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10-8-13

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SUPREME COURT OF
OF THE STATE OF WASHINGTON

IN RE THE MATTER OF SUSPENSION OF PROFESSIONAL
GUARDIAN LORI A. PETERSEN CPG No. 9713

APPEAL FROM THE DECISION OF THE CERTIFIED
PROFESSIONAL GUARDIANSHIP BOARD
Nos. 2010-005, 2010-006, 2010-007, 2010-008, 2009-013

REPLY BRIEF OF LORI A. PETERSEN

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I. INTRODUCTION

Lori Petersen is an experienced Certified Professional Guardian (hereinafter “CPG”) and she properly applied the substituted judgment standard in deciding to move D.S. and J.S. The findings of the Certified Professional Guardian Board (hereinafter the “Board”) ignore substantial portions of the record that includes medical testimony, testimony of care providers, and unrebutted testimony that Peterson Place refused to provide 24 hour awake care. The Board also misapplied the substituted judgment standard, and failed to ensure procedural safeguards in the disciplinary process. This court should dismiss the Board’s complaint.

II. THE FINDINGS OF FACT AND CONCLUSIONS OF LAW ARE UNSUPPORTED BY THE RECORD

Prior to the Board vote to approve disciplinary sanctions Ms. Petersen filed a Response to the hearings examiner’s Findings of Fact, Conclusions of Law, and Recommendations to the Board. That response is part of the record before this Court and provides detailed Objections to the findings of the trial court. The Board erroneously argues that its findings are “verities” for lack of opposition. Brief of Respondent Certified Professional Guardianship Board at 16. Disciplinary Regulation (hereinafter “DR”) 513.2 states that the Supreme Court will review decisions to suspend or decertify a professional guardian “after

consideration of the transmitted record.” DR 513.2. The instant appeal is the first of its kind and briefing was allowed by this court in response to Lori Petersen’s request to provide argument more suited to a constitutional venue. The transmitted record included Ms. Petersen’s very detailed Response to the findings and recommendations of the hearings examiner, including specific citations to the record in objection to the hearings examiner’s findings of fact. In footnote 5 on page 37 of her Opening Brief, Ms. Petersen specifically references her responses and her intent that they serve as her objections to the findings of the hearings examiner. However, because Ms. Petersen does not wish to leave the Board’s factual allegations unresponded to, she submits the following reply to the Board’s findings of fact.

A. Disputed Findings re: E.R.

The Board did not find that Ms. Petersen violated any standards of practice with regard to E.R., but because E.R. was a resident at Peterson Place, Ms. Petersen’s experiences with his treatment, his healthcare providers, and the inability of Peterson Place to serve his medical needs had an influence on her later decisions to move J.S. and D.S.

Failure to Include Findings re: E.R.: After E.R. moved from Peterson Place, Mary Lou Rief, an independent nurse who does medical evaluations for Ms. Petersen, and Karri Sandifer, Ms. Petersen’s case

manager and owner of her own adult family homes, entered the room of E.R. to pick up his personal items. They were disturbed to find a red note on his door that was covered in fecal matter and stated “Ed, its nighttime. Go back to sleep.” Transcript of Proceedings (hereinafter “TP”) 276:16-18. They were equally concerned to discover that the electricity to the room had been intentionally cut off by the staff, leaving E.R. in complete darkness. TP 277:4-5.¹

Upon hearing of these circumstances, Ms. Petersen was extremely concerned. The staff at Peterson Place did not provide 24 hour awake care and instead of checking on E.R. in person throughout the night, they locked him up in a dark room with a note on the door telling him to go back to bed. The actions of Peterson Place staff showed an institutional disregard for E.R.’s basic personal dignity. The image of E.R. stumbling through a dark room unable to find a bathroom while scratching at his locked door with fecal matter covered hands was an image that would raise concerns with any qualified guardian.

B. Disputed Findings re: D.S.

Finding 1.24: To the extent that D.S.’s family members testified to a lack of concern about quality of care at Peterson Place, the family members did not have access to the same information that raised concerns

¹ This testimony was unrebutted during the administrative hearing.

from Ms. Petersen. The family members did not know about E.R. being locked in a dark room with no ability to get to the toilet and they did not know about the issues involving J.S., including his frequent falls and unreported trips to the emergency room, all discussed in further detail below.

The family members of D.S. could not, and did not, have a complete picture of the totality of the circumstances under which Ms. Petersen made her difficult decision to move D.S. from Peterson Place. This is one reason why the substituted judgment standard does not extend the Duty to Consult beyond the ward. See *infra* at VI A. The testimony of D.S.'s family members does not fully and accurately represent the true conditions at Peterson Place.

Finding 1.25: This finding ignores contradictory testimony by case manager Kerri Sandifer who describes in detail the condition of D.S.'s primary glasses as having only a minor scratch on one lens which did not impact D.S.'s ability to use the glasses or affect her quality of life. TP 450.

Finding 1.26 & 1.27: The findings are contradicted by the testimony of Ms. Petersen and Keri Sandifer regarding the timely search of D.S.'s file for the glasses prescription, which was missing. TP 449-450. Keri Sandifer went to Peterson Place to pick up the glasses'

prescription only to discover that Peterson Place did not have it in its proper folder, and had allegedly given the prescription to D.S.'s granddaughter to fill. *Id.*

The finding wrongly portrays Ms. Petersen as dismissive and disconcerned about the glasses, without providing any basis for this opinion. Ms. Petersen and Keri Sandifer testified that every possible action was taken to provide the optometrist with the required information and to facilitate the acquisition of the second pair of glasses. TP 507-512. Any delay is largely attributable to a lack of organization of medical paperwork and poor communication from Peterson Place (TP 449-450; 507-512), which was one of the overarching concerns that led to the later moves of D.S. and J.S.

Finding 1.28: The finding that there was “considerable delay” in obtaining the second pair of glasses is unsupported by the record. There was no testimony defining an “appropriate” amount of time to obtain a second pair of glasses under the circumstances, and Ms. Petersen provided testimony from herself and Kari Sandifer that every possible action was taken to obtain the glasses as quickly as possible. TP 507-512 (Ms. Petersen); TP 446-451 (Ms. Sandifer). The Board did not present evidence that the delay was unreasonable in light of the circumstances. The Board did not present evidence that D.S. was unable to use her

primary glasses until the second pair was obtained by Ms. Petersen. The findings erroneously fail to note that the glasses D.S. possessed were working, and that the new glasses were a second pair, not replacements.

Finding 1.31: Mary Lou Rief and Kari Sandifer had both discussed the move of D.S. with Colleen, the resident manager at Peterson Place. TP 260. On multiple occasions Mary Lou Rief, who is a registered nurse, requested 24 hour awake care for Ms. Petersen's other wards residing at Peterson Place, E.R. and J.S. Colleen repeatedly refused to provide 24 hour awake care. TP 260; TP 287, Ex 93. Heidi Peterson herself testified that the house's contract and fee structure did NOT provide 24 hour awake care as an option. TP 46. It is unreasonable to expect Ms. Petersen to repeatedly request a service that she knew from prior requests was not available at Peterson Place, and to expect her not to draw conclusion from the repeated denial of the prior requests. TP 260; TP 287, Ex 93.

Finding 1.32: The following are some of the factors relied upon by Ms. Petersen when making her decision to move D.S.:

- 1) Kari Sandifer testified that she told Ms. Petersen that D.S. was not receiving good care and needed to be changed throughout the night, stating, "If you're laying there and you are incontinent and you're just laying there in your own waste, okay. It's not only bladder, but bowels. You're getting cross-contamination, which in women, it does happen. You have bowel getting into the vaginal area when you have

incontinence. You're lying there in it during the night.”
TP470. D.S. needed to be checked every two hours to prevent
this significant problem.

- 2) When testifying that D.S. had appropriate care at Peterson Place, the “involved” family members did not have all of the information about the home. TP 144; TP 145. The decision to move D.S. was based on information related to all three wards at Peterson Place. The following is a list of some of the information upon which the decision to move D.S. was made:
 - a. May 13, 2009, Letter from Registered Nurse Mary Lou Reif expressing concern over Heidi Peterson’s handling of J.S., and indicating that Heidi Peterson had been asked to improve the level of care for J.S. Ex 22
 - b. October 27, Note from Mary Lou Reif, RN, to Lori Petersen outlining the care needs of D.S. and informing Ms. Petersen that those care needs were not being met at Peterson Place. The note specifically refers to the risk to D.S. of Urinary Tract Infections and her need for 24 hour awake staffing. Ex 25
 - c. October 29, 2009, email from Doria Hayes of DSHS to Lori Petersen, after having conducted a consultation with J.S. Email concerns lack of 24 hour awake staffing at Peterson Place. Ex 93
 - d. November 4, 2009, note from Mary Lou Reif RN, to Lori Petersen describing incidents at Peterson Place where the staff had been giving D.S. medication without notifying Ms. Petersen. Note also describes various other concerns including the ongoing problem with urinary tract infections and the need to place D.S. in a home with 24 hour awake staff. Ex 26
 - e. November 5, 2009, letter from LeAnn Swanson, RN, of Horizon House indicating that D.S. required a high level of care and should be checked every 2 hours 24 hours a day to prevent skin breakdown. Ex 14

- f. November 8, 2009, Letter from Mary Lou Reif, RN, indicating that she spoke with staff at Peterson Place about 24 hour awake staffing for D.S. and the need for increased care, and that the staff would not agree to provide increased care. Ex 24
- g. DSHS investigation report from December 1, 2009 showing violations by Peterson Place. While the report was not prepared until after D.S. was moved, Ms. Petersen and her staff had personally observed the violations later described in the report and had considered their observations of these violations when making the determination to move D.S. Ex 15

About a month after the move, on November 19, 2009, DSHS copied Ms. Petersen on a letter of non-compliance to Peterson Place stating that the facility was not in compliance with various requirements, including the need to maintain proper care plans, taking actions to prevent recurrent UTI's, and other violations. While written after D.S.'s move, the letter confirms the issues previously observed by Ms. Petersen, and relied upon by her in making her decision to move D.S. Ex 73

Finding 1.33: This finding fails to discuss the other violations discovered at Peterson Place by DSHS which violations were factors in Ms. Petersen's decision to move D.S. and J.S. For example:

- 1) Peterson Place violated WAC 388-76-10660 by failing to notify Ms. Petersen that chemical restraints were being

used to subdue J.S. and D.S. Ex. 15. Mary Lou Reif, RN, observed that this medication caused D.S. to hunch over and drool into her cereal. TP 281.

- 2) Peterson Place violated WAC 388-76-10220 by failing to keep a log of accidents affecting residents, specifically J.S. and D.S. Ex. 15
- 3) Peterson Place violated WAC 388-76-10350 by failing to ensure that each resident's assessment was reviewed and updated to document the resident's ongoing needs and preferences if and when those needs and preferences changed. Ex.15

Furthermore, finding 1.33 erroneously suggests that Mary Lou Rief was an employee of Empire Care. The only evidence presented, showed clearly that she was an independent contractor. The finding appears to insinuate that she was employed by Empire Care, and therefore, her testimony should be given little weight. TP 228. The finding also apparently was intended to suggest that Mary Lou Rief's report to DSHS was made under the direction of Ms. Petersen. There is no evidence in the record to support this conclusion. The report was made by Mary Lou Rief because she is a registered nurse, and therefore a "mandated reporter" under RCW 74.34.020 (11). The violation existed, as corroborated by DSHS, (Ex. 15, Ex. 73) and she had no discretion to ignore the problems. Carrying out her duty should increase her credibility not eliminate it altogether.

Failure to Make Findings with regard to D.S.: The Hearings Examiner and the Board disregarded important evidence of lack of 24 hour awake care that demonstrates why Ms. Petersen made the decision to move D.S. Heidi Peterson testified that Peterson Place was not an awake at night facility. She stated, "All of our--- all of our – three of those residents were admitted without 24-hour-awake staff. Our contract clearly stated that, that we were not an awake-at-night facility, which was --- the contract was signed by me and Lori." TP 46 (emphasis added). This should have ended the entire grievance given that the UNREBUTTED medical evidence established that E.R., D.S., and J.S., all suffered from chronic Urinary Tract Infections (UTI) that required the more expensive availability of 24 hour awake staff.

Evidence shows that medical professionals recommended the move of D.S. due to her increasing care needs. After D.S.'s October 6, 2009, hospital stay, a nurse practitioner recommended to Heidi Peterson that D.S. receive hospice care. TP 78-79. After an evaluation of D.S. the hospice provider determined that they could not provide the in home hospice services that D.S. required, and that D.S. needed to be checked every 2 hours, 24 hours per day. Ex 14. Ms. Petersen and her staff discussed the need for 24 hour staffing with regard to all three clients at Peterson Place, and they were informed that 24 hour staffing was not

available. TP 261. On this issue, the considerable medical evidence shows that D.S. needed 24 hour awake staffing due to the UTI Problems. TP 78-79; TP 470; Ex 14.

C. Disputed Findings re: J.S.

Finding 1.55: This finding is directly contradicted by the testimony of several individuals who confirm that J.S. had been made aware of the move in advance of the move. First, Ms. Petersen was present in the room when Dr. Moise told J.S. about the move in advance of the move. TP 560. Second, Ms. Petersen and Mary Lou Rief both told him on separate occasions about the upcoming move to hospice house. TP 257. Third, Kari Sandifer testified to speaking to J.S. about the move prior to the move. TP 434-436.

Finding 1.56: The morning of his move the individuals involved or interested in J.S.'s care met together and recommended said move at the meeting. TP 505-506. Ms. Petersen testified that she did not know who scheduled the meeting, or why she was belatedly notified about the meeting. TP 506.

Finding 1.59: J.S. was without his wheelchair for only a short period of time before it was delivered by Melody Taisey, who had a larger automobile capable of transporting the wheelchair. TP 570. The allegation that Ms. Petersen was not answering her telephone calls is

double hearsay. TP 195-196. There is NO evidence that Ms. Petersen was unavailable to talk with Hospice House on the day of the move. In fact, her coordination of all the people involved in the move proves the contrary.

Finding 1.60: To state that Dr. Moise “had no concerns regarding the level of care J.S. received at Peterson Place” is wrong. Dr. Moise testifies in detail to the circumstances under which she determined that J.S. needed to be moved. TP 379 -380; TP 394; Ex 92; Ex 93. Dr. Moise stated that it was her opinion, based on all information at her disposal, that J.S. needed to be moved and that was why she recommended the move. TP 394.

Dr. Moise wrote a prescription ordering J.S. to obtain “24 hour care at “Hospice House” or a skilled nursing facility.” TP 394; Ex 54. The Guardian, upon receipt of Ex. 54, moved J.S. to “Hospice House” as ordered. Dr. Moise was concerned that J.S. only had two weeks to live, was not eating, could not receive proper pain medication, and that he should be in Hospice House with 24 hour awake nursing care. TP 394; Ex 54.

Ms. Petersen felt it would be a violation of her duty to J.S. to ignore his doctor’s orders and Dr. Moise agreed. Dr. Moise stated, “If the guardian got this information from developmental disability or from the

caregivers, and believed what she told me and did not ask for a move, I think that would have been wrong.” TP 395. When Dr. Moise was asked, “...and if she didn’t carry out what you told her to do, that would also be very wrong?” Dr. Moise answered “Yes.” TP 395.

Finding 1.61: Ms. Petersen and her agents repeatedly informed Heidi Peterson, through her on site manager Colleen, that J.S. (and D.S.) required 24 hour awake staff. The repeated response was that 24 hour awake staff was not available. TP 586; TP 245; TP 260-261; TP 263; TP 454-456. Heidi Peterson admitted at the hearing that the contract with Ms. Petersen stated that Peterson Place did not provide 24 hour awake staffing. TP 46.

The lack of 24 hour awake staffing was not a secret. On October 29, 2009, Jean Hayes from DSHS conducted a consultation with J.S. and sent an email containing her findings to Lori Petersen. The email states, “Colleen would like to see him in a home where someone is available during the day and night. She would like to have the other residents to have quiet during the night.” Ex 93. This was the same message that Ms. Petersen and her agents had been receiving from Peterson Place for some time.

Finding 1.62: When Ms. Petersen moved J.S. she had been informed by his doctor, Dr. Moise, that J.S. only had 2 weeks to live. TP

394. The only reason he was able to move back into a Heidi Peterson facility at a later time is because his condition unexpectedly improved. The successor guardian, Tom Robinson, testified that the "Hospice House" was beneficial to J.S. TP 335. The findings mistakenly state that J.S. moved back to his original residence, the "Colbert" house, after he was released from "Hospice House." In fact he moved into the "Fleming" house, which happened to be owned by Heidi Peterson, but was not the facility in which J.S. lived prior to moving to "Hospice House" and which did not provide 24 hour awake staff when Ms. Petersen was guardian. TP 584-585. The Fleming house did not have a vacancy when J.S. was first moved from his original home. TP 416-420.

Failure to Make Findings Re: J.S.:

- 1) J.S. suffered from frequent falls at Peterson Place that caused bruising and Peterson Place staff negligently failed to report these repeated falls to Ms. Petersen. T.P. 244-245, Ex 15, Ex 55.
- 2) Keri Sandifer and Ms. Petersen asked Colleen, the resident manager at Peterson Place, to provide 24 hour care and she refused. TP 586; TP 245.
- 3) Colleen, the resident manager at Peterson Place, requested that J.S. be moved because he was a disruption to the household and Peterson Place could not provide him with the appropriate level of care. TP 260-261; TP 263, Ex 93.
- 4) Jean Hayes, at the Dept. of Developmental Disabilities contacted Dr. Moise and informed her that she was concerned about J.S. with respect to J.S. not having sufficient attention at Peterson Place. TP 387-389. Ex 92; Ex 93.

III. REPLY TO LEGAL ARGUMENTS

A. Ms. Petersen Properly Applied The Substituted Judgment Standard In Her Decision To Move D.S. And J.S.

The Board has misapplied the substituted judgment standard as described in *Raven v. Dep't of Soc. & Health Servs.*, 2013 WL 3761521 (2013); citing *In re Guardianship of Ingram*, 102 Wn.2d 827, 829-31, 689 P.2d 1363 (1984). In making a substituted decision on behalf of a ward, the “goal is to do what the ward would do, if she were competent to make the decision.” *Raven*, 2013 WL 3761521 at 6; citing *Ingram*, 102 Wn.2d at 829-831. In describing what “substituted judgment” means, the *Raven* court cited to RCW 7.70.065 (1)(c):

Before any person authorized to provide informed consent on behalf of a patient not competent to consent under RCW 11.88.010(1)(e),...,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).

1. There is no absolute duty to consult with third parties.

The Board attempts to create an absolute duty to consult with third parties that is not required under *Raven* nor RCW 7.70.065(1)(c). The Board argues that Ms. Petersen breached a duty to J.S. and D.S. by not adequately considering the opinions of family members and friends of the

ward. But such consultation is not required and may in some cases be inappropriate where those individuals have personal biases and lack access to certain information only available to the guardian.

Substitute judgment requires that the guardian determine “in good faith” what the ward would do if competent. RCW 7.70.065(1)(c). It does not define how the guardian is supposed to make this determination and certainly does not establish a mandatory duty of consultation with anyone downstream who claims to have an interest in the ward’s care. *Id.* If the determination cannot be definitively made, then the statute requires that the guardian look to the “best interests” of the ward. *Id.* The “best interests” should be determined by consulting with medical professionals. Here, Ms. Petersen determined that J.S. and D.S. were not averse to receiving increased medical treatment at new facilities and that such medical treatment was in their respective best interests. Her actions conform with the requirements of *Raven* and RCW 7.70.065(1)(c).

2. The ward in *Raven* exhibited a historical aversion to specific medical treatment that was not present with regard to J.S. and D.S.

The guardian in *Raven* had “in good faith determined that Ida, when competent, had consistently rejected traditional medical methods and had always expressed a preference to die at home with minimal medical intervention.” *Raven* at 7. The ward in *Raven* had been living at

home refusing traditional medical treatment for many years. The *Raven* Court found that the guardian appropriately determined that the ward's preference, if competent, would be to stay at home and receive only non-traditional care. *Raven* at 7.

a. The move of J.S. was consistent with his prior care and treatment.

Unlike *Raven* where the ward had a long expressed desire to die in her own home without modern medical intervention, J.S. had never expressed such desires. J.S. had originally been living in a home with family members where his care needs had not been met and his money and his medications were being stolen. While he did not want to move out of this inappropriate setting, he was able to settle into Peterson Place and was comfortable with the move. Lori Petersen had every reason to believe that the same "settling down" period would happen after his doctor ordered the move to "Hospice House", a well-regarded facility in Spokane.

The move of J.S. from Peterson Place to Hospice House was made for the same reasons as his initial move from home into Peterson Place. Like his prior living situation before moving to Peterson Place, by the time he left, the facility was no longer capable of providing the end of life medication and 24 hour awake staffing which he required. J.S.'s doctor, as well as other health care professionals including Mary Lou Reif, RN,

and Jean Hays (DSHS), and even the Peterson Place manager Colleen, all agreed that a move would be in J.S.'s best interests. TP 260-261; TP 263; TP 379-380; TP 394; TP 586; Ex 54; Ex. 92; Ex. 93. J.S.'s doctor testified that it would have been wrong if Ms. Petersen had not moved J.S. TP 395. Ms. Petersen's decision to move J.S. appropriately applied the substituted judgment standard because she had a reasonable belief based on J.S.'s prior move, that he would settle in and be more comfortable at "Hospice House" after the temporary difficulties of the move had passed.

Significantly, unlike the ward in *Raven*, who had refused the concept of modern medical treatment while she still possessed capacity, there is no record of J.S. having refused the type of palliative treatment which was prescribed by Dr. Moise. J.S. had been sick for a number of years, during which time his level of medical treatment constantly increased. As his needs increased, so did the type and location of his care. He never objected to the increased care, which care was primarily intended to facilitate his own comfort. From Ms. Petersen's perspective, the move to Hospice House at a time when she thought J.S. was only going to live a short time, was simply the next step in what had been an ongoing process of increasing levels of care.

- b. *D.S. had given no prior indications that she would object to moving.*

There is no evidence in the record to indicate that D.S. was in any way opposed to a move to another facility. As with J.S., the circumstances surrounding the decision to move D.S. were unlike the circumstances surrounding the ward in *Raven*. D.S. was already in a facility where she was receiving care. Her move to a new facility was merely a reflection of her increased care needs and the fact that Peterson Place could not, or would not, provide 24 hour awake care to deal with her incontinence and confusion. Ms. Petersen, based on the advice of medical professionals including nurses Mary Lou Rief and LeAnn Swanson, moved D.S. from a facility that did not provide 24 hour awake care to a facility that did provide such care. Ms. Petersen appropriately determined that it was in the best interest of D.S. to move and that D.S. would have chosen the move if she had had decisional making capacity.

B. Even When Compared To The Due Process Procedures Afforded To Attorneys, The Process Of The Board Fails To Provide Due Process Of Law To Certified Professional Guardians.

The Board attempts to analogize the due process requirements for CPG disciplinary proceedings to those afforded to attorneys. While the Supreme Court is composed of attorneys with wide and deep experience in the law, Lori Petersen has taken over 100 wards to hospital for UTI problems. With all due respect, this Court has vastly less institutional

knowledge of the demands of day to day guardianship work than it does with the practice of law. Even if the analogy has merits, the Board's disciplinary procedures still fall far short of the due process protections afforded to attorneys.

1. Burden of Proof.

The burden of proof argued for by the Board provides significantly less procedural protection than that afforded to attorneys in disciplinary proceedings. In attorney disciplinary proceedings, complaints against attorneys must be proved by a "clear preponderance" standard. *In re Disciplinary Proceeding Against Allotta*, 109 Wn.2d 787, 792, 748 P.2d 628 (1988). Although the Board argues that CPG Board disciplinary procedures provide an equivalent level of due process to those for attorneys, the lower burden of proof adopted by the Board is just one example of where the CPG procedural protections are inferior to those for attorneys.

2. The definition of "quorum."

The definition of "quorum" contained in the Board regulations is substantially different from that contained in the Rules for Enforcement of Lawyer Conduct (hereinafter "ELC"), and that difference deprived Ms. Petersen of due process protections to which she was entitled. Under ELC 2.3 (b) (4) a "quorum" is defined as "A majority of the Board members..."

and requires that “at least 7 members vote.” This requirement ensures that important disciplinary decisions will not be based on the votes of a minority of the Board.

Conversely, the decision to file the complaint against Ms. Petersen moved forward with only three out of twelve members voting. Ex. 36. This was possible because the Board disciplinary regulations define a quorum as “a majority of the Board members who are not disqualified as above.” DR 512.4.5. In Ms. Petersen’s case, the result was that the decision to file the initial complaint was made by only three out of twelve members of the board (Ex. 36), and the decision to approve the findings and recommendations of the hearings examiner was made by only six of the twelve voting members of the Board.³ Unlike a disciplinary matter involving attorneys, where the attorney is guaranteed to have more than half of the disciplinary board involved in making any decision, in the two most important decisions of this case, less than a majority of the Board even participated.

3. The selection of the hearings officer.

³ According to the January 30, 2013, Board minutes, seven voting members were present, and one (William Jaback) had a conflict that precluded him from voting. Thus, only 6 members voted. While the minutes state that the motion passed 6 to 1 (with Andrew Heinz dissenting) this number does not properly add up to the list of members present (7) and the fact that Mr. Jaback did not vote.

The right to an unbiased decision maker is a fundamental aspect of due process which was violated with regard to Ms. Petersen. In matters of attorney discipline, the Rules for Enforcement of Lawyer Conduct proscribe a detailed process for selection of hearings examiners that prevents the Board of Governors (hereinafter "BOG") from hand picking a favorable hearings officer.

The CPG Board process for selecting a hearings examiner lacks any procedural protections. The CPG disciplinary regulations allow for the Board chair to select a hearings examiner, or alternatively, act as hearings examiner himself or herself on its own complaint. DR 510.2. The hearings examiner in Ms. Petersen's case is contracted and paid by the Board to serve one year terms as the *de facto* exclusive hearings examiner for the Board.

The CPG process lacks the following protections present in the process for selecting hearings examiners in lawyer discipline cases: 1) there is no diverse panel to provide recommendations of proposed hearings examiners which insures proper vetting (ELC 2.5 (c)); 2) there are extended five year terms for hearings examiners which reduces the likelihood that a hearings examiner will be influenced by his or her own short term self interest in being rehired on an annual basis (ELC 2.5 (e)); 3) there is a list of hearings examiners from which a different individual is

appointed to each case thus preventing the BOG from hand picking a favored individual (ELC 2.5 (f)-(g); and 4) there is a provision in the attorney disciplinary regulations allowing for the removal of the appointed hearings officer by the respondent if he or she finds it necessary (ELC 10.2 (b) (1)). If, as the Board suggests, CPG disciplinary proceedings are analogous to attorney disciplinary proceedings, the CPG Board should be required to institute the same protections as are available to attorneys. There is nothing about hand picking your own judge that even appears fair.

C. Unfair Procedures And Biased Decision Makers Resulted In A Violation Of The Appearance Of Fairness Doctrine With Regard To Ms. Petersen's Matter.

In attempting to define "obscenity" Justice Potter Stewart famously stated, "... I know it when I see it..." *Jacobellis v. State of Ohio*, 378 U.S. 184, 197, 84 S.Ct. 1676 (1964). Identifying a violation of the Appearance of Fairness doctrine is a similarly nebulous endeavor, but like Justice Stewart, you simply know it when you see it, and it is seen here with Ms. Petersen's case.

From the beginning to the end, this disciplinary proceeding has lacked the appearance of fairness that is the cornerstone of our judicial system. First, Ms. Petersen was forced to testify under oath in a "fact finding hearing" presided over by the man, Commissioner Valente, who

had been her constant antagonist during the time that they both served together on the CPG Board. TP 482-484. Then, following Commissioner Valente's recommendation, the Board voted to file a complaint against Ms. Petersen only minutes after voting to reduce the burden of proof by which it had to prove the allegations contained in said complaint. Only three out of twelve board members participated in the vote to file the complaint. Then, the Board appointed its handpicked hearings examiner to preside over the administrative hearing. Unsurprisingly, this hearings examiner based his findings of fact and conclusions of law exclusively on the testimony of the Board's witnesses, and ignored substantial testimony and documentary evidence which contradicted the Board's claims. When the Board received the favorable findings, conclusions, and recommendations of the hearings officer, which largely mirrored the board's complaint and the initial findings of Commissioner Valente, the Board predictably voted to approve the recommendations. Again, less than a majority of the board, six of twelve voting members, voted to impose sanctions.

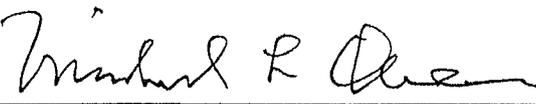
The Board disciplinary process lacks procedural protections to prevent the type of unjust treatment Ms. Petersen has faced throughout this process. The lack of those procedural safeguards, combined with the biases and conflicts of interest which pervaded the proceedings, give the

appearance of unfairness in the process. Like Justice Stewart who just knew it when he saw it, this court should see the facts and circumstances surrounding this case for what they are, the actions of a few persons managing an over powerful board with no superior court oversight that lacks any appearance of a fair disciplinary process for Ms. Petersen.

IV. CONCLUSION

Throughout the proceedings, the Board treated each of Lori Petersen's three wards who lived at Peterson Place in their own world-bubble. A guardian cannot do so. The Board disregarded the important interrelations between the substandard care provided to one resident of Peterson Place and how that substandard and non 24 hour care affected Ms. Petersen's later decisions with regard to other residents. It was not coincidence that all three of the individuals involved in this grievance process needed similar 24 hour care and were removed from Peterson Place, and not three separate facilities. Ms. Petersen and her agents observed substandard care at the facility that necessarily affected all future decisions she made. When she moved the wards it was in their best interests, under the advice of experienced professionals, and comported with the substituted judgment standard. The complaint against Ms. Petersen should be dismissed.

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PROOF OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington, that on the date written below, I caused to be served a true and correct copy of the foregoing document upon counsel listed below by electronic mail:

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OFFICE RECEPTIONIST, CLERK

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Please find attached for filing the Reply Brief of Lori A. Petersen.

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