

No. 50336-1

IN THE COURT OF APPEALS FOR
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.

BRIEF OF APPELLANT

MASTERS LAW GROUP, P.L.L.C.
Kenneth W. Masters, WSBA 22278
241 Madison Avenue North
Bainbridge Island, WA 98110
(206) 780-5033
Attorney for Appellant

TABLE OF CONTENTS

INTRODUCTION	1
ASSIGNMENTS OF ERROR.....	2
ISSUES PERTAINING TO ASSIGNMENTS OF ERROR.....	2
STATEMENT OF THE CASE	3
A. Iverson alleged that NCPI's failure to properly monitor and care for her mother, Bessie Ritter, caused her death.	3
B. During a difficult discovery process in which the trial court repeatedly compelled discovery from the facility, NCPI sought summary judgment.	3
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.....	4
D. Notwithstanding Dr. Brentnall's medical opinion, the trial court granted summary judgment on causation.....	9
ARGUMENT	10
A. The standard of review is <i>de novo</i>	10
B. Frye does not apply.	11
C. NCPI's other factual arguments do not permit summary judgment.....	17
CONCLUSION.....	18

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Anderson v. Akzo Nobel Coatings, Inc.</i> , 172 Wn.2d 593, 260 P.3d 857 (2011).....	<i>passim</i>
<i>Bernethy v. Walt Failor’s Inc.</i> , 97 Wn.2d 929, 653 P.2d 280 (1982).....	10
<i>Frye v. U.S.</i> , 293 F. 1013 (1923).....	<i>passim</i>
<i>Jones v. Allstate Ins. Co.</i> , 146 Wn.2d 291, 45 P.3d 1068 (2002).....	10
<i>Marsh v. Valyou</i> , 977 So. 2d 543 (Fla. 2007).....	15
<i>Mountain Park Homeowners Ass’n v. Tydings</i> , 125 Wn.2d 337, 883 P.2d 1383 (1994).....	10
<i>Mulcahy v. Farmers Ins. Co. of Wa.</i> , 152 Wn.2d 92, 95 P.3d 313 (2004)	10
<i>Reese v. Stroh</i> , 128 Wn.2d 300, 907 P.2d 282 (1995).....	<i>passim</i>
<i>Reese v. Stroh</i> , 74 Wn. App. 550, 874 P.2d 200 (1994)	14
<i>Ruff v. King Cnty.</i> , 125 Wn.2d 697, 887 P.2d 886 (1995).....	10
<i>State v. Cauthron</i> , 120 Wn.2d 879, 846 P.2d 502 (1993).....	10, 12, 14
<i>State v. Ciskie</i> , 110 Wn.2d 263, 751 P.2d 1165 (1988).....	11

<i>State v. Copeland,</i> 130 Wn.2d 244, 922 P.2d 1304 (1996).....	10, 14
<i>State v. Gregory,</i> 158 Wn.2d 759, 147 P.3d 1201 (2006).....	12, 14
Statutes	
Washington’s Vulnerable Adults Act (WVAA)	4, 17
Other Authorities	
ER 102.....	11
ER 702.....	11, 12, 14
ER 703.....	14

INTRODUCTION

Causation in cases involving medical negligence is often – if not always – a battle of the experts. That truism holds here too, but the trial court nonetheless granted summary judgment on causation. This Court should reverse and remand for trial.

The defense led the trial court into this error. It argued on reply that the holding in the controlling case¹ – which the defense failed to cite in its motion for summary judgment – was mere *dicta*, while conceding that it is the controlling authority! The defense argued that plaintiffs must prove that the precise causation theory is “generally accepted” in the scientific community under *Frye v. U.S.*, 293 F. 1013 (1923). That is directly contrary to the holding in *Anderson*.

Bessie Ritter died after suffering severe constipation for 10 days. Her nursing facility had direct and clear doctors’ orders to monitor her bowel movements, to take corrective action within a few days, and to call a doctor if the problem persisted. The facility did nothing. A highly qualified, Board Certified Gastroenterologist opined that the facility’s neglect caused Ms. Ritter’s death. Her Estate is entitled to a trial. This Court should give her one.

¹ *Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d 593, 260 P.3d 857 (2011).

ASSIGNMENTS OF ERROR

1. The trial court erred in granting summary judgment. CP 764-65.
2. The trial court erred in denying reconsideration. CP 757-60.
3. The trial court erred in entering judgment for the defendants. CP 758-60, 766-67.

ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Did the trial court err in granting summary judgment on causation, where a highly qualified medical doctor opined to a reasonable medical certainty that the defendant's neglect caused the plaintiff's death?
2. Under controlling Washington law, is it sufficient for a plaintiff to show causation via a differential diagnosis based on established science showing a strong correlation that is "generally accepted" in the scientific community, without also having to prove that the precise causal mechanism is generally accepted?
3. Did the trial court err in denying a motion for reconsideration that spelled out the above controlling law (which the plaintiff also argued in response to the summary judgment motion) that directly supports the plaintiff's claims?
4. Did the trial court err in entering judgment based on the above erroneous rulings?

STATEMENT OF THE CASE

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 respondents, Prestige Care, Inc. and Northwest Country Place, Inc. (collectively, "NCPI" or "facility"). CP 1-2, 8. Iverson alleges that NCPI 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 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 98-107.

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 (WVAA). CP 336-37. As discussed below, the facility essentially argued that Iverson's expert could not establish causation due to **Frye**. 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 481-562.² 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.

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

² Dr. Brentnall's declaration (without Exhibits) is attached as Appendix A.

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.*

NCPI records show “Ms. Ritter did not have any bowel movements during this . . . 10 days.” *Id.* (citing CP 501-02).³ Yet Ms. Ritter already “suffered from constipation following her discharge back to the facility on 8/22/14”. CP 483 (citing CP 509-10).⁴ “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.* (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

³ The vitals report is attached as Appendix B.

⁴ These hospital records are attached as Appendix C.

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).

The NCPI 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).⁵ Moreover, the facility “did not follow the physician orders set forth on Ex. 3 [App. D] and referencing the ‘HBP,’” which the doctor understood as “the House Bowel Program or Constipation Management Protocol identified in the attached Ex. 4.” CP 483 (citing CP 506-07).⁶

As a result of these failures, NCPI breached the Constipation Management Protocol and physician orders by:

- (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.

⁵ This medication administration record is attached as Appendix D.

⁶ This constipation management protocol is attached as Appendix E.

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.

CP 483 (paragraphing added for readability). In short, NCPI beached the standard of care.

According to Dr. Brentnall, these breaches caused Ms. Ritter's death. CP 484-85. Specifically, 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 pregnant women, patients with inherited or acquired neurologic colon disorders, and 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 reached her causation opinion via 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 (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 546-47,⁷ 549⁸). 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 the Washington State Supreme Court's decision in ***Anderson*** precludes summary judgment here. CP 745-51; 757-60. It entered a final judgment, and a supplemental judgment. CP 758-60, 766-67. Iverson timely appealed. CP 761-69.

⁷ The hospital "Discharge Summary" is attached as Appendix F.

⁸ The death certificate is attached as Appendix G.

ARGUMENT

A. The standard of review is *de novo*.

The trial court granted summary judgment on causation under *Frye*. Causation is generally a question of fact for the jury that is not subject to determination as a matter of law. *Ruff v. King Cnty.*, 125 Wn.2d 697, 703-04, 887 P.2d 886 (1995); *Bernethy v. Walt Failor's Inc.*, 97 Wn.2d 929, 935, 653 P.2d 280 (1982). Thus, “only when the facts are undisputed and the inferences therefrom are plain and incapable of reasonable doubt or difference of opinion . . . may [causation] be a question of law . . .” *Bernethy*, 97 Wn.2d at 935.

The *Frye* analysis is reviewed *de novo*. *Anderson*, 172 Wn.2d at 600 (citing *State v. Copeland*, 130 Wn.2d 244, 255, 922 P.2d 1304 (1996) (quoting *State v. Cauthron*, 120 Wn.2d 879, 887, 846 P.2d 502 (1993))). Summary judgments are also reviewed *de novo*, “with all inferences taken in favor of the nonmoving party,” here Iverson. *Id.* (citing *Mulcahy v. Farmers Ins. Co. of Wa.*, 152 Wn.2d 92, 98, 95 P.3d 313 (2004) (citing *Jones v. Allstate Ins. Co.*, 146 Wn.2d 291, 300, 45 P.3d 1068 (2002); *Mountain Park Homeowners Ass’n v. Tydings*, 125 Wn.2d 337, 341, 883 P.2d 1383 (1994))).

B. Frye does not apply.

Anderson is controlling⁹ and dispositive here, but in Iverson's favor. There, a child suffered from medical abnormalities, and a medical expert was prepared to testify within a reasonable degree of medical certainty as to the cause: *in utero* exposure to defendant's organic solvents while the mother worked for defendant. 172 Wn.2d at 597-98. The defendant successfully moved *in limine* to strike most of the plaintiff's experts under **Frye**. *Id.* at 599. The trial court then granted the defendant's motions for summary judgment. *Id.*

The Supreme Court granted direct review and reversed on the **Frye** issue. The Court began with a reminder that notwithstanding their "gate keeping function" regarding evidence, courts must be mindful that evidence rules are interpreted so "that the truth may be ascertained and proceedings justly determined." *Id.* at 600 (quoting ER 102). Thus, "[e]xpert testimony is usually admitted under ER 702 if it will be helpful to the jury in understanding matters outside the competence of ordinary lay persons." *Id.* (citing **Reese v. Stroh**, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (citing **State v. Ciskie**, 110 Wn.2d 263, 279, 751 P.2d 1165 (1988))).

⁹ Although NCIP failed to cite **Anderson** in its summary judgment motion, it conceded **Anderson** states the controlling law in its Reply. CP 627.

“Nonetheless, novel scientific evidence, especially that still in the experimental stage, continues to present special challenges.”

172 Wn.2d at 601 (cite omitted; emphasis added). **Anderson** quotes

Frye on the proper focus:

Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.

Id. at 601 (quoting **Frye**, 293 F. at 47) (emphasis added).

Under **Frye**, therefore, “the court’s role is to determine whether the theory has been generally accepted in the relevant scientific community.” *Id.* (citing **Reese**, 128 Wn.2d at 306). “If there is a *significant* dispute among *qualified* scientists in the relevant scientific community, then the evidence may not be admitted,’ but scientific opinion need not be unanimous.” *Id.* at 603 (quoting **State v. Gregory**, 158 Wn.2d 759, 829, 147 P.3d 1201 (2006)). “Only after novel scientific evidence is found admissible under **Frye** does the court turn to whether it is admissible under ER 702.” *Id.* at 603 (citing **Cauthron**, 120 Wn.2d at 889-90) (emphasis added).

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 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 604-05.¹⁰ 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 NCPI 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.*

¹⁰ In a significant footnote, the Court notes that the journal study was designed only to show correlation, not causation. 172 Wn.2d at 605 n.3.

But the **Anderson** Supreme 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., **Gregory**, 158 Wn.2d at 829; **Copeland**, 130 Wn.2d at 255; **Reese**, 128 Wn.2d at 309; **Cauthron**, 120 Wn.2d at 887. [Emphasis added.]

And as the Court had said in **Reese**, 128 Wn.2 at 309 (*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." [Cites 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)]. A jury can certainly evaluate the foundation for Dr. Fallat's opinion that the failure to prescribe Prolastin therapy caused a preventable worsening of the Plaintiff's condition. Furthermore, the jury can evaluate the Defendant's reasons for failing to apply Prolastin as well as the lack of substantial statistical support concerning the therapy's efficacy.

Indeed, the "absence of 'a statistically significant basis' for the expert's opinion that the plaintiff would have benefited from the Prolastin therapy neither implicated **Frye** 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 are pure opinions and are based on experience and training rather than scientific data.” *Id.* (emphasis added). Indeed, many “medical opinions on causation are based upon differential diagnoses.” *Id.* (emphasis added):

A physician or other qualified expert 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. *E.g.*, **Reese**, 128 Wn.2d at 307, 309; **Marsh v. Valyou**, 977 So. 2d 543, 548 (Fla. 2007). [Footnote omitted.]

This holding is dispositive here. But **Anderson** even went on to expressly reject the defendant’s “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, NCPI led the trial court into that twilight zone – and left it there. After failing to cite **Anderson** in its moving papers, NCPI 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** on this issue 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, an expert opines on causation.

Indeed, there is nothing “novel” about the “theory” that constipation may cause a cecal volvulus. 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 are squarely within that high-risk group. *Id.* Based on this frankly common knowledge among caregivers, Dr. Brentnall opined to a reasonable medical certainty that NCPI’s failure to follow its own medical protocols caused Ms. Ritter’s death. That is sufficient to carry the causation issue to the jury.

As the trial court expressly noted, whether and when Ms. Ritter had a bowel movement is a disputed 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 they may have opined contrary to Dr. Brentnall, that simply raises a genuine issue of material fact on causation. See CP 344-45. Yet the trial court searched the literature for a statement that constipation causes cecal volvulus. RP 19-20. It thought *Frye* required that analysis. RP 21-22. But that is directly contrary to *Anderson*, which holds that *Frye* does not apply to the causation question. This Court should reverse and remand for trial.

C. NCPI's other factual arguments do not permit summary judgment.

NCPI also argued that Dr. Brentnall's opinion was "flawed because it was not based on the complete record." CP 631. It did not cite any authority that an expert has to consider every alleged "fact" in reaching her opinion. *Id.* This argument is meritless.

NCPI also argued that the WVAA claim's causation element necessarily requires expert testimony. RP 632-33. Regardless of the frail legal basis for this argument, Dr. Brentnall supplied that testimony. This argument is meritless.

CONCLUSION

“When you have eliminated all which is impossible, then whatever remains, however improbable, must be the truth.”

Sir Arthur Conon Doyle, THE CASE-BOOK OF SHERLOCK HOLMES, *The Adventure of the Blanched Soldier*, at 1011 (1926)

“Just because two variables have a statistical relationship with each other does not mean that one is responsible for the other.”

Nate Silver, THE SIGNAL AND THE NOISE: WHY SO MANY PREDICTIONS FAIL, BUT SOME DON'T (2012)

KISS

Kelly Johnson, Lead Engineer, Lockheed Skunk Works
(~1960)

For the reasons stated, this Court should reverse summary judgment and remand for trial.

RESPECTFULLY SUBMITTED this 24th day of October 2017.

MASTERS LAW GROUP, P.L.L.C.



Kenneth W. Masters, WSBA 22278
241 Madison Ave. North
Bainbridge Island, WA 98110
(206) 780-5033

CERTIFICATE OF SERVICE

I certify that I caused to be mailed, a copy of the foregoing **BRIEF OF APPELLANT** postage prepaid, via U.S. mail on the 24th day of October 2017, to the following counsel of record at the following addresses:

Co-counsel for Appellant

Stephen Hornbuckle
THE HORNBUCKLE FIRM
1408 – 140th Place NE, Suite 250
Bellevue, WA 98007
shornbuckle@thehornbucklefirm.com

Overnight Mail / FedEx
 E-Mail
 Facsimile

Counsel for Respondent

Matthew J. Kalmanson
HART WAGNER
1000 SW Broadway
Portland, OR 97205
MJK@hartwagner.com

Overnight Mail / FedEx
 E-Mail
 Facsimile



Kenneth W. Masters, WSBA 22278
Attorney for Appellant

APPENDIX A

Declaration of Teresa Brentnall, M.D.



FILED
LEWIS COUNTY
2017 MAR -6 AM 11:58
SUPERIOR COURT
CLERK'S OFFICE

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

SS
MS

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
BRETNALL, 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
26 that the facility did not do anything to address Ms. Ritter's constipation until the evening of

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
26 includes not just the facility's own medical record, but also the condition of the patient and the

1 imaging of her abdomen when she was admitted to PCH on 9/1/14. This is further supported by
2 the AGA Guidelines, which define constipation as “infrequent bowel movements, typically
3 fewer than 3 per week, patients [can] have a broader set of symptoms, including hard stools, a
4 feeling of incomplete evacuation, abdominal discomfort, bloating, and distention, as well as
5 other symptoms (eg, excessive straining, a sense of ano-rectal blockage during defecation, and
6 the need for manual maneuvers during defecation), which suggest a defecatory disorder.” See
7 Ex. 7, AGA Guidelines.

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

15 9. Through the process of differential diagnosis, it is in my opinion more
16 likely than not, that the untreated constipation of Bessie Ritter during the period between 8/22/14
17 and 9/1/14 led to her development of a cecal volvulus. Cecal volvulus is a twisting of the colon.
18 Ms. Ritter's colon likely twisted as a result of the ten day period of constipation at LCP. This
19 opinion is supported by known facts regarding the anatomy of the colon and by the presence of a
20 "large amount of stool" in the colon in the imaging study of 9/1/14. The large amount of stool
21 causes the colon to distend and interferes with muscle function. The colonic distension- from
22 constipated stool decreases capillary blood flow, leads to decreased colonic motility (atony),
23 increases the risk of torsion of the colon, and likely led to the twisting of Ms. Ritter's cecum.
24 This distension by constipated stool was avoidable and preventable through the implementation
25 of the Constipation Management Protocol ordered by the doctors at LCP.
26

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

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

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

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

5 13. Ms. Ritter's constipation at Liberty Country Place between 8/22/14 and
6 9/1/14 was, more likely than not, treatable and avoidable. This conclusion is based on
7 experience and on the fact that she suffered from a prior episode of constipation at LCP, leading
8 to a partial small bowel obstruction and hospitalization on 8/19/14. This episode completely
9 resolved with the use of laxatives. The failure to give her laxative medication, as prescribed by
10 her doctor, led to untreated constipation, the buildup of the heavy stool burden referenced above,
11 and the ultimately the twisting of the cecum. These events were preventable and avoidable,
12 more likely than not, by following doctor's orders and giving Ms. Ritter the medication and
13 treatments she was prescribed. Further support for this opinion is found in the LCP medical
14 record, which indicates Ms. Ritter was given medication for constipation on 8/7/14 and 8/13/14
15 and promptly had a bowel movement the day following the treatment at each episode. The
16 documented, effective use of laxatives at LCP on those dates demonstrates that the episode of
17 severe constipation between 8/22/14 and 9/1/14 was preventable and avoidable.

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

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

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.
5
6

7
8 By Teri Brentnall
9 Teresa Brentnall, MD
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

APPENDIX B

Vitals Report for 8/1/2014 – 9/1/2014

Vitals Report

08/01/2014 - 09/01/2014

Date Taken	Vital	Value	Details	Taken By
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 09:23	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
08/08/2014 04:25	Bowel Movement		Size: Small	Julie N Blair 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 Blair 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 02:58	Bowel Movement		Size: None	Julie N Blair Delaney NAC

APPENDIX C

**Providence Centralia Hospital
Records for 9/1/2014 – 9/4/2014**

Progress Notes (continued)

Progress Notes by Yancey A Sloane, MD at 9/2/2014 21:35 (continued)

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. 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

Progress Notes (continued)

Progress Notes by Yancey A Sloane, MD at 9/2/2014 21:35 (continued)

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 likely 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. 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 D

Medication Administration Record

PRN Medications Flowsheet: Ritter, Bessie

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

Administration Note:

Information:

Order	Time	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su
DSS (docusate sodium) capsule; 250 mg - 1000 mg; oral Once A Day - PRN (HBP) [DX: Constipation NOS] 07/25/2014 - Open Ended	PRN																								
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 MCM. (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																								
Duraorb 3ml via nub Q6h	0001 0600 1200 1800																								
Decid Q4H																									
Physician: Ellis, David ph (560) 785-0300	Diagnosis: 250.00 DM, uncomplicated, type II, 300.00 Anxiety state NOS, 584.00 Constipation NOS																								
Resident: Ritter, Bessie	Unit: Ivy Lane	DOB: 7/20/1920	Age: 89	Sex: F																					
Admit Date: Jul 25 2014 6:16PM																									

MatrixCare Report

Date Generated: 07/29/2014 12:49:34 PM

Page 1 of 5

LCPREGS0000064
NWCP00308

APPENDIX E

Constipation Management Protocol



**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 regularly.*
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.*

POLICY & PROCEDURE, CONSTIPATION MANAGEMENT PROTOCOL, page 2 of 2.

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.*

filename:ppConstipation.wpd

LPC 5185

APPENDIX F

Hospital Discharge Summary

WCH PROVIDENCE CENTRALIA HOSPITAL
914 S Scheuber RD
Centralia WA 98531-9027
Inpatient Record

RITTER,BESSIE MARIE
MRN: 60004633380
DOB: 7/30/1930, Sex: F
Adm: 9/1/2014, D/C: 9/4/2014

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

Author: Atul Thakker, MD
Printed: 9/10/2014 5:34
Title: 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

WCH PROVIDENCE CENTRALIA HOSPITAL
914 S Scheuber RD
Centralia WA 98531-9027
Inpatient Record

RITTER,BESSIE MARIE
MRN: 60004633380
DOB: 7/30/1930, Sex: F
Adm: 9/1/2014, D/C: 9/4/2014

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

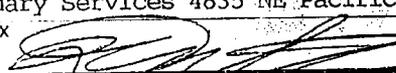
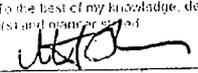
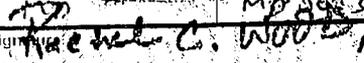
Date

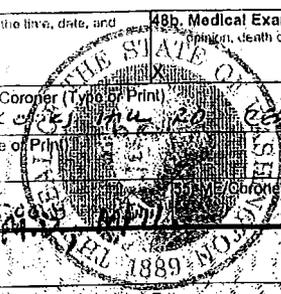
- Hip pain
chronic right hip pain
- CHF (congestive heart failure) (HCC)
- Diabetes mellitus (HCC)

APPENDIX G

Bessie Ritter's Death Certificate

STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number:				Washington State Certificate of Death				State File Number:			
1. Legal Name (Include AKA's if any) First Middle LAST Suffix								2. Death Date			
Bessie Marie Ritter								Sept. 4, 2014			
3. Sex (M/F)		4a. Age - Last Birthday		4b. Under 1 Year		4c. Under 1 Day		5. Social Security Number		6. County of Death	
Female		84		Months Days		Hours Minutes		541-30-3620		Lewis	
7. Birthdate		8a. Birthplace (City, Town, or County)		8b. (State or Foreign Country)		8. Decedent's Education					
July 30, 1930		Medford		Oregon		Associate's Degree					
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify:								11. Decedent's Race(s)		12. Was Decedent ever in U.S. Armed Forces? No	
No								Caucasian			
13a. Residence Number and Street (e.g., 624 SE 5 th St.) (Include Apt. No.)								13b. City or Town			
1272 Park Ave. East								Tenino			
13c. Residence County		13d. Tribal Reservation Name (if applicable)		13e. State or Foreign Country		13f. Zip Code + 4		13g. Inside City Limits?			
Thurston				Washington		98589		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
14. Estimated length of time at residence.		15. Marital Status at Time of Death		16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage)							
		Divorced									
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED))						18. Kind of Business/Industry (Do not use Company Name)					
Department of Child Services						County Government					
19. Father's Name (First, Middle, Last, Suffix)						20. Mother's Name Before First Marriage (First, Middle, Last)					
Benjamin E. Geary						Georgianna Mary Henry					
21. Informant's Name		22. Relationship to Decedent		23. Mailing Address: Number and Street or RFD No.		City or Town		State		Zip	
Gera Iverson		Daughter		PO Box 1224		Tenino, WA		98589			
24. Place of Death, if Death Occurred in a Hospital:						Place of Death, if Death Occurred Somewhere Other than a Hospital:					
Hospital Inpatient											
25. Facility Name (If not a facility, give number & street or location)						26a. City, Town, or Location of Death		26b. State		27. Zip Code	
Providence Centralia Hospital						Centralia		WA		98531	
28. Method of Disposition		29. Place of Final Disposition (Name of cemetery, crematory, other place)				30. Location-City/Town, and State					
Removal/Burial		Laurel Cemetery				Cave Junction, OR					
31. Name and Complete Address of Funeral Facility								32. Date of Disposition			
First Call Mortuary Services 4835 NE Pacific St. Portland, OR 97213											
33. Funeral Director Signature X 											
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.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMALL BOWEL OBSTRUCTION										Interval between Onset & Death 2-4 weeks	
Due to (or as a consequence of):										Interval between Onset & Death	
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 b.										Interval between Onset & Death	
Due to (or as a consequence of):										Interval between Onset & Death	
c.										Interval between Onset & Death	
Due to (or as a consequence of):										Interval between Onset & Death	
d.										Interval between Onset & Death	
35. Other significant conditions contributing to death but not resulting in the underlying cause given above								36. Autopsy?		37. Were autopsy findings available to complete the Cause of Death?	
CACHEXIA								<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Manner of Death		39. If female		40. Did tobacco use contribute to death?				44. Injury at Work?			
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		<input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
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)				Apt. No.			
45. Location of Injury Number & Street:				City or Town				County:			
								State:			
46. Describe how injury occurred				47. If transportation injury, specify:				Zip Code+ 4:			
				<input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)							
48a. Certifying Physician - To the best of my knowledge, death occurred at the time, date, and place stated, and due to the cause(s) and manner stated.								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.			
X 											
49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print)								50. Hour of Death (24hrs)		52. Date Signed (mm/dd/yyyy)	
ATUL THAKKER 1720 CENTRALIA RD CENTRALIA, WA								07:35		09/15/2014	
51. Name and Title of Attending Physician if other than Certifier (Type or Print)								54. License Number		56. Was case referred to ME/Coroner?	
								MP 848 352008		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
53. Title of Certifier		57. Registrar Signature		58. Date Received (mm/dd/yyyy)							
Dr. Rachel C. Wood				SEP 22 2014							
59. Amendments											



MASTERS LAW GROUP

October 24, 2017 - 11:11 AM

Transmittal Information

Filed with Court: Court of Appeals Division II
Appellate Court Case Number: 50336-1
Appellate Court Case Title: Geraldine Iverson, P.R. for Estate of Bessie Ritter v Prestige Care, Inc., et al, Respondents
Superior Court Case Number: 15-2-00391-5

The following documents have been uploaded:

- 0-503361_Briefs_20171024110616D2270476_4886.pdf
This File Contains:
Briefs - Appellants
The Original File Name was Brief of Appellant.pdf

A copy of the uploaded files will be sent to:

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

Comments:

Sender Name: Tami Cole - Email: paralegal@appeal-law.com

Filing on Behalf of: Kenneth Wendell Masters - Email: ken@appeal-law.com (Alternate Email: paralegal@appeal-law.com)

Address:
241 Madison Ave. North
Bainbridge Island, WA, 98110
Phone: (206) 780-5033

Note: The Filing Id is 20171024110616D2270476