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July 23, 2010

VIA FAX

Ronald A. Cowan  
Disability Law Center  
3330 Arctic Blvd, Ste. 103  
Anchorage, AK 99503

Dear Mr. Cowan:

We are writing in response to your letter of June 22, 2010 to Shawn Morrow. At the outset we trust you are still authorized by the adolescent and his mother to have access to the information we are providing. If this is not the case, we ask that you please so inform us immediately and return this document without reading further or making any copies. As indicated previously, we represent Bartlett Regional Hospital and are responding on its behalf. We always welcome the opportunity to constructively examine ways to improve patient care and that is why we fully cooperated with your requests for information. In considering the assertions of the DLC, we have fully considered all relevant facts as those facts were presented to our clinicians, the applicable statutory requirements and the judgment of our experienced clinicians. We believe the care provided at Bartlett was entirely appropriate.

We do not have the ability to duplicate your investigation and have not attempted to do so. We have access to only our own records. We do not have the ability to interview the other involved providers. We have, however thoroughly reviewed the sequence of events that occurred at the Hospital. All providers involved at the Hospital considered the best interests of the adolescent and acted on sound principles of patient care. All listened to and did their best to work with both he and his mother on an expedited basis during their limited time at Bartlett. The adolescent, who without question presented a significant risk to himself and others, was safely transferred to API, which was his mother's expressed intention from the very outset. Every single involved professional, including those who saw the adolescent at the Hospital and those who saw him later, believed the transfer necessary and appropriate. And as you note, some of what you criticize, such as the admissions policies at API and the transfer procedures, are things the Hospital has no control over and cannot be criticized for.

At the outset, it is apparent that the DLC engaged in a retrospective analysis. As you note in your report, the DLC has had almost 1 year to analyze the underlying facts. On the other hand, our clinicians had access to the facts only as they unfolded over the

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approximate 20 hours the adolescent was at Bartlett. In this case the adolescent and his mother arrived at the Bartlett Emergency Room without prior notice late on a busy Friday afternoon. Our clinicians could only address the facts they had access to at the time. And in making the clinical judgments made, our clinicians had to consider all of those facts, not just some of them. On the other hand, it appears the DLC has overlooked critical facts, as many critical facts are nowhere mentioned in its report. Furthermore, it considered events that had not even occurred at the time the underlying clinical judgments were made, information our clinicians could not possibly have had access to. The DLC has apparently not had the care given reviewed by qualified health care professionals for while it has criticized some of the judgments of our providers, it has given no indication that it consulted any qualified health care provider to review those judgments.

It is not our purpose to identify every error, omission or inconsistency in your report. But it is important that what happened be accurately and fairly portrayed. It is likewise important that the legal standards be accurately described. That is the purpose of what is set forth below. The following are the facts as we understand them.

**February 20, 2009 (Friday)**

**1452 hours.** The adolescent, his mother and his Cornerstone advocate arrived at Bartlett and were seen shortly thereafter by the triage nurse, who noted he has had “AGITATED and AGGRESSIVE BEHAVIOR (Escalating violent behavior at home. Defiance towards mother.)” He described feelings of depression, has had situational stress and anxiety. He also described feelings of sadness and anger. His family described him as aggressive and combative. As the nurse told you, she clearly recalls being told there were concerns expressed about harm to him and harm to others. The nurse understood these concerns led to him being brought to the ER. Per standard procedure, he was placed under 1-on-1 supervision with his mother being present. A more in depth assessment was planned. This was described as a typical emergency room visit.

**1516 hours.** The adolescent, his mother and his Cornerstone advocate were seen by an Advanced Nurse Practitioner. His chief complaint was recorded as “ANXIOUS, WITHDRAWN, BEHAVIOR CHANGE and MEDICAL CLEARANCE AND AGITATED, ANGRY, AGGRESSIVE and VIOLENT BEHAVIOR.” The ANP noted these behavioral problems escalated 3 weeks ago and he has experienced situational problems and exhibited a behavior change. He had not been sleeping, has had anxiety and has been depressed. His symptoms were described as “severe”. He was reported to be smearing feces over the bathroom. The ANP understood that Cornerstone had contacted API because he was a threat to himself and to others. She described a history of “frightened friends and/or relatives.” She recalls the mother wanted a referral from the Emergency Room to API and that she also wanted the Emergency Room to arrange her travel, neither of which the Emergency Room could do. She was concerned about the

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adolescent's mental health and his behavioral issues, as well as the desire of the mother for a referral to API and as a result, called Cornerstone and JAMHI.

**1540 hours.** The ANP noted she had consulted with JAMHI, who consulted API.

**1600 hours.** The adolescent was seen by an experienced JAMHI clinician, who is a licensed professional counselor. She described his presenting problem as: "16 y.o. male brought to ER by Mom and family advocate after complaints of violent behavior towards peers at school, staff and Mom. Client is using chairs and table knives as weapons when agitated. He has been spreading feces across the wall in the bathroom, masturbating in inappropriate settings, and escalating violence towards others. His symptoms from autism, oppositional defiant disorder and mood disorder are interfering with his ability to cope with his environment in a profound way."

His homicidal ideation was unclear. He had a history of violent behavior, with the clinician noting he becomes aggressive with others and is a victim of violence from peers. He tends to escalate when limits are set, especially with his mother the past couple of months.

He was described as slightly agitated during the interview, rocking back and forth and avoiding eye contact. He did not want to describe the events leading up to coming to the ER and became upset when his mother responded.

The JAMHI clinician believed him to be significantly impaired. The JAMHI clinician assessed his risk as a "high risk of grave disability."

**1700 hours.** The on call psychiatrist for Bartlett received a phone call from the JAMHI clinician, who indicated she was in the ER with the adolescent and his mother. She requested admission of the adolescent to the mental health unit. The JAMHI clinician reported the adolescent was "Violent, escalating, taking knives, gesturing, furniture as weapons. Physical altercations with peers." She also reported violence to school staff and violence towards his mother. This was reported as an acute situation that had been escalating over time. It was also reported that arrangements had already been made by other providers for the adolescent's transport to API, which could not be accomplished immediately, so he needed admission to the mental health unit overnight until his transport could be accomplished.

The Bartlett psychiatrist, who had provided several years of treatment to the adolescent and thus knew he and his mother well, understood this represented a crisis and also understood that API considered this enough of a crisis to hold a bed for the adolescent.<sup>1</sup>

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<sup>1</sup>This understanding was apparently confirmed by your interview with the API social worker: "The social worker explained that API's admission criteria was that an individual either had to be determined to be 'gravely disabled' and/or pose a 'serious risk of harm to themselves or others.'" (DLC Letter Attachment at page 22). This

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He believed admission to API and therefore Bartlett was entirely appropriate. The clinical decision to admit the adolescent was based on his history of escalating violent behavior, which had been ongoing and was not expected to change without intervention. This decision to admit was also based on the need to expedite access to more definitive treatment. In the psychiatrist's experience, one of the most reliable predictors of future violent behavior is a past history of violent behavior, and the history of escalating violence as given here was very concerning to him. The goal of admission at Bartlett was to preserve the safety of the adolescent and others, as well as expedite access to more definitive treatment, which had already been arranged by his other providers. Given the information presented, the admitting psychiatrist believes it would have been irresponsible to have discharged him home or elsewhere.

The psychiatrist approved the JAMHI clinician's request for admission and according to Bartlett policy, cleared the admission through the Nursing Supervisor. The Nursing Supervisor provides a second check on the appropriateness of admission and in this case approved the JAMHI clinician's request for admission. This is an important step in the case of an adolescent because 1:1 staffing has to be arranged. This is so because Bartlett does not have specific programming for treatment of adolescent patient. For safety measures, children and adolescents in the mental health unit are kept in a room with 1:1 staff supervision at all times to ensure they are protected from the adult patients there.

Before calling in admission orders, the psychiatrist discussed the adolescent with the ANP. He discussed her history and examination and confirmed that it was medically appropriate to admit him to the mental health unit. The ANP documented this conversation, as well as her subsequent conversation with the ER physician and noted the adolescent would be admitted to the mental health unit.

The psychiatrist admitted the adolescent on a "voluntary" basis, as confirmed in the admission orders and in the Application for Voluntary Admission signed by the adolescent's mother. He is not aware of any objection to this admission.

**1709 hours.** The ER physician noted he had discussed the case with the ANP and that he agreed with the plan of treatment, including the need to transport to API. Before writing this note, he would have reviewed the available records, which would have included the record of examination by the ANP and the interview record of the JAMHI clinician. He discussed the case with the ANP and with the JAMHI clinician and signed a POA order, both to protect the adolescent and others and to facilitate his transfer to

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understanding is also confirmed by API's Admissions Policy and Procedures, which you reference as requiring that "in order to be admitted the individual had to meet the definition of mental illness, as well as the 'gravely disabled' or the 'likely to cause serious harm' conditions". . . In addition, there must be a determination that no less restrictive treatment alternative is available in the community." API's Certificate of Need for Hospitalization also confirms this assessment, as it certified that the adolescent "is dangerous to self and others without inpatient care." (DCL Letter Attachment at 24-5).

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API. While he does not now recall signing this order, he would have done so only after reviewing all available information and considering the recommendation of the JAMHI clinician. The POA order was filled out with the assistance of the JAMHI clinician, who wrote: "Client has escalating aggression, easily agitated and unable to maintain safety when upset. Client has used furniture as weapons with Mom at home, and been recipient of violence from peers as result of functioning level, as a result of oppositional disorder. . ." In reviewing these records, he believes POA order was clearly appropriate given the history of escalating violence, the recommendations of the JAMHI clinician, which included her assessment that the adolescent was at "high risk of grave disability" and the need to have such an order in place so that transfer API could be accomplished as expeditiously as possible.<sup>2</sup> He believes that any other course of action would have placed the adolescent at risk, interfered with the prior arrangements of prompt transfer to API and would have been irresponsible given the circumstances.

**1840 hours.** Verbal Orders for Admission were given by the Bartlett psychiatrist for the voluntary admission of the adolescent to the mental health unit.

**1944 hours.** The adolescent was transported to the mental health unit and according to all information we have received, spent a safe and quiet night there.

**February 21, 2009 (Saturday)**

The Bartlett psychiatrist began working on this case as his first order of business on Saturday morning, as he had received a report that the transport would be arriving sometime that morning. As set forth above, he knew the adolescent and his mother from prior treatment and because of this relationship was highly motivated to help them. He gave this case his full and complete attention until the adolescent was transferred, which as reflected in his note covered a period of 3 hours and 15 minutes. He gave this case precedence in a very busy mental health unit, with other patients having to wait for the psychiatrist to conduct his rounds with them. He reviewed the record of the ANP and the JAMHI clinician's handwritten report, which confirmed his impression of the acute nature of the situation. He noted there were multiple indicators supporting the need for acute psychiatric admission, an impression that was strengthened by the fact that the adolescent's admission to API had already been arranged by non-Bartlett providers. He was particularly concerned that the adolescent had been violent with others and had been the victim of violence himself. He noted that the JAMHI clinician had been unable to

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<sup>2</sup>The need for a POA appears to have been confirmed by your interview with the API social worker, who evidently told you that "while it was not unheard of that an adolescent could be admitted to API as a voluntary admission, it was rare and only occurred on a space-available basis. The social worker went on to state this was because, given limited beds and other resources, API's primary mission was to provide services to those individuals who were in crisis and/or most in need of their services. The social worker apparently further told you that "API's admission criteria was that an individual either had to be determined to be 'gravely disabled' and/or pose a 'serious risk of harm to themselves or others.'" (DLC Letter Attachment at page 22). And of course, the State would not have paid for the transport of a voluntary admission. See Footnote 10 *infra*.

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rule out homicidal ideation, that the adolescent had police involvement, that there had been complaints about the adolescent being violent at school, with staff and with his mother, at times using chairs and table knives as weapons. He had been spreading feces on the wall in the bathroom and masturbating in inappropriate settings. His violence was described as escalating.

The Bartlett psychiatrist interviewed the adolescent that morning. He acknowledged hitting boxes and throwing things, but denied hitting anyone and essentially denied the reports of his violent behavior. The interview yielded little useful information.

The Bartlett psychiatrist spoke with the adolescent's mother several times throughout the morning by phone. He was told that the adolescent was escalating frequently, with violent outbursts. He was told the adolescent didn't understand the consequences of his actions, and that he was defiant and lashing out. He was told the adolescent threatened his mother with a chair, and that he throws other things. He was told the adolescent got into a physical altercation at Cornerstone. These behaviors were represented to be escalating, and his mother indicated she very much wanted the adolescent admitted to API.

The Bartlett psychiatrist called API and spoke with the Admitting Screening Officer (ASO). The ASO confirmed the requirements for doctor to doctor contact before transfer had been fulfilled. She confirmed the appropriateness of admission to API, acceptance of the patient to API and the history of prior arrangements. The ASO told the Bartlett psychiatrist that a POA would be necessary for the transport and that the adolescent could not be admitted without one, even if his mother was willing to have him come on a voluntary basis. The ASO was adamant that a POA had to be in place.<sup>3</sup> The ASO also informed the Bartlett psychiatrist that parents are not allowed to be present at API during the admission process. The Bartlett psychiatrist had not been aware that a POA was already in place and assumed the responsibility of preparing the order himself.

Among the many calls made by the Bartlett psychiatrist that morning was a call to the JAMHI clinician on call that day. With her assistance a meeting of all involved parties was convened on short notice. This meeting took place in the mental health unit conference room. Present were the adolescent's mother, her advocate from CCS, the JAMHI clinician, the ASO from API (by speaker phone) and the psychiatrist. During this meeting, the ASO confirmed with the adolescent's mother that a POA was necessary for the adolescent to be transported and that he could not be admitted without it. The adolescent's mother raised various concerns, which those present listened to, considered and addressed. Each concern had to do with API requirements or transfer requirements that were beyond the control of Bartlett to change. The goal of getting the adolescent

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<sup>3</sup>This appears to be consistent with what the API social worker told you and the API Policies and Procedures as referenced above. See Footnotes 1 and 2 *supra*.

