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**SUPREME COURT OF THE STATE OF WASHINGTON**

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RESA RAVEN,

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH  
SERVICES,

Respondent.

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**SUPPLEMENTAL BRIEF OF RESPONDENT**

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 ORIGINAL

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## I. INTRODUCTION

This case involves a well-founded determination that Resa Raven perpetrated “neglect” of her ward, Ida, a “vulnerable adult,” as those terms are defined under the Abuse of Vulnerable Adults Act, chapter 74.34 RCW.<sup>1</sup> Ida was aged, disabled, and completely dependent upon others for her most basic needs. But Ida’s desires were simple: She wanted to receive palliative care in her own home. As Ida’s guardian, Raven’s duty was to pursue the in-home care that Ida needed. Raven perpetrated neglect under the Act by delaying and failing to pursue options for Ida’s in-home care that were identified for her, including forgoing visits to Ida for months at a time, despite receiving reports of Ida’s rapidly deteriorating health. Raven’s pattern of inaction and delay deprived Ida of the care she needed, caused her to experience pain, and amply justifies DSHS’s finding that Raven committed neglect of a vulnerable adult under the Abuse of Vulnerable Adults Act, chapter 74.34 RCW.

Raven’s attempt to cast the finding of neglect as based on her failure to illegally institutionalize Ida against her will is contradicted by the record. Moreover, her attempt to import negligence “proximate cause”

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<sup>1</sup> To preserve Ida’s confidentiality, only her first name is used. Raven was previously known as, and is referred to in the record, as “Eileen Lemke-Maconi.” Administrative Record (“AR”) 97.

standards into clear statutory language that contains no such requirement should be rejected.

## **II. STATEMENT OF THE CASE**

### **A. Raven Is Appointed To Make All Medical And Care Decisions For Ida**

DSHS petitioned to have a guardian appointed for Ida in March 2004, after finding Ida experiencing delusions and refusing care. AR 105, 108. Ida was 82, suffered from numerous physical and mental conditions, and was confined to her bed and completely dependent on others for her most basic needs. AR 97-100. She was mentally ill, paranoid, and suffered from dementia. AR 102-03, 698. Ida and her husband Richard received Medicaid-funded care in their Lacey apartment. AR 695, 1519. Between March 2004 and January 2007, Raven acted as Ida's guardian of the person, appointed to make all of Ida's medical and care decisions. AR 109-11. Raven was a licensed mental health counselor with no previous experience as a guardian. AR 111.

As Raven's care plan recognized, Ida required significant in-home care. AR 1519-23. Ida often refused treatment, but did accept pain medications. AR 104, 106. She had historically opposed nursing home care, but had consented to temporary treatment in a nursing home in 1996, and temporary in-patient psychiatric treatment in 2001. AR 104, 106. To

accommodate Ida's preferences, Raven developed a basic in-home, palliative care plan. AR 1519-23. Although Ida sometimes refused care, daily care and medication logs show that she accepted in-home palliative care and medications on the vast majority of days it was offered. AR 884-1162.

Ida needed significant in-home caregiver services to prevent or alleviate bedsores, known as "skin breakdown" or "pressure ulcers." AR 99. Bedsores develop when a person lies in the same position for an extended time, cutting off blood flow to underlying tissue. Verbatim Report of Proceedings ("RP") RP 228-29, 234-36. If left untreated, they can progress into serious injuries in which the tissue dies and the skin splits open to expose the underlying tissue and bone.<sup>2</sup> *Id.* To avoid bedsores, Ida needed to be repositioned and have her skin bathed after incontinence. AR 99, 776. Raven used Catholic Community Services ("CCS"), a licensed home care agency, to provide Ida's in-home care. AR 104.

Ida also needed pain medications for her bedsores and chronic conditions. AR 102-03. Her pain, mental illness and dementia made her combative with caregivers. AR 98-99, 102-03. Raven recognized pain medicine as the potential "key" to Ida's cooperation with in-home care.

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<sup>2</sup>Detailed information and photos of bedsores are included in the record at AR 1950-66.

AR 1569. For approximately 32 months, Raven relied on Ida's husband Richard to give Ida her medications, but Richard often refused, believing they made Ida too sleepy. AR 102. On December 5, 2006, Raven finally replaced Richard with specially trained caregivers for administration of Ida's medication under a process called "nurse delegation."<sup>3</sup> AR 1294-95.

Raven lived and worked less than 10 miles from Ida's apartment, but relied primarily on telephone reports for Ida's condition. AR 1893.<sup>4</sup> She documented six visits to Ida's home in 2004 (April 2 and 15; June 3, 10, and 29; and October 18); two visits in 2005 (both in August); and five visits in 2006 (January 19, August 17, October 16, November 4, and December 30). AR 113.<sup>5</sup>

#### **B. Ida's First Hospice Team And Doctor Quit**

In August 2005, Raven secured Ida with home hospice care through "Assured Home Health." AR 119. Eight months later, Assured and Ida's doctor quit, after Assured staff had repeatedly informed Raven that Ida's husband Richard, encouraged by CCS caregivers, refused to

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<sup>3</sup>The delegation of nursing tasks (including administering medication) to non-nurses is governed by Department of Health rules. WAC 246-840-910 through -990.

<sup>4</sup>Raven's business address (AR 1523) was located 7.9 miles from Ida's apartment, and her residence address (AR 1666) was 9.65 miles from Ida's Lacey apartment. <http://classicmapquest.com> (visited November 20, 2012).

<sup>5</sup>Raven's log reflects that she did not see or talk to Ida on all of these occasions. AR 1570, 1572, 1586. Raven believed that she visited Ida more often, but testified that all "substantive" visits were documented in her records. RP 833-834.

give Ida her medications, and CCS caregivers resisted the repositioning Ida needed to prevent bedsores. AR 119-24.

On November 17, 2005, Raven met with Assured and Ida's case manager to discuss the problems with Ida's home care, but Raven decided to wait until after the holidays to make any changes to avoid "stress" on Ida's family. AR 120. In February or March 2006, additional Medicaid funding was authorized to pay for three daily care shifts. AR 122. When CCS failed to fill all three shifts, Ida's case manager asked Raven to supplement Ida's care with independent caregivers. *Id.* Raven said they "would have to do the best with what they had," because she wanted to use agency-supervised caregivers. *Id.* A month later, Raven received another call informing her that Ida still lacked additional caregivers. AR 1586. She recorded no activity for 45 days, next logging a call from Assured on May 5, threatening to terminate hospice because of Richard's refusal to give Ida medications. AR 1587. Assured and Ida's doctor quit on May 17, after Ida assaulted and injured a hospice worker. AR 123-24.

**C. With Ida's Care In Disarray, Raven Seeks Guidance From The Superior Court, But Fails To Follow Its Instructions**

Twenty-five days later, Raven petitioned the superior court for instructions, describing Ida's situation as an "impending crisis of care." AR 1524. She told the court that Ida did not have enough caregivers and

lay for extended periods of time in her urine and feces. AR 1521, 1531. She said the CCS caregivers failed to reposition Ida and influenced Richard to refuse to give Ida her medications. AR 1521-30. In a hearing on June 2, 2006, the court instructed Raven that Ida was “in need of better care” and asked her to admit Ida to a nursing home. AR 1537, 1539. Raven said Ida refused facility care. The court instructed Raven to take steps to stop the interference, including retaining an attorney and, if necessary, seek sanctions against Richard. AR 1544-45. The court asked Raven to schedule another hearing to report progress. AR 1549.

Raven updated the court almost four months later. AR 1551. She reported that Richard still failed to give Ida her medications as ordered. AR 1552. She had a medical appointment for Ida on October 16, and hoped to secure a new doctor and hospice team. AR 1551-55. She never hired an attorney or took legal action to stop Richard’s interference. RP 822-26. She decided to keep CCS as Ida’s caregiver agency after it agreed to replace Ida’s caregivers and use nurse-delegated staff to give Ida her medications. RP 594-95. Although Ida’s caregivers were replaced in June and nurse delegation was established on December 5, 2006, CCS never filled all of Ida’s caregiving shifts, and Raven never remedied this deficiency. AR 1294-95; RP 42-43, 297, 1589, 1657.

**D. Ida's Second Hospice Team Finds "Inadequate Caregiving" And Ida Is Hospitalized With Over 30 Bedsores**

Ida obtained a new doctor on October, 16, 2006, and Providence Hospice began working with her on November 4. AR 127-28. Within two weeks, Raven was notified that Providence wanted to pull out because of Richard's interference. AR 129-30, 1594. From the outset, hospice staff documented "inadequate care-giving." AR 1360. Ida had new bedsores which were not kept clean of her waste because CCS filled only two of the three care shifts. AR 689.

Ida's sores worsened through November and December 2006. AR 128-30. By November 21, her skin was burned from urine exposure. AR 128. One bedsore had reached stage IV and was "oozing." RP 126-27.<sup>6</sup> Raven received phone calls from Ida's care team, describing Ida's bedsores. AR 1595-96. Raven testified that she did not "know enough about bed sores," but understood "there was clearly something wrong."<sup>7</sup> RP 668. But she made no changes to Ida's home-care. RP 4, 48-49, 302, 820.

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<sup>6</sup> A stage IV wound is open down to the muscle and bone. RP 229.

<sup>7</sup> A hospice nurse testified that Ida's alternating-pressure air mattress may have contributed to skin breakdown. The mattress was replaced, but Ida's wounds worsened because she continued to lack sufficient caregivers to reposition and clean her. AR 139. In undisputed testimony, Ida's nurse testified that the primary cause of Ida's skin breakdown was poor nutrition, failure to receive regular repositioning, and exposure of her wounds to urine and feces. RP 170:11-18.

After a windstorm, Ida's care staff found her and Richard without power on December 15, 2006, with Ida's airflow mattress deflated, and Ida laying on the floor, soaked in urine. AR 139-40, RP 132. Her backside was covered with bedsores. One was open down to the bone. AR 140. Providence Hospice referred Raven to DSHS for neglect of Ida on December 29, 2006. AR 689-90. Raven gave a DSHS investigator telephonic permission to hospitalize Ida on December 30. AR 131. Ida was admitted with over 30 bedsores. AR 128, 1450. Raven testified that she had never observed Ida's bedsores and her log reflects that she had last seen Ida on November 4. AR 1594, 1645.

Ida was stabilized by January 2, 2007, but Raven had no plan for her care following discharge. AR 131, 1435-36. Providence Hospice and CCS called Ida's home plan "unsafe," and declined to continue services. AR 131. Raven again refused to consider using independent caregivers or nursing home care. AR 877, 1341-42, 1376. On January 8, 2007, Raven ultimately consented to have Ida admitted to a nursing and rehabilitation center. AR 131. Ida initially resisted care. AR 1451-53. With regular repositioning, hand-feeding and wound treatment, Ida became compliant with care and her bedsores gradually improved. AR 132, 1453. She died on April 24, 2007. AR 132.

**E. The Finding Of Neglect Against Raven**

DSHS concluded that Raven neglected Ida under RCW 74.34.020 because she failed, as a person with the duty of care for Ida, to secure the goods and services Ida needed in her home and to prevent Ida from experiencing pain. AR 162-63, 168-69. The finding was not based on Raven's decision to reject nursing home care. Instead, DSHS concluded that once Raven believed that she could not transfer Ida to a nursing home, Raven had a duty to ensure that Ida received appropriate care *in her own home*. AR 162. On judicial review, the finding of neglect was overturned by the superior court, but reinstated by Division II of the Court of Appeals.

**III. ARGUMENT**

**A. Once Raven Determined That Ida Should Remain In Her Own Home, She Perpetrated Neglect By Failing To Pursue All Reasonably Available Options To Secure In-Home Care**

Raven perpetrated neglect of Ida by repeatedly breaching her duty to pursue the goods and services Ida needed—in-home care and medications—depriving Ida of such critical care and causing her to experience pain.

The Abuse of Vulnerable Adult Act defines neglect as “a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm

or pain to a vulnerable adult . . . .” RCW 74.34.020(12).<sup>8</sup> In construing the “duty of care” element, the Court of Appeals held that Raven’s duty was to “mak[e] every reasonable effort to provide the care Ida needed.”<sup>9</sup> *Raven v. Dep’t of Social & Health Serv’s*, 167 Wn. App. 446, 450, 273 P.3d 1017 (2012). Raven agrees that this is the correct standard of care for a medical guardian. Petition at 19.

Raven perpetrated neglect by delaying and failing to make every reasonable effort to secure adequate in-home care for Ida. Even after being informed for months that Richard and CCS caregivers actively sabotaged Ida’s care, she put on hold any decision to change the situation to avoid “stress” to Ida’s family during the 2005 winter holidays. In June 2006, she failed to follow any of the court’s instructions to stop interference with Ida’s home care, even after Raven herself had described the situation a month earlier as a “crisis of care.”<sup>10</sup> And her failure to visit Ida for months at a time prevented her from observing Ida’s health

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<sup>8</sup> The statute contains a third, alternative definition, which is not relevant here. DSHS held that Raven perpetrated neglect under both of the first two alternatives. AR 168-69.

<sup>9</sup> Contrary to Raven’s argument, the court rejected any notion that a guardian’s duty includes “guaranteeing” the ward’s health. *Raven*, 167 Wn. App. at 450.

<sup>10</sup> In later pleadings, Raven blamed the superior court for her failure, complaining that it failed to clearly inform her of its legal authority to sanction Richard. Corrected Opening Brief of Respondent at 13 (Court of Appeals). First, the court specifically advised Raven to consider consulting an attorney, which Raven did not do. Second, Raven’s professed ignorance of the law is not supported by the record, since at one time she threatened to bring Ida’s daughter before the court to address an ongoing dispute in Ida’s care. AR 1586.

downturn in November and December 2006, or understanding the urgency for Ida to receive more in-home care to keep her bedsores clean of human waste, as urged by Providence Hospice. AR 1360.

Raven's claim that "no agency" had caregivers available for Ida is contradicted by the record. Petition at 17. In June 2006, another agency expressed interest in working with Ida, but Raven decided to continue using CCS. AR 856-59, 1589; RP 660-61. Her argument also incorrectly implies that an agency was the only viable source of caregivers, but Ida also had access through Medicaid to independent caregivers. WAC 388-71-0500. Under the circumstances, Raven's refusal to use them was unreasonable. The qualifications for agency and independent caregivers are identical, and in some circumstances the Legislature *requires* the use of independent caregivers, rather than agency staff. RCW 74.39A.326; WAC 388-71-0500 - .05665. If Raven was unqualified to supervise the care that Ida needed, the standards of practice for professional guardians required her to resign. *See* AR 1833 (guardians must not exceed their capacity and must ensure that the ward is served by qualified persons).

Additionally, Raven's attempt to blame lost paperwork for the delay in nurse delegation ignores the fact that as Ida's guardian, she was responsible to actively "monitor" Ida's care. AR 1836-37. Nurse

delegation could proceed under governing regulations after Ida obtained a new doctor on October, 16, 2006. AR 1592. Although Raven knew it was important to replace Richard through nurse delegation, she failed for over a month to review its progress, and then only did so when Providence Hospice threatened to quit due to Richard's continuing interference.<sup>11</sup> AR 1594.

Raven and the amici are wrong to suggest that Ida's resistance to *nursing homes* excused Raven from pursuing the *in-home* care that Ida preferred. The record establishes that even with the difficulties posed in Ida's case, additional options to supplement Ida's home care were available. Raven's repeated delays and failure to pursue them deprived Ida of critical services and caused her to experience pain. Accordingly, Raven neglected Ida, and DSHS properly concluded so.

**B. Raven Perpetrated Neglect By Failing To Make Substitute Decisions For Ida As Ida's Circumstances Changed**

As Ida's health deteriorated, Raven contends that it became impossible to fulfill Ida's home care plan. *See* Petition at 2-3, 17-18. But, once Raven concluded that her own plan could not be achieved, she had a legal duty to determine the treatment choice that Ida would have chosen, if competent, under changing circumstances. Raven breached this duty. She

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<sup>11</sup> Raven did not check on nurse delegation after earlier receiving a call from Ida's case manager on October 23, 2006, informing her that caregivers had found several bottles of medication hidden by Richard. AR 1593.

did not investigate and consider all factors required for substitute decision-making. She did not interview Ida or counsel her on her residential care choices. And, if she determined that Ida's competent choice was to remain at home with *substandard* care, she was required to file a modified plan with the court, because it would have been a substantial modification of her previously filed plan. By failing to make decisions under changing circumstances, Raven abdicated her role as guardian and improperly left Ida in stasis.

**1. Guardians Must Develop A Care Plan Including The Treatment The Ward Would Accept, If Competent**

Raven was required to develop and file with the court a "specific plan of care" to meet Ida's needs, inform the court of substantial changes in Ida's condition, and file updated plans as necessary. RCW 11.92.043(1), (3). The law imposed these duties on Raven because the guardianship court is the "superior guardian", which acts through the guardian as its "agent" to protect the ward's interests. *See In re Guardianship of McKean*, 136 Wn. App. 906, 913, 151 P.3d 223 (2007), (citing *In re Guardianship of Gaddis*, 12 Wn.2d 114, 123, 120 P.2d 849 (1942)).

In developing Ida's plan, Raven could consent only to the treatment Ida would accept, if competent, and was prohibited from

admitting Ida to a residential facility against her will. RCW 7.70.065(1)(c); 11.92.043(5), 11.92.190; *see also In re Guardianship of Ingram*, 102 Wn.2d 827, 838, 689 P.2d 1363 (1984). If Raven could not determine Ida's competent choice, she was authorized to accept the treatment based on Ida's best interests. RCW 7.70.065(1)(c).

To discern Ida's competent choice, Raven was required to weigh a number of factors, including Ida's historic choices and insight from her family. *Ingram*, 102 Wn.2d at 840. Raven also was required to give "substantial weight" to Ida's "expressed wishes," which necessarily required her to *ask* Ida about them. *Id.* at 840-41. The codified standards of practice for guardians instruct guardians that "[w]henever feasible a guardian shall consult with the incapacitated person" and "acknowledge the residual capacity of the incapacitated person to participate in or make some decisions." AR 1833. Raven also was required to research all options for Ida's residential care, and encourage Ida to accept the care meeting her best interests. AR 1833, 1836; Br. of Elder Law Attorneys Add. B at 2b- 18.<sup>12</sup>

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<sup>12</sup> As discussed further in DSHS's Answer to Amici Briefs at 7-9, the training materials submitted by amicus Washington Association of Professional Guardians instruct guardians to strongly urge a ward to accept the residential treatment in the ward's best interest. The Court of Appeals' finding that guardians should "aggressively pursue" facility care when needed by the ward is consistent with these training materials. *Raven*, 167 Wn. App. at 467. The Court did not hold that guardians must *illegally* institutionalize wards against their will, as Raven and the amici argue.

**2. Raven Failed To Engage In Proper Substitute Decision-Making To Determine Ida's Competent Choice As Her Conditions Changed**

Raven breached her duty to engage in substitute decision-making because she failed to consider all *Ingram* factors as Ida's circumstances changed. Raven concluded that Ida's competent choice was to accept in-home palliative care sufficient to keep her comfortable, and all care plans Raven filed called for Ida to receive appropriate in-home care. AR 1263, 1514-23, 1551-55. When Ida's home care had been deficient for several months and Ida lost her hospice and doctor in May 2006, Raven informed the court of her intent to rectify Ida's home care, and she re-iterated this goal in her follow-up report in September 2006. AR 1534-55; *see also* AR 2064-65 (October 6, 2006, letter from Raven saying she is "desperately" in search of home care sufficient to keep Ida comfortable).

Yet Raven knew that her plan was not being fulfilled. AR 1360, 1531, 1594. Once she formed any belief that the plan she herself designed could not be accomplished, her duty required her to determine Ida's competent choice under the changed circumstances and file an updated plan, if necessary. RCW 7.70.065(1)(c), 11.92.043. In other words, Raven was required to reconsider whether Ida's competent choice would be to remain at home in pain and with sub-standard care, or if given that circumstance Ida would have chosen to be admitted to a residential facility. This required her to investigate and consider *all Ingram* factors—including Ida's then-current wishes for treatment—and advise Ida on all

residential care options, including nursing homes and nursing home alternatives. Raven failed to perform these duties.

At page 19 of her Petition, Raven maintains, without citation to the record, that she spent “hours” talking to Ida about nursing home care, but the record reflects only one discussion about any type of facility, in June 2004. AR 1571, 1588.<sup>13</sup> And Raven admitted that when Ida developed life-threatening bedsores in the winter of 2006, she did not recall speaking to Ida about nursing homes or alternatives. RP 776. In fact, several witnesses recall Raven explaining that she could not accept any agreement from Ida to consent to facility care, but was required instead to enforce Ida’s historic opposition to facility care over her current wishes. AR 877, 1341-42, 1376.

There is no evidence that Raven considered the fact that Ida had consented to temporary facility care in 1996 and 2001, or questioned under what circumstances Ida might agree to temporary facility care. Raven testified that she never spoke to Ida about *temporary* facility care. AR 1632. Instead, Raven improperly based her refusal to consider or even talk to Ida about facility care on only one factor: Ida’s *historic* resistance to nursing homes. And, it appears Raven accepted Ida’s statements at face value, without trying to sort out whether Ida’s resistance to facilities was

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<sup>13</sup> In the June 2004 conversation, Ida said she feared Raven would put her in a “looney bin.” There is no record of any further conversation between Raven and Ida about any type of facility, including nursing homes or alternatives. As discussed in DSHS’s Answer to Amici Briefs at 9, Raven knew about alternatives to nursing homes, which include “adult family homes” operated in a residential home and assisted living facilities, both of which are required by law to provide a “home-like” setting to residents.

influenced in any degree by her delusions and mental illness. Thus, Raven failed to properly engage in substitute decision-making by failing to consider all relevant *Ingram* factors.

**3. Raven's Failure To Properly Engage In Substitute Decision-Making Improperly Left Ida In Stasis**

Had Raven properly engaged in substitute decision-making, she could have sooner secured the comfort and care that Ida would have chosen, if competent, or at least could have imposed much-needed order in Ida's home. By properly investigating and weighing all of the *Ingram* factors, Raven may have been able to determine that Ida would have accepted at least temporary facility treatment when she lacked enough in-home caregivers to attend to her painful bedsores, or Raven may have determined that Ida's competent choice could not be determined under then-existing circumstances. In either case, Raven could have authorized Ida's transfer to a facility sooner, under RCW 7.70.065(1)(c). Alternatively, proper consideration of all *Ingram* factors may have led Raven to conclude that Ida would have chosen to remain at home with insufficient caregivers to keep her clean and pain-free. But, because this would have been such a substantial departure from the previous care plan Raven filed, she would have been required to file a modified care plan with the court under RCW 11.92.043.<sup>14</sup> Either of these courses of conduct

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<sup>14</sup> The court had never approved a plan of substandard home care, was not aware of Ida's substantial change of condition in the winter of 2006, and last instructed Raven in June 2006 to remedy Ida's insufficient home care. AR 1537-38. Had Raven returned to inform the court that Ida's plan was impossible, it could have approved of the decision to keep Ida at home with insufficient care or could have called for any more evidence it

were sanctioned by the law, which provided clear guidance to Raven on how to make her choice. The law did not, however, sanction the course of conduct Raven actually followed: to urge Ida's care team to fulfill a plan she herself deemed impossible and made more difficult to achieve by her failure to pursue or approve potential sources of supplemental care.

**C. Statutory Neglect Does Not Equal Common Law Negligence**

Both the statutory language and purpose of the Abuse of Vulnerable Adults Act contradict Raven's attempt to import common-law negligence principles into a finding of neglect. Thus, this Court should reject her claim that DSHS must prove proximate causation of harm to make a finding of neglect.

The Abuse of Vulnerable Adults Act defines neglect as "a pattern of conduct or inaction by a person or entity with a duty of care" that *either*: "fails to provide the goods and services that maintain physical or mental health of a vulnerable adult," *or* "that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult . . . . RCW 74.34.020(12). Because the first alternative definition does not

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needed to approve the decision under *Ingram*. The court may have wished to hear further from the county mental health professional, who had made the decision not to pursue involuntary treatment for Ida in November 2006 based, in part, on her understanding that Ida had *sufficient* in-home care. *See* AR 2137. The court could have entered an order requiring Ida to receive pain medications and hygiene, even over her objections, if it determined that Ida's *competent* choice would have been to die at home with dignity and without pain. Or, if it had found that Ida's competent choice could not be determined under the circumstances, it could have ordered the treatment then in Ida's best interests.

require actual harm, the Court of Appeals properly held that the plain meaning requires a showing that the vulnerable adult either goes without needed goods or services or suffers pain. *Raven*, 167 Wn. App. at 464-65. This Court should likewise reject Raven's argument that an actual harm element must be imported into the first alternative definition. *See Kilian v. Atkinson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002) (the court should not read into the statute language which is not included by the Legislature).

DSHS is directed to use neglect findings for protective purposes, not for seeking damages.<sup>15</sup> RCW 74.34.067(6). It follows that DSHS is not required to prove actual harm to the vulnerable adult, proximately caused by the guardian. Including it as an element in all cases would make proving neglect equivalent to prevailing in a tort action—a level of proof that the Legislature did not intend<sup>16</sup> and which is unworkable in the administrative context of protective findings under the Act. If actual harm were required in each case, DSHS's authority to extend protective services would depend on the subjective condition of each victim: A hardy victim suffering no harm resulting from a guardian's repeated breach would be

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<sup>15</sup> The Act includes a special cause of action for damages upon a showing of actual harm, which would be superfluous if neglect required proof of actual harm in all cases. RCW 74.34.200.

<sup>16</sup> *See Warner v. Regent Assisted Living*, 132 Wn. App. 126, 134, 130 P.3d 865 (2006) (“[n]eglect” has “its own standards of proof which are different from common law negligence”), *citing Conrad v. Alderwood Manor*, 119 Wn. App. 275, 78 P.3d 177 (2003); *see also Schumacher v. Williams*, 107 Wn. App. 793, 28 P.3d 792 (2001).

ineligible for protective services, while a more fragile victim suffering harm under the same conditions would be. Because the construction urged by Raven defeats the Legislature's intent, it should be rejected. *See State v. McDougal*, 120 Wn.2d 334, 351, 841 P.2d 1232 (1992) (rejecting a statutory construction that is "clearly inconsistent with the purposes and policies of the action in question").

#### IV. CONCLUSION

Raven did not make every reasonable effort to provide the in-home care that Ida needed. This Court should affirm the finding that she perpetrated neglect under the Abuse of Vulnerable Adults Act.

RESPECTFULLY SUBMITTED this 10<sup>th</sup> day of December, 2012.

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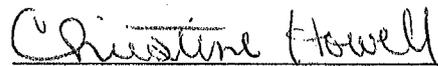
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