, fall squarely within that risk group. *Id*. Based on this frankly common knowledge among caregivers, Dr. Brentnall opined to a reasonable medical probability that the facility’s failure to follow its own medical protocols caused Ms. Ritter’s death. This is sufficient to carry the causation issue to a jury.

As the trial court expressly noted, whether and when Ms. Ritter had a bowel movement would be a question of fact. RP 18. And it noted that the defense experts had no opinion on causation, or deferred to Dr. Brentnall, the gastroenterologist. *Id*. Even to the extent that they may have contradicted Dr. Brentnall, they simply raised genuine issues of material fact on causation. *See* CP 344-45.

Yet the trial court searched the medical literature for a statement that constipation causes cecal volvulus. RP 19-20. It thought ***Frye*** required that analysis (RP 21-22), which is directly contrary to ***Anderson***: ***Frye*** does not apply to a pure medical opinion on causation based on the venerable medical theory and methodology of differential diagnosis. Review is unwarranted here.

B. *L.M.* does not reverse or modify *Anderson*, but rather follows it, so it remains controlling here.

The facility relies on this Court's very recent decision in ***L.M.***, which came down after ***Iverson***. *See, e.g.*, PFR at 15-16. Crucially here, ***L.M.*** plainly reaffirms ***Anderson***:

> ***Anderson*** resolves this dispute: "***Frye*** does not require every deduction drawn from generally accepted theories to be generally accepted."

L.M., 193 Wn.2d at 130 (quoting ***Anderson***, 172 Wn.2d at 611). Rather, doctors may "draw . . . a deduction from generally accepted science." *Id*. at 130-31.

In ***L.M.***, the specific issue was whether ***Frye*** barred defense experts from testifying that the natural forces of labor (NOFL) caused a child's avulsions and ruptures (BIP), despite some scientific debate on whether NOFL could cause BIP. *See, e.g.*, *Id*. at 121-24. Applying ***Anderson***, this Court found the literature saying that NOFL could cause BIP sufficient to permit the testimony. *Id*. at 130-31.

Interestingly, the phrase "differential diagnosis" appears nowhere in ***L.M.***[13] In any case, ***Anderson*** holds that a physician "may base a conclusion about causation through a process of ruling

[13] Apparently, the expert's testimony was not based on a differential diagnosis, but rather on a literature review. *See, e.g.*, *id.* at 121-24.

out potential causes with due consideration to temporal factors, such as events and the onset of symptoms" – otherwise known as differential diagnosis. ***Anderson***, 172 Wn.2d at 610. Indeed, such "expert medical opinions are pure opinions and are based on experience and training rather than scientific data." *Id*. (emphases added). This Court requires only that medical expert testimony be based upon a reasonable degree of medical probability. *Id*.

In ***L.M.***, this Court did examine the scientific literature on whether NFOL could cause permanent BIP. 193 Wn. 2d at 131-33. But there, the jury had heard the testimony on both sides, resolving any dispute about general acceptance, and this Court affirmed. *Id*. By contrast, here the trial court has barred plaintiffs from presenting any testimony whatsoever. The facility's objections go to the weight of Dr. Brentnall's opinion, not its admissibility. *See, e.g.*, ***L.M. v. Hamilton***, 200 Wn. App. 535, 551, 402 P.3d 870 (2017) (any gap in research caused by ethical restraints against performing experiments on babies (or here, the elderly) goes to weight, not admissibility). It was error for the trial court to exclude Dr. Brentnall's opinion and dismiss Ms. Iverson's case.

In light of this Court's very recent reaffirmance of ***Anderson***, which controls the outcome here, review is unwarranted.

C. Ample peer-reviewed medical studies support Dr. Brentnall's differential diagnosis.

In any event, ample medical literature supports Dr. Brentnall's differential diagnosis. *See, e.g.*, BA 16 (citing CP 485, 524-33, 535-44); Reply 6-7; CP 516-44 (several studies). Dr. Brentnall cited two specific studies. CP 485. The first says that chronic constipation is a common cause of all sorts of volvulus:

> The etiology of colon volvulus is probably multifactorial. Some factors are <u>common to all locations of volvulus</u>, such as ***chronic constipation***. . . . [Emphases added.]

CP 525. The word "etiology" means cause:

> **1 :** CAUSE, ORIGIN . . . *specif* **:** all of the causes of a disease or an abnormality . . . **2** . . . . **b :** . . . *specif*: a branch of medical science concerned with the causes and origins of diseases.

WEBSTER'S THIRD NEW INT'L DICTIONARY 782 (1993). Thus, in plain English, one cause of cecal volvulus is chronic constipation.

While the second article is specifically about sigmoid volvulus, it does discuss chronic constipation more generally (CP 539-40):

> Chronic constipation is a common malady that can have various causes. . . . Such are typically found in elderly . . . patients . . . The underlying cause of the megacolon and constipation in these patients is unknown, and it has not been demonstrated which comes first—megacolon or constipation. If, however, motility of the large bowel is examined by barium enema, effective peristalsis is found to be almost nonexistent in the dilated bowel. Whether absence of motility first produces constipation and megacolon or whether it is chronic constipation that precedes dilatation and subsequent loss of motor tone is uncertain ***and probably moot***.

> The practical problem to be faced is that a colon with absent or ineffective peristalsis often produces a functional obstruction, which may indeed become complete. [Emphasis added; paragraphing altered for readability.]

The first article identifies acute obstructions like this as symptomatic of cecal volvulus in elderly patients like Ms. Ritter. CP 526 ("The classic patient is elderly, institutionalized, and under psychotropic medications that cause chronic constipation"; "cecal volvulus may present with a picture of acute intestinal obstruction").

Taken together, this medical literature makes clear that chronic constipation is endemic to cecal volvulus. But there is more. An oft-cited 2005 study identifies "conditions such as . . . chronic constipation" as "implicated in caecal volvulus formation in anatomically susceptible people, presumably through . . . colonic distension." Consorti and Liu, *Diagnosis and treatment of caecal volvulus*, POSTGRAD MED. J. 2005;81:772-76 at 772 (2005).[14] Dr. Brentnall identified colonic distension caused by a "large amount of stool" as the mechanism that helped kill Ms. Ritter. CP 484.

A slightly more recent study identifies "Chronic constipation [and other things] . . . as factors important in the development of cecal volvulus." Gingold & Murrell, *Management of Colonic Volvulus*,

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[14] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743408/.

CLINICS OF COLON & RECTAL SURGERY, 2012 Dec; 25(4): 236-44, at nn. 39-43 (2012).[15] The same study notes that in "older patients, cecal volvulus was associated with chronic constipation," among other causes. *Id*. Ms. Ritter was 84 years old when she died.

There are dozens more studies like this. While none of them says that the *sole cause* of cecal volvulus is chronic constipation, that is not required by any law anywhere. The facility cited no studies saying that constipation cannot be *a cause* of cecal volvulus. ***L.M.***, ***Anderson***, ***Reese***, and every other relevant case, say that where, as here, the etiology of a medical condition includes the cause that a highly qualified doctor like Dr. Brentnall pinpoints to a reasonable medical probability as the relevant cause of death, it is for the jury to decide the weight to be given to her opinion, not the court.

D. The irrelevant foreign cases the facility cites are contrary to *L.M., Anderson*, and *Frye*.

The real purpose of the facility's arguments can be seen in its all-too-frequent references to ***Daubert v. Merrell Dow Pharm., Inc.***, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). PFR 11, 12, 17. The facility admits that this Court rejected ***Daubert*** in ***Copeland***, 130 Wn.2d 244. PFR 11. Yet it cites factually inapposite

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[15] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3577612/.

Daubert cases as conflicting with ***Iverson***. PFR 17-18. Of course they do. But ***Daubert*** is not our law.

And conflicts with foreign cases based on law that this Court has rejected are not a basis for granting review in this Court. RAP 13.4(b). This Court rejected ***Daubert*** because it requires judges to "analyze [scientific] opinions involving matters far beyond their knowledge." ***Copeland***, 130 Wn.2d at 260. By contrast, the "***Frye*** standard recognizes that 'judges do not have the expertise required to decide whether a challenged scientific theory is correct,' and therefore courts 'defer this judgment to scientists.'" *Id.* at 255 (quoting ***Cauthron***, 120 Wn.2d at 887). In short, ***Daubert*** is more restrictive and intrusive, not less. ***Frye*** is the law, as is ***Anderson***. The Court of Appeals properly applied it.

CONCLUSION

This Court should deny review.

RESPECTFULLY SUBMITTED this 22nd day of May 2019.

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APPENDIX A

Corrected Unpublished Opinion

(with order granting motion for reconsideration and to strike)

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

GERALDINE IVERSON, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BESSIE RITTER, Appellant, v. PRESTIGE CARE, INC. and NORTHWEST COUNTRY PLACE, INC., Respondents.	No. 50336-1-II UNPUBLISHED OPINION

SUTTON, J. — Geraldine Iverson, personal representative of Bessie Ritter's estate, appeals the superior court's orders granting summary judgment dismissal and denying reconsideration of her medical negligence claim against a nursing home owned and operated by Prestige Care, Inc. and Northwest Country Place, Inc. (collectively "NCPI"). Iverson alleges that NCPI's failure to properly monitor and treat Ritter's constipation caused Ritter to develop a cecal volvulus[1] resulting in her death. NCPI argues that the medical causation opinion offered by Iverson's expert, Dr. Teresa Brentnall, is a novel scientific theory subject to the *Frye*[2] test, and because the experts

[1] A "cecal volvulus" is a twist in the bowel resulting from the cecum being loose in the abdomen. A cecal volvulus occurs when the cecum, the first portion of the large intestine, loops around itself and creates a bowel obstruction. Clerk's Papers at 336.

[2] *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

disagree as to whether her causation opinion is generally accepted in the medical community, the opinion is not admissible under *Frye*.

We hold that because Dr. Brentnall's causation opinion is based on a differential diagnosis, *Frye* is not implicated. Because Dr. Brentnall's causation opinion is admissible, there are genuine issues of material fact on causation. Thus, the superior court erred in granting summary judgment dismissal of Iverson's medical negligence claim. We reverse and remand for further proceedings.

FACTS

On July 25, 2014, Ritter was admitted to NCPI, a nursing home in Centralia, Washington. The record reflects that in the 10 days between August 22 and September 1, she did not have a bowel movement. The facility did not treat Ritter's constipation until August 30 when she was given Milk of Magnesia. The following day she was given a Dulcolax suppository because she still had not had a bowel movement. On September 1, Ritter was admitted to the hospital after vomiting several times.

On September 2, Ritter underwent emergency surgery that showed a "[d]istal 15-20 cm of terminal ileum and cecum wrapped in it twisted closed loop obstruction with markedly nonviable ileocecal valve." Clerk's Papers (CP) at 425. The attending physician's postoperative diagnosis stated that Ritter had a bowel obstruction with cecal volvulus. Ritter died on September 4.

Following Ritter's death, Iverson sued NCPI for medical negligence and violation of the Abuse of Vulnerable Adults Act.[3] Iverson alleged that the NCPI staff failed to (1) monitor Ritter's bowel movements, (2) act on her lack of bowel movements, and (3) answer her call light. Iverson alleged that these failures caused Ritter's death; specifically, that NCPI's negligence in treating Ritter's constipation caused Ritter to develop a cecal volvulus that resulting in the rupture of her colon and, ultimately, her death. It is undisputed that Ritter died due to a cecal volvulus.

NCPI filed a motion for summary judgment dismissal. NCPI argued that Iverson failed to establish a prima facie case for medical negligence because she did not produce any admissible testimony from a qualified medical expert to explain that any of NCPI's agents or employees caused Ritter's death. In addition, NCPI argued that summary judgment dismissal was proper as a matter of law because Iverson relied on Dr. Brentnall's causation opinion which was not admissible under *Frye* because the opinion was based on a novel scientific theory which was not generally accepted by the medical community.

In support of its motion for summary judgment, NCPI provided the opinions of Dr. Michael Chiorean (a gastrointestinal specialist), Dr. Brant Oelschlager (a general gastrointestinal surgeon), and Dr. Michael Peters (a diagnostic radiologist). Dr. Chiorean explained that "[t]here's zero evidence that constipation leads to cecal volvulus." CP at 387. Dr. Oelschlager echoed this assertion and expounded that he was unaware of any "literature that shows that the short-term treatment of constipation in any way affects the development of cecal volvulus." CP at 436. Dr. Oelschlager further explained that cecal volvulus is not caused by constipation; rather, it occurs

[3] Iverson does not appeal the superior court's summary judgment dismissal of the Abuse of Vulnerable Adults Act, ch. 74.34 RCW, claim.

when the cecum is loose in the abdomen rather than attached. Dr. Peters also testified that constipation plays no causal role in the development of a cecal volvulus. He, like Dr. Oelschlager, stated that the only possible cause of cecal volvulus is that the cecum is not fixed in the abdomen in the right place.

In response to NCPI's motion for summary judgment, Iverson provided the declaration of Dr. Brentnall (a board-certified gastroenterologist). In her declaration, Dr. Brentnall stated that she reviewed "records from [the facility] for the admission beginning July 25, 2014 and records from Providence Centralia Hospital, including records from the admissions of August 19, 2014, and [of] September 1, 2014." CP at 482.

From those records Dr. Brentnall determined that Ritter suffered from constipation following her return to NCPI on August 22, as evidenced by the imaging study taken on September 1 at Providence Centralia Hospital. Additionally, she determined that Ritter went without a bowel movement between August 22 and September 1 because an oral contrast, administered on August 19, remained in her system when an imaging study was conducted on September 1. Dr. Brentnall stated that, "it is in my opinion more likely than not, that the untreated constipation of Bessie Ritter . . . led to her development of a cecal volvulus." CP at 484.

Iverson argued that under *Anderson*,[4] *Frye* is not implicated by an expert opinion on causation.

[4] *Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d 593, 260 P.3d 857 (2011).

In response, NCPI argued that (1) Iverson failed to satisfy *Frye*, (2) Dr. Brentnall's expert opinion on causation is not admissible, (3) Iverson either misunderstood or misconstrued *Anderson*, (4) Dr. Brentnall's expert testimony was not based on the complete medical record because she did not consider Ritter's adhesions[5] as an alternative cause for her development of a cecal volvulus, and (5) Iverson failed to prove a genuine issue of material fact.

The superior court agreed with NCPI, granted summary judgment, and dismissed Iverson's medical negligence claim. Iverson filed a motion for reconsideration, which the superior court denied. Iverson appeals the orders granting summary judgment and denying reconsideration.[6]

ANALYSIS

Iverson argues that the superior court erred by granting summary judgment dismissal because under *Anderson*, *Frye* is not implicated when an expert's causation opinion is based on a differential diagnosis.[7] Thus, under *Anderson*, Dr. Brentnall's causation opinion is admissible and her opinion creates genuine issues of material fact on causation rendering summary judgment dismissal improper. We hold that because Dr. Brentnall's causation opinion is based on a differential diagnosis, *Frye* is not implicated.

[5] "Adhesions" are bands of scar tissue. CP at 556.

[6] Iverson did not provide any arguments to support her challenge to the order denying reconsideration; therefore, we do not consider this issue. RAP 12.1(a).

[7] *Anderson*, 172 Wn.2d at 597.

I. STANDARDS OF REVIEW

We review a grant of summary judgment de novo, viewing the facts and reasonable inferences in the light most favorable to the nonmoving party. *Keck v. Collins*, 184 Wn.2d 358, 368, 357 P.3d 1080 (2015). Summary judgment dismissal is proper only when the pleadings, depositions, and admissions in the record, together with any affidavits, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. CR 56(c); *Young v. Key Pharms., Inc.*, 112 Wn.2d 216, 225-26, 770 P.2d 182 (1989). The purpose of a summary judgment motion is to avoid an unnecessary trial where no genuine issue as to a material fact exists. *Young*, 112 Wn.2d at 225-26.

The moving party bears the initial burden of showing there are no genuine issues of material fact. *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162, 194 P.3d 274 (2008). If the moving party meets its burden of producing factual evidence showing that it is entitled to judgment as a matter of law, the burden shifts to the nonmoving party to "'produce evidence sufficient to support a reasonable inference that the [moving party] was negligent.'" *Rounds,* 147 Wn. App. at 162 (quoting *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001)). To make the requisite showing, the party opposing summary judgment must submit "competent testimony setting forth specific facts, as opposed to general conclusions[,] to demonstrate a genuine issue of material fact." *Thompson v. Everett Clinic*, 71 Wn. App. 548, 555, 860 P.2d 1054 (1993).

Summary judgment is proper in a medical negligence case if the plaintiff fails to produce competent medical expert testimony establishing that the injury was proximately caused by a failure to comply with the applicable standard of care. *Rounds*, 147 Wn. App. at 162-63 (citing *Seybold*, 105 Wn. App. at 676).

II. *FRYE* IS NOT IMPLICATED

A. APPLICABILITY OF *ANDERSON*

Our Supreme Court in *Anderson* explained when *Frye* is implicated. *Anderson* held that "the *Frye* test is not implicated if the theory and the methodology relied upon and used by the expert to reach an opinion on causation is generally accepted by the relevant scientific community." *Anderson v. Alzo Nobel Coatings, Inc.*, 172 Wn.2d 593, 597, 260 P.3d 857 (2011). "[I]f the science and methods are widely accepted in the relevant scientific community, the evidence is admissible under *Frye*, without separately requiring widespread acceptance of the plaintiff's theory of causation." *Anderson*, 172 Wn.2d at 609. This is because "[m]any medical opinions on causation are based upon differential diagnoses." *Anderson*, 172 Wn.2d at 610. The Frye test is implicated only where the opinion on causation is based on novel science. *Anderson*, 172 Wn.2d at 611.

A physician "may base a conclusion about causation through a process of ruling out potential causes with due consideration to temporal factors, such as events and the onset of symptoms." *Anderson*, 172 Wn.2d at 610. *Anderson* further explained that

> [I]f the science and methods are widely accepted in the relevant scientific community, the evidence is admissible under *Frye*, without separately requiring widespread acceptance of the plaintiff's theory of causation. Of course the evidence must also meet the other evidentiary requirements of competency, relevancy, reliability, helpfulness, and probability.

> . . . .
>
> Many expert medical opinions are pure opinions and are based on experience and training rather than scientific data. We require only that "medical expert testimony . . . be based upon a reasonable degree of medical certainty" or probability.

Anderson, 172 Wn.2d at 609-10 (citations omitted, internal quotation marks omitted) (quoting *McLaughlin v. Cooke*, 112 Wn.2d 829, 836, 774 P.2d 1171 (1989)).

Here, Dr. Brentnall conducted a differential diagnosis of Ritter's symptoms by reviewing "the events that led to the cecal volvulus that was the immediate cause of Ms. Ritter's demise." CP at 485. She considered Ritter's medical records along with her own experience, education, and training as a board certified gastroenterologist with 20 years of experience. CP at 481-82. In her declaration, Dr. Brentnall stated that she reviewed "records from [the facility] for the admission beginning July 25, 2014 and records from Providence Centralia Hospital, including records from the admissions of August 19, 2014, and [of] September 1, 2014." CP at 482.

Dr. Brentnall explained that from those records she determined that Ritter suffered from constipation following her return to NCPI on August 22, as evidenced by the imaging study taken on September 1 at Providence Centralia Hospital. Additionally, she determined that Ritter went without a bowel movement between August 22 and September 1 because an oral contrast, administered on August 19, remained in her system when an imaging study was conducted on September 1.

Through the process of differential diagnosis, Dr. Brentnall opined that "the untreated constipation of Bessie Ritter during the period between [August 22] and [September 1] led to her development of a cecal volvulus." CP at 484. Because Dr. Brentnall's causation theory is based

on a differential diagnosis, a process well accepted in the medical community, her opinion does not implicate *Frye*.

NCPI's experts, Drs. Chiorean, Oelschlager, and Peters, disagreed with Dr. Brentnall's conclusion that constipation causes a cecal volvulus, but they did not disagree with Dr. Brentnall's underlying methodology. Because the experts have differing opinions on causation, there are genuine issues of material fact. Because there are genuine issues of material fact on causation, and viewing the facts and inferences in the light most favorable to the nonmoving party, we hold that the superior court erred in granting summary judgment dismissal. Thus, we reverse the order of summary judgment dismissal of the medical negligence claim and remand for further proceedings.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Sutton, J.
SUTTON, J.

We concur:

A.C.J.
LEE, A.C.J.

Bjorgen, J.
BJORGEN, J.

Filed
Washington State
Court of Appeals
Division Two

February 26, 2019

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

GERALDINE IVERSON, as personal representative of BESSIE RITTER, Appellant, v. PRESTIGE CARE, INC. and NORTHWEST COUNTRY PLACE, INC., Respondents.	No. 50336-1-II ORDER GRANTING APPELLANT'S MOTION FOR RECONSIDERATION AND ORDER AMENDING UNPUBLISHED OPINION

The unpublished opinion in this case was filed on January 3, 2019. Upon the motion of appellant for reconsideration, it is hereby

ORDERED that appellant's motion for reconsideration is granted and the unpublished opinion previously filed on January 3, 2019, is amended as follows:

Page 3, footnote no. 3 following the first sentence is deleted.

Page 5, footnote no. 6 following the last sentence of the second paragraph is deleted.

IT IS SO ORDERED.

Sutton, J.
SUTTON, J.

We concur:

Lee, A.C.J.
LEE, A.C.J.

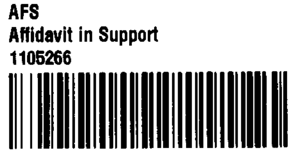
Bjorgen, J.
BJORGEN, J.

APPENDIX B

CP 481-87

Dr. Brentnall's Declaration

(without exhibits)



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Special Set/Dept. 2/Judge Lawler
Date of Hearing: Friday, March 17, 2017
at 1:30p.m.
w/Oral Argument

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON IN
AND FOR THE COUNTY OF LEWIS

GERALDINE IVERSON, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BESSIE RITTER

Plaintiff,

v.

PRESTIGE CARE, INC. and NORTHWEST COUNTRY PLACE, INC.

Defendants.

Cause No.: 15-2-00391-5

DECLARATION OF TERESA BRENTNALL, MD IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

I, Teresa Brentnall declare as follows:

1. I am over the age of majority and am otherwise competent to testify in this matter. I have personal knowledge of the facts set forth in this declaration and if called upon to testify to such matters, I could and would do it competently. I am a physician licensed and currently practicing in the State of Washington.

2. I am Board-Certified in Gastroenterology and have 20 years of experience in that subspecialty of medicine. I personally provide care for patients in addition to my academic teaching, research and administrative responsibilities. My background is more fully described in my curriculum vitae, a copy of which is attached to this declaration as Exhibit "1."

1 3. Based on my education, training and experience, I am familiar with the
2 diagnosis, care and management of patients presenting with similar problems to those of Ms.
3 Bessie Ritter, including untreated severe constipation. I am aware of standards of care in the
4 community for the evaluation and treatment of the constipation and physical conditions
5 presented by Ms. Bessie Ritter. Regardless of whether the patient is in a rehab center, hospital,
6 or skilled nursing facility, the standard of care applicable to her requires that her care facility
7 address the documented failure to have a bowel movement and follow doctor's orders in
8 connection with the failure to have a bowel movement. The standard of care requires
9 administration of medication in accordance with doctor's orders and follow-up to ensure that the
10 medication is effective.
11 4. My opinions expressed in this Declaration are based upon my review of
12 medical records concerning the care of Ms. Bessie Ritter provided to me by The Hornbuckle
13 Firm. These include: records from Liberty Country Place for the admission beginning July 25,
14 2014 and records from Providence Centralia Hospital, including records from the admissions of
15 August 19, 2014, and September 1, 2014.
16 5. Ms. Bessie Ritter resided at the Liberty Country Place with the Defendants
17 from on or about 7/25/14 to 9/1/14. Ms. Ritter died on 9/4/14.
18 6. It is my professional opinion, within a reasonable degree of medical
19 probability, based on my review of the above medical records, my experience, my education and
20 training, that Liberty Country Place did deviate from the accepted standard of medical care in the
21 treatment of Ms. Bessie Ritter. Ms. Ritter was readmitted to Liberty Country Place from
22 Providence Centralia Hospital on 8/22/14 at 6:50 p.m. and was discharged back to Providence
23 Centralia Hospital on 9/1/14 at 6:25 p.m. The medical records from Liberty Country Place show
24 that Ms. Ritter did not have any bowel movements during this time period of 10 days. These
25 records are attached hereto as Exhibit 2. The records from Liberty Country Place ("LCP") show
that the facility did not do anything to address Ms. Ritter's constipation until the evening of
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1 8/30/14, when for the first time she was given Milk of Magnesia. A copy of the medication
2 administration record demonstrating this lack of treatment is attached hereto as Exhibit 3. LCP
3 did not follow the physician orders set forth on Ex. 3 and referencing the "HBP," which I
4 understand to be the House Bowel Program or Constipation Management Protocol identified in
5 the attached Ex. 4. LCP breached the Constipation Management Protocol and physician orders
6 by: (1) not administering docusate sodium after more than one day without a bowel movement;
7 (2) not administering Milk of Magnesium after three days without a bowel movement; (3) not
8 giving Ms. Ritter a suppository after three days and one shift without a bowel movement; (4) not
9 calling the physician after having no results from these medications. These breaches were
10 repeated daily during the time period between 8/23/14 and 8/30/14, when Ms. Ritter was finally
11 given medication for constipation.

12 7. The medical records are the most reliable evidence of bowel movements
13 that we have available. The medical records from Liberty Country Place indicate that Ms. Ritter
14 suffered from constipation following her discharge back to the facility on 8/22/14. This is
15 confirmed by the imaging study taken on 9/1/14 at Providence Centralia Hospital ("PCH"),
16 which shows that a "large amount of stool amount of stool is seen in the right colon and
17 transverse colon." See Ex. 5, Imaging studies from PCH. That Ms. Ritter went without a bowel
18 movement at Liberty Country Place between 8/22/14 and 9/1/14 is further confirmed by the
19 presence of residual oral contrast noted on the 9/1/14 imaging study. The contrast was
20 administered on 8/19/14 and should have passed from her system in 5 days. To illustrate, the
21 Sitz Marker test, a commonly used test to measure bowel transit, is considered abnormal if the
22 radio-opaque markers consumed in the test have not cleared the body within 5 days. See Ex. 6,
23 [Indications/Directions for use of Sitzmarkers: SIMPLIFIED SITZMARKS METHOD]. It is
24 grossly abnormal for the oral contrast not to have cleared Ms. Ritter's system between 8/19/14
25 and 9/1/14. The objective evidence of severe constipation at Liberty Country Place is strong and
includes not just the facility's own medical record, but also the condition of the patient and the
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imaging of her abdomen when she was admitted to PCH on 9/1/14. This is further supported by the AGA Guidelines, which define constipation as "infrequent bowel movements, typically fewer than 3 per week, patients [can] have a broader set of symptoms, including hard stools, a feeling of incomplete evacuation, abdominal discomfort, bloating, and distention, as well as other symptoms (eg, excessive straining, a sense of ano-rectal blockage during defecation, and the need for manual maneuvers during defecation), which suggest a defecatory disorder." See Ex. 7, AGA Guidelines.

8. Differential diagnosis is the method used in medicine to determine the cause of an illness. The method involves using information such as symptoms, patient history, and medical knowledge to determine the cause of an illness. The clinician applies known facts and clinical experience to narrow the possible causes of an illness and determine the likely cause. I have used this method to form the opinions contained in this declaration. Differential diagnosis is well accepted in the scientific community and is used every day by thousands of physicians throughout the country.

9. Through the process of differential diagnosis, it is in my opinion more likely than not, that the untreated constipation of Bessie Ritter during the period between 8/22/14 and 9/1/14 led to her development of a cecal volvulus. Cecal volvulus is a twisting of the colon. Ms. Ritter's colon likely twisted as a result of the ten day period of constipation at LCP. This opinion is supported by known facts regarding the anatomy of the colon and by the presence of a "large amount of stool" in the colon in the imaging study of 9/1/14. The large amount of stool causes the colon to distend and interferes with muscle function. The colonic distension- from constipated stool decreases capillary blood flow, leads to decreased colonic motility (atony), increases the risk of torsion of the colon, and likely led to the twisting of Ms. Ritter's cecum. This distension by constipated stool was avoidable and preventable through the implementation of the Constipation Management Protocol ordered by the doctors at LCP.

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10. This mechanism of injury is supported by the study of cecal volvulus in pregnant women. Cecal volvulus is one of the most common causes of bowel obstruction in this group. Increased production of progesterone causes the bowels to move more slowly, relax and stretch out. The colon fills up with stool as a result, leading to a cecal volvulus. Other groups that are especially prone to constipation have an increased risk of volvulus: this includes patients with chronic illnesses and decreased ambulatory capacity, patient's with constipation due to inherited or acquired neurologic disorders of the colon (including Hirschsprung's, Parkinson's, and Chagas disease). The mechanism underlying these conditions includes dilation of the colon with stool, decreased colon motility with colon expansion, decreased capillary blood flow, which all leads to increased risk of colonic torsion. Patients with constipation are 7 times more likely to develop volvulus. This process is likely what led to Ms. Ritter's cecal volvulus. J Visc Surgery 2016; 153: 183-192. Ex. 8 hereto. JR Coll Physicians Edinb 2016; 46: 157-159. Surg Clin North Am 1982; 62:249-260. South Med J. 1982; 933-936. Medscape Sigmoid and Cecal Volvulus 2016. Copies of these articles are attached as Ex. 9.

11. Adhesions can be a cause of cecal volvulus, however, we know that this is not the -cause of Ms. Ritter's cecal volvulus, because there was no evidence of adhesions per the operative notes following Ms. Ritter's surgery on 9/2/14. I have considered the events that led to the cecal volvulus that was the immediate cause of Ms. Ritter's demise, and on a more probable than not basis, the ten day period of untreated constipation and resulting heavy stool burden were proximate causes of the twisting of the cecum and Mrs. Ritter's demise.

12. Medical literature also supports my opinions set forth here. "Some factors are common to all locations of volvulus, such as chronic constipation, high fiber diet, frequent use of laxatives, history of laparotomy and anatomic predisposition." See- Management of the colonic volvulus in 2016; Journal of Visceral Surgery (2016) 153, at p. 183. "The classic patient is elderly, institutionalized, and under psychotropic medications that cause chronic constipation." *Id.* at 185. A copy of this article is attached hereto as Exhibit 8. In Ms. Ritter's case, untreated

constipation during the period between 8/22/14 and 9/1/14 led her colon to fill with stool. It does not matter whether you call this episode chronic constipation, constipation, or acute on chronic constipation. The mechanism for causing the cecal volvulus, more likely than not, is the same as set forth above.

13. Ms. Ritter's constipation at Liberty Country Place between 8/22/14 and 9/1/14 was, more likely than not, treatable and avoidable. This conclusion is based on experience and on the fact that she suffered from a prior episode of constipation at LCP, leading to a partial small bowel obstruction and hospitalization on 8/19/14. This episode completely resolved with the use of laxatives. The failure to give her laxative medication, as prescribed by her doctor, led to untreated constipation, the buildup of the heavy stool burden referenced above, and the ultimately the twisting of the cecum. These events were preventable and avoidable, more likely than not, by following doctor's orders and giving Ms. Ritter the medication and treatments she was prescribed. Further support for this opinion is found in the LCP medical record, which indicates Ms. Ritter was given medication for constipation on 8/7/14 and 8/13/14 and promptly had a bowel movement the day following the treatment at each episode. The documented, effective use of laxatives at LCP on those dates demonstrates that the episode of severe constipation between 8/22/14 and 9/1/14 was preventable and avoidable.

14. There is little question that the twisting of the cecum was the immediate cause of Ms. Ritter's demise. The discharge summary at Providence Centralia Hospital and Death Certificate confirm this. See Ex's 11 and 12. The twisting of the cecum, was more likely than not, the preventable result of ten days of treatable, avoidable constipation at Liberty Country Place. It is not a coincidence in my opinion that Ms. Ritter's demise followed a ten day episode of constipation at LCP. Her premature demise was the avoidable result of poor care on the part of LCP.

15. All of the opinions stated in this declaration are expressed within a reasonable degree of medical probability and are based on my education, training and experience

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1 and upon my review of the records listed in this declaration; and upon the literature cited. The
2 literature cited in this declaration is reliable authority resulting from my research into the issues
3 involved in Ms. Ritter's care.
4
EXECUTED this 5th day of March 2017, in Seattle, Washington.
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By *Teri Brentnall*
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Teresa Brentnall, MD
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APPENDIX C

CP 501-02

Vitals Report

Vitals Report

08/01/2014 - 09/01/2014

Date Taken	Vital	Value	Details	Taken By
Riter, Bessie MR#: 4071 Discharged Physician: David Ellis MD				
08/31/2014 23:31	Bowel Movement		Size: None	Frances K Garrett RN
08/31/2014 22:14	Bowel Movement		Size: None	Frank T Flammang NAC
08/31/2014 20:13	Bowel Movement		Size: None	Elizabeth Roe
08/31/2014 13:02	Bowel Movement		Size: None	Michelle Hall NAC
08/31/2014 01:15	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/30/2014 11:55	Bowel Movement	0mL	Size: None	Michelle Hall NAC
08/29/2014 22:19	Bowel Movement		Size: None	Frank T Flammang NAC
08/29/2014 09:20	Bowel Movement	0mL	Size: None	Cynthia Denman
08/29/2014 00:28	Bowel Movement		Size: None	Frank T Flammang NAC
08/28/2014 21:00	Bowel Movement		Size: None	Angela C Taylor NAC
08/28/2014 08:23	Bowel Movement	0mL	Size: None	Cynthia Denman
08/27/2014 20:59	Bowel Movement		Size: None	Chris Patterson NAC
08/27/2014 03:37	Bowel Movement		Size: None	Jessica M Maurer NAC
08/26/2014 20:48	Bowel Movement		Size: None	Elizabeth Roe
08/26/2014 09:28	Bowel Movement	0mL	Size: None	Cynthia Denman
08/26/2014 01:02	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/25/2014 13:06	Bowel Movement		Size: None	Michelle Hall NAC
08/24/2014 12:15	Bowel Movement	0mL	Size: None	Michelle Hall NAC
08/23/2014 12:10	Bowel Movement	0mL	Size: None	Chelsea M Kell NAC
08/23/2014 04:52	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/18/2014 15:10	Bowel Movement		Size: Large	Crystal Brown
08/18/2014 05:42	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/17/2014 08:26	Bowel Movement	0mL	Size: None	Cynthia Denman
08/17/2014 03:58	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/16/2014 21:41	Bowel Movement		Size: None	Cynthia C Stacy NAC
08/16/2014 12:40	Bowel Movement	0mL	Size: None	Cynthia Denman
08/16/2014 04:51	Bowel Movement		Size: Medium	Julie N Bair Delaney NAC
08/15/2014 04:42	Bowel Movement		Size: None	Julie N Bair Delaney NAC .
08/14/2014 21:02	Bowel Movement		Size: None	Tasha Macomber
08/14/2014 00:23	Bowel Movement		Size: Large	Frances K Garrett RN
08/13/2014 22:25	Bowel Movement		Size: None	Frank T Flammang NAC
08/12/2014 12:10	Bowel Movement	0mL	Size: None	Michelle Hall NAC
08/11/2014 09:14	Bowel Movement	0mL	Size: None	Cynthia Denman
08/11/2014 03:03	Bowel Movement		Size: None	Jessica M Maurer NAC
08/10/2014 09:32	Bowel Movement	0mL	Size: None	Cynthia Denman
08/10/2014 04:34	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/09/2014 19:34	Bowel Movement		Size: None	Cynthia C Stacy NAC
08/09/2014 13:25	Bowel Movement	0mL	Size: Medium	Cynthia Denman
08/09/2014 13:24	Bowel Movement	0mL	Size: Large	Cynthia Denman
08/09/2014 09:25	Bowel Movement	0mL	Size: None	Cynthia Denman
08/09/2014 04:48	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/08/2014 09:49	Bowel Movement	0mL	Size: None	Cynthia Denman

Vitals Report

08/01/2014 - 09/01/2014

Date Taken	Vital	Value	Details	Taken By
Ritter, Bessie MR#: 4071 Discharged Physician: David Ellis MD				
08/08/2014 04:25	Bowel Movement		Size: Small	Julie N Bair Delaney NAC
08/08/2014 03:41	Bowel Movement		Size: Large	Frances K Garrett RN
08/07/2014 04:12	Bowel Movement		Size: None	Julie N Bair Delaney NAC
08/06/2014 13:41	Bowel Movement	0mL	Size: None	Michelle Hall NAC
08/05/2014 23:10	Bowel Movement		Size: None	Frank T Flammang NAC
08/04/2014 22:40	Bowel Movement		Size: None	Frank T Flammang NAC
08/04/2014 21:42	Bowel Movement		Size: None	Angela C Taylor NAC
08/03/2014 09:56	Bowel Movement	0mL	Size: None	Cynthia Denman
08/02/2014 19:08	Bowel Movement		Size: None	Cynthia C Stacy NAC
08/02/2014 09:40	Bowel Movement	0mL	Size: None	Cynthia Denman
08/01/2014 20:37	Bowel Movement		Size: None	Cynthia C Stacy NAC
08/01/2014 02:56	Bowel Movement		Size: None	Julie N Bair Delaney NAC

APPENDIX D

CP 509-10

Hospital Records

Absolute Monocytes	0.71	0.00-0.80 K/uL
Absolute Eosinophils	0.13	0.00-0.50 K/uL
Absolute Basophils	0.06	0.00-0.10 K/uL

IMAGES evaluated directly visually by Attending.

Ct Abdomen Pelvis Wo Contrast

9/1/2014 CT ABDOMEN PELVIS WO CONTRAST DATE OF EXAM: 9/1/2014 INDICATION: ABDOMINAL PAIN (SEVERE) PROCEDURE: Utilizing the Toshiba Aquilion 64 scanner, axial images of the abdomen and pelvis were obtained without administration of contrast. Additional sagittal and coronal reformatted images were also obtained. FINDINGS: Limited images of the lung bases demonstrate trace left-sided pleural effusion, new since prior study. Atherosclerotic calcifications of the coronary arteries, distal thoracic aorta, abdominal aorta and its visceral branches and iliac/femoral arteries are present. There is no evidence for abdominal aortic aneurysm or ectasia. Spleen, adrenal glands, kidneys and liver appear unremarkable within limits of a noncontrast study. There is mild prominence of the main pancreatic duct. Evaluation of the pancreas is extremely limited due to lack of intravenous contrast and adjacent dilated fluid-filled loops of bowel. A few subcentimeter hypoattenuating liver lesions are present. These are too small to characterize but most likely represent hepatic cysts. Gallbladder is surgically absent. There is no evidence for pneumatosis intestinalis or portal venous gas.Residual oral contrast from prior study of 08/19/2014 is seen in the distal left colon and rectosigmoid. There are multiple markedly dilated loops of small bowel. Terminal ileum and distal ileal loops have normal diameter. These findings are consistent with partial small-bowel obstruction. The exact zone of transition is not known it is most likely situated in the distal ileum. Large amount of stool is seen in the right colon and transverse colon. Evaluation of the pelvis is limited due to streak artifact from left hip prosthesis. There is no evidence for free intraperitoneal air. Moderate amount of free intraperitoneal fluid is present, new since prior study. Diffuse osteopenia is present. There are moderate to severe degenerative changes of the right hip joint. Moderate degenerative changes of the sacroiliac joints are seen. Moderate to severe degenerative changes of the lumbar and lower thoracic spine are present. There is grade I anterolisthesis of L4 vertebral body over the L5 vertebral body. The There is no evidence for inguinal or ventral hernia. Multiple injection granulomas are seen in the gluteal region bilaterally. There is suggestion of moderate anasarca which could be due to congestive heart failure/fluid overload.

9/1/2014 1. Findings most consistent with partial small bowel obstruction, worse than prior study of 08/19/2014. 2. Moderate free intraperitoneal fluid, new since prior study. 3. Trace left-sided pleural effusion, new since prior study. Dictated By: Mehdi Rohany, M.D. 9/1/2014 19:56:25

Ct Abdomen Pelvis Wo Contrast

8/19/2014 CT ABDOMEN PELVIS WO CONTRAST DATE OF EXAM: 8/19/2014 INDICATION: abdominal pain PROCEDURE: Utilizing the Toshiba Aquilion 64 scanner, axial images of the abdomen and pelvis were obtained without administration of intravenous contrast. Oral contrast was then administered before exam. Additional sagittal and coronal reformatted images were also obtained. FINDINGS: Limited images of the lung bases demonstrate subsegmental atelectasis/scarring in the left lung base. Atherosclerotic calcifications of the coronary arteries, distal

thoracic aorta, abdominal aorta and its visceral branches and iliac/femoral arteries are present. There is no evidence for abdominal aortic aneurysm or ectasia. Spleen, pancreas, adrenal glands, kidneys and liver appear unremarkable within limits of a noncontrast study. A few subcentimeter hypoattenuating liver lesions are present. These are too small to characterize but most like represent hepatic cysts. There is no evidence for pneumatosis intestinalis or portal venous gas. Oral contrast opacifies the stomach and proximal jejunal. The rest of bowel is not opacified with contrast. There are multiple dilated loops of small bowel. Terminal ileum and distal ileal loops have normal diameter. These findings are consistent with partial small-bowel obstruction. The exact zone of transition is not known. Moderate amount of stool is seen in the right colon and transverse colon. Left colon and sigmoid are decompressed. Evaluation of the pelvis is limited due to streak artifact from left hip prosthesis. There is no evidence for free intraperitoneal air Diffuse osteopenia is present. There are moderate to severe degenerative changes of the right hip joint. Moderate degenerative changes of the sacroiliac joints are seen. Moderate to severe degenerative changes of the lumbar and lower thoracic spine are present. There is grade I anterolisthesis of L4 vertebral body over the L5 vertebral body. The There is no evidence for inguinal or ventral hernia. Multiple injection granulomas are seen in the gluteal region bilaterally. There is suggestion of moderate anasarca which could be due to congestive heart failure/fluid overload.

8/19/2014 Findings most consistent with partial small-bowel obstruction. Dictated By: Mehdi Rohany, M.D. 8/19/2014 20:35:18

Xr Chest Ap Portable

9/1/2014 XR CHEST AP PORTABLE DATE OF EXAM: 9/1/2014 INDICATION: Weakness fever FINDINGS: Comparison is made with the prior study on 08/19/2014. The heart size is unchanged. The lung fields appear clear except for compressive atelectasis in the basilar regions. The hemidiaphragms are sharp. The pulmonary vascularity is within normal limits. Atherosclerotic plaques are noted in the thoracic aortic knob.

9/1/2014 No acute changes in the chest since 08/19/2014. Dictated By: Terence T. Chan, M.D. 9/1/2014 20:29:09 There are no findings felt actionable on this study. (EC-NS)

Xr Chest Ap Portable

8/19/2014 XR CHEST AP PORTABLE DATE OF EXAM: 8/19/2014 INDICATION: EMESIS FINDINGS: This is a lordotic AP portable projection which accentuates cardiac size. The lung fields are clear except for minimal discoid atelectasis at the left costophrenic angle. There is no pneumothorax. The hemidiaphragms are sharp. The pulmonary vasculature is within normal limits. Costochondral calcifications are noted in the anterior first ribs. Mild atherosclerotic plaques are noted in the aortic knob. There are osteophytes in the dorsal spine.

8/19/2014 No acute cardiopulmonary process is demonstrated. Dictated By: Terence T. Chan, M.D. 8/19/2014 15:58:38 There are no findings felt actionable on this study. (EC-NS)

APPENDIX E

CP 504

Medication Administration Record

PRN Medications Flowsheet: Ritter, Bessie

Date: 8/1/2014 - 8/31/2014

Administration Note:
Information:

Order	Time		F 1	Sa 2	Su 3	M 4	Tu 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	Tu 12	W 13	Th 14	F 15	Sa 16	Su 17	M 18	Tu 19	W 20	Th 21	F 22	Sa 23	Su 24	M 25	Tu 26	W 27	Th 28	F 29	Sa 30	Su 31
DSS (docusate sodium) capsule; 250 mg - 1000 mg; oral Once A Day - PRN (HBP) [DX: Constipation NOS] 07/25/2014 - Open Ended		PRN																															
		Amount																															
Milk of Magnesia (magnesium hydroxide) [OTC] suspension; 400 mg/5 mL; Amount to Administer: 30 ml; oral Once A Day - PRN If no BM in 3 days. (HBP) [DX: Constipation NOS] 07/25/2014 - Open Ended		PRN																															
Dulcolax (bisacodyl) (bisacodyl) [OTC] suppository; 10 mg; rectal Once A Day - PRN If no results from MOM. (HBP) [DX: Constipation NOS] 07/25/2014 - Open Ended		PRN																															
If no results from HBP, notify MD. Once A Day - PRN [DX: Constipation NOS] 07/25/2014 - Open Ended		PRN																															
Duoneb 3ml via neb Q6°	0001 0600 1200 1800																																

DC'd Q4H

Physician:	Ellis, David ph: (360) 785-0300		Diagnoses:	250.00 DM, uncomplicated, type II, 300.00 Anxiety state NOS, 564.00 Constipation NOS	
Allergies:					
Resident:	Ritter, Bessie	MR#: 4071-01	Unit: Ivy Lane	Room/Bed: 125/A	DOB: 7/30/1930 Age: 83 Sex: F
Admit Date:	Jul 25 2014 6:16PM				

CP 504
LCPRECS000064
NWCP003308

APPENDIX F

CP 506-07

Medication Administration Record

POLICIES AND PROCEDURES MANUAL

SUBJECT:	CONSTIPATION MANAGEMENT PROTOCOL
DATE ISSUED:	January 21, 2004
DATE REVISED:	SEPTEMBER 5, 2007
APPROVED BY:	PAULINE MCDANIEL/DNS
PAGE:	1 of 2

POLICY:

It is the policy of Liberty Country Place to provide an individual Bowel Management Plan for those residents who experience an occasional episode of constipation. Goals include:

1. The reduction of the use of laxatives/stool softeners.
2. The provision of a natural means for bowel elimination.
3. The provision of relief for those residents experiencing constipation.
4. The prevention of impactions.
5. The provision of a means to achieve continent bowel regularity.
6. The means to identify those residents at risk for constipation.

CRITERIA:

1. Resident must be free of fecal impaction.
2. Program must be individualized for each resident and based upon a comprehensive nursing assessment.
3. There must be documented Utilization and Review of bowel records.

PROTOCOL:

Licensed staff nurse is to:

1. Check for bowel tones.
2. Check hydration status.
3. Assess diagnostic tests/labs that may be contributory factors.
4. Discontinue laxatives and enemas to the extent possible.
5. Administer Fiber Rich, 8 oz. per day (4 oz. BID). May use up to 4 oz. TID, or 12 oz.
6. Observe for constipation, administer PRN meds, as necessary.
7. Maintain hydration and activity program.

PROGRAM:

1. Encourage fluids, 2000 - 2500 cc, or as resident chooses (unless on fluid restriction–resident normal or average intake may fluctuate).
2. Encourage Geriatric Liberalized Diet.
3. Administer Fiber Rich or equivalent, 8 oz. per day (4 oz. BID). May use up to 4 oz. TID.

PROTOCOL — PRN MEDS:

1. Fiber Rich, 120 cc, 1 day with no bowel movement, prn, resident request.
2. If no bowel movement from Fiber Rich, DOSS 250 mg, 1-4 caps by mouth.
3. If no bowel movement in 3 days, MOM, 1 oz. by mouth every day.
4. If no results from MOM, Dulcolax suppositories, 1 rectally, prn.
5. If no results from medications, notify physician.

* Please write actions and results on bowel status sheet on medication cart. Days or any shift can give DOSS. The next shift may also give DOSS, if all four haven't been given. MOM may also be given on any shift. Suppositories should be given on NOC shift. Report to next shift.

filenamepp\Constipation.wpd

LPC 5185

APPENDIX F

CP 546-47

Discharge Summary

Discharge Summaries signed by Atul Thakker, MD at 9/10/2014 5:34

Author: Atul Thakker, MD
Filed: 9/10/2014 5:34
Editor: Atul Thakker, MD (Physician)

Service: (none)
Note Time: 9/9/2014 17:53

Author Type: Physician
Status: Signed

PROVIDENCE CENTRALIA HOSPITAL

DISCHARGE SUMMARY

ATUL THAKKER MD
Patient: RITTER,BESSIE
Admitting: EMERY CHANG
MR #: 60004633380
LOC: PT TYPE: Account #: 10070138466
Adm Date: 09/01/2014 DOB: 07/30/1930
Date Of Service: 09/04/2014
DEATH SUMMARY

DATE OF ADMISSION: 09/01/2014

DATE OF DEATH: 09/04/2014

ATTENDING PHYSICIANS: Atul Thakker, MD; David Fick, MD; Sang Yoon Oh, MD

PRINCIPAL FINAL DIAGNOSIS: Small-bowel obstruction.

ALL ADDITIONAL DIAGNOSES: Hypothyroidism, diastolic heart failure, chronic kidney disease stage III, lymphedema, diabetes, acute renal failure, acute encephalopathy, acute respiratory failure, metabolic acidosis, postoperative shock, and metabolic encephalopathy.

PRINCIPAL PROCEDURE PERFORMED: Resection of terminal ileum and right colon with ileostomy.

REASON FOR ADMISSION: Bessie is an 84-year-old female admitted to the hospital with signs and symptoms of small-bowel obstruction. The patient had 6 days of symptoms with abdominal distention and was admitted to the hospital for treatment.

HOSPITAL COURSE: The patient was admitted to the hospital where she underwent nasogastric decompression and intravenous fluid rehydration. A discussion was held with the family regarding the patient's advanced age and critical condition and a discussion was held whether comfort care measures were in order versus exploration. A family conference was held and they requested surgical intervention. The patient underwent resection of terminal ileum and right colon with ileostomy. Postoperatively, the

Discharge Summaries (continued)

Discharge Summaries signed by Atul Thakker, MD at 9/10/2014 5:34 (continued)

patient was intubated and transferred to the intensive care unit. She had hypotension, oliguric renal failure requiring high-dose pressor support.

The patient had poor response to maximal medical therapy in the intensive care unit and died on postoperative day #2.

ATUL THAKKER MD

Dictated by ATUL THAKKER, MD 09/09/2014 17:53:43
Transcribed on 09/09/2014 19:22:06 by dlb job# 4196212
Confirmation #: 040422

cc: DAVID ELLIS MD
DAVID FICK MD
YANCEY SLOANE MD

Signed by Atul Thakker, MD on 9/10/2014 5:34

History & Physicals

H&P by Atul Thakker, MD at 9/2/2014 10:34

Author: Atul Thakker, MD
Filed: 9/2/2014 11:12
Editor: Atul Thakker, MD (Physician)

Service: Surgery
Note Time: 9/2/2014 10:34

Author Type: Physician
Status: Signed

Providence Centralia
HISTORY AND PHYSICAL

PRIMARY CARE PHYSICIAN: David A. Ellis

PATIENT NAME: Bessie Marie Ritter **DOB**: 7/30/1930

TODAY'S DATE: 9/2/2014 **MRN:** 60004633380

CHIEF COMPLAINT: abd pain

HISTORY OF PRESENT ILLNESS: The patient is a 84 y.o. female with a history of SBO developed increased pain and distension. No BM for 6 days with increased symptoms. No fever. Poor PO intake. 8/10 pain.

Past Med Hx:

Past Medical History

Diagnosis Date

- Hip pain
  chronic right hip pain
- CHF (congestive heart failure) (HCC)
- Diabetes mellitus (HCC)

APPENDIX G

CP 549

Death Certificate

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Washington State Certificate of Death

Local File Number: | State File Number:

1. Legal Name (Include AKA's if any) First: Bessie | Middle: Marie | Last: Ritter | Suffix:
2. Death Date: Sept. 4, 2014
3. Sex: Female
4a. Age – Last Birthday: 84
4b. Under 1 Year: Months / Days
4c. Under 1 Day: Hours / Minutes
5. Social Security Number: 541-30-3620
6. County of Death: Lewis
7. Birthdate: July 30, 1930
8a. Birthplace (City, Town, or County): Medford
8b. (State or Foreign Country): Oregon
9. Decedent's Education: Associate's Degree
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify: No
11. Decedent's Race(s): Caucasian
12. Was Decedent ever in U.S. Armed Forces? No
13a. Residence Number and Street (e.g., 624 SE 5th St.) (Include Apt. No.): 1272 Park Ave. East
13b. City or Town: Tenino
13c. Residence County: Thurston
13d. Tribal Reservation Name (if applicable): -----
13e. State or Foreign Country: Washington
13f. Zip Code + 4: 98589
13g. Inside City Limits? ☒ Yes ☐ No ☐ Unk
14. Estimated length of time at residence:
15. Marital Status at Time of Death: Divorced
16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage): -----
17. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE RETIRED): Department of Child Services
18. Kind of Business/Industry (Do not use Company Name): County Government
19. Father's Name (First, Middle, Last, Suffix): Benjamin E. Geary
20. Mother's Name Before First Marriage (First, Middle, Last): Georgianna Mary Henry
21. Informant's Name: Gera Iverson
22. Relationship to Decedent: Daughter
23. Mailing Address: Number and Street or RFD No. / City or Town / State / Zip: PO Box 1224 Tenino, WA 98589
24. Place of Death, If Death Occurred in a Hospital: Hospital Inpatient
Place of Death, If Death Occurred Somewhere Other than a Hospital:
25. Facility Name (If not a facility, give number & street or location): Providence Centralia Hospital
26a. City, Town, or Location of Death: Centralia
26b. State: WA
27. Zip Code: 98531
28. Method of Disposition: Removal/Burial
29. Place of Final Disposition (Name of cemetery, crematory, other place): Laurel Cemetery
30. Location-City/Town, and State: Cave Junction, OR
31. Name and Complete Address of Funeral Facility: First Call Mortuary Services 4835 NE Pacific St. Portland, OR 97213
32. Date of Disposition:
33. Funeral Director Signature X [signature]

Part 1 completed by Funeral Director

Cause of Death (See instructions and examples)

34. Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Add additional lines if necessary.

		Interval between Onset & Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SMALL BOWEL OBSTRUCTION	2-4 weeks
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

35. Other significant conditions contributing to death but not resulting in the underlying cause given above: CACHEXIA
36. Autopsy? ☐ Yes ☒ No
37. Were autopsy findings available to complete the Cause of Death? ☐ Yes ☐ No
38. Manner of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending
39. If female: ☒ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days before death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
40. Did tobacco use contribute to death? ☐ Yes ☐ Probably ☐ No ☒ Unknown
41. Date of Injury (MM/DD/YYYY):
42. Hour of Injury (24hrs):
43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area):
44. Injury at Work? ☐ Yes ☐ No ☐ Unk
45. Location of Injury: Number & Street: | Apt No. | City or Town: | County: | State: | Zip Code+4:
46. Describe how injury occurred
47. If transportation injury, specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)
48a. Certifying Physician - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. X [signature]
48b. Medical Examiner/Coroner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print): ATUL THAKKER 1720 [illegible] RD CENTRALIA, WA
50. Hour of Death (24hrs): 0735
51. Name and Title of Attending Physician If other than Certifier (Type or Print)
52. Date Signed (MM/DD/YYYY): 09/15/2014
53. Title of Certifier: MD
54. License Number: MD [illegible]
55. ME/Coroner File Number
56. Was case referred to ME/Coroner? ☐ Yes ☒ No
57. Registrar Signature X Rachel C. Wood [signature]
58. Date Received (MM/DD/YYYY): SEP 22 2014
59. Amendments

Part 2 completed by Certifier

[Seal: THE STATE OF WASHINGTON 1889]

DOH 01-003 (1/13)

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH CENTER FOR HEALTH STATISTICS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL

DOH/CHS 003 March 2012

CERTIFICATE OF SERVICE

I certify that I caused to be filed and served a copy of the foregoing **ANSWER TO PETITION FOR REVIEW** on the 22nd day of May 2019 as follows:

Co-counsel for Respondent

Stephen Hornbuckle The Hornbuckle Firm 1408 – 140th Place NE, Suite 250 Bellevue, WA 98007 shornbuckle@thehornbucklefirm.com	___ _x_ ___	U.S. Mail E-Service Facsimile

Counsel for Petitioners

Matthew J. Kalmanson Hart Wagner 1000 SW Broadway Twentieth Floor Portland, OR 97205 MJK@hartwagner.com	___ _x_ ___	U.S. Mail E-Service Facsimile

Kenneth W. Masters, WSBA 22278
Attorney for Respondent

MASTERS LAW GROUP

May 22, 2019 - 1:04 PM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	96998-1
Appellate Court Case Title:	Geraldine Iverson, P.R. for Estate of Bessie Ritter v. Prestige Care, Inc., et al.
Superior Court Case Number:	15-2-00391-5

The following documents have been uploaded:

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- MJK@hartwagner.com
- shornbuckle@thehornbucklefirm.com

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