

NO. 40809-1-II

ORIGINAL

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

RESA RAVEN,

Respondent,

vs.

WASHINGTON STATE DSHS,

Appellant.

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STATE OF WASHINGTON
BY _____
COURT OF APPEALS
DIVISION II

REPLY 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

P.M. 1-21-2011

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WAC 388-02-0220(2)2
WAC 388-71-0128022

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I. INTRODUCTION

The Department of Social & Health (DSHS) adopts a new standard for Resa Raven, saying that she was required to “try all reasonably available options to secure the care needed by her ward.” DSHS Brief at 22, 21. The DSHS Review Decision and Final Order, which is before the Court, applied a sterner test, holding in COL 56 that Ms. Raven “was ultimately responsible to ensure” that Ida’s care needs were met. AR 168. However, under either standard, in this extraordinarily sad case, one must conclude that no guardian can ensure receipt of services, and that Ms. Raven did in fact try all reasonably available options to help Ida.

II. LEGAL ARGUMENT

A. Interpreting the Definition of “Neglect”

A basic principle of jurisprudence is that one should not be punished for things that are not one’s fault. Criminal law is not supposed to put innocent people in prison. Civil law is not supposed to make people pay who did not breach the contract or breach a duty and cause harm. The same is true for a finding of neglect:

(e) *Factors beyond the individual’s control.* A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

42 C.F.R. §488.335(e). The above regulation specifically applies to allegations of neglect by a nursing home employee. It should have been considered by the DSHS Review Judge in this case because no DSHS rule addresses the point.¹ The federal definition of “neglect”² is similar to the state definition (set forth below) and both concern the care of vulnerable adults. The principle is the same: one cannot be guilty of neglect if the harm that occurred was caused by factors beyond the person’s control.

Another way to put this is there must be *causation* between the alleged breach of duty and the bad outcome. Neglect is defined to mean:

(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; . . .

RCW 74.34.020(12). The first part of this definition says there must be a “pattern of conduct or inaction” that fails to provide “goods and services”—i.e., the conduct or inaction must *cause* the goods and services to not be provided. The second part of this definition says that, alternatively, the pattern of conduct or inaction must fail to “prevent

¹ “(2) If no DSHS rule applies, the ALJ or review judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, and court decisions.” WAC 388-02-0220(2).

² “*Neglect* means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” 42 C.F.R. § 488.301.

physical or mental harm or pain”—i.e., the conduct or inaction must *cause* the harm or pain to not be prevented. In other words, if the harm or pain is *caused by other factors beyond the control* of the person accused of neglect, then the harm was not caused by that person, and he or she is not guilty of neglect.³

DSHS now argues that “Ms. Raven could have fulfilled her fiduciary duty by taking some action, and the neglect finding against her would fail.” DSHS Brief at 26. Ms. Raven took many actions. But she could not control the outcome. DSHS now argues that it is immaterial whether Ida’s overall condition would have been changed by more actions from Ms. Raven. DSHS Brief at 26. That is not the holding of the DSHS Decision, where the Review Judge held that Ms. Raven was guilty of neglect because of her “failure to ensure these critical care needs were met.” AR 168. And held that: “*Attempts* at remedying Ida’s untenable situation were not enough—effective *results* or turning the responsibility

³ DSHS also comes up with the strained interpretation that “neglect” can occur when there is no harm, apparently because the word “harm” is not used in both parts of the definition. DSHS Brief at 24-25. Courts avoid a literal reading of a statute if it would result in an unlikely, absurd or strained consequence. *State v. Elgen*, 118 Wn.2d 551, 555, 825 P.2d 314 (1992). In the neglect definition, the goods and services not being provided are those needed to maintain the person’s health, so to be applicable, their absence must have a deleterious effect on the person. This is harm from the absence of goods and services as opposed to harm from other conduct or inaction. Also, while it is true that RCW 74.34 was passed in part to prevent harm, which is why RCW 74.34.110(2) allows for a petition for a protection order against threatened abuse or neglect, neglect is distinct from threatened neglect. Neglect requires harm and it must be the result of the conduct or inaction of the person accused of the neglect.

over to others who could obtain the necessary results was required.” COL 55 at AR 167 (emphasis in original).

DSHS’ interpretations of the definition of neglect and a guardian’s duties are not supported by any case law. They demonstrate what Pierce Co. Superior Court Judge van Doorninck repeatedly called “unrealistic” and “unreasonable.” DSHS’ position would lead to the conclusion that Ms. Raven is guilty of neglect regardless of the causes and factors beyond her control. DSHS has not contested Ms. Raven’s observation, which is still accurate, that DSHS does not administer the guardianship statutes or have any special expertise regarding a guardian’s duties, and that no deference should be given to its interpretation of the duties of a guardian. Raven Opening Brief at 22.⁴

B. The DSHS Criticism of Ms. Raven’s Actions do Not Withstand Scrutiny.

DSHS’ criticism of Ms. Raven’s actions can be summarized as follows: (1) she ignored the recommendations of Judge Strophy, (2) she should have stopped Richard’s interference, (3) she should have hired a different home care agency, (4) she should have hired IPs, (5) she

⁴ Contrary to DSHS’ assertion in fn. 1, Ms. Raven is not required to expressly assign error to individual Findings of Fact. This requirement is found in RAP 10.3(g), but General Order 98-2 for Division II waived the requirement to separately assign error to each FF or COL. As it turns out, Ms. Raven’s Opening Brief in fn. 2 indentified each FF and COL that she expressly challenged, and then referenced the portion of her brief below, found in Clerk’s Papers 163-80, where these challenges are set forth. RAP 10.3(h) requires a separate concise statement of each error by the agency. Ms. Raven has done this in her Opening Brief at 3-4.

ignored Ida's medication needs, (6) these were "reasonably available options" that Ms. Raven should have pursued, and (7) these "inactions" of Ms. Raven resulted in harm to Ida.

1. Judge Strophy's Recommendations⁵

The concerns brought before Judge Strophy by Ms. Raven in her May 25, 2006 Petition for Direction were: (1) Ida's husband Richard, who was very close to Ida and administered most of her medications, periodically reduced or stopped her medications when he felt that they were making her too sleepy and not eating; (2) a CCS home health aide, Pam, agreed with Richard and coached him. Pam was the aide for both Ida and Richard, had worked with them for years, and was the only aide that Ida trusted; (3) in early May, Richard temporarily stopped an anti-anxiety medication because Ida appeared sedated, although it turned out she had the flu. While off the medication, Ida hurt a hospice aide, which had happened before, so (4) Assured Hospice terminated its services on May 17, 2006; (5) Dr. Standaert terminated his services because hospice had pulled out; and (6) Ida now had only a couple weeks of pain medications remaining and no health care provider to prescribe medications. AR 1524-30.

⁵ It should be noted that the DSHS Review Decision and Final Order found that Ms. Raven "did not receive any viable guidance from the court [Judge Strophy]." AR 125. The position in DSHS' briefing is different than the decision before the Court.

Judge Strophy offered the following suggestions to Ms. Raven:

1. He first said that Ms. Raven could place Ida in a nursing home or other facility for better care, even if she resisted. When Ms. Raven pointed out to him the restriction on her authority in RCW 11.92.190, Judge Strophy said “that seems to trump perhaps what I just indicated would be my inclination.” AR 1538-41.

2. He said Ms. Raven could contact the designated mental health professional to see if Ida could be civilly committed. AR 1541-42. This has been attempted twice in 2003 and once in 2004 without success, AR 106, and again without success in mid November 2006. AR 1595.

3. Ms. Raven said her tentative plan was to fire the current CCS home care agency caregivers and hire some from Armstrong home care agency. Judge Strophy and Ms. Raven agreed she had authority to switch caregivers, but neither knew if she could fire Pam, since Pam was also Richard’s aide. AR 1543-47.

4. Judge Strophy said he was “flying by the seat of his pants” but maybe Ms. Raven could file a show cause notice against Richard to bring him into court to send the message that he needs to give Ida her medications. He said he could authorize fees to hire an attorney. He did not know if such a show cause order would be over-reaching, or if Richard was competent, and said perhaps DSHS should file a guardianship

regarding Richard. Ms. Raven said she would talk to Richard about a guardianship petition and “he may be more cooperative.” AR 1544-48.

2. DSHS’ Position Regarding Richard

DSHS is highly critical of Ms. Raven for “ignoring” the option she had of hiring an attorney to “take action against Richard.” DSHS Brief at 10, 32. This criticism has been lodged before. DSHS argued at the administrative hearing that Ms. Raven should have filed a motion to compel Richard to administer her pain medications, but as the DSHS Review Decision noted, DSHS presented “no argument that there would have been a legal basis to file such a motion.” AR 125.

Now DSHS’ attorney has found the legal basis, and opines that “Ms. Raven appears unaware of the court’s inherent and statutory rights to sanction Richard for interference. *See King v. DSHS*, 110 Wn.2d 793, 800, 756 P.2d 1303 (1988); Ch. 7.21 RCW.” DSHS Brief at 33.

King v. DSHS was a child abduction/possible homicide case where a two year old was suspected to have died at the hands of his father, and his twin sibling was badly hurt and now missing. The court ordered the father to disclose the whereabouts of his other son. The man refused and was jailed for contempt of court.

Is this what DSHS proposes for Richard? To threaten him with jail if he refused to give Ida (or force her to take) her medications?

Contempt of court is defined to include the “intentional disobedience” of a “lawful order” of the court. RCW 7.21.010(1). Imprisonment or a fine of up to \$2,000/day can be imposed to coerce performance. RCW 7.21.030. The sanction can only be imposed for failure or refusal “to perform an act that is yet within the person’s power to perform.” RCW 7.21.030(2). There must be a finding by the court that the person has the *present* ability to comply with the order. *Britannia Holdings Ltd. v. Greer*, 127 Wn.App. 926, 933-34, 113 P.3d 1041 (2005).

Richard was the long-time, elderly spouse of Ida. He also was receiving home health care, had many medical problems, and unbeknownst to anyone until November 2006, hoarded and hid a large quantity of his own medications. AR 1551, 869. His health was precarious enough that he died in March 2007, just two months after Ida was taken from their apartment. AR 1603. Ida often refused medications. She had a history of going on hunger strikes if she thought people were trying to medicate her. AR 701. Richard was unable to consistently give Ida her medications, nor did he have the power to force her to take medications. A contempt sanction would have been inappropriate.

Remarkably, DSHS’s position is that “It is immaterial that efforts by Ms. Raven to pursue legal action against Richard . . . may have been unfruitful. The neglect exists because of the inaction by Ms. Raven.”

DSHS Brief at 26. If that is true, how can DSHS say that Ms. Raven's duty was "to pursue reasonably available options"?

What would be accomplished by sanctioning Richard? He was on Medicaid and could not have paid a fine, and if jailed, who would give Ida her medications? Her daughter had two disabled children, an APS "history," and could not take care of Ida. AR 1600. Ida had no doctor for months, and thus no nurse delegation in place, so only family could administer medications. Without Richard, there would be no one.

If DSHS were so concerned about Richard's interference, and felt that it caused Ida to not receive needed care, then why didn't DSHS find Richard guilty of neglect? After the hearing with Judge Strophy, Ms. Raven made a referral to DSHS Adult Protective Services (APS) for possible neglect by Richard and the caregiver Pam for refusing to consistently administer Ida's medications. AR 1588. Within a few days, the APS investigator reported to Ida's AAA case manager that "she can't really do anything with this case. She hasn't found substantiation." AR 858. This conclusion was reached by DSHS, yet it blames Ms. Raven for not taking "action" against Richard.

3. Other Home Care Agencies Were Not Available.

In February 2006, Ida was approved for more home care hours. Her case manager at the Area Agency on Aging (AAA), however, was not

optimistic. The evening shift was to start at 7 p.m., a difficult time to get caregivers. AR 843. And because it took two people to turn Ida, the shifts were short and scattered throughout the day. The AAA case manager noted in her file on 1/20/2006, "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 846. On 2/10/2006, Ida's home care agency, CCS, reported its worker wouldn't agree to work a half hour evening shift. AR 851. The AAA case manager contacted the other two home care agencies, KWA and Armstrong. On 2/13/2006, KWA agreed to inquire. Armstrong didn't have any available workers. AR 851-52. In June 2006, the AAA case manager apparently informed CCS that KWA and Armstrong "didn't have the staffing to fill the need that was – for the three shifts or any of the shifts." RP 300:15-17.⁶

⁶ The DSHS Review Decision found that "at no time did the Department fund the 24 hours per day of personal care that Ida needed." AR 132. The Providence Hospice RN Zaire was asked: "Q: What kind of care should she have been receiving? A: She needed to have 24-hour care in the home so that she could be turned regularly. Q: Is that possible in the home? A: It would be possible given the right resources." RP 171:20-23. This is consistent with the observation by Judge van Doorninck at the 3/26/2010 hearing: "I just don't think there are resources available. If wealthy people can hire private nurses, poor people don't have access to that." VP 10. The difficulty in part lay in the short, scattered shifts. If workers had been paid for longer shifts, they likely would have tolerated Ida's behaviors more readily than being paid for an hour or less to come in and turn Ida, the thing she most fought. This was noted at the 6/16/2006 meeting: "Short Shifts verses one: Workers may be more willing to work one longer shift. (gas cost and timing of schedule)" AR 1222. There was talk of possibly combining Ida and Richard's hours, or of getting an exceptional rate beyond 280 hours for Ida. The state's budget limits, and the short scattered shifts were factors beyond Ms. Raven's control.

On 12/29/2006, when APS was investigating Ida's condition, APS contacted the AAA case manager. The case manager's writes, "Discussed that there are more hours available however the difficulty is with finding a caregiver." AR 875. She called the other agencies and reported back to APS "and let her know that I was not able to locate additional caregivers through KWA or Armstrong." AR 876. A week later, KWA phoned the AAA case manager: "She reports they have not found a caregiver to work with client." AR 879. Armstrong also phoned back: "They have not been able to find any caregivers to work with client. Dee voiced concern that it is hard to find people who will work at night and on weekends especially for a client who is violent. She said she doesn't believe she will be able to staff client fully in any event." AR 879. In short, the other home care agencies were not "reasonably available options."

DSHS is critical of Ms. Raven for not replacing CCS with one of the other home care agencies in June 2006. DSHS Brief at 23. The DSHS Review Decision is not critical of Ms. Raven for this decision. AR 122. The record shows a sensitively considered decision. Ms. Raven weighed the value of keeping Pam, the only aide Ida trusted and who she would let bathe her, against Pam's resistance to some medications. At the meeting with CCS and the AAA on 6/16/2006, a new CCS supervisor got involved and Ms. Raven demanded, and CCS agreed, to replace all the other

caregivers. The AAA case manager recommended staying with CCS. Armstrong was in transition and KWA had few options for nurse delegation. Ms. Raven then learned for the first time about nurse delegation and how it would take the medications out of Richard's hands. She subsequently vigorously tried to find an ARNP or doctor so that nurse delegation could be started. RP 594-96, 301; AR 858-59, 1222. This shows a sensitive, involved guardian, not an inactive one.

4. Individual Providers Were Not a Reasonable Option.

The Department's criticism of Ms. Raven "rejecting" IPs is founded upon one record entry. The AAA case manager asked Ms. Raven on 2/26/2006 to contact Work Source to find and hire caregivers for the evening shift. AR 852. The case manager wrote Ms. Raven "is hesitant to do this as she likes the idea of having a caregiver who is supervised to care for client." When the case manager said that she hadn't been able to find workers for that shift, she wrote Ms. Raven responded "we will just have to do the best we can with what we have." *Id.* This is criticized by the DSHS Review Judge (but not the ALJ), AR 154, and described by DSHS as placing her personal interests over Ida's needs. DSHS Brief at 27.⁷

⁷ The phrase "do the best we can" may be more the words of the AAA case manager than Ms. Raven's. In the assessment and service summary completed by the AAA case manager on 11/12/2004, she writes: "Client has chosen not to see a Dr. for any of her conditions and is non compliant with medications or skin protocol. Her caregivers,

In fact, Ms. Raven's response was a realistic one. She explained that the AAA case manager was frustrated about not finding anyone. Regarding IPs, she testified: "I believe that I responded that, 'Yes, at some point we may need to do that,'" but that she was still trying to sort out whether they could use the existing care agency, and she had concerns about the lack of supervision over IPs. RP 582:1-583:7.

Both the ALJ and Review Judge, at AR 122-23, held that it was speculative as to whether IPs would have had the skills to serve Ida:

It is speculative whether any person available through the Work Source job bank would have had the skills and training to serve a client such as Ida without the supervision and training that would be provided by a home health agency. Ida was a client who took "a lot of supervision resources" Clark test. CCS, which advertised for workers through fliers at Evergreen College, word of mouth, and classified advertisements, was unable to find staff to fill all the hours of personal care the Department had approved for Ida.

Three home health agencies, using all the resources at their disposal, repeatedly were unable to find caregivers willing to work very short, undesirable shifts for this difficult patient. It is wishful thinking to believe Ms. Raven could have done otherwise. She had fewer resources and wasn't in the business—no guardian is—of providing home care. Even if she had found workers, it is doubtful they would have been qualified. The DSHS Decision concludes that Ms. Raven should have

medical guardian and daughter do the best they can to care for client within her boundaries." AR 693.

been willing to find, hire, and supervise IPs, or resign and have another guardian do it. AR 167-68. This conclusion is unreasonable and misses the point. Changing guardians would not have altered the other factors that beset this situation, such as the untenable evening shifts, Richard's interference with medications, the lack of a doctor and nurse delegation, or Ida's resistance to care. The Department's application of the law to facts here is appropriately reviewed *de novo*.⁸

5. Ms. Raven Did Not Ignore Ida's Medication Needs.

It is undisputed that unless Ida had a prescribing provider (ARNP or doctor), nurse delegation could not be set up and only Ida's family could administer medications. Ida did not have a doctor when the guardianship began, and it was only through the dogged efforts of Ms. Raven that a doctor and hospice care was obtained in August 2005. For reasons unknown, nurse delegation was not put into place by the doctor or hospice (or a Fentanyl patch for pain, so that oral pain medications would not have been necessary), so Richard remained in charge of administering medications. The first time Ms. Raven heard about nurse

⁸ As argued in Ms. Raven's Opening Brief, the Review Decision appeared to give great weight to a factual finding it inserted: that the subject of IPs was raised again at the 6/16/2006 meeting, *see* Opening Brief at 38-39, although the DSHS position now is that Ms. Raven might not have been at the 6/16/2006 meeting but that is immaterial: she was told about IPs in February. DSHS Brief at 35. Ms. Raven was at the 6/16/2006 meeting. The notes taken by the CCS supervisor, the AAA case manager, and Ms. Raven, all discuss the tasks assigned to each person involved, with Ms. Raven's being to find a doctor and coordinate with hospice. AR 1222-23, 859-60, 1589. *None* of these contemporaneous records mention anything about IPs.

delegation was in June 2006, RP 595, *after* Ida's doctor and Assured Hospice terminated their services. She then went to great efforts to locate an ARNP, filled in with emergency medications when the ARNP quit, and finally succeeded in obtaining a new doctor on October 16, 2006 because the receptionist at the doctor's office didn't realize Ida had previously been terminated. AR 1592-93, Opening Brief 41-44.

It is not Ms. Raven's fault that Ida's previous doctor and hospice agency did not tell her about nurse delegation, or that Ida had burned the bridge with so many doctors, or that Ida needed transport by ambulance but Medicaid would not pay for an ambulance for routine visits to the doctor, AR 161,⁹ or that the state Dept. of Health had lost the nurse delegation paperwork. AR 870, 1594. It was also not Ms. Raven's fault—no one knew until late October 2006—that Richard had hoarded many medications over the years, a few of which were Ida's.¹⁰ Ms. Raven actively attempted to obtain for Ida the medications she

⁹ This is a good example as to why the professional guardians' Standards of Practice are hortatory but do not establish the elements of neglect. The standards say that a guardian "shall actively promote" the health of the ward by arranging for regular preventative care, including "routine medical examinations." AR 1836. With Ida, this was impossible.

¹⁰ Richard hoarded about 50 bottles of medications, hidden in plastic bags, piles of newspapers and clothing he refused to let anyone touch. AR 867, 1593. The AAA case manager and APS investigator examined all the medications and determined that only about 2 or 3 of them were Ida's and the remainder Richard's. AR 867, 869, 1593. These findings help explain some of the erratic behavior of Richard, but also show that overall Ida apparently was getting most of her medications.

needed. There is no basis, other than hyperbole, for DSHS accusing her of five months of inaction. DSHS Brief at 34.

6. DSHS Misinterprets the Laws Governing Guardians.

DSHS says that Ms. Raven should have put Ida in a residential treatment facility and see how she reacted. AR 162, DSHS Brief at 30. Ms. Raven did not have that luxury. While it's true RCW 11.92.190 prohibits the involuntary detention, not the placement, in a facility, if the guardian already knows in advance that the person does NOT want to be put into a nursing home or other residential treatment facility, as Ms. Raven knew of Ida, then the combination of RCW 11.92.190, 11.92.043(5), and 7.70.065(1)(c) prohibits the guardian from putting the person in a nursing home.

RCW 7.70.065(1)(c) requires the guardian to "first determine in good faith that the patient, if competent, would consent to the proposed health care." Only if that determination cannot be made, is the guardian permitted to choose health care that "is in the patient's best interests."

With Ida, it was well established that she was unwilling to be placed in a nursing home or other residential care facility. AR 103. She had a consistent history of refusing to be permanently institutionalized or taken out of her home. AR 153. As difficult as it was, and as unpopular as it made her with several health care providers, Ms. Raven was correct in

asserting Ida's right to self-determination and resisting the repeated calls to put Ida in a nursing home.

7. Ida's Decline Was Not Caused by Any Breach by Ms Raven, but Instead by Factors Beyond Her Control.

An immovable fact in this case is that on November 4, 2006 Ida had **NO** pressure sores. AR 128-29, RP 169. Similarly, on August 28, 2006, an assessment by a different nurse revealed **NO** pressure sores. AR 864. These findings occurred at the time when Ida only had her CCS caregivers (Pam remained until 10/19/2006, AR 1593), no evening shift, no bihourly turning, no hospice care, no nurse delegation, no second home care agency, and no IPs. Richard administered her medications. There also are no citations to the record by DSHS of Ms. Raven languishing in pain or lying in her feces during this time. Instead, most of DSHS' cites refer to late November and late December 2006, discussed below.

The DSHS argument is that Ida needed to receive adequate medications, to better cooperate with care, to prevent her condition from decline. She needed more frequent turning to prevent pressure sores, more frequent bathing to avoid skin breakdown. Ida's actual assessments show that she had ten pressure sores on 11/12/2004, two on 10/19/2005, "multiple" stage 1 and 2 pressure sores on 1/13/2006,

zero pressure sores on 8/28/2006, and zero on 11/4/2006. AR 99-101. This improvement in Ida's skin during the middle and later part of 2006 may explain why it was not obvious to Ms. Raven or others that Ida needed the evening shift filled, and why no one after the early spring of 2006 again mentioned IPs. This is not to say that Ida's care was perfect. There are reports of Richard periodically withholding medications for reasons he thought were right, but as discussed earlier, Ms. Raven had no practical way of actually controlling Richard.

A chronological look at Ida's decline from mid November 2006 through December shows that it was most likely due to an incorrectly firm mattress supplied by Providence Hospice in mid November, and then a deflated mattress in mid December due to a severe winter storm and power outage. These were factors beyond the control of Ms. Raven, not a failure by her to provide Ida services.

The greatest decline came after the storm and power outage. In December, Ida actually had much more care than prior to November. In addition to her CCS workers, she had a doctor, nurse delegation for medications, a pain patch, two bath aides 3 times a week, and a hospice and/or wound care nurse who visited almost daily. But then external events happened, and unfortunately, Ida also resisted care.

11/16/06—CCS reports Ida has two new sores on her back. AR 870.

11/25/06—hospice wound nurse assesses coccyx pressure sore (her worst one) as stage II or III. AR 1278. (Not stage IV, as the hospice social worker wrote. AR 1367)

11/27/06—Fentanyl patch applied for pain. Pain rating changes from “it hurts” to “denied.” AR 1285. (Most entries to pain in December by hospice indicate either unable to assess, or Ida has pain when moved.)

11/29/06—hospice nurse notes: “New low air loss mattress for pressure redistribution *over past week*. . . Pt is developing numerous areas of deep tissue injury. . . Mattress is a Pegasus BiWave product which is very firm and may be contributing to this breakdown.” AR 1287. (*italics added*), *see also* RP 192-93, 230. Ida has had the new mattress from Providence Hospice about 1 week.

11/30/06—hospice social worker (SW) reports that hospice will be bringing in a new mattress. AR 871.

12/1/06—new Pegasus mattress arrives; 2 bath aides 3/wk. AR 1289.

12/6/06—nurse delegation in place; aides trained to provide meds, including anti-anxiety medication Lorazepam and atypical anti-psychotic medication Risperdal. AR 871

12/6/06 to 12/10/06—pain management flow sheet shows Ida has pain patch and receiving Lorazepam and Risperdal daily. AR 1301.

12/12/06—hospice nurse notes: “Pt verbally cursing & reaches out to grab & pinch—caregivers state pt treats family member the same as nursing staff & caregivers—Duragesic pain patch in place upper back. Pt eats poorly, **non cooperative in any care of herself. Pt wants to lay on back.**” AR 1304. (*bold added*)

12/14/06—“Pt rec’d Risperdal & Lorazepam gel @ 0815—c.g. **Tosha stated she cannot see difference in behavior or comfort.**” AR 1307. (*bold added*)

12/15/06 to 12/17/06—Winter storm and power outage deflates Ida’s mattress and she lies for about 12 hours on the cold, hard floor the first day and on a mat the next two days. **After the power outage, Ida’s stage III pressure sores became significantly worse,** with stage IV

breakdown. AR 139-40. The hospice SW was asked if there was a time Ida's skin breakdown "really began to spiral downward and get significantly worse? A: After the power failure. . . it never stabilized after that, it really spiraled after that." RP 136:12-16. (bold added)

12/14/06 to 12/21/06—Ms. Raven is without power or telephone service from the winter storm, and trapped in her rural home by fallen trees. She talks to the hospice SW on 12/21/06. AR 138, 141. On direct exam the SW says she told Ms. Raven that Ida was in "dire straits." RP 134:2-6. On cross exam, the SW acknowledged that she felt hospice and CCS "had things under control" at that time. RP 154:3-13.

12/22/06—hospice nurse: "coccyx wound getting deeper." AR 1318.

12/24/06—hospice nurse: "**Instructed caregivers that pt should be positioned off coccyx; They responded that she won't stay. Assisted caregivers to position pt on rt side with pillows. Patient immediately pulled out pillows & rolled onto her back although reason for positioning explained.**" AR 1323. (bold added)

12/27/06—hospice assessment: "coccyx 3 4" AR 1328.

Having an additional shift of caregivers at 7 p.m. to reposition Ida would not have changed her compliance with the repositioning. She could have immediately pulled out the pillows and gone back onto her back. It is pure speculation that *if* Ms. Raven had found IPs, they would have stayed with the job, Ida would have cooperated, and it would have made a difference in the outcome of her pressure sores or condition. Findings of fact must be based on evidence. RCW 34.05.461(4). Speculation and inference are not evidence. *State v. Hutton*, 7 Wn.App. 726, 728, 502 P.2d 1037 (1972).

While it may have been a good idea for Ms. Raven to have visited Ida after regaining power on 12/21/06, there is no evidence that it would have made any difference in Ida's condition or outcome. Mr. O'Brien, the only qualified expert in this case,¹¹ testified that Ms. Raven did not have a duty to personally examine Ida's body. RP 657:20-25. He said monthly visits by Ms. Raven would have been better "but I also don't think that it would have changed a thing." RP 645:24-25.¹² A causal link is missing between a breach by Ms. Raven, if any, and the harm to Ida. She is not guilty of neglect.

C. DSHS Minimizes the Real Impact of a Neglect Finding.

The argument of DSHS boils down to this: A neglect finding does not affect Ms. Raven's personal interest that much because it would not prohibit her from being hired on a private basis by an individual in their

¹¹ Mr. O'Brien has worked as a guardian since 1982 and served on the certified guardian board since its inception. Mr. O'Brien was Ms. Raven's expert and testified that in his opinion Ms. Raven did not breach her duty of care as Ida's guardian, either with respects to her visits to Ida, her decisions regarding Ida's care, and her reporting to the court. DSHS's expert, Mr. Deutch, was deemed unqualified. He had served as a guardian in only one case, involving issues very different than in this case. FF 46, AR 115.

¹² DSHS quotes only the first part of Mr. O'Brien's sentence, without quoting the rest: "but I don't think that it would have changed a thing." DSHS Brief at 29. This happens on a number of occasions. Ms. Raven is quoted as noting, "Standard of care would be to change her every two hours." DSHS Brief at 35. DSHS omits the remainder of the sentence: "but this would require nursing home placement, which has its own risks." AR 1586. Ms. Raven's business partner is quoted as saying it may be necessary to immediately go and observe a medically fragile ward after a power outage. DSHS Brief at 29. DSHS omits to explain the context of Ms. Helfrich's answer: she was referring to a case of hers where the medically fragile ward was living alone, had no home care aides, no hospice aides, no one regularly checking on him and Ms. Helfrich knew that his power was out. RP 496:5-19.

own home. DSHS Brief at 39. How many Ph.D. geriatric psychologists, as Ms. Raven is, earn their living by being hired privately?

RCW 43.43.834(1) and (2)(b) says that any business, organization or person that serves children or vulnerable adults *must* require applicants to disclose criminal backgrounds and any civil adjudicative proceeding, which includes findings of neglect. Any business or organization that serves children or vulnerable adults can for \$10 obtain a background check on the person, including any criminal history and final findings of abuse or neglect. <http://www.wsp.wa.gov/crime/crimhist.htm#abuse>. For the price of postage, any person can obtain from DSHS the identity of a person with a finding of neglect, per WAC 388-71-01280:

The department will maintain a registry of final findings and, upon request of any person, the department may disclose the identity of a person or entity with a final finding of abandonment, abuse, financial exploitation or neglect.

A final finding of neglect is the equivalent of a professional death sentence. In a case like this, where so many factors beyond the control of Ms. Raven caused or contributed to the harm suffered by Ida, a finding of neglect against Ms. Raven would be both unfounded and wrong.

D. Ms. Raven Should be Awarded Fees and Costs

In *Costanich v. DSHS*, 164 Wn.2d 925, 931, 194 P.3d 988 (2008), which reversed a DSHS finding of abuse, the Court quoted the purpose of the Equal Access to Justice Act, found after RCW 4.84.340:

[c]ertain individuals . . . may be deterred from seeking review of or defending against an unreasonable agency action because of the expense involved in securing the vindication of their rights in administrative proceedings . . . The legislature therefore adopts this equal access to justice act to ensure that these parties have a greater opportunity to defend themselves from inappropriate state agency actions and to protect their rights.

This is the type of case the EAJA was designed to support. Ms. Raven had to try to defend herself against a powerful DSHS agency if she ever wanted to work again as a geriatric psychologist. It has come at an extraordinary emotional toll and financial cost, summarized in Ms. Raven's declaration and includes lost business and \$100,000 in attorney's fees at the administrative agency level that can never be recouped. Affirming the award under the EAJA of her fees for this judicial review is the fair and just thing to do.

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) (italics added). The issue before this Court is not the DSHS investigation or the initial filing of neglect charges. It is the "agency action"—the DSHS Review Decision and Final Order. *Costanich v. DSHS*, 138 Wn.App. 547, 563, 156 P.3d 232 (2007).

An examination of the cases cited by DSHS do not support its contention that DSHS' action was substantially justified. In *Plum Creek Timber v. Forest Practices Appeal Board*, 99 Wn.App. 579, 993 P.2d 287

(2000), the Court affirmed the state agency and reversed the trial court, so no fees were awarded. In *Silverstreak, Inc., v. Dept. of Labor & Indus.*, 159 Wn.2d 868, 154 P.3d 891 (2007), the Court affirmed the state agency's interpretation of established case precedent and the agency's own regulations saying that dump truck drivers were entitled to a higher prevailing wage for work done on the Sea-Tac third runway construction. However, because the state agency had issued a policy memorandum that contradicted the agency's regulations, and had expressly told the trucking contractor it could pay a lower wage to these drivers, the state agency was estopped from enforcing its regulations against this contractor. Only in that sense, because of the estoppel, did the petitioner prevail. In all other regards, the state agency was affirmed, and thus no fees were awarded.

In Ms. Raven's case, there was clear statutory law restricting a guardian's authority set forth in RCW 11.92.190, 11.92.043, and 7.70.065. There was also long-established case law, such as *In re Anderson* and *In re Ingram* cited in Ms. Raven's Opening Brief, establishing the requirement that guardians give substantial weight to their ward's repeated express wishes, and that guardians are prohibited from forcing wards into treatment for their own good. This was *not* an area of ambiguity. Nor did it involve an agency interpreting its own regulations. This was a *complex* case, but only insofar as one needed to know the various applicable laws,

not because those laws justified the DSHS action. DSHS was WRONG on the law, unlike the state agencies in *Plum Creek* and *Silverstreak*. Its interpretation of the duties of a guardian, to which no deference is given, is filled with misapplication of the law, unreasonable conclusions, and impermissible speculation. The DSHS Review Decision is not substantially justified in law and fact. Justice demands that Ms. Raven's long nightmare be brought to an end and the neglect finding be finally put to rest. Justice also demands that she be awarded her fees and costs in this judicial review, knowing they are only a fraction of the fees and costs she has been burdened with because of DSHS' wrongful actions.

V. CONCLUSION

Resa Raven requests that the Pierce County Superior Court orders below be affirmed, reversing the DSHS Review Decision, and awarding attorney's fees and cost on judicial review and before this Court.

RESPECTFULLY SUBMITTED this 21st day of January, 2011.

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 21 day of January, 2011, 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 First Class Mail

Dated this 21 day of January, 2011.



Ben Drachler
Paralegal

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