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COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

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STATE OF WASHINGTON
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RESA RAVEN,

Respondent,

v.

WASHINGTON STATE DSHS,

Appellant.

ORIGINAL

ANSWER OF RESPONDENT TO BRIEF OF AMICUS CURIAE
DISABILITY RIGHTS WASHINGTON

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I. INTRODUCTION

The Respondent Resa Raven appreciates the strong focus by the Amicus Curiae Disability Rights Washington (DRW) on the rights of Ida to choose to remain at home, absent involuntary commitment, and agrees with DRW's warning that holding guardians strictly liable for bad outcomes at home will exert tremendous pressure on them to opt for the safer harbor of a nursing home placement rather than risk the possible censure and professional ruin of a charge of neglect. In holding that "*Attempts* at remedying Ida's untenable situation were not enough—effective *results*" were required, and that Ms. Raven "was ultimately responsible to ensure" Ida's needs were met, CL 55 - 56, AR 167 - 168, the Review Decision held Ms. Raven responsible for bad outcomes regardless as to the surrounding difficulties, in other words, strictly liable. The inability of home care agencies to find willing caregivers, Ida's repeated resistance to care, the impossibility of putting nurse delegation in place for five months while there was no doctor or ARNP, the Dept. of Health then losing the nurse delegation papers, Hospice providing Ida the wrong pressure sore mattress in November, the severe winter storm deflating the new mattress—all of that was immaterial to the Review Judge. In normal jurisprudence these would be considered intervening causes breaking the proximate cause. In the similar federal definition of

neglect, a person cannot be found guilty if the “neglect was caused by factors beyond the control of the individual.” 42 CFR § 488.335(e). There is no case law, statute, or regulation cited by DSHS or the Review Judge for a strict liability interpretation of neglect or of a guardian’s responsibilities. It should be reversed and Ms. Raven freed of this charge.

II. LEGAL ARGUMENT

The DSHS Review Decision and Final Order is the agency order before the Court, not the slight softening of that decision by the current DSHS briefing. *Costanich v. DSHS*, 138 Wn.App. 547, 563, 156 P.3d 232 (2007); WAC 388-71-01275. The incorrect interpretation of the law concerning forced nursing home placement is interwoven with the Review Decision’s misinterpretation of neglect in the home. As DRW points out, in several places the Review Decision incorrectly concludes that Ms. Raven should have put Ida in a nursing home because of the problems with her home care. *See* CL 43, 44, AR 160-162. It appears that Ms. Raven’s decision to not put Ida in a nursing home was *part* of the Review Decision’s basis for finding neglect. The Review Decision held that this decision by Ms. Raven was not neglect “early on in the guardianship,” CL 45, AR 162, which leaves most of the two year guardianship in question. The Review Decision said the “untenable option of leaving Ida in home care” was illustrated by the fact that Ida could “only be transported to

regular, but necessary, medical examinations by ambulance,” however, Medicaid would not pay for such non-emergency transport. CL 43, AR 161.¹ Leaving Ida in her home later in the guardianship appears to be part of the basis for the neglect finding.

A. The Review Decision Wrongly Accuses Ms. Raven of Inaction

The key holding in the Review Decision is found in Conclusion of Law 56 at AR 168:

The [Guardian’s] lack of attention and remedial action as Ida’s court appointed guardian for medical decisions contributed to Ida’s inadequate pain management, inadequate re-positioning, and inadequate bath care for at least several months if not longer. These three basic medical care needs were critical to Ida’s well-being and, as Ida’s court-appointed guardian for medical decisions, the [Guardian] was ultimately responsible to ensure these basic needs were met.

An examination of the record shows that Ms. Raven took many steps to address these needs. *See* Respondent’s Corrected Brief at 13-18 and 40-45 and Reply Brief at 11-21. To accuse her of inattention or

¹ The Review Decision used the phrase “regular, but necessary, medical examinations,” and said that Ms. Raven “conceded” this point. CL 43, AR. This misconstrues the cited transcript. Ms. Raven said that it was very difficult to get a doctor to visit patients in their home and that Medicaid would not pay for ambulance transport to a doctor for a “routine care visit.” She also explained that the obstacle to care at home could be overcome if they could get a nurse or nurse practitioner to come on site. RP 558:4-18. This occurred when hospice was in place. It is clear from the record that Ida consistently refused care from doctors, fired them, etc. She did not see doctors for what we might call “regular” medical exams. The only times she saw doctors was when it was an emergency, because that’s the only time she’d let them see her. Ida’s opposition to traditional medicine and her desire to remain at home was well known. She had made that clear while competent and later. Ms. Raven should not be punished for respecting Ida’s wishes. She also cannot control doctors’ practices or the Medicaid budget.

inaction is not supported by the record. To blame her for not remedying the situation is unfair given all the factors beyond Ms. Raven's control.

A recounting of some of the steps Ms. Raven took will show how the Review Decision is tantamount to imposing strict liability for bad outcomes. This will create the incentive, as DRW warns, for guardians to take the easy way out, deal short shrift with autonomy and rights, and put more of their "wards" into nursing homes.

1. Ms. Raven did all that she could regarding Ida's pain medications

It is particularly unfair to accuse Ms. Raven of inaction regarding Ida's medications, or to say that Ms. Raven waited five months before taking action on the nurse delegation. Respondent's prior briefs recount in detail the vigorous steps Ms. Raven took to set up nurse delegation as soon as she heard about it in June 2006. *See* Respondent's Corrected Brief at 40-44 and Reply Brief at 14-16. Nurse delegation could not occur until there was a doctor or ARNP in place, which took five months because Ida and her family had burned so many bridges. *See* Respondent's Corrected Brief at 27-29.

DSHS's position in its briefs is that Ms. Raven should have taken "action" against Ida's husband Richard to address the medication issues, saying that this was what Judge Strophy recommended. That is not what

the Review Decision concluded. It said that Ms. Raven “did not receive any viable guidance from the court [Judge Strophy].” FF 68, AR 125. It noted that Judge Strophy said Ms. Raven may want to hire an attorney “to perhaps pursue compliance by Ida’s caregivers and spouse,” but the Review Decision also found that DSHS had not given any legal basis for Ms. Raven pursuing such a motion against Richard. FF 68, AR 126, 125.²

2. Review Decision wrongly concludes Ms. Raven should have gotten Ida bihourly turning and medical care.

The Review Decision held in CL 46, AR 162-63:

Bi-hourly repositioning, timely bathing due to incontinence, and effective administration of prescribed medications were neither optimal nor aspirational health care goals. These tasks were required to be performed under Ida’s care plan to prevent exactly what was occurring, skin breakdown . . . Once the [Guardian] became aware that minimum care and medication tasks under Ida’s care plan were not being met, she had a duty to immediately take action to remedy the situation.

² In briefing before this Court, DSHS for the first time articulates a legal basis, citing the contempt of court laws. *See* Appellant’s Opening Brief at 10, 32. As Respondent pointed out, this would not have accomplished anything—Richard was poor, so could not have paid a court fine; if he were jailed then Ida would have no one to administer medications, since it could not be done by aides until nurse delegation was set up; and Richard himself was disabled and in ill health, so a contempt order probably could not be issued. *See* Respondent’s Reply Brief at 7-9. Instead, Ms. Raven made a complaint to Adult Protective Services (APS) of neglect by Richard and the caregiver for not consistently giving the prescribed medications. AR 1588. APS concluded that it “can’t really do anything with this case” and didn’t find substantiation of neglect. AR 858. If DSHS found neglect, it *could have* filed for a protection order against Richard or the caregiver. RCW 74.34.110 and .150. Yet, the questions would still remain—what relief would DSHS have obtained? Remove Richard? How would that help Ida? Order compliance by Richard? It’s doubtful he was capable of compliance, given that he wasn’t taking his own medications. AR 1551, 869.

The Review Decision concluded that these conditions were present “for at least several months if not longer.” CL 56, AR 168. This is not what the record shows. As detailed in Respondent’s prior briefing, Ida had NO skin breakdown or pressure sores when she was examined by a nurse on 8/28/2006, and by another nurse on 11/4/2006. AR 864, 128-29; RP 169. This was Ida’s condition at the time there was *no* evening shift, *no* IPs, *no* bihourly turning, *no* hospice care, *no* nurse delegation, and Richard was administering medications. *See* Respondent’s Reply Brief at 17-21, Respondent’s Corrected Opening Brief at 15-17. The “bihourly” repositioning was clearly boilerplate language in the care plan. *See* Respondent’s Corrected Opening Brief 34-37. Ida’s skin in early November 2006 was actually better than few weeks later, when Ida had an additional bath aide three times a week from the hospice/home health care agency. AR 2098-97. The actual reasons for Ida’s skin breakdown starting in late November 2006 were likely an improper, hard mattress from the new hospice agency and then a severe winter storm that deflated the next mattress in December. *See* Respondent’s Reply Brief at 18-20.

The Review Decision says Ms. Raven “had a duty to immediately take action to remedy the situation.” When? And to do what? In mid November 2006, when Ida’s skin first started to breakdown, Ms. Raven was contacted by the hospice medical social worker. The Review Judge

added a sentence to FF 75, at AR 129: “The [Guardian] did not seek immediate medical attention for Ida based on these reports, but deferred to the hospice agency caring for Ida in determining if the situation was acute enough to seek emergency medical attention.” The Review Judge then criticized Ms. Raven for that decision, saying that she had a duty “to inspect Ida’s wounds personally” upon hearing the hospice report. CL 49, AR 164.

Why is it improper for a guardian to rely upon the first hand report of trained hospice medical personnel who know more than perhaps 99% of guardians about pressure sores? The only qualified expert, Mr. Tom O’Brien, testified that Ms. Raven did not have a duty to personally examine Ida’s pressure sores. RP 657:20-25.

Ms. Raven told the hospice medical social worker in late November 2006 that she pre-authorized emergency medical care whenever hospice thought it was needed “as long as they also obtain the approval from Ida’s doctor, and we all understand that there is a risk whenever such a medically fragile person as Ida is transported to the emergency room.” AR 1595.³ In the past when Ms. Raven had accompanied Ida in the

³ Earlier, on 11/15/2006, the hospice social worker said Ida should go to a nursing home, which Ms. Raven said she could not authorize. By the time of their conversation on 11/22/2006, the mental health professional had declined to commit Ida. The social worker reported to Ms. Raven “the hospice staff is settling into the case and have

ambulance to the hospital, she observed that Ida, who was very thin and combative, could hurt herself because she would flail around, and Ms. Raven also worried about psychological harm, as Ida did not want to be taken out of her house. FF 97, AR 137. The ALJ and Review Judge held that it was reasonable for Ms. Raven in August 2006 to minimize trips in the ambulance in order to minimize trauma to Ida. FF 98, AR 137. Why was it Ms. Raven's duty in November 2006, as the Review Judge held, "to seek immediate medical attention"? That would have required an ambulance trip to the doctor's office or ER. The hospice nurses themselves, even in mid to late December 2006 after Ida's pressure sores were worse because of the winter storm and deflated mattress, did not think Ida should be transported to the emergency room. The hospital would send Ida home, resulting in two painful ambulance trips, or would perform aggressive surgical debridement, a major intervention inconsistent with hospice care. FF 106, AR 140.

The Review Judge's critique boils down to this: Ms. Raven should have personally seen the pressure sores, even though the guardianship expert witness said she did not need to see the sores, and Ms. Raven should have taken Ida to the doctor or ER, even though the hospice nurses in mid to late December said transport by ambulance was not appropriate

accepted that this is an appropriate role for them given the lack of institutional options for Ida." AR 1594-95.

or needed for Ida. If a guardian can be found guilty of neglect for following the advice of hospice wound care nurses about pressure sore treatment, then competent, caring professionals will be driven from the field, or will ignore the protests of their “wards” and put them into nursing homes.

3. IPs were not a viable option for Ms. Raven.

DRW correctly notes that guardians do not control the resources available to low-income Medicaid recipients wanting to live in the community. The State does, and the State’s budget crisis makes Medicaid programs perennially exposed to cutbacks. DRW Brief at 17-20 and fn. 2.⁴ While Ida was approved for additional caregiver hours, they were not enough to create more than a short work shift about 1 hour long for two aides at around 6 or 7 p.m., about the least likely time one would sign up

⁴ Some of the proposed cuts are set forth in DRW Brief, Ex. 6. The Appellant DSHS argues that the amici and introducing new arguments and that amici cannot submit documents outside of the record, citing *Bldg. Indus. Ass’n of Wash. v. McCarthy*, 152 Wn.App. 720, 748 n. 12, 218 P.3d 196 (2009). These are not new arguments. In response to DSHS’ argument that Ms. Raven could have asked her business partner to supervise IPs, Ms. Raven pointed out that it the business partner had on only one occasion, with a non-complicated client, hired an IP—and that it was not an *Individual Provider*, the term for aides hired for about \$10/hour for Medicaid clients, but was an *Independent Provider*, serving a non-Medicaid client, who clearly would have had far more resources. See Respondent’s Reply Brief in Pierce County, Clerk’s Papers at 358. Likewise, as in the WAPG Brief, Ms. Raven has previously argued that DSHS and other professionals involved in Ida’s care had responsibilities under the applicable laws. See Respondent’s Reply Brief in Pierce County, CP at 375-77. Finally, the *Bldg. Indus. Ass’n of Wash.* case involved the application of RAP 9.12, which is a special rule for the review of summary judgment orders. This case is not reviewing a summary judgment order. Amici are permitted to file documents with the court not entered below. See *State v. Boyd*, 160 Wn.2d 424, 441 n. 1, 158 P.3d 54 (2007) (Court denied the State’s motion to strike amici exhibits).

for a 1 hour job. Three home care agencies—whose job is to find aides—could not find aides to staff that time slot. Maybe they could have been found if more hours were offered or a higher salary, but that is within the State’s control, for they set the Medicaid budget, not the home care agencies, and certainly not Ms. Raven. There is no basis in reality to think that Ms. Raven could have located, hired and supervised a steady corps of IP workers, for about \$10 or \$15, to come at around 6 p.m. and turn a fragile, foul-mouthed, sometimes combative, elderly woman and wipe her bottom. In the words of Judge van Doorninck, that’s not realistic. If three home care agencies could not find caregivers for that time slot, despite the outreach and advertising they did, it is wishful thinking or hindsight blaming to say Ms. Raven could have. They certainly were not a “*reasonably available* source of care and services.”

DSHS accuses Ms. Raven of “summarily rejecting” the idea of IPs. However, the Review Decision itself said “It is speculative whether any person available through the Work Source job bank would have had the skills and training to serve a client such as Ida without the supervision and training that would be provided by a home health agency. Ida was a client who took ‘a lot of supervision resources.’” FF 62, AR 122-23. This was a reasoned decision. And despite the insertion by the Review Judge of a sentence saying that IPs were discussed with Ms. Raven at a June 2006

meeting, FF 62, AR 123, the better reading of the record is that IPs were only discussed in the spring of 2006, and not again during the guardianship, perhaps because Ida's condition steadily improved in 2006 until later in November. *See* Respondent's Corrected Opening Brief at 37-39. Even if the IP topic had been discussed twice, it is speculative to think IPs would have been found, stayed, and actually made a difference.

B. The Review Decision is Tantamount to Strict Liability

The Review Decision is a case of armchair second guessing not based on the reality of a guardian's world. The Review Judge says Ms. Raven "had a duty to regularly monitor Ida's residential placement and regularly review alternatives to placement." CL 48, AR 163. The record seems extremely clear as to Ida's wishes regarding "placement"—it was to stay at home. If with all these facts, the rule is a guardian has to keep questioning the person's choice, then RCW 11.92.190, 11.92.043(5), and 7.70.065(1)(c) will become pointless, for eventually the guardian will tire of worrying and will just put the person in a nursing home.

The Review Decision says that if Ms. Raven had gone to court it would "have forced the court and the Department to take alternative and possibly more aggressive action in providing care for Ida." CL 55, AR 16. This is not the proper standard. It is speculation. It is like saying if a different pitcher had been on the mound he might have thrown 10

strikeouts. We can only judge what Ms. Raven did in the case she had, with its myriad difficulties and constraints. Remarkably, the Review Judge, faced with the above, concludes that the application of the law to these facts of this case “is fairly straight forward.” CL 56, AR 168. He concludes that “*attempts* at remedying Ida’s untenable situation were not enough—effective *results*” were required, and that Ms. Raven “had a duty to ensure” that Ida’s needs were met, and finally, that as the guardian, Ms. Raven “was ultimately responsible to ensure these basic needs were met.” CL 46, 55, 56, AR 162, 167-68. This is strict liability. It will terrify guardians. It will harm the people it is meant to protect more than it will help them.

III. CONCLUSION

For the reasons stated herein, Ms. Raven requests that the DSHS Review Decision be reversed, and attorney’s fees and cost be awarded.

RESPECTFULLY SUBMITTED this 29 day of August, 2011.

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