ORIGINAL

NO. 40809-1-II

COURT OF APPEALS

DIVISION II

OF THE STATE OF WASHINGTON

RESA RAVEN,

Respondent,

vs.

WASHINGTON STATE DSHS,

Appellant.

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OPENING BRIEF OF RESPONDENT

Jeff Crollard, WSBA #15561
CROLLARD LAW OFFICE, PLLC
1904 Third Ave., Ste. 1030
Seattle, WA 98101
Telephone (206) 623-3333
Fax (206) 623-3838
Attorney for Respondent

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I. INTRODUCTION

This is a judicial review of an administrative action, involving allegations by the Department of Social & Health (DSHS) that a vulnerable adult, Ida, was neglected by her limited guardian of the person, Resa Raven. DSHS lost before the Administrative Law Judge, who held a five day hearing and found no neglect. The DSHS Review Judge reversed the ALJ, and then the DSHS Decision was reversed by the Pierce County Superior Court. DSHS now appeals the superior court's reinstatement of the finding of no neglect, and the court's award to Ms. Raven of attorney's fees under the Equal Access to Justice Act.

The DSHS Review Decision described the tremendous difficulties posed by this case ("one could not script a more trying case for caregivers, family members, public and private care agencies, courts, and guardians than the one at hand.")[1] and yet, in the end, expected Ms. Raven to be a miracle worker, to accomplish what an army of professionals and lay people could not do: convince an 85 year old Ida, who had been bedridden for 10 years, and her dysfunctional family, to accept health care that she needed.

Ms. Raven, however, was in an untenable position. Ida likely needed to be in a treatment facility to receive more consistent care, but she

[1] Administrative Record (AR) 158-159.

insisted on living at home, and the law prohibited Ms. Raven from putting Ida in a nursing home or other care facility against her will. Ida had compromised cognition and made poor choices, but the mental health professionals decided she was feisty and medically complicated but not a candidate for involuntary commitment. Ida, a Medicaid patient, had been awarded additional hours of home care service, but the home care agency, despite repeated months of trying, was unable to find caregivers willing to fill a one half to one hour evening shift, at little more than minimum wage, to serve a patient who often spat, bit, and fought her caregivers. Ida needed more consistent medications, but the only person for months at a time authorized to administer medications was her husband, because Ida had burned the bridge with several past doctors and nurses, so that none were available to delegate medication administration to paid caregivers, leaving only unpaid family authorized to administer medications—a husband who was mentally compromised and doing his best, and Ida, who often refused her pills.

Despite this, and without citing *any* authority, the DSHS Review Decision held that Ms. Raven as the guardian "was ultimately responsible to ***ensure***" that Ida's care needs were met. AR 168. By that standard, most guardians across the state would be guilty of neglect on a daily basis. Guardians, however, cannot do the impossible, including creating

resources that don't exist, or forcing a ward to accept care or move into a nursing home against the ward's known wishes. The DSHS Review Decision is a misstatement of the law and reality.

II. ASSIGNMENTS OF ERROR

1. The DSHS Review Decision erroneously interpreted or applied the law governing the duties and authority of guardians, and the meaning of the term "neglect," where:

   a. It holds, without citing any statute or case law, that a guardian must ensure actual receipt of services by a ward,
   b. It engages in speculation and unrealistic assumptions about the ability of a guardian to create resources or control others,
   c. It imposes duties on a guardian not found in the guardianship statute, and ignores significant restrictions on a guardian's authority to detain a ward in a care facility or to force care against a ward's wishes, and
   d. It enters a finding of neglect against a guardian without proving a breach of duties or how any action or inaction of the guardian *caused* harm to the ward.

2. The DSHS Decision is not supported by evidence that is substantial when viewed in light of the whole record, where:

   a. It adds key foundational Findings of Fact that misconstrue the record, creating duties for Ms. Raven that do not exist and misidentifying the causes of harm to Ida, and
   b. It bases Conclusions of Law almost entirely on speculation and unrealistic assumptions about guardians and the courts.

3. The DSHS Decision violated due process when it used a preponderance of the evidence standard for a finding of neglect, where:

a. A person is a licensed, certified professional whose livelihood is at stake if a final finding of neglect is entered by DSHS, and

b. In similar cases the courts have held that the state must prove similar charges by clear, cogent, and convincing evidence.

III. STATEMENT OF THE CASE

A. Procedural History

DSHS, through Adult Protective Services (APS) issued a notice of neglect on 6/15/07, and amended notices on 6/19/07 and 1/8/08, alleging two incidents of neglect and a general allegation that Ms. Raven failed to provide Ida the services she needed. AR 1221-23, 1971-73, 686-688. A five day in-person hearing was held before Administrative Law Judge Rebekah Ross (ALJ Ross) on April 14-17, 2008 and June 13, 2008. ALJ Ross found in Ms. Raven's favor, dismissing all charges of neglect. AR 2. DSHS Review Judge James Conant upheld the dismissal of the two specific neglect allegations, but reversed ALJ Ross on the allegation that Ms. Ravens had not ensured sufficient care in Ida's home. AR 168-170.

Ms. Raven sought judicial review. The case was transferred to Pierce County because Ms. Reese had served for years as a guardian ad litem in Thurston County. Ms. Raven challenged the DSHS Review Decision on the three grounds pursuant to RCW 34.05.570(3)(d), (e) and

(a).[2] Pierce County Superior Court Judge Kitty-Ann van Doorninck upheld the constitutionality of the DSHS rule and did not rule on whether the DSHS Review Decision was supported by substantial evidence. Judge van Doorninck reversed the DSHS Review Decision on the basis that it erroneously interpreted or applied the law. Clerk's Papers (CP) 1-8. The court below awarded Ms. Raven $25,000 in attorney's fees and costs under the Equal Access to Justice Act. CP 93-95. DSHS appealed the superior court orders to this Court. CP 102-03.

B. Statement of Facts

1. Ida had a long history of refusing care

Ida was in her mid 80s during the 2004 to 2006 time period of this case. She lived at home with her husband and had been bedridden since 1996. Ida was incontinent. She had contractures causing her legs to be locked into a splayed position. Attempted movement of her legs, such as for repositioning and cleaning, was extremely difficult and painful. Ida also suffered from a chronic mental illness, dementia, and sometimes had hallucinations. She had periodic urinary tract infections (UTIs), rheumatoid arthritis, and congestive heart failure. Ida was often hostile, combative, and uncooperative with care, and she refused to see a physician. AR 98.

[2] Ms. Raven expressly challenged the Findings of Fact in the DSHS Review Decision: 6, 38, 44, 45, 46, 59, 60, 62, 68, 75, 78, 88, and 108 and Conclusions of Law: 8, 15, 16, 17, 18, 31, 43, 44, 46, 48, 49, 50, 51, 52, 53, 54, 55, and 56. Clerk's Papers (CP) 163-180.

Ida had a long history of periodic skin breakdown. She would only lie on her back. When care givers positioned pillows for pressure relief, Ida would pull them out. Caregivers were reluctant to turn her more often than once or twice a day because Ida would moan in pain and say her bones were popping. AR 99-100.

Ida seldom took medications, except for Tylenol or Ibuprofen and herbal medications. Ida had glaucoma and cataracts, but refused surgery. AR 102.

Ida was strong-willed and independent. In 2001, a physician noted: "Very alert, talkative lady that is oriented to person, place, and time. She basically hardly lets me get a word edgewise." An ER doctor in 2001, evaluating concerns about Ida's home living situation, noted that *Ida was unwilling to be placed in a group home or a nursing home.* In 2002, Ida was put on hospice at home; Ida told her case manager and a caregiver that she wanted to die at home. AR 103.

Ida was verbally and physically abusive to care providers, and would scratch and pinch them, and throw items, causing injuries to providers. Her aggressive behavior towards caregiver's was exacerbated when her spouse didn't give Ida her pain medication on a consistent basis. AR 103.

In 2001, APS investigated an allegation of self neglect by Ida concerning behaviors risky to her skin integrity. APS concluded that Ida had some psychiatric symptoms of paranoia and risk to her skin integrity, but that she was not self-neglecting and had a "long history and lifestyle pattern of independence and reliance on naturopathic and alternative medicine." AR 104-5.

The ALJ and Review Judge found that since 2001 Ida fairly consistently refused medical attention, even when in her best interest. In 2003 when a caregiver told Ida that her dark stool indicated internal bleeding and she needed to get to a doctor, Ida said she did not care, and that she wanted to die. AR 106-7.

In December 2003, Ida's daughter contacted police because Ida would not allow a visiting doctor to inspect her infected foot. Ida told the police that she had the right to refuse medical treatment. Ida's daughter reported that Ida had fired multiple doctors in the past because she was upset with them. The Designated Mental Health Professional (DHMP) determined that Ida was not detainable under the Involuntary Treatment Act. This determination was made again in late 2004 by a DMHP and by a registered counselor from Providence Hospital. AR 107.

In September 2003, Ida's doctor from the clinic Sea Mar withdrew because of Ida's refusal to come to his office. In December 2003, Ida's case manager from the Area Agency on Aging (AAA), the entity that supervised Ida's care, noted that Ida still did not have a doctor, as she refused to leave her home, and they could not find a doctor who would make home visits. AR 115-116.

2. A limited guardianship is established

In January 2004, DSHS determined that Ida was self-neglecting and filed a guardianship petition. The GAL report said it was unclear whether Ida's delirium was from an UTI or an underlying mental disorder, and whether Ida's refusal to eat or to take medications was from the delirium or a choice that she had the

capacity to make. The GAL recommended selecting a limited guardian of the person with a mental health background. AR 104-5, 108-9.

Ms. Raven is a licensed mental health counselor, who specializes in forensic evaluations. She had recently become a certified professional guardian and Ida was her first ward. Throughout the guardianship, Ida also had a case manager from the AAA and from Catholic Community Services (CCS), the agency providing in-home personal care for Ida. AR 111-112.

Resa Raven was appointed Limited Guardian of the Person for Ida on March 12, 2004. The Court Order stated:

> "The authority of the guardian should be limited as follows:
>
> (1) consent to or refuse medical treatment; and
> (2) to decide who shall provide care and assistance."

The Order provided that: "The power and duties of the guardian shall be as specifically stated in this order and as required by RCW 11.92." AR 109-110.

Once Ms. Raven was appointed Ida's limited guardian, she met with Ida and the individuals involved with Ida's care, including Ida's daughter and husband. She had several in-depth conversations with Ida. Ms. Raven reviewed Ida's records at the hospital, the AAA and CCS. Ms. Raven noted that Ida was variable in her response to medical care, but very consistent in her resistance to placement in a nursing home or other care facility. She determined, and the ALJ and

Review Judge agreed, that Ida when competent had consistently refused to be placed in a nursing home or other long term care facility. AR 108, 112.

Ms. Raven was concerned that Ida did not have a primary care doctor since it looked like everything that could be done to find a doctor had been tried. There were few physicians willing to take Medicaid patients, and most of those in the area had already decided they would not serve Ida. Sea Mar, the primary clinic in Ida's community for Medicaid patients, refused to see Ida again. Ms. Raven and Ida's AAA case worker called every Medicaid provider on the AAA list and were unable to find any doctor for Ida. Ms. Raven spoke to people in the medical and guardian community to see if anyone knew of a doctor or nurse practitioner who might accept Ida. A major obstacle was that Ida could only be transported by ambulance, Medicaid would not pay for an ambulance for routine visits to a doctor's office, and no doctor would come to her. Ms. Raven explored every resource she knew of to find a doctor for Ida, without success. She reported this problem to the court in her Initial Personal Care Plan on 6/11/04 and in her first Annual Personal Care Plan on 9/15/05. AR 116-118, 1519-1521.

In August 2005, Ida was taken to the emergency room because of pressure sores on her leg and the need for medicine. Ms. Raven stayed with Ida during the eight hours she was in the ER, and participated in the care planning. During that hospital stay, it was determined that Ida was eligible for hospice care because her life expectancy was less than six months. This enabled

Ida to obtain a primary physician by being placed on hospice, with Assured Home Health and Hospice. AR 118-119.

3. Ida's skin condition and problems with caregivers

During the time period at issue, Ida's skin condition fluctuated. Her November 12, 2004 comprehensive assessment indicated that she had 10 pressure sores. Her October 19, 2005 assessment notes just two pressure sores, and with none on her bottom or back. AR 100-101.

On October 25, 2005, Ida's primary caregiver from CCS stated resistance to the hospice nurse's recommendation that Ida be given pain medication on a regular basis and frequently repositioned to avoid pressure sores. The caregiver said the medication made Ida sleep too much and that one turn per day was sufficient. Ida's husband also reported that she slept all day if given the prescribed amount of pain medication. AR 102-3.

A care conference with Ms. Raven, the AAA case manager and hospice nurse and social worker was held on November 17, 2005 to discuss the concerns about cooperation from CCS and Ida's husband. Ida required two caregivers to safely reposition her but funds were not available for this enhanced personal care. Ms. Raven agreed that care in a skilled nursing home would be the best solution for Ida, but she said she could not institutionalize Ida against her will. The group agreed to focus on convincing Ida's daughter to influence Ida's husband to provide the pain medication more frequently. AR 119-121, 1225.

A nurse examination of Ida on December 14, 2005 revealed new skin breakdown. The caregivers said that Ida was in too much pain when repositioned and would not allow them to turn her every two hours. By January 7, 2006, Ida was developing stage 1 sores on her bottom and legs, and by January 31, 2006, these had progressed to stage 2. Pressure sores are staged 1, 2, 3 and 4, with 4 the worst. AR 119-121.

A care conference was held on January 10, 2006, attended by Ms. Raven and the care providers. Ida's hospice nurse requested increased caregiver hours and recommended that Ida be repositioned 6 times per day and have two people turn her. The plan agreed upon was for Hospice to train the CSS caregivers in special procedures to turn Ida, and the AAA case manager would ask DSHS to fund more personal care hours. AR 121-122.

In February or March 2006, DSHS approved additional care hours for Ida. The funding request said that it would allow CSS to provide staff to turn Ida three times a day. AR 775. CSS advertised for workers through fliers, word of mouth and classified ads, but CSS could not find people willing to fill all the hours of personal care DSHS had approved. The AAA case manager said she would ask other home care agencies if CCS was unsuccessful. AR 101, 121-122.

On February 24, the AAA case manager contacted Ms. Raven and said that Ms. Raven might need to find some Independent Providers (IPs) for the evening shift. A home care agency hires and supervises its own aides, whereas

IPs are hired and supervised by the patient or the patient's representative. Ms. Raven expressed hesitancy about hiring IPs, who would not be supervised by a home care agency. Both the ALJ and Review Judge found that it was speculative as to whether any person available through the Work Source job bank as an IP, as suggested to Ms. Raven, would have the skills and training to serve a client as difficult as Ida without significant supervision and training. AR 121-122.

CCS had a schedule to provide two caregivers for shifts at 8:00 a.m., 1:00 p.m., and 5:00 p.m. The shifts ranged from one half hour to three hours. By December 2006, Ida had been approved to receive 280 hours of care per month, but CCS was only able to fill an average of 189 hours per month, and was sending workers on a consistent basis only for the first two shifts. AR 132.

CCS told Ida's AAA case manager how difficult it was to find workers to cover the evening shift. The AAA case manager recounted the difficulties:

> She required two people to turn her, to reposition her, and it was - - seemed impossible with the agency caregivers that we had in there that they were able to. They could never find enough people to staff Ida for one thing, she was combative and would throw things at people and scream at people and yell obscenities at them.
>
> And also, the hours that were needed, it's very hard to find agency caregivers who will work weekends and who will work after 5:00. And she needed people there, two people, one person there for a half an hour to an hour, which is pretty much impossible to get caregivers to do, and then another person there who could be there longer term. I think we had someone try to go in there four to six times a day. I can't remember the amount, but there was no way.
>
> Verbatim Report of Proceedings (RP) 28.

4. Assured Home and Hospice leaves Ida

On May 16, 2006, Assured Hospice terminated their services to Ida because she was not consistently receiving medication from her husband, resulting in agitation and Ida hurting the workers. Ida's hospice doctor quit the same day and said he would not provide care in the future for Ida. AR 123-124.

5. Ms. Raven seeks Court direction

Because of the major change in Ida's situation—losing her doctor—Ms. Raven petitioned the Court for direction. She said ideally Ida would be in a nursing home, but pointed out that this could not happen except through involuntary commitment by a DMHP. She asked the Court for any direction or suggestions. A court hearing was held on June 2, 2006. AR 124-126.

Judge Strophy, Ret. of Thurston Co. County Superior Court, initially said that he thought Ms. Raven could place Ida in a nursing home, but when Ms. Raven pointed out her concern that RCW 11.92.190 prohibited her from doing so against Ida's will, Judge Strophy said the statute may trump his earlier inclination. He suggested she may want to seek an assessment by the DMHP, which had already been done, or file a motion to compel Ida's husband to administer her pain medications, although he provided no legal basis for such a motion. AR 124-126.

6. Further steps taken by Ms. Raven to obtain care for Ida

Ms. Raven had ongoing concerns about CCS's care for Ida. However, Ida had developed a good relationship with one of CCS's care providers, Pam,

and Ms. Raven was concerned that Ida would be more resistant to care or stop eating if Pam were not her care provider. Pam was influencing Ida's husband, Richard, to not regularly administer Ida's medication. Neither Ms. Raven nor Judge Strophy knew if Ms. Raven could remove Pam from the home, because Pam was also Richard's caregiver. AR 132-133, 797-801.

On June 16, 2006, Ms. Raven met with the case managers and supervisors from the AAA and CCS. Ms. Raven demanded that if CCS were to remain, it needed to change its staffing. CCS said it would replace the caregivers, find additional workers, and pursue Nurse Delegation, a process where a RN trains caregivers to give medications, which would take the medication issue out of the hands of Ida's husband. The meeting notes indicate that Ms. Raven had the task of locating a doctor and hospice care again. AR 133.

In late June 2006, Ms. Raven found an Advanced Registered Nurse Practitioner (ARNP) willing to write prescriptions for Ida. One month later, the ARNP became employed at an agency and was unable to keep Ida as a client. Ms. Raven now had no one to write prescriptions. Ms. Raven told the AAA case manager that she had exhausted all possibilities for getting a doctor or ARNP, had spoken with both hospice programs, and would have to take Ida to the ER when she ran out of medication. In August 2006, Ida's medications ran out. Ms. Raven had her transported to the ER. Ms. Raven was given a list of doctors who accepted Medicaid but none were taking new patients. AR 126-127.

On August 31, 2006, Ms. Raven was able to make an appointment for Ida at Sea Mar clinic, apparently because the receptionist was unfamiliar with Ida and booked her as a new patient. Ida was to be seen for a possible leg injury and Ms. Raven also hoped to obtain a new primary care doctor. Ida was seen by Dr. Spencer, who accepted her as her patient. AR 127.

On October 6, 2006, Ms. Raven wrote to Dr. Spencer:

> At this point I am desperately in search for services that will allow Ida to receive hospice care, (or I suppose, some other form of in-home nursing services) so that she can continue to reside in her Lacey apartment. I think it unlikely that she will be with us much longer, and I am eager to make her as comfortable as possible in the time that she has remaining.

Dr. Spencer decided she wanted a new hospice team, Providence Hospice, to take over Ida's care. Ms. Raven met the Providence Hospice nurse and medical social worker at Ida's apartment on November 4, 2006, and when Providence Hospice took on Ida's case on that date, Ida had *no* pressure sores. AR 127-129.[3]

The AAA case manager contacted Ms. Raven on November 16, 2006 to tell her that Ida had new pressure sores and Providence Hospice was considering terminating its services due to inadequate care in Ida's home. She also informed Ms.

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[3] The Providence Hospice social worker testified that when their care began in early November 2006 "There was no obvious skin breakdown that I could see," RP 116. The Providence Hospice nurse, Ms. Zaire, at RP 169, stated the same:

Q. When you first began treating Ida, what was the condition of her skin?
A. She did not have areas of breakdown, certainly not pressure areas that she developed later. She had like an ingrown toenail that hurt that she had when we first came in. That was the only area.
Q. So she didn't have any wounds when you first came?
A. No.

Raven that Nurse Delegation was almost in place. It had been delayed earlier because a nurse cannot delegate medication administration without the patient having a doctor/ARNP. Unfortunately, after Ida obtained a doctor in October 2006, the Washington State Department of Health inadvertently misplaced the nurse delegation paperwork. It had just been found in a DOH mail bin. AR 120-130, 870.

In mid to late November 2006, Ida developed pressure sores, which by 11/21/06 were stage 3. On 11/22/06, the hospice medical social worker contacted Ms. Raven, very concerned about Ida's pressure sores. Ms. Raven told the hospice social worker her that she would authorize Ida being taken to the hospital if that was hospice's recommendation. The social worker told Ms. Raven that per hospice policy they could take a patient directly to the hospital if needed. AR 128-130.

Prior to late November 2006, Providence Hospice had purchased an air flow mattress for Ida to address her skin issues. A hospice wound care nurse believed the mattress ordered by Providence may have contributed to Ida's rapid skin breakdown. AR 139. A second hospice nurse testified "there was a concern that it was ineffective and might be making it worse. There was the concern that she was not getting enough—getting enough inflation." RP 192-193. The mattress was replaced on 11/29/06. AR 139.

The hospice medical social worker and clinical manager believed Ida should be admitted to a nursing home or other 24-hour care facility. Ms. Raven agreed that Ida should be in a nursing home, but said she lacked the authority to

do so against Ida's will. She said the only way for Ida to be institutionalized against her will was through the involuntary commitment process.[4] AR 129.

On 11/15/06, a DMHP evaluated Ida and determined that she was not detainable. (AR 129) Ms. Raven spoke to the DMHP, a Ph.D. psychologist, and told her that "detaining Ida so that she could be medically and psychiatrically stabilized and adequately assessed would be a great first step, and may allow Hospice to maintain Ida in her home." AR 1595. However, on 11/20/06, the DMHP told Ms. Raven that Ida was not detainable, was neither violent nor delusional, "but was rather an obstinate older medically fragile woman whose symptoms were primarily medical." AR 1596. The DMHP also told the AAA case manager on 11/16/06 that she was "not going to detain client [Ida] as she is not appropriate for committing to psych ward which is all she is legally able to do. She said that she is as feisty as she was 2 years ago, which is the last time she saw client." AR 871.

7. Winter storm interrupts care and worsens pressure sores

In mid December 2006, there was a severe winter storm in Washington State that caused power outages at Ida's apartment in Lacey and at Ms. Raven's residence. Ms. Raven was without power from December 13, 2006 to December 21, 2006, and because of felled trees was trapped in her rural home for days. Ida's apartment was without power for most of December 15 to 17, 2006. Ida's hospice social

[4] In the past, Ms. Raven had served as a DMHP for years and thus was familiar with the involuntary commitment process under RCW 71.05. RP 856-57.

worker and nurse arrived on the evening of December 15, 2006. The house was dark and cold. The CCS afternoon caregivers were there. Ida's pressure relieving mattress relied upon electricity and was deflated and hard. Ida was soaked in urine and lying on the deflated mattress. AR 138-140.

After lying on her hard mattress for approximately two days in mid December, Ida's skin breakdown became significantly worse. Stage 3 pressure sores developed into stage 4, exposing muscle or bone. Ms. Raven did not know about this until she was reached by hospice on December 21, 2006. She again authorized transport of Ida to the hospital, but was told by hospice that this was not necessary as the ER would not be able to take care of the pressure sores and would likely send Ida back home. The type of treatment provided in a hospital—surgical debridement—also would have been a major intervention, inconsistent with the reason that Ida was receiving hospice care. AR 140.

Ms. Raven lives in a heavily wooded rural area. After the storm, she could not get to her driveway, or access the office in her garage because of downed trees. She finally had electricity and was able to receive a phone call from the hospice social worker on 12/21/06, who told her that hospice had been in Ida's home and was providing care to Ida. AR 140-141.

8. Ida is removed from her home and dies.

In late December 2006, Ms. Raven and the Providence Hospice social worker agreed to hold a major care conference in early January to reassess Ida's

care and their options. At this point, Ida had stage 4 skin breakdowns on her buttocks, back, and legs. Hospice concluded that Ida needed 24 hour facility care and contacted APS to see if that were possible. AR 130.

On December 29, 2006, an APS supervisor called Ms. Raven and told her that she had made arrangements for Ida to be taken to the emergency room in two hours. The APS supervisor had not met Ida. The supervisor also said that Ida should be admitted to a nursing home. Ms. Raven told her about the legal constraints regarding involuntary placement in a nursing home. Ms. Raven agreed to send Ida to the emergency room and Ida was later admitted to the hospital on December 30, 2006. AR 130-131.

On January 5, 2007, CCS notified Ms. Raven that it was no longer able to provide care to Ida, and the AAA discussed terminating its services. APS said that Ida could be placed in a rehabilitation facility, as an extension of a hospital, and that this might be a permissible way around RCW 11.92.190. On January 8, 2007, Ms. Raven consented to have Ida admitted to Evergreen Nursing and Rehabilitation Center (Evergreen) as a "rehabilitation" center. Although Ms. Raven thought that Ida could return home after receiving rehabilitation at Evergreen, Ida passed away on April 24, 2007 at Evergreen. AR 131-132. The DSHS Review Judge observed at AR 162: "It is difficult to determine, in any definitive way, the consequences of taking an incapacitated person out of their home and placing them in a residential treatment facility when that person has held a long-

term desire to remain in their home. One could reasonably argue that the final change in residency had as much, or more, to do with Ida's eventual demise a short time after placement as her physiological medical conditions."

The DSHS Review Judge, nevertheless, concluded at AR 168-9 that:

As complex and trying as this case may have been for all concerned, legal resolution based on application of the relevant law to the facts is fairly straight forward. The Appellant's [Ms. Raven] 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 personal 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 Appellant was ultimately responsible to ensure these basic needs were met. The Appellant's failure to ensure these critical care needs were met did constitute a pattern of conduct or inaction that failed to provide the services to maintain Ida's physical health and failed to avoid and prevent physical harm to her.

IV. LEGAL ARGUMENT

A. Summary of Argument

The DSHS Review Judge incorrectly concluded that Ms. Raven committed neglect of Ida by "failing to ensure" that Ida's critical care needs were met. It is not the duty of Ms. Raven, or any guardian, to *ensure receipt* of services. Guardians must inform themselves of a ward's needs and the resources available and make reasonable efforts to meet those needs. But guardians work within the constraints of the law and reality. They cannot force treatment, create resources that don't exist, change a ward's personality, alter nurse delegation laws, or prevent power outages.

The DSHS Decision identifies no breach of duty by Ms. Raven that *caused* harm to Ida. The DSHS Decision notes that Ida experienced pain, but it was not caused by Ms. Raven. Ms. Raven was one of the few professionals who did not abandon Ida and who tried to respect her individuality and choices while still trying to get her the services she needed. The DSHS Review Decision should be reversed.

B. Standard of Review

Judicial review of an agency action is conducted under the Administrative Procedures Act, RCW 34.05.570. The DSHS Review Decision and Final Order (hereinafter DSHS Decision) is considered the "agency action." *Costanich v. DSHS,* 138 Wn.App. 547, 563, 156 P.3d 232 (2007). The Court may set aside the agency order, affirm it, or remand the matter to the agency for further proceedings. RCW 34.05.574(1).

Ms. Raven challenged the DSHS Decision on three grounds pursuant to RCW 34.05.570(3)(d), (e) and (a), namely that DSHS has:

> (1) "erroneously interpreted or applied the law,"
>
> (2) "The order is not supported by evidence that is substantial when viewed in light of the whole record before the court." And
>
> (3) "the order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied."

The Court reviews *de novo* an agency's conclusions of law and its application of the law to the facts. *Tapper v. Empl. Sec. Dept.*, 122 Wn.2d 397, 402-03 858 P.2d 494 (1993). Courts only give deference to an agency's interpretation of a statute if it is ambiguous *and* within the agency's area of special expertise. *Waste Mgmt. of Seattle, Inc. v. Utilities and Transp. Comm'n.*, 123 Wn.2d 621, 627-28, 869 P.2d 1034 (1994). Deference is *not* given an agency's interpretation that is implausible or contrary to legislative intent, or that conflicts with the statute. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 470, 70 P.3d 931 (2003); *Brown v. DSHS*, 145 Wn.App. 177, 183, 185 P.3d 1210 (2008) (overturning a DSHS finding of abuse). Ultimately it is the court's obligation to determine the meaning of a statute. *City of Redmond v. Central Puget Sound Growth Mgt. Hr'gs Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998).

DSHS does *not* administer the guardianship statutes or have any special expertise regarding the interpretation of a guardian's duties. No deference should be given to the DSHS's interpretation of Ms. Raven's duties as a guardian.

In reviewing an agency's findings of fact, the "substantial evidence" test is whether the record contains "a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the order." *Port of Seattle v. Pollution Control*, 151 Wn.2d 568, 588 90 P.3d 659

(2004)(citations omitted). Findings of fact must be based on the evidence in the record. RCW 34.05.461(4). Speculation and inference are not evidence. *State v. Hutton,* 7 Wn.App. 726, 728, 502 P.2d 1037 (1972) (Administrative rulings based on speculation or interference do not satisfy the substantial evidence standard.).

Finally, with regards to the ALJ's findings of fact and credibility determinations, the DSHS Review Judge "shall give due regard to the presiding officer's opportunity to observe the witnesses." RCW 34.05.464(4); *Costanich v. DSHS, id.*, 138 Wn. App. at 555.

C. Statutory Background

1. Definition of Neglect

The Vulnerable Adult Statute defines "neglect" at RCW 74.34.020(11) in pertinent part as:

> (a) 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;

Key to the plain language of the above definition is that the "pattern of conduct or inaction" by the person with a duty of care must be what "fails to provide" the services needed by the vulnerable adult, or that "fails to prevent" harm, i.e., there must be *causation.* Any other interpretation would lead to an absurd result: holding a person liable for pain or harm that they did not cause.

The DSHS Decision at AR 168 that Ms. Raven was inattentive to Ida's critical needs and that this constituted neglect is an application of law to facts that is reviewed de novo. In this case, the DSHS Decision is factually incorrect—Ms. Raven was not inattentive—and it misstates Ms. Raven's duties as a guardian. It also fails to show any breach by Ms. Raven that *caused* harm to Ida. Put differently, the DSHS Decision does not show, based on the record as opposed to speculation, what duties of Ms. Raven that if done appropriately would have led to Ida receiving and accepting the care she needed.

2. Duties and Limitations on Legal Guardians

The duties of a guardian of the person are set forth in RCW 11.88 and 11.92, particularly in RCW 11.92.043. Nowhere in the statutes or any case law is it stated that a guardian must ensure receipt of services or that a guardian is the guarantor against all ills.

RCW 11.92.043(1) requires the guardian of the person to file with the court a personal care plan that includes an assessment of the incapacitated person's needs and the guardian's plan for meeting those needs. RCW 11.92.043(2) requires annual reports with information about the incapacitated person's mental and medical status, services received, the guardian's activities and the like. RCW 11.92.043(3) requires reporting to the court within 30 days any substantial change in the

incapacitated person's condition. Ms. Raven fulfilled all of these duties. AR 635, 1514-1518, 1519-1523, 1524-1533.

RCW 11.92.043(4) is a general statement of the guardian's duties and requires that the guardian of the person:

> Consistent with the powers granted by the court, to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs, assert the incapacitated person's rights and best interests.

Selectively quoting a few words from the above statute ("to care for and maintain the incapacitated person in the setting . . . appropriate to the incapacitated person's personal care needs") could lead one to conclude that Ms. Raven should have put Ida in a nursing home or other treatment facility where she could have received more consistent medications and personal care. However, RCW 11.92.043(4) also requires a guardian to assert the ward's rights, and other statutes expressly limit the guardian's authority.

RCW 11.92.043(5) requires a guardian of the person to provide consent to health care "consistent with RCW 7.70.065."

The referenced RCW 7.70.065 is the substitute decision making statute, applicable to guardians and other surrogates, and intended to preserve the incapacitated person's right of self-determination when exercised by a surrogate:

> Before any person authorized to provide informed consent on behalf of a patient not competent to consent . . . exercises that authority, *the person must first determine in good faith that that patient, if competent, would consent to the proposed health care.* If such a determination cannot be made, the

> decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

RCW 7.70.065(1)(c) (emphasis added).

In the landmark case of *In re Guardianship of Ingram,* 102 Wn.2d 827, 836, 689 P.2d 1363 (1984), the Washington State Supreme Court held that in effectuating substituted judgment, "[t]he goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances, including her present and future competency." *Id.* at 839. Moreover, "the ward's expressed wishes must be given substantial weight, even if made while the ward is incompetent." *Id.* at 840. "If the ward, despite her inability to understand her needs, is persistent and determined in her preference, it should be given additional weight in the determination." *Id.* at 842. (citation omitted).

A guardian is further constrained by RCW 11.92.190, which prohibits a guardian from detaining a ward in a residential treatment facility against her will:

> No residential treatment facility which provides nursing or other care[5] may detain a person within such facility against their will. Any court order, other than an order issued in accordance with the involuntary treatment provisions of chapters 10.77, 71.05, and 72.23 RCW, which purports to authorize such involuntary detention or purports to authorize a guardian or limited guardian

[5] The statute does not define the phrase "residential treatment facility which provides nursing or other care," but clearly it would apply to nursing homes, adult family homes and boarding homes. These are residential care facilities that provide nursing or other care. *See,* RCW 18.51, 74.42; RCW 70.128; and RCW 18.20. By contrast, a hospital is a treatment facility but not a *residential* facility, so RCW 11.92.190 would not apply to it.

to consent to such involuntary detention on behalf of an incapacitated person shall be void and of no force or effect.[6]

The record is clear that while Ms. Raven believed Ida could have received more appropriate care in a nursing home or other group homes, Ida had consistently and repeatedly expressed her opposition to placement in such facilities, so this option was not available to her. Ms. Raven had to do the best she reasonably could with Ida's choice to remain at home.

Ms. Raven's actions must be viewed in the context of her limited authority. It required her to make decisions on Ida's behalf that honestly reflected her good faith assessment of what Ida, with Ida's individual preferences and consistently-expressed views on health care, would have chosen for herself if she were competent to decide, and it prohibited Ms. Raven from placing Ida in a residential care facility against her will.

3. Nurse Delegation Laws Limited Ms. Raven's Options

Nurse delegation is the process whereby a Registered Nurse (RN) can "delegate" certain nursing services to an aide. For services that are delegable, such as the administration of oral medications, the nurse must

[6] RCW 11.92.190 is based on *In re Anderson*, 17 Wn.App. 690, 692, 564 P.2d 1190 (1977), a case in which well meaning parents of a mentally ill young adult had her involuntarily detained in a psychiatric hospital against her will. The *Anderson* court held that because of the liberty interests at stake the involuntary detention process can only be done by the county designated mental health professional (CDMHP, now called DMHP) pursuant to RCW 71.05. Accordingly, a guardian may not place a ward in a nursing home or authorize other restrictive residential treatment care over the ward's objection.

train the specific aide about the specific service for the specific resident, and then evaluate and monitor that delegation. Without nurse delegation, paid aides and caregivers, such as a home health care aide or independent provider, cannot administer medications. RCW 18.79.260(3).

Family members can administer medications without the need to comply with nurse delegation rules because they are not governed by the licensing/certification laws. In Ida's case, until nurse delegation was in place, the only individuals who could administer medications to Ida were the hospice nurses and family members. Hospice nurses were not present every day or multiple times per day, so they could not be the mainstay for medication administration. The only family member living with Ida, and available to administer medications, was her husband Richard.

Nurse Delegation cannot occur if the patient does not have a doctor or ARNP. Nurses cannot, for example, write prescriptions—it is outside their scope of practice. However, doctors and ARNPs can, and nurses work under their direction. RCW 18.79.260(2).

In this case, Ida lost her doctor in May 2006 after the first hospice care agency quit, and then she briefly had an ARNP from mid-June to mid-July 2006. Ms. Raven was not able to obtain a doctor again until mid-October 2006. During the July to October period, no one was serving as Ida's doctor or ARNP, so nurse delegation could not be set up for many

months.[7] Once Ida got a doctor on October 17, 2006, nurse delegation could be put into place. Unfortunately, the Dept. of Health then misplaced the nurse delegations documents until mid November 2006, causing further delays. These were events out of Ms. Raven's control. Her only choice for many months was to work with Richard as best as possible.

D. DSHS Erroneously Interpreted or Applied Guardianship Laws

Ms. Raven's duties were set forth in the March 12, 2004 Order Appointing Limited Guardian of the Person, specifically:

> "The authority of the guardian should be limited as follows:
>
> (1) consent to or refuse medical treatment; and
> (2) to decide who shall provide care and assistance."

The court order gave *limited* guardian of the person authority to Ms. Raven. However, even if Ms. Raven was a full guardian of the person, she still could not have consented to care that Ida had consistently, expressly refused when competent and subsequently, and she still could not have detained Ida in a residential treatment facility against her will.

Thus, DSHS at AR 124-25 erroneously interprets the guardianship duties of Ms. Raven when it states: "Notwithstanding [Ms. Raven's] lack of success in procuring necessary care staff to meet Ida's care needs, she did not seek dismissal as guardian of person for Ida from the court." Her

[7] Ms. Raven's note of 9/26/06 reflects this reality, stating that nurse delegation was set up for three aides "but this will have to be started once Ida is under medical care." AR 1593.

current authority as a limited guardian did not include the duty to hire and supervise care staff, but even if she had obtained more authority, it would not authorize her to override Ida's wishes or create resources that didn't exist. It also is impermissible speculation to conclude that seeking dismissal as guardian would have altered Ida's situation, as no other guardian could have more authority than allowed by law.

The DSHS Decision erroneously held at AR 168-69, without citing any statute or case law, that Ms. Raven was ultimately responsible to "ensure" that Ida received the services she needed. But a guardian cannot guarantee the delivery of care or force treatment in the ward's "best interests." If that were the law, then the wards of guardians who reside in nursing homes would never be neglected, and wards who are homeless and suffer from alcoholism would all be receiving needed out-patient services and doing well, or if they weren't, their guardians could be charged with neglect. That is not the real world.

The DSHS Decision reflected frustration with the constraints of the law, rather than adherence to it. At AR 161-62, DSHS says that Ms. Raven should have placed Ida in a residential care facility "and then deal with whatever opposition she may have expressed at that time." However, Ms. Raven already knew Ida's long-stated opposition to residential care facility, so she could not consent to such placement without violating RCW 7.70.065(1)(c).

The DSHS Decision at AR 164-65 erroneously held that Ms. Raven had the duty to personally inspect Ida's pressure sores in order to become knowledgeable about her medical needs. Ms. Raven is not a medical professional. She received information from the health care professionals taking care of Ida. The expert Tom O'Brien (the only expert found credible) was asked: "Did Resa Raven have a duty to personally examine Ida's body in order to assess her needs?" and responded: "Certainly not." RP 631. No guardian can be an expert in all matters. Ms. Raven's background was in mental health, which is what the GAL recommended. Ms. Raven used her skills and reasonably relied upon the medical professionals to inform her of Ida's medical needs, to provide consent as needed.

The DSHS Decision at AR 166-67 erroneously held that *if* Ms. Raven had made more in-person visits to Ida in late 2006 she "could have re-evaluated her decision not to place Ida in some form of full-time residential facility." This is impermissible speculation. Ms. Raven was in regular contact with the medical and care providers about Ida's skin condition and needs, and already knew Ida's wishes about such placement.

The DSHS Decision at AR 166-67 further erroneously held that more in-person visits would have impressed upon Ms. Raven "the need to immediately retain adequate staffing in the home." This erroneously describes the records and is impermissible speculation. Ms. Raven understood the need for Ida to have more care. The home care agency

serving Ida had been unable to fill the difficult evening shift hours. It was not realistic to expect Ms. Raven, or any guardian, to hire, train and supervise independent care providers. Ms. Raven also had pre-authorized hospital care whenever Ida's hospice providers thought more medical assistance was needed.

DSHS at AR 167-68 erroneously held that "effective results or turning the responsibility over to others who could obtain the necessary result was required." It is an unfortunate but common scenario that a person's medical care needs may not be met in a home setting, but the person wants to stay at home for a variety of reasons. Ms. Raven was trying to respect Ida's long standing wish to remain at home. Ida's rights would not have changed by switching guardians. Moreover, what would it have accomplished to resign as guardian? No other guardian would have had authority to place Ida in a residential care facility, or likely could have obtained more staff when three home care agencies could not. Ida's guardianship was established to try to get care for a very difficult to serve individual. That was not reason to terminate it. Again, this demonstrates that the DSHS has no expertise in guardianship law.

DSHS at 167-68 also erroneously held that Ms. Raven "had a duty to let the court know of her need to be released from the guardianship duties based on her decision not to place Ida in a full-time care facility and

her inability to procure staff to meet Ida's basic medical needs in Ida's home." Ms. Raven had kept the guardianship court informed of the difficulties in this case. She was told that she needed to "procure staff"—the meeting notes from the 6/16/06 meeting with AAA and CCS make no mention of this—so there was no need to resign over this issue.

DSHS at 167-68 further erroneously held that *if* Ms. Raven had gone to the court in late 2006, such action "would have impressed upon the court and the Department the immediate seriousness of Ida's situation" and "would have forced the court and the Department to take alternate and possibly more aggressive action in providing care for Ida." This is pure speculation, prohibited by RCW 34.05.461(4). And what could DSHS or the court have done even if they'd been "confronted" by Ms. Raven? Force Ida to accept care? Detain her? Only through the Involuntary Treatment Act, which had already been found not applicable in 2003, 2004, and mid November 2006.

E. DSHS Erroneously Interpreted or Applied the Neglect Law

DSHS has pointed to no care needed by Ida that was not provided *because of* Ms. Raven's conduct or inaction. There is only speculation. When Ms. Raven's conduct is viewed in the context of the various laws constraining Ms. Raven's authority and the conditions in effect at the time of the conduct, it is clear that her conduct did not constitute neglect

under RCW 74.34.020(11). Instead, there were obstacles beyond Ms. Raven's control that limited her ability as a guardian to solve the problems with Ida's care, including: the prohibition against placing Ida in residential care, the refusal of the DMHPs to involuntarily commit Ida, the loss of a doctor/ARNP and the ability to put nurse delegation of medications in place earlier, the further delay when the Dept. of Health lost the nurse delegation paperwork, Ida's refusal to be repositioned frequently, the inherent difficulty of filling a 1 hour evening shift for a combative patient on Medicaid, and a faulty mattress and then a winter storm that rapidly accelerated the downturn in Ida's skin condition. These were external forces beyond Ms. Raven's control. The DSHS Decision failed to show any breach of Ms. Raven's duties that caused harm to Ida. Put differently, it does not show, based on the record as opposed to speculation, what duties of Ms. Raven that if done appropriately would have led to Ida receiving and accepting the care she needed. Ms. Raven is not guilty of neglect.

F. The DSHS Decision is Not Supported by Substantial Evidence When Viewed in Light of the Whole Record

On a number of key facts, the DSHS Decision was incorrect. Without these foundational facts, the DSHS decision cannot stand.

1. Ida did NOT need repositioning every 2 hours

The DSHS Decision states in FOF 6, 59, 75 (AR 99-100,119-121,128-29) and COL 17 (AR 149) and 46 (AR 162-63) that repositioning Ida every two hours, and frequent bathing, were not aspirational goals but basic medical needs required under her Care Plan to prevent skin breakdown. At AR 168-69, DSHS concludes that Ms. Raven was guilty of neglect for failing to ensure this level of service.

However, the reference in Ida's care plans to reposition Ida every two hours was pre-printed *boilerplate* language. The AAA care plans contained the entry "Bedfast all/most of time" and the sentence "Assist the client to change position at least every 2 hours." *See, e.g.*, AR 737-38. Ida's AAA case manager was asked to explain the sentence "Assist the client to change position at least every two hours":

> Q. Now, was this ever explained to Ms. Raven? Do you have any knowledge that this was every explained to her why this was important, the repositioning?
>
> A. *Well, every assessment has this information in it when someone is bed bound, it's always included. The computer automatically includes it in the assessment.*

RP 39-40. In other words, it's boilerplate language. In fact, as expert Tom O'Brien pointed out, it would've never been possible to turn Ida every two hours in a home setting since she did not have night time staff. The individualized care instructions on her care plans instead refer to turning her 2 or 3 times a day, a reflection of the reality of the pain Ida experienced when turned. And moreover, Ida clearly did NOT need

bihourly turning to prevent pressure sores. She was never turned on a frequent basis from 2004 through 2006, yet her pressure sores significantly improved for much of that time. She had 10 pressure sores on her 11/12/04 AAA Assessment, and just 2 pressure sores on her 10/19/05 AAA Assessment. AR 99-100. A visiting nurse on 8/28/06 said Ida had NO skin breakdown on her back, buttocks, back of legs and knees, both heels, inner knees, and outer right knee. AR 863. The hospice nurse and social worker said that Ida had NO pressure sores on 11/4/06. AR 128-29, and RP 169. Something must have been going right to create these results, i.e., Ida's needs were being met, and it wasn't through the frequency of repositioning and bathing called for in the boilerplate care plan language. Thus, the DSHS Decision's criticism of Ms. Raven's failure to provide frequent bathing and repositioning every two hours was built on a house of cards, a misunderstanding of the care plan and Ida's actual needs.

The actual cause of the rapid decline in Ida's skin integrity in late 2006 was due most likely to two factors beyond Ms. Raven's control: (1) a faulty mattress purchased by the new hospice agency in November 2006; and (2) a winter storm that cut the power to Ida's apartment in mid-December 2006 and left her on a hard, deflated mattress. These had nothing to do with the frequency of repositioning or bathing, which were unchanged during this period. [8]

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[8] The 11/21/06 notes and testimony of Hospice nurse Zaire reveal her concern that the new mattress purchased by hospice in mid November 2006 was worsening Ida's skin breakdown. AR 1272; RP 192-193. Hospice wound care nurse Yanisch also noted on 11/29/06 her concern about Ida's mattress: "Patient is developing numerous areas of deep tissue injury. . . Mattress on bed is a Pegasus Bi-Wave product which is very firm and may be contributing to this

Prior to November 4, 2006, Ida did not have more caregivers or receive more repositioning and bathing than later in November and December 2006. Hospice was re-established on 11/4/06, and nurse delegation went into effect in 12/7/06, so presumably she was receiving more care and more consistent medications, making it *easier* to provide care and repositioning. Yet starting in late November 2006, Ida's pressure sores got much worse. The *only* factors that changed during this period were the faulty (too hard) mattress in late November 2006 purchased by the new hospice agency, and the winter storm power outage in mid December 2006 that completely deflated Ida mattress. The only logical explanation is that these two factors were the proximate causes of the rapid decline in Ida's skin condition in late 2006. It cannot credibly be claimed that Ms. Raven was responsible for these events.

2. Ms. Raven was NOT told to hire Independent Provider caregivers

The DSHS Decision adds the assertion that Ms. Raven had been told to hire IPs to fill the evening shift, had a duty to do so, and implies

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breakdown." AR 1287; RP 230. Nurse Zaire further testified that the deterioration of Ida's skin was probably more rapid after the power outage from the winter storm in mid December 2006:

> [T]he deterioration probably was more rapidly after a period of time as she had an air mattress underneath her which deflated so that she was -- during the power outage and that it was because of the hard surface that she laid on for hours at that time. RP 170-71.

that it would have altered the outcome for Ida. AR 122-23, 133, 152. This misrepresents the record and is pure speculation.

In describing the meeting on June 16, 2006 between Ms. Raven, and AAA and CCS, the DSHS Review Decision inserts this sentence in FOF 62 (AR 123): "The option of hiring independent providers was discussed." That is not supported by substantial evidence. The AAA case manager made this assertion in her deposition, RP 49- 50; however, the contemporaneous and detailed notes taken at the meeting of 6/16/06 make no mention of IPs being discussed. *See* AR 1222. Those notes include a specific To Do list for the AAA case manager (check on Nurse delegation, more skilled nursing, get increased DSHS hours); for the CCS supervisors (replace workers—primary and backups, explore nurse delegation eligibility, schedule workers); and for Ms. Raven (find physician, coordinate with hospice). These three professionals were working as a team and each had their assignments. There was *no* mention of IPs.

The DSHS Decision at AR 145 states that where a contemporaneous business record conflicts with memory testimony of a witness, the Review Judge will rely upon the business record in supplementing a finding of fact. That should have been done here, rather than accepting the later self-serving deposition testimony of the AAA case manager.[9] [10]

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[9] ALJ Ross found in her Credibility Determination that Ms. Raven was credible and that many of the other people involved in Ida's care were not because they were looking for someone to blame for Ida's horrible condition. In AR 157-58, the Review Judge rejected the ALJ's credibility finding regarding the other

Moreover, there were inherent difficulties in hiring any workers for the short evening shift. These difficulties would not go away just because the caregiver was hired by a guardian rather than a home care agency. Many would argue that being hired by a home care agency is more attractive because of the prospect of other jobs. The difficulties were inherent to who Ida was (suspicious, paranoid, resisted care and had burned bridges with virtually every care provider for 10 years), and inherent in the very difficult time slot to be filled, which, the AAA case manager said "is pretty much impossible to get caregivers to do."[11]

Both the ALJ and Review Judge also held that it was speculative as to whether IPs would have had the skills to serve a difficult patient like Ida. AR 122-23. DSHS engages in speculation when it implies at AR 154 that Ms. Raven could have hired IPs and that this would have altered the outcome for Ida. This is unrealistic and not supported by substantial evidence in the record.

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people. That decision should be re-visited, given this inconsistency with the contemporaneous records, and the requirement in RCW 34.05.464(4) that the Review Judge "shall give due regard to the presiding officer's opportunity to observe the witnesses."

[10] The only time that IPs were mentioned to Ms. Raven was on February 24, 2006 when the AAA case manager said that she may need to consider hiring IPs to fill the evening shift. The AAA and the CCS home care agency then continued to try to find workers willing to fill this difficult shift. There are NO subsequent entries in the records of anyone ever again asking Ms. Raven to consider hiring IPs. AR 122.

[11] The evening shift was to start at 7 p.m., a difficult time to get caregivers. AR 812. The AAA case manager was not optimistic, noting in her file on January 20, 2006 after a staffing meeting, "Another issue that may prove impossible is staffing. We may not be able to find someone who is willing to come to client's home 3 times per day for ½ hour even if we are granted permission to authorize 2 caregivers." AR 815.

3. Ms. Raven did Not Have a Duty to Visit Ida Monthly nor did Her Not Doing so *Cause* Ida Harm

The DSHS Decision selectively quotes Ms. Raven's expert Tom O'Brien to try to create a standard for frequent in-person visits by the guardian. AR 149, 164-65. Mr. O'Brien wrote training materials—which are not the same as statutes—recommending monthly visits as a general rule. But Mr. O'Brien testified that in this case: "*I don't think that it would have changed a thing.*" RP 645. And Ms. Raven had met extensively with Ida in August and October 2006 during a hospital stay and doctor appointment, and for four hours on November 4, 2006 to set up new hospice care. She then was in frequent contact with the array of health care providers taking care of Ida on an almost daily basis. Ms. Raven was well informed of Ida's condition and needs. During the winter storm in December 2006, she was trapped in her house and without electricity or phone service until 12/21/06. When she could communicate with hospice on 12/21/06, Ms. Raven again said that she would consent to sending Ida to the hospital or acute care if that was needed, but hospice said it was unnecessary, and that a change in Ida's care was needed but not urgent. AR 139-41; RP 154. It is impermissible speculation to hold that visiting Ida more often in November/December 2006 would have changed the outcome for Ida.

4. Ms. Raven Made Many Efforts to Obtain Medications and Care for Ida

The DSHS Decision at AR 162-63 and AR 165-66 asserts, without support in the record, that Ms. Raven failed to take action to try to remedy the very difficult

situation she was faced with in meeting Ida's needs, and that following the June 2, 2006 hearing before Thurston Co. Judge Strophy, she appears to have just "thrown up her hands" in frustration and let Ida deteriorate. Nothing could be further from the truth. A review of the record shows the many efforts made by Ms. Raven:

1. After 6/2/06, Ms. Raven made a referral to APS to investigate possible neglect by Ida's husband Richard and the worker Pam. AR 1589. APS concluded on 6/12/06 that it could not substantiate neglect or do anything with the case. AR 877.

2. 6/16/06, Ms. Raven met with the AAA case manager and supervisor, and CCS case manager and supervisor, described above. AR 878, 1590, 1969-70.

3. 6/21/06, CCS reports to Ms. Raven that it has found replacement caregivers, one is nurse delegable. They say all new caregivers will be ready by 7/1/06. Ms. Raven locates an ARNP new to the area who has agreed to pick up the case and can prescribe medications. AR 1590.

4. 6/26/06, Ms. Raven obtained 30 days dosage of Lorazapam and Methadone for Ida. AR 1590.

5. 6/30/06, Ms. Raven and the AAA case manager are informed by CCS that they have three nurse delegated workers ready to step in, but CCS wanted to wait until its case manager was back from vacation 7/10/06. Ms. Raven calls CCS on 7/12/06 and is told there's now only 1 trained aide. AR 860, 1591.

6. 7/18/06, Ms. Raven is contacted by Ida's new ARNP and informed she's taken a job with an agency and cannot take individual clients to the agency. Ida is again without a health care provider who can write prescriptions. AR 1591; RP 599-600.

7. 7/27/06, Ms. Raven again calls Assured Hospice, who says they'll talk to their medical director to see if he'll write prescriptions for Ida. *Id.*

8. 8/8/06, Ms. Raven calls Ida's AAA care manager, tells her she's "exhausted all possibilities of a physician for client," has spoken to both hospice agencies, and Ida will be out of medicine in about 1 week. AR 862.

9. 8/15/06, Richard reports that Ida is out of meds and becoming combative. Ms. Raven arranges for ambulance transport to the ER. 8/17/06, Ida is examined, has a UTI, is given two months prescription of Percocet, Ativan, and anti-biotics. AR 862, 1591. Ms. Raven talks to the hospital social worker and is given a list of doctors who may take Medicaid patients. She calls all of them and none are taking new patients. RP 600-01; AR 1592.

10. 8/31/06, Ms. Raven is able to make an appointment for Ida at Sea Mar because the receptionist was unfamiliar with Ida and booked her as a new patient. The soonest appointment was for October 16, 2006 with Dr. Spencer. AR 127-28, 1592.

11. 9/26/06, Ms. Raven is told by CCS of injuries to their caregivers from Ida. Richard is giving Ativan an hour before workers arrive, but needs to give it on a regular basis to counteract chronic anxiety. Ms. Raven reviewed medication dosages with CCS and communicated need for Richard to administer the meds as prescribed. Nurse delegation is set for three aides at CCS but cannot begin until Ida has a doctor/ARNP. AR 1593.

12. 9/29/06, hearing before Judge Strophy for Annual Personal Care Report, described below.

13. 10/3/06, Ms. Raven is informed that Ida is out of medications. On 10/4/06, she calls a friend who is a hospital social worker and he is able to obtain Ida a two week prescription for Ativan. AR 1593.

14. 10/6/06, Ms. Raven writes to Sea Mar's Dr. Spencer, telling of how she is "desperately in search for services that will allow Ida to receive hospice care" for Ida, described above. AR 2064-65.

15. 10/16/06, doctor visit at Sea Mar for Ida, Ms. Raven, Cheryl with Dr. Spencer, who decided she wanted a new hospice team, Providence Hospice, to take over Ida's care at home. AR 1593-94.

16. 10/19/06, Ms. Raven visits Ida and notices the home reeks of urine. She complains and is told that because Ida had recently run out of medications and was hurting the aides, they were instructed to back off. AR 865, 1594.

17. 10/23/06, Caregivers at Ida's apartment did a "mini-dig out" because the apartment had not passed the public housing inspection. Caregivers found 50 bottles of medications, some with Ida's name on them, hidden in plastic bags under piles of newspaper and clothing. AR 867, 1594.

18. 10/27/06, the AAA case manager and APS investigator examined all the medication bottles and determine that only 2 or 3 of the bottles were Ida's and the remainder Richard's, who had not consistently taken his medications for the past two years. AR 867, 869, 1594. *These findings help explain some of the erratic behavior of Richard, but also seem to show that overall Ida was getting her medications.*

19. 11/4/06, Providence Hospice service begins for Ida. Ms. Raven visits. Ida is pleasant and has no pressure sores. AR 1595; RP 169.

20. 11/15/ 06, Ms. Raven is contacted by the Providence hospice social worker who says Ida won't let the nurse do anything, is agitated, and that Richard is giving expired medications if at all. The caregivers are not nurse delegated so they cannot intervene. Ms. Raven called the AAA to get them to pressure CCS to "get them on the issue of nurse delegation ASAP." Ms. Raven also was called by the DMHP and urged involuntary commitment of Ida to stabilize her, but Ida was deemed not detainable. AR 1595.

21. 11/16/06, the AAA case manager and Ms. Raven are informed that the State Department of Health lost the CCS workers criminal background check paperwork and just found it in a mail bin. It is hoped that nurse delegation will be set up in a week. AR 870, 1595.

22. 11/22/06, Ms. Raven is phoned by the hospice social worker who is upset over a worsening pressure sore on Ida's coccyx and urine burns on her legs. Ms. Raven tells the hospice social worker that "I will support their medical team seeking emergency medical care for Ida at any point that they feel it is warranted so long as they also obtain the approval from Ida's doctor, and we all understand there is a risk whenever such a medically fragile person as Ida is transported to the emergency room." The social worker tells Ms. Raven that hospice can arrange an inpatient stay for up to five days if needed, and that the hospice staff is settling into the case. AR 1596.

24. 12/7/06, the AAA case manager is called by the CCS nurse delegator and informed that she has seen Ida with her caregivers and they are all nurse delegated at this time. The RN says they will assist with medications and that Ida may have a pain patch and gel medication. AR 871.

This is the real world of a Medicaid, homebound patient, who suffers from mental illness, has no doctor (for most of the period) and a dysfunctional family. To blame Ms. Raven, or say that Ms. Raven "threw her hands up" in frustration, is incorrect and an unwarranted insult. To say that a guardian can ensure actual receipt of services is wildly unrealistic.

5. Ms. Raven DID Inform the Court of Ida's Condition

The DSHS Decision at AR 165-68 incorrectly asserts that Ms. Raven did not adequately inform the court of Ida's condition and the difficulties obtaining services. This is not the case. Ms. Raven's Initial Personal Care Plan on 6/11/04 told the court that she had not been able to locate a doctor for Ida. She said: "at this point it is not productive or feasible to attempt to force Ida to accept medical treatment. The risk of her trying to harm herself through starvation increases when she feels pressured to participate in treatment that she does not want." AR 1517.

In her first Annual Personal Care Plan on 9/15/05, Ms. Raven reports that Ida is doing well physically, has no major pressure sores, that her mental condition fluctuates, and that Ms. Raven has still not been able to locate a physician willing to serve her. AR 1519-21.

Ms. Raven's Petition for Direction to the court on May 25, 2006 told the court of the entire dynamic of the case, including "a cantankerous, medically fragile and psychotic ward, a hostile, enmeshed caretaking staff, and a family in relentless denial." AR 1527. She reported the loss of hospice care and doctor, and said that although she did "not expect any magic solutions from the court or any other quarter for that matter, I welcome and seek any direction that is available." AR 1530.

Ms. Raven's Annual Personal Care Report on 9/29/06 reported the many problems she had with the caregivers, as she reported in her Petition on 5/26/06. She reported Ida's doctor and hospice quit earlier that year because of caregiver problems, that Ida ran out of medicine and then temporarily was served by an ARNP, and that she had an appointment with Sea Mar and hoped to get a doctor again at that point. AR 1551-53.

In short, the record shows that Ms. Raven kept the court informed of the many problems with this difficult client and the court never asked Ms. Raven to terminate her role as guardian or to proceed differently than she had. The guardianship court is in a better position than the DSHS Review Judge to determine whether Ms. Raven has fulfilled her duties.

G. The Standard of Proof for Neglect Should be by Clear, Cogent and Convincing Evidence

In *Nguyen v. State, Dep't of Health Med. Quality Assurance Comm'n,* 144 Wn.2d 516, 29 P.3d 689 (2001), *cert. denied,* 535 U.S. 904

(2002) and *Ongom v. Dept. of Health,* 159 Wn.2d 132, 134, 148 P.3d 1029 (2006) the Court held that a state-issued professional license or certificate may only be revoked upon the presentation of clear, cogent, and convincing evidence. *Ongom* and *Ngyuen* focused on the impact that revocation or suspension would have, stating in *Nguyen* that a disciplinary proceeding would subject the doctor "to grave concerns which include the potential loss of patients, diminished reputation, and professional dishonor." Favorably quoting U.S. Supreme Court law, the *Nguyen* court held that the clear, cogent and convincing standard was "necessary to preserve fundamental fairness in a variety of *government-initiated proceedings* that threaten the individual involved with `a significant deprivation of liberty' or `stigma.'" *Nguyen, id.* at 527-28.[12]

Here, a final finding of "neglect" will have a devastating impact on Ms. Raven's livelihood as a licensed mental health counselor and certified professional guardian; however, but the standard of proof used by DSHS to prove neglect in this case was by a "preponderance of the evidence in the record." AR 145.

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[12] The evidentiary standard of proof is a procedural due process protection under the federal and state constitution. If the question asked is of high importance to the affected party, then the standard is higher. The intermediate standard of clear, cogent and convincing evidence applies to civil matters where the interest protected is more than a mere monetary judgment. Common to these proceedings is a decision that is long lasting or negatively reflects on the character of an individual. *Mansour v. King County,* 131 Wn. App. 255, 263-67, 128 P.3d. 1241(2006). An upheld finding of neglect clearly fits this criteria.

A finding of neglect would permanently bar Ms. Raven from working unsupervised with children or vulnerable adults, RCW 43.43.842 (a harsher punishment than the suspension in *Ongom.*) A finding of neglect is placed on the DSHS state registry, available to *anyone* with Internet access. WAC 388-71-01280. This would surely bring "diminished reputation, and professional dishonor" upon Ms. Raven. In addition, such a finding would seriously threaten her future employment in her chosen field. Under RCW 43.43.834(1) and (2)(b), any business, organization or person that serves children or vulnerable adults *must* require job applicants to disclose criminal backgrounds and any civil adjudicative proceeding, as defined in RCW 43.43.830, which includes findings of neglect.

Thus, an upheld finding of neglect would haunt Ms. Raven at every turn, foreclosing her working with facilities and nearly all agencies, businesses or organizations that serve children or vulnerable adults. Those are the two groups of people she has worked with and on behalf for years, and devoted years of effort, training and education to better serve, and now intends to focus on serving the elderly as a gero-psychologist. With liberty and property interests of this magnitude, due process and justice require that the DSHS prove this alleged "neglect" by a higher standard than mere preponderance of the evidence.

H. Ms. Raven Should be Awarded Fees and Costs on Appeal

Under the Equal Access to Justice Act (EAJA), "a court shall award a qualified party that prevails in a judicial review of an agency action fees and other expenses, including reasonable attorneys' fees, unless the court finds that the agency action was substantially justified or that circumstances make an award unjust." RCW 4.85.350(1).

DSHS must prove that its Review Decision was substantially justified and had "a reasonable basis in law and fact." *Aponte v. DSHS*, 92 Wn.App. 604, 623, 965 P.2d 626 (1998); *Hunter v. Univ. of Washington*, 101 Wn.App. 283, 294, 2 P.3d 1022 (2000). It is "the government's burden" to demonstrate that Petitioner's attorney's fees should be denied. *Aponte, id.* at 623.

The DSHS action in this case did *not* have a reasonable basis in law and fact. DSHS reversed a well-reasoned Initial Order by ALJ Ross, who had presided over the five day fair hearing. The DSHS Review Decision reached conclusions of law that misinterpreted the law, were unsupported by the facts, and engaged in impermissible speculation.

The trial court's award of attorney's fees under the EAJA is not to be disturbed absent a clear showing of abuse of discretion. *Constr. Ind. Training. v. Wash. Apprentice*, 96 Wn.App. 59, 66, 977 P.2d 655 (1999). Statutory fees of up to $25,000 can be awarded for each level of judicial

review, including before the Court of Appeals. *Costanich v. DSHS*, 164 Wn.2d 925, 935, 194 P.3d 988 (2008). Ms. Raven requests that the court's award of fees and costs under the EAJA be affirmed, and that she be awarded fees and costs on appeal under the EAJA and RAP 14.2.

V. RELIEF REQUESTED

WHEREFORE, Petitioner requests that this Court grant the following relief:

1. Enter an Order Affirming the Reversal by the Pierce County Superior Court of the DSHS Review Decision and Final Order, and affirming the ALJ's Initial Order dismissing the finding of neglect;

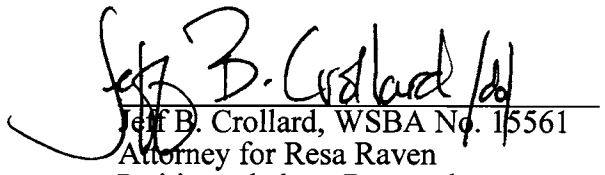
2. Enter an Order Affirming the Award of Attorney's Fees and Costs by the Pierce County Superior Court;

3. Award attorney's fees and costs on appeal pursuant to RCW 4.84.350 and RAP 14.2; and

4. Such other relief as the Court deems just.

Dated this 20th day of September, 2010.

CROLLARD LAW OFFICE, PLLC



Jeff B. Crollard, WSBA No. 15561
Attorney for Resa Raven
Petitioner below, Respondent on appeal

CERTIFICATE OF SERVICE:

I certify that on the 20th day of September, 2010, a true and accurate copy of the above titled document in this matter was served in the manner indicated below on:

Catherine Hoover, AAG
Office of the Attorney General
7141 Cleanwater Drive SW
PO Box 40124
Olympia, WA 98504-0124
By email: CatherineH1@atg.wa.gov
And First Class Mail

Dated this 20th day of September, 2010.

Diane Oggoian
Paralegal

FILED
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DIVISION II
10 SEP 20 PM 2:43
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BY
DEPUTY