2014 WL 9911015 (Ariz.Super.) (Trial Motion, Memorandum and Affidavit)
Superior Court of Arizona.
Pima County

Reyna Van TASSELL, on behalf, of herself and all those entitled to, recover for the death of Byron Van, Tassell, Plaintiff,

v.

UNIVERSITY MEDICAL CENTER CORPORATION, an Arizona corporation, Southern Arizona Regional Rehabilitation Hospital, LP, doing business as Healthsouth Rehabilitation Hospital of Southern Arizona, John Does I-V, ABC Corportions I-V, Defendants.

No. C20099898.
February 23, 2014.

Plaintiff's Response to Motion for Partial Summary Judgment of Defendant UMC

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Hon, Charles Harrington.

Defendant UMC's "Motion for Summary Judgment on Plaintiffs Adult Protective Services Act ('APSA') Claim" seeks dismissal ONLY of the APSA claim, not plaintiff's other claim of Wrongful Death/Medical Malpractice. Therefore, this is a Motion for PARTIAL Summary Judgment. The motion should be denied because plaintiff has stated an APSA claim under Arizona law. This case involves the only available trauma hospital for all of Southern Arizona and a patient with a severe spinal cord injury. Evidence in this case has shown a troubling and pervasive failure by University Medical Center to provide for the basic nutrition and physical needs of its paraplegic patients. This is exactly the kind of case that Arizona's Adult Protective Services Act was meant to apply to. Plaintiff's Response is supported by the Memorandum of Points and Authorities attached; Plaintiff's Separate Statement Of Facts In Support Of Her Response To All Motions For Summary Judgment Filed By Defendants On January 28, 2014; the court file and such oral argument as this court allows.

RESPECTFULLY SUBMITTED this 28th day of February 2014.

LAW OFFICE OF JOJENE MILLS, P.C.

JoJene E. Mils

Attorney for Plaintiff

MEMORANDUM OF POINTS AND AUTHORITIES

I. APPLICABLE LAW

As stated above, is important to note that Defendant UMC requests only the dismissal of plaintiffs claim under the Adult Protective Services Act ("APSA"). Defendant UMC does not seek dismissal of plaintiffs wrongful death claim, alleging medical malpractice. Defendant apparently concedes that plaintiff has presented sufficient evidence to present her medical malpractice claim to the jury.

Defendant UMC also does not claim that the first two elements of an APSA claim are missing. Defendant does not dispute that University Medical Center was "employed to provide care" under A.R.S. §46-455(B). The court of appeals held; that acute care hospitals "provide care" so as to be the subject of an APSA claim. *In re Estate of Wyatt, 232* Ariz. 506, ¶ 14, 307 P.3d 73 (App. 2013).

Defendant also does not dispute that Byron Van Tassell was a "vulnerable adult" while at UMC. A " 'Vulnerable adult' means an individual who is eighteen years of age or older who is unable to protect himself from **abuse**, neglect or exploitation by others because of a physical or mental impairment." A.R.S. §45-451(9). During the admission at issue, December 4-26, 2007, Van Tassell suffered blood clots in his lungs and chest effusion, coded, had surgery, was sedated and] intubated and in the ICU for seven days, and throughout, was a paraplegic, unable to move below his mid-chest. (Def. Jt. SOF, UMC Discharge Summary) I

Defendant's motion rests on the APSA element, "whose life or health is being or has been endangered or injured by neglect, **abuse** or exploitation...." A.R.S.§45-455(B). Defendant correctly notes that the statute defines each of these three concepts:
"Neglect" means a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health. §45-451(A)(6)

"**Abuse**" means:

(a) Intentional infliction of physical harm.

(b) Injury caused by negligent acts or omissions.

(c) Unreasonable confinement.

(d) Sexual **abuse** or sexual assault. §45-451 (A)(1)

"Exploitation" means the illegal or improper use of a vulnerable adult or his resources for another's profit or advantage. §45-451(A)(4)

Defendant UMC correctly cites the only two Arizona cases that interpret these definitions. *In In re Estate of Wyatt,* 232 Ariz. 506, 307 P.3d 73 (App. 2013), the court stated,
Negligence is not actionable under APSA unless the plaintiff is able to show "a pattern of conduct ... resulting in deprivation of food, water, medication. medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health."

Id. At ¶ 13. However, this definition focused only upon the "neglect" definition. The court in *Wyatt* failed to consider the "injury caused by negligent acts or omissions" language of §45-451(A)(1). The court also failed to make any reference to *Estate of McGill ex rel McGill v. Albrecht,* 203 Ariz. 525, 57 P.3d 384 (2002), in which the Arizona Supreme Court dealt precisely with the question of what acts state a claim under the APSA. The court held,

> We therefore conclude that we can neither automatically limit the negligent act or omission wording of A.R.S. § 46-451(A)(1) to a series of negligent acts nor say that a single act of negligence involving an incapacitated person will never give rise to an APSA action. We hold instead that to be actionable **abuse** under APSA, the negligent act or acts (1) must arise from the relationship of caregiver : and recipient, (2) must be closely connected to that relationship, (3) must be linked to the service the caregiver undertook

> because of the recipient's incapacity, and (4) must be related to the problem or problems that caused the incapacity.

McGill at ¶ 16. Further,

Nor does the statute's text permit us to conclude that something more than negligence is required to constitute **abuse**. What more could that be? Defendants suggest that a "mental state greater than mere lack of due care is required," such as "intent to harm or at least disregard of the likely harm." Supplemental Brief of Defendant Beach at 1. But **abuse** as a basis for an action is defined as being either intentional harm, negligent harm, unreasonable confinement, or sexual **abuse** or assault. A.R.S. § 46-451(A)(1)(a) to (d). Thus, the legislature explicitly stated that both intentionally caused harm and negligently-caused harm could constitute **abuse**. Nor could we conclude that the legislature meant to require a showing of gross negligence to sustain a plaintiffs burden of proving **abuse**. The statute speaks only of negligent acts or omissions. The legislature surely knows how to require a showing of gross negligence, having used that term in a great number of statutes. See, e.g., A.R.S. § 33-155 1(C)(2) ("Grossly negligent" means a knowing or reckless indifference to the health and safety of others.).

McGill at ¶ 20. |

II. SUMMARY JUDGMENT STANDARD

Summary judgment is only appropriate if the evidence, viewed in the light most favorable to the nonmoving party, demonstrates that there are no genuine issues of material fact, and that the moving party is entitled to judgment as a matter of law. *Orme School v. Reeves,* 166 Ariz. 301, 305, 802 P.2d 1000, 1004 (1990). The court must not weigh the evidence or determine the truth of the matter but only determine whether there is a genuine issue for trial. *Id.* at 311, 802 P.2d at 1010. In determining whether genuine issues of material fact exist, a court must draw all reasonable inferences in favor of the party opposing the motion. *Rowland v. Kellogg Brown & Root, Inc.*, 210 Ariz. 530, ¶ 2, 115 P.3d 124, 125 (App.2005). Summary judgment is not appropriate where a court would be required to "pass on the credibility of witnesses with differing versions of material facts," "weigh the quality of documentary or other evidence," or "choose among competing or conflicting inferences," *Orme School v. Reeves,* 166 Ariz. 301, 311, 802 P.2d 1000.] 1010 (1990); *Shaw v. Petersen,* 169 Ariz. 559, 561, 821 P.2d 220, 222 (App. 1991). ;

III. DEFENDANT UMC'S TREATMENT OF BYRON VAN TASSELL; MEETS ANY STANDARD FOR "ABUSE" OR "NEGLECT" UNDER THE APSA.

A. ***UMC's Negligence Involved Deprivation of Food and Other Basic Services Necessary to Maintain Minimum Physical or Health, Over a Significant Number of Days.***

Byron Van Tassell fell from a ladder and became a paraplegic on November 4, 2007. While receiving rehabilitation as a new paraplegic at HealthSouth, his physicians became fearful that he was suffering blood clots. They transferred him to Defendant UMC on December 4, 2007. While at UMC, his physicians discovered he did indeed have blood clots and also fluid in his chest. When a chest tube failed on December 8, 2007, he coded, was taken to surgery and placed on a ventilator. He was in ICU, after his surgery, from December 8 to December 14, 2007. He continued his recovery at UMC on a medical-surgery floor until December 26, 2007, when he was transferred back to HealthSouth. He was at UMC for 23 days. (Pf SOF ¶¶ 2-3)

Throughout this case, Defendant UMC has trumpeted how Van Tassell's physicians saved his life. However, the hospital's services were not limited to treating the blood clots and chest fluid. Hospitals are also required by law and the standard of care to protect the patient from other injuries and conditions, when those patients cannot protect themselves. (Pf SOF ¶ 13)

While Byron Van Tassell was recovering from his blood clots and surgery at UMC, he was dependent upon the hospital staff for all of his needs. His medical conditions, as well as his newly-acquired paralysis, severely limited his ability to take care of himself. He was unconscious and intubated for a number of days. He required food. He required a bed. He required bathing. He required skin care. By accepting Van Tassell as its patient, UMC undertook all these responsibilities. (Def. Jt SOF , Ex 4)

During Byron Van Tassell's 23 days at UMC, he developed a serious pressure ulcer over his tailbone (a "sacral" pressure ulcer) and a second wound on his right buttock from shearing. (Pf SOF ¶4) These wounds followed the development of an episode of severe malnutrition in the hospital that ultimately caused Van Tassell to lose 45 pounds, or over 20% of his weight, in less than three weeks. (Pf SOF ¶ 7) The sacral wounds progressed from no wound at admission. to a Stage 1 wound, to a Stage 2 wound, to a Stage 3 wound, with the second friction/shear wound, all during the UMC admission. (Pf SOF ¶4; Exemplars of. wound stages are Ex. 12 to Pf SOF)

These wounds would cause Van Tassell to suffer complications that would ultimately require 24 more hospitalizations over the next four years, multiple! surgeries and, ultimately, his death. (Pf SOF ¶6, 39) Plaintiffs spinal cord | medicine experts, Elizabeth James, M.D., testified how defendants' negligence caused Van Tassell's death. (Pf SOF ¶ 135-152) Dr. James and even a UMC experts testified that the complications Van Tassell suffered are exactly the kinds of complications expected from pressure ulcers, which is why these medical errors have been studied so pervasively. (Pf SOF ¶ 133)

B. ***UMC's Failures Involved One of the Most Studied Medical Errors in Hospital Medicine.***

The injury in this case is not the usual kind of medical malpractice injury.: The injury in this case, pressure ulcers, sometimes referred to as bedsores, is perhaps one of the most studied "quality indicators" in medicine. (Pf SOC ¶ 14-22) In the last three decades, the U.S. Government has published numerous policy statements and evidence-based guidelines aimed at preventing and treating pressure ulcers. (Pf SOF ¶¶ 15, 16, 18, 19)
Preventing pressure ulcers has been a nursing concern for many years. In fact, Florence Nightengale in 1859 wrote, "If he has a bedsore, it's generally not the fault of the disease, but of the nursing." Others view pressure ulcers as a "visible mark of caregiver sin" associated with poor or nonexisting nursing care. Many clinicians believe that pressure ulcer development is not simply the fault of the nursing care, but rather a failure of the entire health care system--hence a break down in the cooperation and skill of the entire health care team (nurses, physicians, physical therapists, dieticians, etc.)

U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Patient Safety and Quality: An Evidence-Based Handbook for Nurses." Chapter 12 titled, "Pressure Ulcer: A Patient Safety Issue, " (Pf SOP ¶ 15)

The evidence about prevention is so clear, that by 2006, the federal government designated Stage 3 pressure ulcers as "never events," or "Serious and costly errors in the provision of health care services that should never happen." The U.S. government's designation of Stage 3 pressure ulcers as "never events" was motivated by the billions of dollars of unnecessary costs and the unnecessary suffering that pressure ulcers cause. (Pf SOF ¶20) The government also announced in 2006 that in 2007, hospitals would be required to report any Stage 3 pressure ulcer that was not "present on admission" and announced that Medicare and Medicaid would stop paying for hospital services when a Stage 3 pressure ulcer occurred in a hospital, beginning in October 2008. (Pf SOF ¶ 20)

Naturally, these regulation changes by Medicare, especially the announcement that there would be financial penalties for pressure ulcers, caused a huge response in the medical industry. Some examples of hospitals' efforts to meet the "present on admission" regulations and reduce the incidence of pressure ulcers included: special committees were set up to work with the entire nursing staff; more documentation in the computer; automatic notification of wound care nurses by computer programs when the patient's Braden scale indicted high risk; prevalence studies; education at conferences about how other hospitals were reducing prevalence of pressure ulcers; music played over the hospital communications system that was a cue for repositioning patients; financial incentives for nurses. (Pf SOF ¶29)

Evidence in this case shows curiously meager information about pressure ulcer prevention at UMC. (Pf SOF ¶25-30) University Medical Center had policies and procedures that directly addressed pressure ulcer prevention and treatment and the policy documents themselves show they were revised in August 2007. (Pf SOF ¶38, UMC "Pressure Ulcer Prevention (1825.0)) [1] The hospital provided some inservice education about pressure ulcers and sometimes posters around the hospital. However, most of the nurses deposed could not think of any unusual efforts at the; hospital regarding pressure ulcers as "never events" or changes in procedures in the 2000-2007 time frame. (Pf SOF ¶¶26-27)

More importantly, an examination of the standard of care and UMC's policies, versus what actually happened at UMC during Van Tassell's 12/4/07 admission, shows a hospital culture at odds with the standard of care and policies in every aspect of pressure ulcer prevention and treatment. It appears that UMC's policies were merely window-dressing, as follows:

C. *Evidence Developed in this Case Shows UMC Staff Routinely Violated the Hospital's Own Policies and the Standard of Care.*

Plaintiffs allegations that the care was negligent are assumed to be true. when the court considers whether summary judgment is necessary. *Rowland v. Kellogg Brown & Root, Inc.*, 210 Ariz. 530, ¶ 2, 115 P.3d 124, 125 (App.2005)(In determining whether genuine issues of material fact exist, a court must draw all reasonable inferences in favor of the party opposing the motion.) The question, then, is whether the allegations assumed to be true, state a claim under the APSA. Plaintiff respectfully suggests that in reviewing a claim under Arizona's APSA, the basic facts of this case, which are not disputed by UMC, satisfy the summary judgment standard, with all inferences resolved in favor of a jury trial. In other words, these basic facts require that plaintiff's claim be submitted to a jury: (1) Van Tassell's dramatic weight loss of 45 pounds in 23 days, while UMC was ! responsible for providing his food, (necessarily implicating the care of numerous nurses and dieticians); (2) Van Tassell's development of a pressure ulcer; (3) the worsening of that pressure ulcer from Stage 1 to Stage 2 to Stage 3 over the course of 15 days, (necessarily implicating the care of numerous nurses); (4) the development of a second friction/shear wound; (5) UMC's admission, through its nurses and experts, that its basic services required reasonable nutrition and pressure ulcer prevention and treatment.

Nevertheless, plaintiff has provided detailed record evidence of UMC's failures. Plaintiff's opposition to Defendant UMC's Motion for Partial Summary Judgment is based upon the facts that are provided to the court in Plaintiff's Separate Statement Of Facts In Support Of Her Response To All Motions For Summary Judgment Filed By Defendants On January 28, 2014. Plaintiff will not 1 repeat all the available evidence here, but will summarize the highlights that show that Van Tassell's injuries and death were caused by a system-wide failure to provide adequate nutrition and nursing support to this patient.

1. Nursing care is chronicled in a document called a "Patient Plan of Care." UMC nurses and experts testified the nursing "Plan of Care" was maintained and continuously amended to reflect the patient's desired outcomes and the planned interventions. "Desired Outcomes" are defined by the UMC Department of Patient Care Services as "Standards of Care" for Spinal Cord Trauma patients. This policy listed as "Standards of Patient Care (Desired Patient Outcome)," the following: "4. The patient will experience no additional injury," and "9. The patient will maintain intact skin integrity." UMC nurses testified that | when the patient develops pressure ulcers, this should have been added to the "Plan of Care" with planned interventions. Major medical conditions, such as severe malnutrition, should also be specifically addressed. Yet in the 23 days that Van Tassell was at UMC, neither his pressure ulcers nor his severe malnutrition were ever listed as a condition or diagnosis on the plan of care. That these life-threatening conditions were never listed and planned for by the UMC nurses, in this long hospitalization, was an indication to plaintiffs experts that this hospital staff did not consider such problems to be priorities. (Pf SOF ¶ 40-48)

2. According to its own expert, UMC was required under federal law to provide nutrition services to its patients that will allow the patient "to retain the highest practical level of nutrition status." (Pf SOF ¶ 49) Every scholarly article on pressure ulcer prevention and treatment emphasizes the critical role that adequate nutrition plays in wound prevention and healing. (Pf SOF ¶50)

During his two hospitalizations after his fall. Van Tassel] did not sutler any significant weight loss. (Pf SOF ¶56) When Van Tassel! entered UMC on. December 4, 2007, he was not malnourished, but a dietician warned that he was "at risk." (Pf SOF ¶(58)

In this 23-day admission, Van Tassell lost 45 pounds, or over 20% of his weight. (Pf SOF ¶7, 54) He was discharged with a diagnosis of "severe protein calorie malnutrition." (Pf SOF ¶59) That Van Tassell suffered such a severe weight loss in such a short period of time, during the December 4, 2007 UMC admission, is a concern even for UMC's nutrition expert, Nancy Collins, who describes herself as a "professional expert witness." (Pf SOF ¶52)

On multiple occasions during the December 4, 2007 UMC admission. Van' Tassell's physicians ordered that he be evaluated by a dietician from UMC's nutrition services. However, with one exception, each time Van Tassell was! evaluated by an uncredentialed diet intern or a diet tech. Testimony established! that diet techs were only supposed to see low risk nutrition patients. This was a; high-risk spinal cord-injured patient with poor intake and a stage 2 pressure ulcer. In addition, registered dieticians signed off on the students' and interns' notes without ever seeing the patient. This was inappropriate care, according to plaintiffs dietician expert. (Pf SOF ¶57-76)

The explanation for why Van Tassell became severely malnourished involves a long list of failures: his protein labs were not checked regularly, in violation of hospital policy; his oral intake was not documented, in violation of the standard of care; when he had to go on a ventilator, he received no nutrition for at least 4 days, despite a physician's order for tube feeding; next, his tube feeding was clearly insufficient and was stopped for unknown reasons without a physician's order; after the tube feeding was stopped, Van Tassell was not assessed by a dietician for several more days and when he was assessed, the student dietician's plan for the patient was inadequate according to a UMC dietician who was questioned and UMC's own nutrition expert; the nurses were unaware of the dietician's assessments and recommendations and repeatedly charted that he had no risk of malnutrition, after he had been diagnosed with malnutrition by his physicians (Pf SOF ¶51 -76).

The final insult came just prior to Van Tassell's discharge from UMC to HealthSouth. He was evaluated, for the first time by a credentialed dietician.; Melissa Einfrank. She noted his severe malnutrition as indicated by his laboratory values and that he was meeting only 44% of his calorie needs and 36% of his protein needs. She listed a number of interventions that would be necessary after discharge "at rehab facility." Yet in a 7-page "Patient Discharge Instruction and Plan," prepared by UMC for the patient's transfer to HealthSouth, the only information provided about his nutrition was "Diet-Regular." Plaintiffs nutrition expert, Ms. *McKee,* felt this "was indicative of the poor care he received there...." (Pf SOF ¶76).

Ms. McKee testified about the extraordinary deterioration in Van Tassell's nutrition during his stays at UMC and HealthSouth, as did plaintiffs physician expert, Jennifer James, M.D. Both experts testified about how the severe malnutrition caused and worsened the pressure ulcers. (Pf SOF ¶77, 139-140)

One question raised by all this evidence is whether UMC's obvious failure to provide sufficient dietary services is related to the fact that hospitals are not paid ! for dietician services to patients. (Pf SOF ¶79)

3. An essential part of pressure ulcer prevention, especially in a high risk i patient, is the constant assessment of the patient's skin integrity, so as to watch for the beginning of a pressure ulcer, or further deterioration. (Pf SOF ¶80-84) Yet the evidence shows that nursing assessment of Van Tassell's skin was haphazard at best and completely absent during crucial times. (Pf SOF ¶85-91) UMC's "Skin I Care Nurse," Annie Blackett, was skeptical about her nurses' ability to assess wounds. "They keep saying Stage 2 because everybody loves to stage something. whether they know what the stage is or not." She testified it was very hard to teach the nurses competency in staging pressure ulcers. (Pf SOF ¶87) UMC did not even require that patient's wounds be photographed. (Pf SOF ¶92)

4. Wound care nurses are specially trained to provide expert assessment, consultation and treatment recommendations for pressure ulcers. (Pf SOF ¶93) In December 2007, there was only one wound care nurse available for all ; consultations at UMC. (Pf SOF ¶97) This was Annie Blackett, R.N. Ms. Blacken! was asked whether this was adequate staffing and stated, "Well

in my opinion I'm sure I would have liked more help; there is no question. But, you know, I-- I felt that 1 was covering the referrals as needed." (Pf SOF ¶28)

UMC's nursing policies contain clear criteria for when floor nurses were required to request consults from the UMC wound nurses. (Pf SOF ¶94) Despite the presence of multiple criteria present with Van Tassell, no nurse ever requested a consult, throughout this hospitalization. Ms. Blackett did not see the patient until December 17, 2007, at the request of the physician and saw the patient i only once. The only documentation of her visit was orders for a special mattress and treatment for the wounds. No progress note was found. She *never* saw him again, despite worsening of his condition. (Pf SOF ¶97)

5. A critical element of pressure ulcer prevention is positioning--keeping pressure off bony surfaces. (Pf SOF ¶ 107-110) Yet, turning/repositioning was not consistently followed at UMC. (Pf SOF ¶111-113_) By 2007, the medical Industry had developed many different ways of prompting hospital staff to reposition patients. (Pf SOF ¶(29) UMC adopted no such policies. (Pf SOF ¶30) For the ED, 3NE and 4NE units that Van Tassel! was on, there was no required; documentation or computer prompts for when or even if the nurses actually repositioned their patients. (Pf SOF ¶112) However, as an example of choices the hospital could have made to prevent patient injuries, the computer system DID require that the nurses affirmatively document that they performed "fall risk prevention" every two hours, 24 hours a day. There was no such mechanism for pressure ulcers. (Pf SOF ¶112)

6. UMC also had special support mattresses for high-risk patients. Under hospital policy criteria, the hospital was required to provide a special i mattress from the beginning of Van Tassell's admission (Pf SOF ¶116-119), yet he was not assessed for a special mattress and did not receive one until two weeks into the admission, after he had already developed his sacral pressure ulcer. (Pf SOF ¶120)

7. Despite policy requirements, Van Tassell's pressure ulcers were not reported to his physicians until two weeks into his admission, after at least 30 assessments by nurses showing a need to report his condition. (Pf SOF ¶123-128)

D. ***No Matter What Standard the Court Applies Under the APSA, This, Case States a Claim.***

Even the health care industry has admitted that most pressure ulcers are a result of negligent medical care. In 2010, the "National Pressure Ulcer Advisory Panel" hosted a multi-disciplinary conference on pressure ulcers. The resulting Consensus Statement defined "Avoidable" and "Unavoidable" Pressure Ulcers.
An avoidable pressure ulcer can develop when the provider did not do one or more of the following: evaluate the individual's clinical condition and pressure ulcer risk factors; define and implement interventions consistent with individual needs, individual goals and recognized standards of practice; monitor and evaluate the impact of the interventions or revise the interventions as appropriate.

An unavoidable pressure ulcer can develop even though the provider evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions consistent with individual needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Black, et al., NPUAP Consensus Statement, (Pf SOF ¶22) Although this consensus statement was published in 2010, Judy Gates, R.N., the wound care expert for Defendant HealthSouth, acknowledged that this was also the standard of care in 2007. (Pf SOF ¶(21)

Evidence in this ease shows that UMC did not "evaluate the individual's clinical condition and pressure ulcer risk factors; define and implement interventions consistent with individual needs, individual goals and recognized standards of practice; monitor and evaluate the impact of the interventions or revise the interventions as appropriate." In other words, this was an avoidable pressure ulcer.

This was an avoidable pressure ulcer because of multiple, systemic failures! at UMC. All of the facts coalesce to form the impression that the culture at UMC, across nursing, nutrition and wound care nurses, was that pressure ulcer prevention and even nutrition, were not a priority, even for a high risk patient like Van Tassell, even in the face of wide discussion in the medical industry of the need and mechanisms for prevention, even though nutrition and pressure ulcer prevention involve caring for the basic physical needs of the patient. No matter what this court determines is the proper standard for a negligence claim under the APSA, reasonable jurors could certainly believe that these facts show "something more." that a single act of negligence, justifying the claim.

If the court applies the standard announced by the Arizona Supreme Court in *Estate of McGill ex rel McGill v. Albrecht*, 203 Ariz. 525, 57 P.3d 384 (2002), the facts shown here meet the standard of "aris[ing from the relationship of caregiver and recipient, [and are] closely connected to that relationship, [and are] linked to the service the caregiver undertook because of the recipient's incapacity, and [and are] related to the problem or problems that caused the incapacity." *Id.* at ¶16. UMC accepted spinal cord-injured patients like Van Tassell, who are at high risk for pressure ulcers because of this very incapacity. Patients like Van Tassell are forced to rely upon hospital staff for the components of pressure ulcer prevention; (assessment, nutrition, interventions such as repositioning, specialized wound care, reporting to physicians and reassessing these plans when wounds develop or worsen). Yet evidence in this ease shows that across staff disciplines, UMC failed to follow its own prevention and intervention policies for this well-known and very preventable problem. The *McGill* test is satisfied.

Even if this court applies the test from *In re Estate of Wyatt*, 232 Ariz. 506, 307 P.3d 73 (App. 2013), "a pattern of conduct ... resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health," plaintiff presents a jury Issue. The facts here involve conduct by multiple nurses, the wound care nurse and by hospital dieticians, all in violation of hospital policy aimed directly at food, nursing services, shelter (the mattress the patient lay on)--services necessary to maintain minimum physical health. In the face of massive publicity about pressure ulcers as "never events," Southern Arizona's only trauma center was failing to follow even its own basic, written policies.

IV. CONCLUSION

For all these reasons, this court should order that plaintiff may submit her claim under the APSA, including Byron Van Tassell's pain and suffering and plaintiff's claim for attorneys fees, to the jury.

RESPECTFULLY SUBMITTED this *28th* of February 2014

LAW OFFICE OF JOJENE MILLS, P.C,

<<signature>>

Attorney for Plaintiff

Original of the foregoing filed, and one copy hand-delivered this 28th day of February 2014 to:

Hon. Charles Harrington

Pima County Superior Court

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Footnotes

1 Plaintiff asked Defendant UMC to produce. “All hospital policies and procedures, applicable in 2006, 2007 or 2008, including nursing policies and procedures, pertaining to pressure ulcers (prevention, treatment, reporting, prevalence), mattresses or surfaces, wound care nurses, consultation with wound care nurses and/or nutritionists, Braden scale, positioning, any policies and/or procedures relating to paraplegics or any other policies and/or procedures that arc relevant to the issues in this case.”

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