Meeting Materials
3/11/2013

CERTIFIED PROFESSIONAL GUARDIAN BOARD

Sound Senior Assistance, CPGA No.10504 **Madeleine Hudson, CPG No. 5196** **Barbara Hunter, CPG No. 11251**	**CPGB No. 2011-001** **AGREEMENT REGARDING DISCIPLINE AND STIPULATED FINDINGS** ***Disciplinary Regulation 514***

The parties, Sound Senior Assistance CPGA No. 10504, a certified professional guardian agency, Madeleine Hudson CPG No. 5196 and Barbara Hunter CPG No. 11251, certified professional guardians and the Certified Professional Guardian Board (Board) enter into this Agreement Regarding Discipline and Stipulated Findings (Agreement) pursuant to the Board's Disciplinary Regulations for Certified Professional Guardians. Madeleine Hudson and Barbara Hunter have committed violations of the Standards of Practice for Certified Professional Guardians, resulting in this disciplinary proceeding before the Board. This Agreement is a resolution of this disciplinary proceeding and shall become effective after all parties have signed the Agreement. This Agreement will be a part of the professional guardian record of Sound Senior Assistance, Madeleine Hudson and Barbara Hunter and will be a public record and subject to public access.

1. JURISDICTION

1.1 At all times relevant herein, Madeleine Hudson was a certified professional guardian (CPG) pursuant to General Rule (GR) 23, CPG No. 5196. Madeleine Hudson is a manager/member and one of the designated certified professional guardians of Sound Senior Assistance, CPGA No. 10504.

1.2 At all times relevant herein, Barbara Hunter was a certified professional guardian (CPG) pursuant to General Rule (GR) 23, CPG No. 11251. Barbara Hunter is a member and one of the designated certified professional guardians of Sound Senior Assistance, CPGA No. 10504.

1.3 At all times relevant herein, Sound Senior Assistance was a certified professional guardian agency (CPGA) pursuant to General Rule (GR) 23, CPGA No. 10504.

1.4 The Certified Professional Guardian Board is responsible for reviewing any allegation that a certified professional guardian or certified professional guardianship agency has violated an applicable statute, fiduciary duty, standard of practice, rule, or regulation. Pursuant to its Disciplinary Regulations, the Board may impose discipline, sanctions, costs and other remedies upon a finding of violation, or may recommend that the Washington Supreme Court impose discipline, sanctions and costs, when the recommendation is for suspension or decertification of the certified professional guardian or agency.

2. STATEMENT OF FACTS

2.1 On or about January 10, 2011, the Board opened a grievance, based on the lack of response by the CPG's regarding end of life decision making for J.C. incapacitated person served by the CPG's and CPGA.

2.2 J.C. entered full hospice care as a "full code" on December 21, 2010. The hospice social worker alleges several attempts at contacting the CPG's unsuccessfully for the removal of life-sustaining treatment.

2.3 On January 6, 2011, IP passed away. Hospice social worker reports no communication attempts were made by either CPG's in regards to J.C. care while under hospice or post death.

2.4 Ms. Hudson and Ms. Hunter with Sound Senior Assistance failed to cooperate with this investigation and repeatedly failed to respond to correspondence from AOC, the Snohomish County Superior Court, and the Certified Profession Guardian Board (Board). After, 11 months and several unanswered requests for information the Board sent a suspension letter to Ms. Hudson and Ms. Hunter and they contacted the Snohomish County Superior Court and the Board to resolve this matter.

3. VIOLATIONS OF THE STANDARDS OF PRACTICE

3.1 Based on the facts set forth in paragraphs 2.1, 2.2, 2.3, and 2.4 Madeleine Hudson and Barbara Hunter's conduct constitutes grounds for discipline pursuant to Standards of Practice 408.1, 408.3, and 408.5, which provides in pertinent part:

SOP 408.1 The guardian shall provide informed consent on behalf of the incapacitated person for the provision of care, treatment, and services an shall ensure that such care, treatment and services represents the least invasive form of intervention that is appropriate and available.

SOP 408.3 The guardians shall be familiar with the law regarding the withholding or withdrawal of life-sustaining treatment.

SOP 408.5 The guardian shall be available to respond to urgent need for medical decisions. The guardians shall provide instructions regarding treatment or non-treatment to be followed by medical staff in emergencies.

3.2 Based on the facts and violations set forth above, Ms. Hudson and Ms. Hunter's conduct constitutes grounds for discipline pursuant to General Rule (GR) 23(c)(2)(viii) and Disciplinary Regulation (DR) 503, which provide in pertinent part:

> **GR 23 Rule for Certifying Professional Guardians – Certified Professional Guardian Board**
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> . . .
>
> (2) Duties and Powers.
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> . . .
>
> (viii) Grievances and Discipline. The Board shall adopt and implement procedures to review any allegation that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, or regulation. The Board may impose sanctions upon a finding of violation. Sanctions may include decertification or lesser remedies or actions designed to ensure compliance with duties, standards, and requirements for professional guardians.

DR 503 A professional guardian may be subject to disciplinary action for any of the following:

503.1 Violation of or noncompliance with applicable statues, court orders, court rules, or other authority.

503.3 Failure to perform any duty one is obligated to perform as a professional guardian.

503.4 Violation of the oath, duties, or standards of practice of a professional guardian.

503.13 Failing to cooperate during the course of an investigation as required by the Board's Regulations.

4. AGGRAVATING AND MITIGATING FACTORS

Pursuant to DR 515.1.4, the Board may consider the existence of aggravating and mitigating factors in determining the sanctions to be imposed.

4.1 Aggravating Factors. Previous disciplinary sanctions for timeliness of filing court documents.

4.2 Mitigating Factors. Absence of a prior disciplinary record.

5. PRIOR RECORD OF DISCIPLINE

Ms. Hunter and Ms. Hudson with Sound Senior Assistance have no prior records of discipline with the Board.

6. DISCIPLINARY SANCTIONS AND REMEDIES

The Board imposes the following disciplinary sanctions and remedies on Ms. Hudson's for the conduct described in this Agreement. The Board is issuing a Letter of Admonishment to DR 515.1, any disciplinary sanction or remedy imposed by the Board on a certified guardian is a disciplinary sanction.

Letter of Reprimand: The Board herby imposes a Letter of Reprimand on the Respondent. This Agreement constitutes the Letter of Reprimand and shall be placed in the Board's disciplinary files for the Respondent.

7. VIOLATION OF AGREEMENT

7.1 Failure to comply with the terms of this Agreement shall constitute additional grounds for discipline pursuant to DR 514.4. Failure to comply includes, but is not limited to, failure to respond to necessary medical treatment for IP's, failure to have end of life preparations for all IP's, and failure to respond to investigations and correspondence regarding conduct.

7.2 In the event of an alleged breach of this Agreement, the Board will issue a Complaint pursuant to its Disciplinary Regulations, providing notice and an opportunity for a hearing to the certified professional guardian agency and to the certified professional guardian(s) alleged to be in breach of the ARD. If the Board finds that Suspension Pending Disciplinary Proceedings is warranted, it may proceed pursuant to Disciplinary Regulation 519.

7.3 This Agreement is binding as a statement of all known facts relating to the conduct of Ms. Hudson's but any additional existing acts may be proven in any subsequent disciplinary proceedings.

8. NOTICE

This Agreement shall be retained by the AOC in Ms. Hudson's disciplinary file. This Agreement shall be open to public access and disclosure. Notice of the discipline imposed shall be sent to all superior courts pursuant to DR 514.3.2.

9. ENTIRE AGREEMENT

This Agreement comprises the entire agreement of the parties with respect to the matters covered herein, and no other agreement, statement, or promise made by any party which is not included herein shall be binding or valid. This Agreement may be modified or amended only by a written amendment signed by all parties.

10. SEVERABILITY

The provisions of this Agreement are intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason, the remainder of the Agreement will not be affected.

11. LAWS GOVERNING

This Agreement shall be governed by the laws of the State of Washington, and any question arising from the Agreement shall be construed or determined according to such law. This Agreement is a public record and is subject to public disclosure or release.

12. RIGHT TO COUNSEL

Ms. Hudson acknowledges that each has the right to individual counsel for representation in this disciplinary matter, at her expense, as set forth in Disciplinary Regulation 509.1.

13. PRESENTATION OF AGREEMENT TO THE BOARD

Ms. Hudson understands that this Agreement is not binding unless and until it is approved and signed by the Board. If the Board rejects this Agreement, Ms. Hudson waives any objection to the participation in the final determination of this matter of any Board member who heard the

Agreement presentation. The SOPC reserves the right to withdraw this offer of settlement at any time prior to the presentation to the Board.

COPY RECEIVED, NOTICE OF PRESENTATION WAIVED:

_____ 12-12-12
Date

Individually and as Designated CPG of Sound Senior Assistance

_____ 12-12-12
Date

Attorney for
WSBA #_____

APPROVED AND ORDERED BY THE CERTIFIED PROFESSIONAL GUARDIAN BOARD THIS

_____ DAY OF _____, 2012.

_____
Honorable James Lawler
Chair, Certified Professional Guardian Board

CERTIFIED PROFESSIONAL GUARDIAN BOARD

IN THE MATTER OF: LORI A. PETERSEN, CPG No. 9713,	CPGB NO. 2010-005, 2010-006 2010-007, 2010-008, 2009-013 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATIONS TO THE BOARD FOR ACTION

A Hearing was held October 22, 2012 to October 24, 2012 before Roderick S. Simmons, Hearing Officer, the Certified Professional Guardian Board (hereinafter "Board") appearing through Robert M. McKenna, Attorney General, by Chad C. Standifer, Assistant Attorney General, and Lori A. Petersen, CPG No. 9713 (hereinafter "Respondent") appearing through her attorneys Helsell Fetterman LLP, by Michael L. Olver, Attorney at Law.

The Respondent was timely notified of the time and place of the Hearing in accordance with the Prehearing Conference Order and Notice of Hearing, dated June 12, 2012.

The Hearing Officer has considered the testimony of the witnesses appearing at the Hearing on behalf of each party, the Disciplinary Proceeding Complaint and the Notice to Answer, both dated April 25, 2012, the Answer of Respondent, dated May 25, 2012, Respondent's Legal Memorandum For Administrative Hearing, dated October 15, 2012, and the Board's Response to Respondent's Legal Memorandum for Administrative Hearing, dated October 19, 2012.

By Stipulation of the parties at the Hearing, the parties consolidated their respective Final Exhibit Lists as Exhibits 1-91 and agreed that said Exhibits were admitted; and said Exhibits have been considered by the Hearing Officer. The Hearing Officer further considered the documentary evidence admitted during the Hearing: Exhibits 24A, and 92-97.

By way of a preliminary Motion, Respondent argued that the standard of proof in this matter under Certified Professional Guardian Board Disciplinary Regulations (hereinafter "DR") 511.12 should be evidence found to be clear and convincing, not a preponderance of the evidence, which latter standard was adopted by the Board November 14, 2011. The Hearing Officer determined the change in the standard of proof was supported by the decision in *Hardee v. State*, 172 Wn.2d 1, 256 P.3rd 339 (2011), and denied the Motion.

I. FINDINGS OF FACT

1.1. Respondent, Lori Petersen, was certified as a Certified Professional Guardian on November 5, 2001, pursuant to General Rule 23, as CPG No. 9713. Exhibit 1A.

1.2. Respondent operates Empire Care and Guardianship and is the Guardian for about 60 individuals. Exhibit 13.

1.3. Respondent was a member of the Board from 2003 to 2009 (six year term) and served on the Standards of Practice Committee (hereinafter "SOPC").

1.4. On December 1, 2009 the Board received a grievance from a family member regarding Respondent's conduct in the case of the Guardianship of D.S., Spokane County Superior Court Case No. 09-4-00115-6. On or about December 3, 2009 the SOPC opened a grievance against Respondent under CPGB No. 2009-013. Exhibit 1B, 88.

1.5. On March 22, 2010 the Board received a grievance from Heidi Peterson, the owner and operator of Peterson Place Adult Family Home, regarding Respondent's conduct in the following cases:

Guardianship of E.R., Spokane County Superior Court Case No. 09-4-00294-2
Guardianship of D.S., Spokane County Superior Court Case No. 09-4-00115-6
Guardianship of J.S., Spokane County Superior Court Case No. 09-4-00177-6

On or about June 20, 2010 the SOPC opened grievances on these cases under CPGB No. 2010-007, 2010-006, and 2010-005, respectively. Exhibit 2, 86.

1.6. On April 15, 2010 the Board received a second grievance from a family member regarding Respondent's conduct in the Guardianship of D.S. On or about June 20, 2010 the SOPC opened a grievance against Respondent under CPGB No. 2010-008. Exhibit 3, 89.

1.7. Respondent testified that Spokane County Superior Court Commissioner Joseph F. Valente, and member of the CPGB, took action to forward the grievances to the CPGB and to push the

grievances forward. A hearing was held before Commissioner Valente in his court on July 15, 2010 regarding the grievances previously filed with the Board. Respondent appeared with her attorney, James Woodard. Mr. Woodard examined witnesses and presented evidence on behalf of the Respondent. Additionally the Commissioner questioned the Respondent at length without objection by her counsel. Exhibit 21.

1.8. On July 26, August 10, and August 13, 2010, Commissioner Valente sent written opinion letters to Mr. Woodard and others involved in the proceeding. Exhibit 43, 44, 66, 69.

1.9. Respondent testified that Commissioner Valente encouraged the filing of the various grievances and the present Disciplinary Proceeding Complaint and otherwise retaliated against her because, while she was a member of the CPGB and SOPC, she opposed a Guardianship Monitoring Project initiated by Commissioner Valente. Respondent further testified that Commissioner Valente is the reason she is facing the present Hearing.

1.10. On or about April 25, 2012 a Disciplinary Proceeding Complaint and Notice to Answer were signed and subsequently served on Respondent by the Board.

1.11. On or about May 29, 2012 the Board received Respondent's Answer, dated May 25, 2012.

Guardianship of E.R.

1.12. Respondent was appointed Full Guardian of the Person and Estate of E.R. on May 12, 2009. He was admitted to the Peterson Place Adult Family Home located at Gary Lane, Spokane, on May 28, 2009. The Agreement signed by the Respondent for his placement states that Peterson Place does not provide 24 hour awake staff.

1.13. On July 18, 2009 E.R. manifested a significant change in his behavior, including aggressive behavior towards staff and trying to leave. Heidi Peterson, the owner of Peterson Place, was out of town on this date. Upon being informed by her staff of these problems she directed them to call 911 to transport E.R. for emergency care. Heidi Peterson notified Respondent of E.R.'s transfer to the emergency room.

1.14. Heidi Peterson informed Respondent of her concerns regarding E.R.'s condition but allowed him to return to Peterson Place, on July 18, 2009, at the insistence of Respondent. An unidentified emergency room staff person informed Heidi Peterson that E.R. was ready to be returned to Peterson Place.

1.15. Later the same day E.R. again became agitated. Peterson Place staff reported to Heidi Peterson that he was trying to climb walls and was swinging his walker at staff. Heidi Peterson directed her staff to call 911 to, again, transport E.R. to the emergency room for treatment. On this second visit E.R. was found to have a urinary tract infection and blockage. 1000ccs of urine were drained from his bladder.

1.16. E.R. was hospitalized overnight and evaluated by a Community Mental Health Professional (hereinafter "CMHP") and other medical providers. He was determined to be ready to be returned to Peterson Place.

1.17. During the time encompassed by the second visit to the emergency room, Respondent testified that the telephone kept ringing, with telephone calls from Heidi Peterson and the CMHP. Respondent in her testimony manifested annoyance at these various telephone calls, testifying "I'm trying to get ready for a triathalon."

1.18. Despite the assurances from the various medical providers regarding E.R.'s fitness to return to Peterson Place, Heidi Peterson refused to permit his return. Respondent was insistent in her conversations with Heidi Peterson that E.R. be allowed to return to Peterson Place even though Heidi Peterson expressed her concerns regarding his condition and its effect on the safety and well-being of staff and residents.

1.19. E.R. was not returned to Peterson Place and remained at the hospital for a period of time until he could be placed elsewhere. He was ultimately placed at Alderwood Manor. Exhibit 6.

1.20. E.R. died August 18, 2009, aged 91. Exhibit 6.

Guardianship of D.S.

1.21. Respondent was appointed Full Guardian of the Person and Estate of D.S. on March 18, 2009. The Order was amended on March 24, 2009 to set a specific Bond. Exhibit 7, 8.

1.22. D.S. was placed at Peterson Place Adult Family Home, at E. Midway Rd, Colbert, WA, by Naomi Webb, her granddaughter, on February 8, 2009 because Ms Webb could no longer provide adequate care for D. S.

1.23. D.S. has family members and friends of family who were actively involved with her and interested in her care and well-being.

1.24. Naomi Webb testified that she visited D.S. about three times per week. Karin Simpson-

Schubert, daughter of D.S. testified that she visited periodically and telephoned daily. Lori Fagin, testified that she is a friend of Robert, a son of D.S., has known her 30 years, and visited her at least one time per month, alone or with Robert. Terry Simpson, son of D.S. testified that he visited her several times. All testified they had no concerns regarding the care D.S. was receiving at Peterson Place. Karin Simpson-Schubert has a Masters from Stanford University in physical therapy, and works with children with developmental disabilities. Lori Fagin has a Masters from WSU in nursing and is a critical care nurse.

1.25. In August 2009 Naomi Webb requested that new glasses be obtained for D.S. because the glasses needed repair, the lenses were scratched, would fall out of the frame when cleaned, and the frame was bent. D.S. is an avid reader. Heidi Peterson telephoned Respondent who approved the request.

1.26. Heidi Peterson transported D.S. to Optic One for an eye exam. Heidi Peterson testified there was no follow-up appointment because Optic One did not get payment from Respondent. Respondent testified there was no follow-up because the Optometrist could not get appropriate responses from D.S because of her dementia.

1.27. An Optic One employee telephoned Heidi Peterson because they had no response from Respondent to telephone calls to the telephone numbers they had been provided. Heidi Peterson gave them the telephone number of Naomi Webb, believing she may have additional contact information. Thereafter Heidi Peterson received a telephone call from Respondent complaining about the telephone calls she (Respondent) was receiving about the glasses. She further complained that Heidi Peterson should not be discussing the eye exam and payment issues with family members.

1.28. D.S. received replacement glasses, after considerable delay, when Respondent obtained a replacement prescription. Respondent and her case manager Kerri Sandifer testified they were told by Peterson Place staff that Naomi Webb had been given the original prescription. Heidi Peterson testified the prescription was always in D.S.'s file. Respondent testified the original glasses were adequate because only one lens was scratched.

1.29. Heidi Peterson telephoned Respondent regarding a change in condition of D.S. Respondent approved sending D.S. to the emergency room for treatment. D.S. was hospitalized from October 6, 2009 to October 8, 2009. Neither Heidi Peterson nor her staff informed Respondent of the

hospital stay.

1.30. Respondent did not inform the children of D.S. of the emergency room visit or the hospital stay, after Respondent subsequently learned of these.

1.31. On or about October 30, 2009 Respondent's case manager informed Heidi Peterson that they planned to move D.S. Respondent subsequently telephoned Heidi Peterson to inform her that D.S. would be moved because Peterson Place had no 24 hour awake care. At no time did Respondent request that Heidi Peterson provide 24 hour awake care, or re-negotiate the services provided by Peterson Place.

1.32. Respondent did not discuss a move of D.S. with any family member. No medical testimony has been submitted to establish any emergency need for a move of D.S. The involved family and friends of D.S. testified D.S. was receiving proper care at Peterson Place. Respondent testified that she did not need to consult with the family because the children had not visited for a couple of years. Respondent further testified the children did not know better than she, as she sees what is happening every day.

1.33. On November 2, 2009 and November 16, 2009 Residential Care Services, a division of DSHS, conducted an unannounced investigation of the Peterson Place residence where D.S. resided, based on a complaint filed by Mary Lou Rief, RN. Ms Rief is identified as one of the team members of Empire Care and Guardianship. One of the allegations related to lack of awake staff. No concerns were found regarding the lack of 24 hour awake care. Exhibit 13, 15, 73.

1.34. On November 6, 2009 Respondent or her staff informed Heidi Peterson that D.S. was being removed because there was no 24 hour awake care.

1.35. Respondent did not consult with or inform D.S.'s family members in advance of this move. The family was informed by Peterson Place staff of the possibility that Respondent might move D.S. The family contacted attorney Lin O'Dell as a possible successor guardian. By agreement Respondent resigned as Guardian and Lin O'Dell was appointed successor Guardian of D.S., on March 26, 2010. Exhibit 48, 51.

1.36. Respondent provided no testimony that she consulted with D.S.'s primarymedical providers as to the need for moving D.S.

1.37. Respondent, through her agent, informed the children of D.S. of the move and her location

1 or 2 hours after the move. Prior to that notification the family members were concerned and upset because D.S. had been removed from Peterson Place and they could not contact anyone who knew her location.

1.38. On or about November 18, 2009 Respondent mailed a letter to the family of D.S. advising them of the name and address of D.S.'s location. The letter also required the family to provide the name of one contact person even though Respondent already had the names and contact numbers of the family. Exhibit 24A.

1.39. The Board offered no testimony in support of the Grievance 2010-008 beyond what was contained in the written grievance.

Guardianship of J.S.

1.40. Respondent was appointed Temporary Guardian of J.S. on April 1, 2009 pending a contested hearing. Respondent was appointed Full Guardian of the Person and Estate of J.S. on May 28, 2009. Exhibit 16, 17.

1.41. Respondent removed J.S. from the home of a family member, where he was being exploited, and placed him at the E. Midway Rd, Colbert, WA, Peterson Place Adult Family Home on, May 1, 2009. This location is in the Mead School District. Previously J.S. was in the Spokane School District. Exhibit 19.

1.42. J.S. suffers from hereditary spinocerebellar ataxia disorder. This disease has many significant impacts on J.S.: the disease causes pain from muscle spasticity, he is legally blind, he has limited ability to eat, he is wheelchair bound, and he has a shortened life expectancy. He was entitled to receive special education benefits until age 21. Exhibit 55, 93, 95.

1.43. Despite the degenerative nature of his disease, J.S. remained cognizant and capable of expressing his needs and opinions.

1.44. Issues surrounding J.S.'s move to Peterson Place created a dispute between Heidi Peterson and Respondent. Heidi Peterson was told not to contact Respondent to discuss these issues while Respondent was so upset with Heidi Peterson. Exhibit 22.

1.45. Melody Hayashi-Taisey had been J.S.'s teacher from 2006 to 2009. She is a teacher in the Spokane School District and part of the homebound program for medically fragile students ages 13-21. When J.S. was moved into the Mead School District Melody Hayashi-Taisey remained in

contact with J.S. as a friend and advocate. She participated in the original move of J.S. to Peterson Place and observed how upset and affected he was by the move. Subsequent to the move to Peterson Place she was told by Mary Lou Rief, Respondent's nurse consultant, that she was done and that they did not need her input.

1.46. A meeting was scheduled with Respondent, Melody Hayashi-Taisy, and others for May 29, 2009 to evaluate the Individual Education Plan (IEP) for J.S. The meeting date was changed to May 28 and Respondent testified she was unable to attend because she had a court hearing to which she was taking J.S. The only court hearing on May 28, 2009 was the hearing to appoint Respondent Guardian of J.S. The Order Appointing Guardian indicates J.S. was not at the court hearing. The GAL, Maxine Schmitz is listed as attending the court hearing. Exhibit 17.

1.47. The GAL attended the IEP meeting and emailed her notes and the IEP to Respondent on May 29, 2009. The email does not indicate the date of the IEP meeting. Exhibit 96, 97.

1.48. The Board alleges Respondent failed to register J.S. in the Mead School District in June 2009 to enable J.S. to receive special summer school activities and services. The Board further alleges the Respondent did not enroll J.S. in September 2009 in the Mead School District for the new school year.

1.49. Respondent testified that J.S. received one of eight scheduled summer in home school visits. Respondent testified that J.S. did not want to attend school and that she was following his preferences. Respondent further testified that Dr. Vivian Moise, M.D., advised her that school learning was not essential and that trips and outings were proper means of stimulation and socialization, which Respondent provided to J.S.

1.50. By September 23, 2009 J.S.'s physician, Dr. Vivian Moise, M.D., considered him to be in the very terminal stages of his disease.

1.51. A Petition to replace Respondent as Guardian of J.S. was filed October 21, 2009. Respondent was replaced as Guardian of J.S. by Thomas Robinson November 4, 2009. Exhibit 38, 53.

1.52. Dr. Vivian Moise, M.D., issued a doctor's order for J.S. on October 29, 2009 providing that J.S. needs 24 hour care at Hospice House or an SNF (Skilled Nursing Facility). Exhibit 54.

1.53. On the morning of October 30, 2009 a Hospice House nurse came to Peterson Place to assess

J.S. for admittance to Hospice House. Respondent's staff arrived to move J.S.

1.54. Melody Hayashi-Taisy arrived at Peterson Place after being informed of the pending move. She testified that the situation was chaotic and that she contacted the Ombudsman and Adult Protective Services. She testified that J.S. was upset about the move and that he fully understood hospice care was for terminally ill patients. Numerous people were in attendance to address the problems caused by this pending move of J.S.

1.55. J.S. was well aware his disease shortened his life span and that members of his family and relatives had died or were dying as a result of the disease. Neither Respondent nor anyone acting on her behalf spoke to J.S. or told him what was going on.

1.56. Respondent testified that she was not invited to this meeting, even though the Hospice House assessment was scheduled that date by Respondent's staff. She arrived later in the day. There was no meeting scheduled with advance notice to people involved or interested in J.S.'s care.

1.57. Respondent arranged the move of J.S. from his family's home at the start of the Guardianship of J.S. and observed how severely upset and affected he was by the move to Peterson Place.

1.58. On October 30, 2009 Respondent moved J.S. from Peterson Place Adult Family Home to Hospice House, a hospice facility.

1.59. J.S. was extremely distressed by the move to Hospice House. He was moved without his reclining wheelchair, in which he preferred to spend substantial time. He was described as sobbing, screaming and being disruptive. Melody Hayashi-Taisy was contacted by Hospice House because they did not know what to do. Respondent was not answering their telephone calls and they could not get in contact with her. Melody Hayashi-Taisey delivered the wheelchair and remained with J.S. until he went to sleep. At some point after his move to Hospice House, J.S. encountered his cousin, who was residing at Hospice House because he was dying from the same neurological disease as J.S., which was known to J.S.

1.60. Respondent offered no testimony regarding why she did not consider or arrange for a move to a Skilled Nursing Facility, or arrange for provision of hospice care at Peterson Place. Dr. Vivian Moise, M.D., had no concerns regarding the level of care J.S. received at Peterson Place. Exhibit 85, 95.

1.61. Respondent did not request that Heidi Peterson provide 24 hour awake care for J.S.

1.62. J.S.'s condition improved at Hospice House, and Dr. Vivian Moise, M.D., issued new orders authorizing his release from Hospice House. Thomas Robinson, as Successor Guardian moved J.S. back to the Colbert, WA, Peterson Place, his former residence. He arranged with Peterson Place for 24 hour awake care. Exhibit 52, 53, 94.

II. CONCLUSIONS OF LAW

2.1. Respondent as a Certified Professional Guardian is subject to discipline by the Board pursuant to GR 23 and the Disciplinary Regulations.

2.2. A Disciplinary Proceeding Complaint and Notice to Answer were timely and properly served on Respondent.

2.3. Respondent timely filed an Answer, and this matter was set for hearing with a Notice of Hearing, timely and properly served on the Respondent, through her attorneys.

2.4. The Hearing Officer has jurisdiction to hear this disciplinary matter.

2.5. In considering the documentary evidence the Hearing Officer did not treat the opinion letters written by Commissioner Valente as binding. The Hearing Officer made independent Findings of Fact and Conclusions of Law.

2.6. The evidence does not establish any violation of the Appearance of Fairness Doctrine.

2.7. The evidence does not establish that Commissioner Valente is biased against Respondent. The transcripts from the hearings he conducted and the written opinion letters he issued demonstrate he acted fairly in all particulars related to these grievances, including the grievance which resulted in Respondent signing an Agreement Regarding Discipline.

2.8. A Guardian has the responsibility under RCW 11.88 to protect people who have incapacity. This responsibility is encompassed in the Standards of Practice Regulation (hereinafter SOP).

Guardianship of E.R. Grievance 2010-007

2.9. The reluctance of Heidi Peterson to agree to the first return of E.R. was reasonable. The emergency room staff failed to detect a urinary tract infection and blockage, which at the time of his second visit to the emergency room the same day, resulted in the removal of 1000ccs of urine (1 Liter). Merely sedating him and discharging him seems inadequate.

2.10. Not agreeing with the opinion of Heidi Peterson or her staff is not a failure to cooperate and carefully consider the views and opinions of professionals who are knowledgeable about E.R. With

respect to the first return of E.R. to Peterson Place, Respondent had the same medical information regarding the suitability of returning E.R. to Peterson Place as was communicated to Heidi Peterson or her staff.

2.11. After E.R.'s second emergency room visit, after treatment of E.R.'s urinary tract infection, and after overnight hospitalization, the medical professionals, including the CMHP, agreed that he was medically ready to be returned to Peterson Place. Respondent relied on independent professional evaluations.

2.12. Respondent could have shown greater empathy in how she handled the initial return of E.R. and the subsequent refusal of Peterson Place to allow E.R. to return. The situation was not beneficial to E.R. and appears to have negatively impacted the already poor relationship between Respondent, her staff, and Heidi Peterson and her staff.

2.13. The evidence does not support a finding that a violation of SOP 401.9 and 401.10 is proved by a preponderance of the evidence, and Grievance 2010-007 should be dismissed.

Guardianship of D.S. Grievance 2010-006 and 2009-013

2.14. A preponderance of the evidence establishes that Respondent violated SOP 401.9 and 402.1 by her failure to timely obtain new glasses for D.S. (The evidence establishes these violations by the clear and convincing standard, as well).

2.15. Reading is an important activity for D.S. and should have been apparent to Respondent. While she approved sending D.S. for an eye exam, she exhibited little enthusiasm for completing the steps necessary to facilitate this activity of daily living that is so enjoyed by D.S.

2.16. Whether the delay in obtaining the glasses is attributable to non-payment of the Optometrist, to D.S.'s dementia making it very difficult to complete the exam, or that the granddaughter had the prescription, is immaterial. The Respondent was dismissive of the need to replace the eye glasses because she deemed the glasses to have one scratched lens, only.

2.17. Respondent ultimately obtained a replacement prescription and new glasses were obtained. The delay is inexcusable. Respondent could have obtained a replacement prescription sooner or telephoned the granddaughter, if she believed the granddaughter had the original prescription.

2.18. Respondent did not violate SOP 405.2. When the request for new glasses was made she authorized the transport of D.S. to have an eye exam, instead of merely replacing the eye glasses with

the same prescription.

2.19. A preponderance of the evidence establishes that Respondent violated SOP 401.9 and 402.1 by moving D.S. from the Peterson Place Adult Family Home on or about November 6, 2009. (The evidence establishes these violations by the clear and convincing standard, as well).

2.20. There was a complete lack of meaningful discussion with D.S.'s involved family members or with the Peterson Place staff regarding this move or the basis for it. There was no evidence of any emergency medical justification for moving D.S. without input from her family.

2.21. The evidence offered by Respondent does not persuade the Hearing Officer that the move was motivated by poor care and the lack of 24 hour awake care. There was no showing that any quality of care issues could not have been addressed by discussion and communication. Respondent did not make a specific demand that Heidi Peterson provide 24 hour awake care for D.S. That such care could have been provided is shown by the 24 hour care J.S.'s successor Guardian obtained for J.S., on J.S.'s return to Peterson Place.

2.22. D.S.'s family members were upset and concerned that their mother had been moved and they could not contact anyone who had information about her condition or location. Respondent did not provide timely notice of the move or D.S.'s new address. Respondent was generally dismissive of the family members in her dealings with them.

2.23. A preponderance of the evidence establishes that Respondent violated SOP 401.9 and 402.1 by failing to inform the children of D.S. of the emergency room visit and subsequent hospitalization of D.S. from October 6, 2009 to October 8, 2009. The failure to notify the children of D.S. regarding these matters is not a violation of SOP 405.2.

2.24. The portion of Grievance 2009-013 regarding Respondent's alleged failure to return a telephone call is not proved.

Guardianship of J.S. Grievance 2010-005

2.25. It has not been established by a preponderance of the evidence that Respondent's conduct relating to J.S.'s IEP and schooling violate SOP 401.5, 401.9, 401.12, or 401.15.

2.26. J.S. received one homebound school visit in the Summer of 2009, which indicates J.S. was receiving educational benefits pursuant to the IEP. Respondent provided evidence she was following the expressed decision of J.S. regarding further schooling, and the opinion of Dr. Vivian Moise,

M.D., regarding alternative means of stimulation and socialization.

2.27. A preponderance of the evidence establishes that in moving J.S. from Peterson Place Adult Family Home the Respondent violated SOP 401.5, 401.9, 401.12, 401.15 and 404.5. (The evidence establishes these violations by the clear and convincing standard, as well).

2.28. Respondent showed no concern for the opinion or interest of J.S. in her decision to move him to Hospice House.

2.29. Respondent knew how severely affected J.S. was by his initial move into Peterson Place. She demonstrated no regard for the likely impact on him when he was moved to a hospice facility, even though she knew he was fully aware of the terminal nature of his hereditary disease.

2.30. Respondent failed to consider placement of J.S. in a Skilled Nursing Facility, re-negotiating the Agreement with Peterson Place to provide for 24 hour awake care, or arranging for provision of hospice care at Peterson Place.

2.31. Respondent failed to consider the preference of J.S. to remain at Peterson Place, a setting with which he was comfortable and familiar, during what were, then, perceived to be his final days.

2.32. Respondent did not transfer the reclining wheelchair with J.S., failing to protect the personal interests of J.S.

2.33. Respondent did not give consideration to the opinions of J.S., or cooperate and fully consider the views and opinions of professionals, relatives or friends of J.S.

2.34. Respondent did not make herself available during the move of J.S. by telephone or otherwise, causing a significant delay in delivering the reclining wheelchair, and otherwise being available to assist J.S., or Hospice House.

2.35. The professional misconduct of Respondent arising from the moving of D.S. and J.S. caused serious injury to J.S., D.S. and D.S.'s family.

2.36. The professional misconduct of Respondent arising from the replacement of D.S.'s eye glasses caused injury to D.S.

2.37. The Board has not established by a preponderance of the evidence that Respondent moved D.S. and J.S. from the Peterson Place Adult Family Home, where they were residing, in retaliation against Heidi Peterson, owner of Peterson Place because of her refusal to permit E.R. to return to Peterson Place.

2.38. The evidence establishes that Respondent did agree to be replaced as Guardian for D.S. (and others) which was accomplished. A preponderance of the evidence does not establish a violation of any SOP by Respondent.

2.39. A preponderance of the evidence does not establish that Respondent failed to answer any questions that caused DSHS to stop payment of the Adult Family Home.

2.40. The Grievance 2010-008 is not proved by a preponderance of the evidence and should be dismissed.

III. RECOMMENDATIONS TO THE BOARD FOR ACTION

In accordance with DR 511.16 and 515 the Hearing Officer makes recommendations to the Board for the following actions regarding sanctions and remedies:

Analysis of Factors

3.1. SOP 515.1.1, the duty violated:

A. Respondent has been found to have violated SOP 401.5, 401.9, 401.12, 401.15, 402.1, and 404.5.

B. These Standards of Practice can be characterized as involving the duty to actively seek out information from other people, including the incapacitated person, to enable the Guardian to make appropriate care and residential placement decisions in order to enhance the well-being of the incapacitated person. This is a paramount duty of any Guardian.

3.2. SOP 515.1.2, mental state: Respondent acted knowingly and wilfully.

3.3. SOP 515.1.3, potential or actual injury: The injury to D.S. and J.S. is actual, and significant. The injury to the children of D.S. is actual.

3.4. SOP 515.1.4.1, existence of aggravating factors:

A. Respondent has substantial experience as a Guardian, including prior service on the Board. While not specifically listed in DR 515.1.4.1, this Regulation's list of factors does not limit consideration of aggravating factors to only those enumerated. It is noted that the Agreement Regarding Discipline (see Exhibit 76) signed by Respondent cites Respondent's substantial experience as an aggravating factor. This factor is given significant weight.

B. Respondent refuses to acknowledge the wrongful nature of her conduct. Respondent's

position in this regard is troubling. It is one thing to dispute allegations of misconduct and challenge the evidence. Respondent has done much more than that. Respondent is insistent that, allegedly, improper actions and motivation by Commissioner Valente are the reason she is facing this disciplinary proceeding. And Heidi Peterson of Peterson Place Adult Family Home is to blame. According to Respondent, it is not her obligation as a Guardian to monitor the care needs of incapacitated persons. Respondent contends it is the obligation of the Adult Family Home owner to advise Respondent when the Adult Family Home can no longer provide appropriate care. This factor is given significant weight.

C. There are multiple offenses involving the Guardianships of D.S. and J.S., but only two complainants. This factor is given less weight.

D. The victims are vulnerable. By the very nature of guardianships, vulnerable people are impacted. Clearly D.S. and J.S. were vulnerable, although J.S. was capable of expressing his views and opinions. Additionally, both these individuals had advocates who helped to ameliorate the effect of the misconduct to a degree. This factor is given some weight.

E. There is a prior disciplinary action by the Board against Respondent, namely a Letter of Admonishment. While this is the lowest level of sanction it has relevance in this matter as it supports a conclusion that Respondent has a pattern of not cooperating or collaborating with others to insure the best interests of incapacitated persons are advanced. This factor is given significant weight.

3.5. SOP 515.1.4.2, existence of mitigating factors:

A. Respondent cooperated with the disciplinary proceedings, but there is no showing that Respondent cooperated beyond what is required of a Certified Professional Guardian in a disciplinary proceeding. This factor is given little weight.

B. Respondent takes referral cases from Adult Protective Service. This factor is given some weight.

C. No other mitigating factors were found to apply.

Sanction

3.6. Imposition of the sanction of decertification pursuant to DR 515.2.1.1, without consideration of aggravating or mitigating factors, requires concluding Respondent engaged in professional

misconduct with the intent to cause serious or potentially serious injury to a party. The Board asserts that "intent" as used in this DR means acting with the knowledge that one's actions may cause serious or potentially serious injury. This definition is more aptly characterized as "willful." See *Goldsmith v. DSHS*, 169, Wn.App 573 (2012). A review of all sections of DR 5.15.2.1 supports the conclusion that decertification is generally appropriate in cases of the most serious misconduct, and that "intent" as used in this DR means acting with the specific purpose to cause serious or potentially serious injury.

3.7. DR 515.2.3 can be characterized as imposition of the sanction of a letter of reprimand when the Guardian engages in professional misconduct that adversely reflects on the professional Guardian's fitness to practice, but which is not so serious as to be criminal in nature.

3.8. DR 515.2.2 can be characterized as imposition of the sanction of a prohibition against taking new cases or suspension for a period of time, or both, when the Guardian engages in professional conduct[1] that approaches criminal conduct that seriously reflects on the professional Guardian's fitness to practice.

3.9. The aggravating factors are significant and substantially outweigh the mitigating factors. For these reasons a sanction of a letter of reprimand is inappropriate.

3.10. The sanction of suspension for 12 months is appropriate for the professional misconduct relating to the residential relocation of D.S. and J.S.

3.11. The sanction of a prohibition of taking new cases for 3 months is appropriate for the professional misconduct relating to the acquisition of new eye glasses for D.S. This sanction to run concurrently.

3.12. The sanction of a prohibition of taking new cases for 3 months is appropriate for the professional misconduct relating to the failure to inform the children of D.S. of the emergency room visit and hospitalization. This sanction to run concurrently.

3.13. By way of remedy under DR 515.3, Respondent shall for a period of 24 months after the period of suspension, at her cost, obtain consultation from a qualified Certified Professional

[1] DR 515.2.2 refers to "professional **conduct** incompatible with the Standards of Practice" (emphasis added). I believe this section intended to refer to "professional misconduct" to be consistent with the other provisions of DR515.2, and that the actual printed word is a typographical error.

Guardian, subject to approval by the Board, to review any decision and the process followed, regarding the residential relocation of any incapacitated person for whom the Respondent is the Guardian, in advance of the relocation. Said consultant shall report to the Board within 30 days of any relocation regarding Respondent's adherence to the relevant Standards of Practice Regulations. In the event of exigent circumstances that require an emergency relocation of an incapacitated person without sufficient time for the consultant to perform a review, the consultant shall report to the Board, within 30 days after the relocation, regarding the exigent circumstances and Respondent's adherence to the relevant Standards of Practice Regulations to the extent practicable under the circumstances.

3.14. Pursuant to DR 516, Respondent should be required to pay costs, including the cost of the discipline process and any other directly provable expense, including attorney fees.

Dated: November 5, 2012.

Roderick S. Simmons, Hearing Officer
Certified Professional Guardian Board

DECLARATION OF SERVICE

I declare that on the date below indicated, at Olympia, Washington, I served a copy of this document upon the following parties of record: Michael L. Olver, Christopher C. Lee, and Kameron L. Kirkevold, Counsel for Respondent; and Chad C. Standifer, Assistant Attorney General, representing the Board, by electronic mail and regular mail.

Dated: 11/9/12

Kim Rood
Administrative Office of the Courts

CERTIFIED PROFESSIONAL GUARDIAN BOARD

In the Matter of: LORI A. PETERSEN, CPG NO. 9713, Respondent.	CPGB NOS. 2010-005, 2010-006, 2010-007, 2010-008, 2009-013 DECLARATION OF SHIRLEY BONDON

I, Shirley Bondon, declare as follows:

1. I am over the age required and competent to be a witness.

2. I am a Manager of Court Access Programs, within the Judicial Services Division of the Administrative Office of the Courts ("AOC"). I have knowledge of, and access to, the documents pertaining to the investigation and administrative adjudication of this matter, which is captioned as CPGB NOS. 2010-005, 2010-006, 2010-007, 2010-008, and 2009-013. I make this declaration based on personal knowledge and in my capacity as an employee of the AOC.

3. The following is a table of expenditures paid by AOC associated with the administrative adjudication of this matter:

Vendor	**Category**	**Price**
AOC – Copy Center	Copies (Grievance File) - 11/11/11	$ 16.97
AOC – Copy Center	Copies (Trial Transcript) - 11/15/12	$ 37.86
Thurston County Superior Court	Copies - 5/28/12	$ 6.00
Thurston County Clerk	Copies - 6/4/12	$ 25.00
Spokane County Clerk	Copies - 4/23/12	$ 336.00
AOC – Premiere Global	Telephone Conference - 6/20/12	$ 3.99
AOC – Premiere Global	Telephone Conference - 9/6/12	$ 3.26
AOC – Mr. Roderick Simmons, Hearings Officer	Travel Expense - 11/1/2012 (Mileage and Per Diem)	$ 803.97
AOC – Top Flight Travel	Travel Expense - 10/23/2012	$ 206.00

ORIGINAL

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

AOC – Enterprise Car Rentals	Travel Expense - 10/23/2012	$ 179.00
Capitol Pacific Reporting (transcript)	Trial Expense - 9/13/2012	$ 959.40
Korina Kerbs, Court Reporter (attendance at trial)	Trial Expense - 10/29/2012	$ 1,497.95
Korina Kerbs, Court Reporter (transcript)	Trial Expense - 11/8/2012	$ 2,454.35
Washington Rapid Transcription Service	Trial Expense - 7/15/2010	$ 152.00
Mr. Roderick Simmons, Hearings Officer	Professional Services	$ 6,783.53
Witness Reimbursement	Two Witnesses @ $10.00 each	$ 20.00
AOC Staff	40 hours @ $60.00/hour	$ 2,400.00
Attorney General's Office	May-October 2012	$24,480.88
TOTAL EXPENSES:		**$40,366.16**

I declare under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

DATED and signed this 29th day of November 2012, in Olympia, Washington.

SHIRLEY BONDON

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

The Supreme Court
State of Washington

BARBARA A. MADSEN
CHIEF JUSTICE
TEMPLE OF JUSTICE
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OLYMPIA, WASHINGTON
98504-0929

(360) 357-2037
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February 21, 2013

Honorable James W. Lawler, Chair
Certified Professional Guardian Board
PO Box 41170
Olympia, WA 98504-1170

Dear Judge Lawler:

Thank you for submitting a letter of commitment and collaboration stating your support for the Supreme Court's grant application to establish a Working Interdisciplinary Network of Guardianship Stakeholders (WINGS). The court is committed to working with you and other stakeholders to address the challenges faced by persons with disabilities and their families in planning their futures, ensuring their safety and well-being, and making medical and end-of-life decisions.

While we know that guardianship is the answer for many people with disabilities, we understand that guardianship is not the answer for everyone. The court looks forward to the opportunity to collaborate with you to ensure that an array of decision-making options and resources are available to anyone who needs them. The WINGS group provides an appropriate mechanism for this work.

We anticipate learning that our grant proposal was successful in March. Shortly after we are notified, we will contact you with information about the next steps. Thank you again for taking the time to express your support and for agreeing to be a part of this important work group. If you have any comments, suggestions or concerns, please feel free to contact me at J_B.madsen@courts.wa.gov and/or Shirley Bondon, Manager, Court Access Programs, Office of Public Guardianship, at shirley.bondon@courts.wa.gov. I value your expertise and appreciate your continued commitment to and support of appropriate decision-making assistance for our neighbors with disabilities.

Sincerely,

Barbara Madsen

Barbara A. Madsen
Chief Justice

February 13, 2013

Honorable Barbara A. Madsen
Washington State Supreme Court
PO Box 40929
Olympia, WA 98504-0929

Dear Chief Justice Madsen:

Re: Applicability of the Uniform Disciplinary Act to Guardian Complaints

Issue

The Court recently received public comments about proposed GR 31.1 (governing public access to the judiciary's administrative records). Several of the comments were written to support a proposal to amend proposed GR 31.1 so that public access to professional guardian records would be governed by standards that are set forth in the Uniform Disciplinary Act (UDA), Chapter 18.130 RCW, rather than by the standards and practices currently used by the Board. The Court asked the Board to submit a written public comment responding to this proposal. In particular, the Board was asked to indicate why, or why not, public access to the Board's professional guardian records should be governed by standards based on those found in the UDA RCW 18.130.095(1)(a).

Background

The Board is a regulatory body which functions similarly to Lawyer Admissions, Licensing and Discipline administered by the Washington State Bar Association (WSBA) for the Washington State Supreme Court and Judicial Discipline administered by the Commission on Judicial Conduct. The Board administers the application or credentialing process for guardian certification, including appeal of denials, annual recertification and the disciplinary process.

Unlike professions governed by the UDA, professional guardians are appointed officials of the court system, selected by the court and supervised both by the Board and the court. The court scrutinizes the actions of a professional guardian in a specific guardianship and the Board scrutinizes a guardian's aggregate conduct across his or her caseload.

Comparison of Pertinent UDA Provisions to Board Public Disclosure Policy:

RCW 18.130.095(1)(a) (UDA in pertinent part):

The secretary, in consultation with the disciplining authorities, shall develop uniform procedural rules to respond to public inquiries concerning complaints and their disposition, active investigations, statement of charges, findings of fact, and final orders involving a license holder, applicant, or unlicensed person. The uniform procedural rules adopted under this subsection apply to all adjudicative proceedings conducted under this chapter and shall include provisions for establishing time periods for initial assessment, investigation, charging, discovery, settlement, and adjudication of complaints, and shall include enforcement provisions for violations of the specific time periods by the department, the disciplining authority, and the respondent. A license holder must be notified upon receipt of a complaint, except when the notification would impede an effective investigation. At the earliest point of time the license holder must be allowed to submit a written statement about that complaint, which statement must be included in the file. Complaints filed after July 27, 1997, are exempt from public disclosure under chapter 42.56 RCW until the complaint has been initially assessed and determined to warrant an investigation by the disciplining authority. Complaints determined not to warrant an investigation by the disciplining authority are no longer considered complaints, but must remain in the records and tracking system of the department. Information about complaints that did not warrant an investigation, including the existence of the complaint, may be released only upon receipt of a written public disclosure request or pursuant to an interagency agreement as provided in (b) of this subsection. Complaints determined to warrant no cause for action after investigation are subject to public disclosure, must include an explanation of the determination to close the complaint, and must remain in the records and tracking system of the department.

UDA Provision 1: Complaints filed after July 27, 1997, are exempt from public disclosure under chapter 42.56 RCW until the complaint has been initially assessed and determined to warrant an investigation by the disciplining authority.

Board: The Board's policy is currently consistent with UDA Provision 1. Grievances[1] which have not been assessed and determined to warrant an investigation are exempt from public disclosure.

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[1] Terms used by the UDA and the Board are not consistent. The term "complaint" used by the UDA has the same meaning as the term "grievance" used by the Board.

A "grievance" is a written document filed by any person with the Board, or filed by the Board itself, for the purpose of commencing a review of the professional guardian's conduct under the rules and disciplinary regulations applicable to professional guardians. The grievance must include a description of the conduct of the professional guardian that the grievant alleges violates a statute, fiduciary duty, standard of practice, rule, regulation, or other authority applicable to professional guardians, including the approximate date(s) of the conduct.

UDA Provision 2: Complaints determined not to warrant an investigation by the disciplining authority are no longer considered complaints, but must remain in the records and tracking system of the department.

Board: The Board's policy is currently consistent with UDA Provision 2. Grievances which are determined not to warrant an investigation are dismissed, but remain in the Board's records and tracking system.

UDA Provision 3: Information about complaints that did not warrant an investigation, including the existence of the complaint, may be released only upon receipt of a written public disclosure request or pursuant to an interagency agreement as provided in (b) of this subsection.

UDA Provision 4: Complaints determined to warrant no cause for action after investigation are subject to public disclosure, must include an explanation of the determination to close the complaint, and must remain in the records and tracking system of the department.

Board: The Board's policy is not consistent with UDA Provisions 3 and 4. The Board treats grievances dismissed without investigation and those dismissed after an investigation similarly. Information about grievances that did not warrant an investigation and those investigated but did not warrant action are disclosed upon written request using established procedures for inspection, copying, and disclosure with identifying information about the grievant, incapacitated person, and professional guardian and/or agency redacted. A request for dismissed grievances must cover a specified time period of not less than 12 months.

The Board is attempting to create a mechanism to balance the conflict between privacy and access to public records. In the practice of guardianship, there are competing concerns. All stakeholders must act to appropriately protect incapacitated persons from potential abuse and exploitation, thus limiting access to certain information is necessary to protect persons subject to guardianship. At the same time, the public has the right to information that will assist them evaluate the guardianship system, and individual guardians and agencies have the right to protect information which could harm their reputations unjustly. The Board has determined that releasing dismissed grievances with specific information redacted achieves the necessary balance of protecting incapacitated

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A "complaint" is the document filed by the Board during a disciplinary proceeding for the purpose of bringing the matter before a hearing officer for a factual hearing on the issue of whether or not the professional guardian's conduct provides grounds for the imposition of disciplinary sanctions by the Board. In a complaint, the Board describes how the professional guardian allegedly violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other authority. The Board must approve the filing of a complaint.

individuals, providing the information needed to assess the system while reducing potential harm to practitioners.

Tracking and Analyzing Grievances to Inform Guardianship Policy Decisions

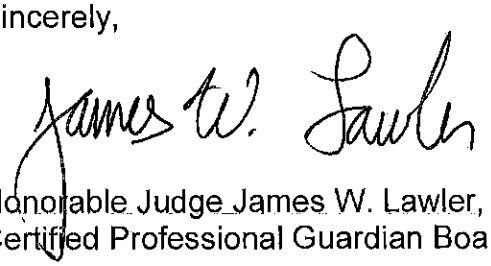
The Board supports tracking and analyzing grievances to inform guardianship policy decisions. The Board's current public disclosure policies do not inhibit tracking and analyzing for systemic change. Redacted information such as identifying information about the grievant, incapacitated person, and professional guardian and/or agency isn't necessary for system analysis.

The Board's ability to analyze data is constrained by resource availability. Board members are volunteers, all with other jobs and responsibilities, and the staff provided by the AOC is overextended making it difficult to perform more than required prioritized tasks associated with certification and grievance investigation. Additional resources would be appreciated.

Request

The Certified Professional Guardian Board (Board) reviewed the BJA Public Records Work Group's proposed changes to General Rule (GR) 31 and the provisions of the UDA. The Board respectfully requests that Board public disclosure provisions remain in GR 31 as currently proposed.

Sincerely,



Honorable Judge James W. Lawler, Chair
Certified Professional Guardian Board