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SUPREME COURT OF THE STATE OF WASHINGTON

RESA RAVEN,

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL
AND HEALTH SERVICES,

Respondent.

PETITIONER RAVEN'S SUPPLEMENTAL BRIEF

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I. INTRODUCTION

This case is about a guardian's attempt to respect the rights of her ward, Ida, an elderly retired nurse, to not be forced into a nursing home, and then being blamed for problems in the home care that were beyond the guardian's control. Ida long had resisted care, having absconded out of a window and fled Alaska to avoid nursing home placement, and then for years, while bedbound and living with her husband in Olympia, often refused needed care, fired her doctors, and said she wanted to die at home. In late 2006, Ida developed bad pressure sores after hospice provided an incorrect mattress and a severe winter storm cut power to the new mattress. The guardian, Resa Raven, a geriatric psychologist, was found guilty of neglect by the Department of Social & Health Services for not forcing Ida into a nursing home or "ensuring" her care needs were met at home despite the obstacles.

A "neglect" finding is a professional death sentence, essentially prohibiting all employment with unsupervised access to children or vulnerable adults. The decision below will likely encourage guardians to bully their wards into nursing homes; or if the prospective ward is on Medicaid, like Ida, with fees limited to \$175 a month, to decline the case altogether. Family caregivers are also threatened by DSHS's interpretation that "neglect" under RCW 74.34 does not require causation or even harm.

II. SUPPLEMENTAL STATEMENT OF ISSUES

A. Can a guardian place and detain an incapacitated person in a nursing home or similar residential treatment facility against her will?

B. Can a guardian be held responsible for “ensuring” that the care needs of an incapacitated person are met, regardless as to the legal and practical limitations on a guardian’s ability to obtain necessary care?

C. Can a guardian be guilty of “neglect” of a vulnerable adult under RCW 74.34.020(12)(a) without proof of causation or harm?

D. Can findings and conclusions by DSHS be upheld that are contradicted by the record or based upon impermissible speculation?

III. PROCEDURAL HISTORY AND STANDARD OF REVIEW

The Department charged Ms. Raven with neglect of Ida.¹ After a five day hearing, the Administrative Law Judge dismissed all charges. The DSHS Review Judge partially reversed, entering the final order at question in this case. Pierce County Superior Court Judge Van Doorninck reversed and awarded Ms. Raven \$25,000 in attorney’s fees under the Equal Access to Justice Act. Clerk’s Papers (CP) 1-8; 93-95. The Court of Appeals, Div. II, reversed in *Raven v. Dep’t of Soc. & Health Servs.*, 167 Wn.App. 446, 273 P.3d 1017 (2012).

¹ Per confidentiality provisions in RCW 74.34.095, Ida is referred to by her first name.

The DSHS Review Decision and Final Order is the “agency action” before this Court, not the DSHS underlying investigation or filing of neglect charges. *Costanich v. DSHS*, 138 Wn.App.547, 563, 156 P.3d 232 (2007). In reviewing the DSHS Review Decision under the Administrative Procedures Act, RCW 34.05.510, this Court stands in the same position as the superior court. *Thurston County v. W. Wash. Growth Mgmt. Hr'gs Bd.*, 164 Wn.2d 329, 341, 190 P.3d 38 (2008).

Ms. Raven challenged the DSHS Review Decision on two grounds: that it “erroneously interpreted or applied the law” and that it “is not supported by evidence that is substantial when viewed in light of the whole record.” RCW 34.05.570(d), (e).² The Court reviews *de novo* issues of law, and the application of law to facts. *Tapper v. Empl. Sec. Dept.*, 122 Wn.2d 397, 402-03 858 P.2d 494 (1993). No deference should be given to DSHS’s interpretation of the duties of a guardian because the courts (not DSHS) have the greater experience and expertise in interpreting a guardian’s duties. *Waste Mgmt. of Seattle, Inc. v. Utilities and Transp. Comm’n.*, 123 Wn.2d 621, 627-28, 869 P.2d 1034 (1994) (courts give deference to an agency’s interpretation of a statute only if it is ambiguous *and* within the agency’s special expertise).

² Ms. Raven withdrew her challenge to the standard of proof used in neglect cases. See Raven Answer to Amici WAPG at 2 (8/25/11).

Findings of fact must be based on 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). Key findings in the DSHS Review Decision are not supported by the record or are based on speculation, as discussed at length in Raven Corrected Opening Brief, 34-45, and Motion for Reconsideration, 1-18.³

IV. SUPPLEMENTAL STATEMENT OF THE CASE

A. **Ida resisted needed care and refused nursing home care**

Ida, in her mid 80s during these events in 2006, was a retired nurse with a deep distrust of the medical establishment, and a long history of noncompliance with care. Administrative Record (AR) 105-06, Finding of Fact (FF) 20-25. She sometimes went on hunger strikes if she thought people were trying to medicate her. AR 102, FF 12; AR 701. She often resisted care that was in her best interests: for example, refusing treatment for glaucoma, cataracts, internal bleeding, and an infected foot, telling doctors and a policeman called to her home that she had the right to refuse treatment. AR 102, FF 12; AR 106-07, FF 26-27; AR 2188, 2165.

³ The Court of Appeals incorrectly concluded that Raven limited her challenge to a small number of findings of fact. *Raven id.* at 472, fn. 9. Raven in her Corrected Opening Brief, fn. 2, identified many findings and conclusions she challenged, and referenced the portion of her superior court brief, CP 163-80, where the challenges were discussed.

Since 1997, Ida had been bedridden at home, with contracted legs locked into an open splayed position. Repositioning was extremely difficult and painful. Report of Proceedings (RP) 221-22; AR 1239-40. Ida resisted being turned because it hurt. Also, when caregivers tried to reposition Ida by placing pillows under her side, she would pull them out, despite the benefits being explained to her. AR 99, FF 6; AR 1304, 1323.

The DSHS Review Judge (DSHS) concluded that Ida was not incompetent when she refused health care and that “there was ample evidence” Ida “did not wish to be subjected to procedures that caused her pain notwithstanding the long-term medical benefits such treatments could bring.” AR 104, FF 19; AR 152, Conclusion of Law (CL) 28.

DSHS concluded Ida had consistently refused “to be permanently institutionalized or taken out of her home for medical treatment purposes.” AR 153, CL 28. In the mid 1990s, she fled Alaska to avoid being put in a nursing home. AR 1599. In 2001, despite being bedridden and incontinent, Ida was “unwilling to be placed in a group home or a nursing home” and later would only agree to treatment for bedsores at home. AR 105, FF 21; AR 106, FF 25. In 2002, she repeatedly told hospice she wanted to die at home. AR 107, FF 27; AR 2043, 2045.

The designated mental health professionals (DMHP) evaluated Ida three times in 2003 and 2004 under the Involuntary Treatment Act, RCW

71.05. They refused to detain Ida or to remove her to a nursing home or residential care facility for involuntary treatment. AR 107, FF 29, 30.

In March 2004, a limited guardianship of the person was established based on self neglect. It was unclear whether Ida's refusal of care was due to a temporary urinary tract infection, underlying mental disorder, or choice. AR 109, FF 36. Ida had no doctor, hospice, or nursing care; she was on Medicaid; and no doctor would take her as a patient. AR 108-09, FF 33, 36; AR 105, FF 21; AR 116-17, FF 50-51.

Ms. Raven was appointed guardian because of her mental health background: she was a licensed mental health counselor, had served as a DMHP for years, was familiar with the Involuntary Treatment Act, and now has a Psy.D in psychology, intending to focus on clinical geriatric psychology. AR 111, FF 39; RP 856-57; CP 28. Ms. Raven met with Ida and her family. She determined "in good faith" that Ida "when competent, consistently refused to be placed in a nursing home or other long-term care facility." AR 108, FF 32. Ida wanted "to spend the remainder of her life at home," with her husband Richard. AR 153, CL 28.

B. In late 2006 Ida's condition worsened, but she continued to resist care and nursing home placement.

Because of her immobility, Ida had a history of pressure sores since 2001. AR 99, FF 6. The number of pressure sores varied during the

guardianship from “multiple” to zero, but until mid November 2006 were never worse than stage II—superficial skin breakdown.⁴

Ida was approved in January 2006 for additional care hours, amounting to approximately a one hour evening shift for two aides. Despite repeated efforts, two home health care agencies could not find any aides willing to work this very short evening shift for a combative and complicated patient. AR 846, 851-52; RP 28, 300. Ms. Raven was approached by the DSHS case manager in February 2006 about possibly finding and hiring private caregivers (called Individual Providers (IPs)) for the one hour shift. Ms. Raven was hesitant because she thought the aides should be supervised by an experienced home health care agency. AR 121-22, FF 60. The ALJ found that the issue of the IPs was never raised again. The DSHS Review Judge disagreed and added a finding that the IP issue was discussed again in June 2006. AR 133, FF 88; AR 123, FF 62.⁵

⁴ Ida had 10 pressure sores in November 2004, two in October 2005, and multiple in January 2006. *Ida had NO pressure sores from August 2006 to early November 2006.* AR 100, 101, 128, FF 7, 8, 75; AR 864; VRP 116, 169. Pressure sores are categorized in four stages: stage I (skin redness), stage II (blister), stage III (skin breakthrough), or stage IV (breakthrough to muscle or bone). AR 1950.

⁵ A significant part of the Review Judge’s finding of neglect is based on Ms. Raven’s “failure” to hire IPs for the evening shift. Contemporaneous, detailed notes of a meeting on June 16, 2006 of Ms. Raven and Ida’s case managers included a specific To Do list for each person. Ms. Raven’s tasks included finding a new doctor and hospice care; the home care agency was to replace some of the aides, etc. None of the notes taken by any of the attendees mentioned IPs. AR 1222-23, 859-60, 1589. The IP issue and Ida’s care plan, including incorrect boilerplate language that Ida needed turning every two hours, are discussed further in Raven Corrected Opening Brief, 34-39, and Reply Brief, 9-14.

From August 2006 to early November 2006, Ida had *no* pressure sores, even though during this time she did not have evening aides. RP 116, 169. In mid November 2006, she developed two sores after being given the wrong mattress by her new hospice agency. AR 139, FF 103; AR 1287, 870. The worst of the sores, on her coccyx, was assessed on 11/25/06 and 11/27/06 by the nurses to be stage II or III, *not* stage III or *IV*, as DSHS held. AR 1278; AR 140, FF 106; AR 128, FF 75.

In mid November 2006, Ida was evaluated again for involuntary treatment. Ms. Raven tried to convince the DMHP to detain Ida for stabilization. The DMHP concluded Ida was not detainable or delusional. She mainly had medical issues, was as feisty as two years earlier, and wanted to remain at home. AR 1594-95, 2137; AR 129, FF 77; AR 871.

By early December 2006, Ms. Raven had established home care for Ida consisting of: two home health care aides in the morning and afternoon, two hours per shift, seven days a week, to clean, feed, dress and reposition Ida; two hospice bath aides three times a week; hospice wound care RN nurse visits almost daily and hospice social worker periodically; medications provided by trained aides rather than Richard; a pain patch and anti-anxiety medications; doctor oversight; and pre-authorized hospitalization if hospice and her doctor thought it necessary. Also, an interfering caregiver, Pam, was gone. AR 1278-89, 871, 1593-95.

In mid December 2006, a severe winter storm and power outages hit the area, deflating Ida's mattress for over two days. AR 139-40, FF 104-05. By 12/20/06, Ida had 10 open areas on her back and feet. AR 1282. Nurse entries for 12/23/06 and 12/25/06 indicate they were NOT infected, contrary to *Raven, id.* at 457. AR 1321, 1322, 1324.

Ms. Raven was trapped by the same severe storm and without electricity or phone service from 12/14/06 to 12/21/06. AR 138, FF 101; AR 141, FF 107. She talked to the hospice social worker on 12/21/06, who told her Ida's needs had been met and the situation stabilized, but the social worker thought Ida needed to be in a nursing home. RP 134, 154; AR 169, CL 58; AR 141, FF 108-09. Hospice nurses testified that at this point, approximately 12/21/06, hospitalization for Ida was *not* appropriate or needed. AR 140, FF 106.

Ida's coccyx pressure sore worsened after the storm; the nurses who treated her did not assess it as a possible stage IV sore until 12/27/06 or 12/28/06. AR 1283, 1328; AR 140, FF 106. On 12/29/06, Ms. Raven was called by DSHS and told of Ida's severe pressure sore. Ms. Raven consented to hospitalization, and Ida was admitted to the hospital the next day, 12/30/06. AR 131, FF 80; AR 1596-97. In the hospital, Ida adamantly opposed nursing home placement, and expressed her wish to die. AR 1434. She was discharged to a nursing

home, where she consistently fought against staff care, as detailed in Raven's Petition for Review, 7-8. Ida died two months later. AR 1603.

V. SUPPLEMENTAL ARGUMENT

A. The DSHS Review Decision undermines the guardian's duty to honor an incapacitated person's right of self-determination when the ward's wishes are known.

RCW 11.92 sets forth a delicate balance of duties for a guardian of the person, and strict limits on the guardian's authority. A guardian shall:

(4) . . . 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. [and]

(5) Consistent with RCW 7.70.065, provide timely, informed consent for health care of the incapacitated person. . . .

RCW 11.92.043. The guardian is charged with asserting the ward's "rights and best interests." Ms. Raven established an array of health care professionals and aides to care for Ida at home, which until late December 2006 maintained Ida. While Ms. Raven felt that Ida could receive better care in a nursing home, AR 129, FF 77, she also was constrained by her duty to follow RCW 7.70.065 and the restrictions of RCW 11.92.190. Before consenting to health care, a guardian "must first determine in good faith that that patient, if competent, would consent to the proposed health care," and may choose care in the person's "best interests" *only* if the patient's wishes cannot be determined. RCW 7.70.065(1)(c).

This Court established guidelines for determining an incapacitated person's wishes almost 30 years ago in *In re Guardianship of Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984). Ingram was an elderly woman diagnosed with delusion, paranoia, and moderate dementia. Her guardian sought court authorization to remove cancerous vocal cords. Surgery offered a much greater chance of survival than radiation. Ingram could not comprehend her medical condition, thinking that her throat problems were caused by bad air. She was, however, described as alert, had fluent speech, and repeatedly said that she wanted to keep her voice and did not want surgery, even to avoid death. *Ingram*, 102 Wn.2d at 829-34.

This Court held that: "The 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." *Ingram*, 102 Wn.2d at 839. The Court held this "is a subjective test based on Ingram's attitudes, biases, and preferences, not what most people would do." *Id.* at 844. The Court further held that "the ward's expressed wishes must be given substantial weight, even if made while the ward is incompetent" and "If the ward, despite her inability to understand her needs, is persistent and determined in her preferences, it should be given additional weight in the determination." *Id.* at 840-42.

This Court has said that the guardian's medical decision for an incapacitated person is a "particularized consideration" regarding the "specific individual." *In re Guardianship of Hamlin*, 102 Wn.2d 810, 815, 689 P.2d 1372 (1984). The guardian may use his or her best judgment in exercising the ward's right to refuse treatment. *In re Welfare of Colyer*, 99 Wn.2d 114, 128, 660 P.2d 738 (1983).

The record consistently shows, and DSHS expressly found, that Ida, both while competent and later, repeatedly expressed her strong opposition to placement in a nursing home or other care facility. Ms. Raven, in good faith, exercised her best judgment to honor Ida's right to refuse that treatment, even though it may have been in her "best interests."

RCW 11.92.190, enacted in 1977, further restricts a guardian's authority to detain a ward. RCW 11.92.190 says: "No residential treatment facility which provides nursing or other care⁶ may detain a person within such facility against their will," and renders void any court order authorizing such detention, unless issued under the involuntary treatment laws. Therefore, in combination, RCW 11.92.190, 11.92.043(5), and 7.70.065(1)(c) prohibit the guardian from putting a ward in a nursing

⁶ The phrase "residential treatment facility which provides nursing or other care" is not defined but would apply to nursing homes, adult family homes and assisted living facilities, which are residential care facilities that provide nursing or other care. See RCW 18.51, 74.42; 70.128; 18.20. By contrast, a hospital is a treatment facility but not a residential facility. Ms. Raven consented to hospital care when needed by Ida.

home or similar facility when the guardian knows such placement is against the person's wishes, as Ms. Raven knew of Ida.⁷

Noting that RCW 11.92.190 prohibits "detention" not "placement," the DSHS Review Decision held that Ms. Raven should have put Ida in a residential care facility when her medical condition was deteriorating and dealt "with whatever opposition she may have expressed at that time." AR 161-62, CL 44.⁸ Ms. Raven already knew of Ida's long opposition to nursing home placement, stated even when bedridden and ill, so she could not consent to such placement without violating RCW 7.70.065(1)(c), 11.92.043(5), and the holdings of *Ingram*, *Anderson*, *Hamlin*, and *Colyer*.

B. DSHS erroneously holds Ms. Raven to the impossible standard of "ensuring" Ida's needs were met, making the guardian a guarantor of her ward's care.

The DSHS Review Decision held that Ms. Raven was "ultimately responsible to ensure" that Ida's critical care needs were met, and her failure to "ensure" that Ida's needs were met constituted neglect. AR 168,

⁷ RCW 11.92.043(5) also prohibits a guardian from consenting to inpatient psychiatric care for a ward. *See also In re Anderson*, 17 Wn.App. 690, 692, 564 P.2d 1190 (1977) (mentally ill adult cannot be involuntarily detained in a psychiatric hospital except pursuant to the involuntary treatment laws).

⁸ DSHS misconstrues the record underlying this conclusion. Ida's pressure sores did not deteriorate significantly until after the 12/15/06 to 12/17/06 winter storm. VRP 169, 136. On 12/25/06, her sores were *not* infected, and she did *not* have a stage IV pressure sore until 12/27/06 or 12/28/06. AR 1324; AR 1283, 1328. The Review Judge erroneously found that Ida had horrendous open wounds "in the latter part of 2006," and described the stage IV pressure sores she had on 12/29/06 as though this were Ida's condition during November and December 2006. AR 116, CL 53; AR 162, CL 44; AR 128-29, FF 75.

CL 56. DSHS further held that “*attempts* at remedying Ida’s untenable situation were not enough—effective *results* . . . [were] required.” AR 167, CL 55. This is a *per se* liability standard, unsupported by any statute, regulation or case. Guardians cannot guarantee the delivery of care, control factors outside their control, or force care upon their wards. If this were the law, all guardians of homeless wards would be guilty of neglect. The better and more appropriate standard is that a guardian should pursue every *reasonably available* care and service option needed by a ward.

DSHS also held that if Ms. Raven could not ensure results, then “turning the responsibility over to others who could obtain the necessary results was required,” and that Ms. Raven had the duty to tell the court “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 care needs in Ida’s home. . . Such action would have forced the court and [DSHS] to take alternative and possibly more aggressive action in providing care for Ida.” AR 167-68, CL 55.

Speculation is not evidence and cannot be the basis for a finding in an agency action. RCW 34.05.461(4); *State v. Hutton, id.*, 7 Wn.App. at 728. A different guardian would not have had more authority to force Ida into a nursing home, cooperate with care, or altered the occurrence of the winter storm. The court could not have removed Ida absent an

involuntary treatment proceeding, which the DMHPs had repeatedly declined. DSHS, in response to a referral by Ms. Raven, had already concluded it could do nothing about the interference by Richard and Pam. AR 1588, 858.⁹ In late December 2006, DSHS itself contacted the three home health care agencies in Thurston County, and none could find caregivers willing to work a one-hour evening shift. AR 875, 876, 879.

DSHS incorrectly concluded that Ms. Raven failed to tell the guardianship court of the difficulties in the case. AR 167, CL 55. Ms. Raven did inform the court of the great difficulties she had in obtaining a doctor and hospice care, of subsequently losing that care, of Ida's condition, and the entire dynamic with the caregivers and family, in four frank reports on 6/11/04, 9/15/05, 5/26/06, and 9/26/06. *See* AR 1514-64, 1567-1604; Raven Corrected Opening Brief, 44-47. The court never asked Ms. Raven to resign as guardian or to proceed any differently.

DSHS's conclusion that Ms. Raven "threw up her hands" in frustration and "let [Ida] deteriorate," or that Ms. Raven displayed a "lack of attention and remedial action," is not supported by the record. AR 166, CL 51; AR 168, CL 56. Ms. Raven has set forth in detail the many steps she took to try to get better care for Ida, including her repeated attempts to

⁹ Before the Court of Appeals, DSHS also offered the unworkable idea that Ms. Raven could have pursued contempt charges against Richard, ignoring the fact that Richard was on Medicaid and could not pay a fine, and if jailed, would have left Ida with no daily companion or person to administer medications. *See* Raven Reply Brief, 7-9.

establish nurse delegation to take medication administration out of the hands of Richard, which was delayed when Ida did not have a doctor and further delayed when the state Dept. of Health lost the paperwork; multiple care meetings with care providers and case managers; and lengthy in-person meetings with Ida in August, October and November 2006. Raven Corrected Brief at 40-45; Reply Brief, 14-21. DSHS itself said “one could not script a more trying case.” AR 158, CL 39.

C. DSHS and the Court of Appeals misinterpreted the RCW 74.34.020(12)(a) definition of “neglect” as not requiring causation or harm.

“Neglect” of a vulnerable adult is defined in the statute as:

“Neglect” means (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)(a).¹⁰

DSHS argued before the Court of Appeals that “neglect” can exist without harm because the word “harm” is not used in the first clause of the above definition. DSHS further argued that causation is not necessary and that it is immaterial whether Ida’s condition would have been different if Mr. Raven had acted. DSHS Brief of Appellant, 24-26. The Court of Appeals adopted this interpretation. *Raven, id.* at 464-65.

¹⁰ The DSHS Review Decision found violation of subsection (a). AR 168, CL 56.

The clause: “a pattern of conduct or inaction . . . that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult” only makes sense if it is referring to goods and services that are *needed to maintain the person's health*. In other words, without the services, the person's health is *not* maintained—i.e., the person's health is *harmed*. Further, not having these services is what *causes* the harm. For if their absence has no effect, they are not services *needed to maintain the person's health*. In short, the proper interpretation of neglect under RCW 74.34.020(12)(a) is that there must be harm and causation. Any other interpretation of the term results in unlikely, absurd or strained consequences, disfavored by the courts. *State v. Elgen*, 118 Wn.2d 551, 555, 825 P.2d 314 (1992); *State v. Thomas*, 121 Wn.2d 504, 512, 851 P.2d 673 (1993) (statutes “are to be given a rational, sensible interpretation.”).¹¹

DSHS also argued below that requiring harm to establish neglect would result in a vulnerable adult having to suffer “before relief under [RCW 74.34] could be extended.” DSHS Brief of Appellant at 25. This ignores the statutory distinction between a *protection order* and a *finding* of neglect. The vulnerable adult, DSHS, and others can petition the court for a protection order if a vulnerable adult has been “neglected, or is

¹¹ DSHS could have drawn from 42 CFR §488.335(e), applicable to nursing homes, which says: “*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.” See Raven Reply Brief, 1-2.

threatened with . . . neglect.” RCW 74.34.110(2). The court can issue an *ex parte* temporary protection order if it appears irreparable injury “*would result*” from delay, and can issue an order restraining a person “*from committing acts of . . . neglect.*” RCW 74.34.110(2); 74.34.130(1). These protective measures can be taken without harm having yet occurred. DSHS’ strained interpretation is not needed to protect vulnerable adults.

By contrast, a *finding* of actual neglect requires proof of the elements of the statutory definition, and if appealed, upheld after judicial review. WAC 388-71-01255, 388-71-01275. This distinction makes sense because the consequences are very different. A protection order forbids the respondent from neglecting a named vulnerable adult. A final *finding* of neglect has serious, permanent consequences, effectively barring Ms. Raven from nearly all employment as a geriatric psychologist for the rest of her life. The financial toll has already been devastating.¹²

¹² A finding of neglect would permanently prohibit Ms. Raven from being employed by and having unsupervised access to the clientele of any licensed facility or agency that provides care to vulnerable adults or children, or in any home and provide state paid services. RCW 74.39A.056(2) *formerly* 74.39A.051(8); RCW 43.43.832(4); WAC 388-71-0540(5) and -0551. Any business caring for vulnerable adults or children must do a background check of prospective employees that includes whether the person has a finding of neglect. RCW 43.43.834(2) and (5). DSHS may share with anyone the names on its registry of persons with a final finding of neglect. WAC 388-71-01280. Ms. Raven’s income as a guardian/guardian ad litem dropped by nearly 50% following the initial neglect finding by the DSHS investigator. She spent \$100,000 in attorney’s fees at the ALJ and administrative review stage alone, for which she will never be compensated. *See* Declaration of Raven in Support of Motion for Fees, CP 25-28. The fees and costs incurred in this case have been financially devastating. *See* Declaration of Raven Regarding Her Continued Financial Status under the EAJA (11-9-2011).

DSHS never identifies a breached duty by Ms. Raven that *caused* harm to Ida. The Review Judge lists several actions he considered duties, and then speculates that if they were done, such as hiring IPs, discussed above, Ida would have received the care she needed. For example, the Review Judge criticizes Ms. Raven for not visiting Ida monthly or personally viewing her pressure sores, and concludes that this would have spurred Ms. Raven to put Ida in a nursing home, or immediately get more in-home staff. AR 166-67, CL 53. This is not causation, but speculation.¹³ It does not address the constraints on Ms. Raven's authority, the practical infeasibility of Ms. Raven locating aides for a one hour evening shift when none of the three home care agencies could, or Ida's resistance to care even when on pain and anti-anxiety medications. AR 1304, 1307, 1323.

The DSHS and Court of Appeals decisions will spur guardians to institutionalize wards in difficult cases, rather than risk professional suicide. This will reduce access to guardians for DSHS clients and other low income people—for such guardians, with fees at \$175/month, and \$200/year for attorney support, *see* WAC 388-79-030, will not have the resources to get court approval of most decisions or pursue every possible option to protect themselves. They will simply opt out. DSHS'

¹³ The only guardianship expert in this case, Tom O'Brien, a member of the Certified Professional Guardianship Board since its inception, testified that he did not think more frequent visits would have changed a thing, and that Ms. Raven did not have a duty to personally examine Ida's pressure sores. RP 645, 657; AR 115, FF 46.

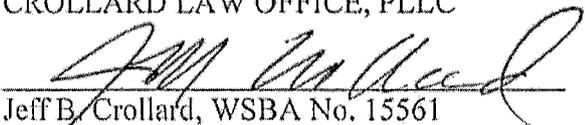
interpretation of neglect will also likely have a chilling effect on the willingness of people to serve as DPOA agents or family caregivers for their ailing or disabled relatives, as they too are defined by DSHS to have a “duty of care” toward vulnerable adults, and the lifetime sweep of a neglect finding simply may pose too great a risk.¹⁴

VI. CONCLUSION

The decisions by DSHS and the Court of Appeals are contrary to statutory law, long established case precedent, and sound public policy. They should be reversed, the decision of the superior court reinstated, and attorney’s fees awarded under the EAJA and RAP 18.1(b). *See* Raven Corrected Opening Brief, 48-49, and Reply Brief, 22-25.¹⁵

Respectfully submitted this 10th day of December, 2012.

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¹⁴ The statutory term “neglect” applies to persons “with a duty of care,” defined by DSHS to include guardians, agents with a durable power of attorney, and persons (such as family members) providing food, shelter, clothing, or health care to a vulnerable adult. WAC 388-71-0105. DSHS pursues RCW 74.34 actions against family members. *See Ryan v. DSHS*, No. 30458-2-III (Wn. App. Div. III) (Oct. 25, 2012). A DPOA agent or family caregiver who fails to provide some of these goods or services could be guilty of neglect under DSHS’ strained interpretation, without proof of causation or harm.

¹⁵ *See also Gutierrez v. Barnhart*, 274 F.3d 1255, 1259 and 1262 (9th Cir. 2001) (For the EAJA, the court examines agency action and litigation positions; the government does not get “first impression” free pass), and *Alpine Lakes Protection Society v. Dept. Natural Resources*, 102 Wn.App. 1, 16-19, 979 P.2d 929 (1999) (implausible agency construction of statutes “begs reason” and supports an award of attorney’s fees under the EAJA).

CERTIFICATE OF SERVICE:

I certify that on the 10th day of December, 2012, a true and accurate copy of the Petitioner's Supplemental Brief was served by First Class Mail and electronic mail to the following persons:

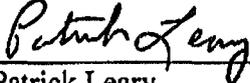
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Dear Clerk,

Enclosed please find Petitioner Raven's supplemental brief.

Thank you for your attention to this.

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