IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF PIERCE

ESTATE OF JOHANNA PRATT, Plaintiff, v. WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, RAINIER SCHOOL, and MEGAN DESMET, Defendants.	No. COMPLAINT

I. INTRODUCTION

JoHanna Pratt was killed by inexcusable medical neglect by Rainier School, in violation of her rights under state common law and the Washington Neglect of a Vulnerable Adult statute, RCW 74.34 et seq. Ms. Pratt suffered physical and emotional harms, and her Estate suffered economic harms, for which this lawsuit seeks compensation.

II. PARTIES

1. Plaintiff Estate of Johanna Pratt is a citizen of the United States and a resident of Pierce County, Washington.

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2. Defendant Rainier School is a habilitation center for individuals with intellectual and developmental disabilities located Buckley, Washington, in Pierce County. Rainier School is owned by the State of Washington and operated by the state's Department of Social and Health Services (DSHS).

2. Defendant Washington State Department of Social and Health Services ("DSHS") is an agency of the state of Washington, responsible for the operation of Rainier School.

3. Defendant Megan DeSmet is the superintendent of Defendant Rainier School and is sued in her official capacity.

III. JURISDICTION & VENUE

1. Pierce County is a proper venue for this action under RCW 4.12.020 because one or more of the defendants is located or conducts business in this county. Also, the events giving rise to this action occurred in Pierce County.

IV. SERVICE OF CLAIM FOR DAMAGES

1. In compliance with RCW 4.92.100, Plaintiffs properly served a completed Claim for Damages on the State of Washington and DSHS on August 19, 2020.

2. More than sixty (60) days have elapsed since the date of service of the Claim for Damages.

3. Therefore, Plaintiff's claims are properly before the above-entitled court.

V. SUMMARY OF PERTINENT FACTS

1. Plaintiff Johanna Pratt had been a resident at Rainier School since 2012.

2. Ms. Pratt had been diagnosed with a mild Intellectual Disability.

3. On November 3, 2017, Ms. Pratt underwent outpatient foot surgery (a "McBride bunionectomy") at a community hospital.

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4. She returned to Rainier the same day in a wheelchair and with a cast on her right foot.
5. Prior to and again following Plaintiff's surgery, Plaintiff's podiatrist provided written instructions to Rainier School staff emphasizing that they should seek immediate medical attention for Plaintiff if she developed any symptoms of shortness of breath.
6. These warnings were consistent with medical standards of care relating to the well-known risk of Deep Vein Thrombosis, a medical condition occurring when a blood clot forms in the blood vessels of the leg.
7. This condition is life-threatening if the clot travels through blood vessels into the lungs, where it can cause a fatal pulmonary embolism.
8. At the time of Plaintiff's surgery, Rainier had no written policy requiring updated medical care plans for residents returning to the facility following medical care in the community.
9. Likewise, there was no written policy for considering and processing recommendations from community medical providers related to medical care received off the Rainier campus.
10. Rainier medical staff failed to incorporate either the pre-surgical instructions or the after-care directions into a comprehensive care plan in relation to Plaintiff's medical needs following surgery.
11. In the evening of November 7, 2017 (four days after the surgery), Ms. Pratt "got up from her bedroom saying she was having a hard time breathing and didn't feel well."
12. Staff at the cottage where Ms. Pratt lived called a Rainier nurse, who came to the cottage and assessed Ms. Pratt at 10:55PM.

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13. The nurse's notes indicate that Ms. Pratt stated that "she had difficulty breathing and that she was experiencing some anxiety[.]"

14. The nurse noted that Ms. Pratt had "slightly elevated respirations," and that Ms. Pratt's pulse rate was 116 beats per minute.

15. Ms. Pratt was not given any additional medical care at that time.

16. At 5:13 PM on November 8, 2017, nearly 24 hours after her shortness of breath symptoms began, Ms. Pratt again reported to her house staff that she was having difficulty breathing.

17. She also reported chest pain.

18. House staff called Rainier nursing staff, who responded, took Ms. Pratt's vital signs, and directed Ms. Pratt's house staff to call 911.

19. At 5:27pm, EMTs arrived.

20. They started an IV, provided an oxygen mask, and placed Ms. Pratt on a cardiac monitor.

21. At 5:35pm, the EMTs placed Ms. Pratt on a stretcher to transport her from the house to the ambulance.

22. Notes from multiple witnesses indicate that, once on the stretcher, Ms. Pratt "appeared to panic."

23. She removed the oxygen mask; repeatedly stated "I can't breathe;" and was "transported out the door yelling and screaming."

24. Ms. Pratt went into cardiac arrest upon reaching the ambulance.

25. EMTs attempted CPR for 33 minutes.

26. Ms. Pratt died in the ambulance, which remained parked in the street in front of her cottage, at 6:17pm on November 8, 2017.

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27. Ms. Pratt's Death Certificate lists her cause of death as "Pulmonary Embolism- post-podiatric surgery (bunion removal)."

28. If Rainier staff had sought immediate medical assistance for Ms. Pratt when her shortness of breath first occurred, her life would have been saved.

29. A "Supplemental Investigation Report" completed by the Washington Developmental Disability Administration ("DDA") in November, 2017, reviewed the circumstances of Ms. Pratt's death.

30. The DDA investigation report concluded that the Rainier nurse who examined Ms. Pratt in the evening on November 7, 2017, following her complaints of shortness of breath should have notified a Rainier doctor regarding Ms. Pratt's elevated pulse.

31. The report also indicates that "our current pathways criteria states that a physician should be notified of a pulse rate over 100."

32. The same report indicates that Ms. Pratt's Rainier house staff should have immediately called 911 upon her report of chest pain on November 7, 2017 (instead of calling the Rainier nurse first) per Rainier's Medical Emergency Policy (Rainer SOP 2.13).

33. Rainier SOP 2.13 indicates that staff should immediately call 911 for any resident complaint of chest pain.

34. An investigation by the State of Washington Aging and Long-Term Support Administration ("ALTSA") found that Rainier's failure to update to develop or update medical care plans for clients returning to the facility following medical care in the community violated a federal rule requiring that state DDA facilities have medical care plans for all residents determined to require 24 hour nursing care, 42 CFR 483.460(a)(2).

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35. The ALTSA survey concludes that "based on record review and interview, the facility failed to ensure an appropriate medical care plan for after surgery for [Ms. Pratt]."

36. The ALTSA report further concludes that "[t]his failure placed the client at risk of harm and may have potentially contributed to her death."

37. The ALTSA survey report resulted in the issuance of an "immediate jeopardy level citation" for Rainier's failure to protect facility residents.

38. While in the care of Rainier School, Ms. Pratt was employed in various capacities and earned income.

39. Prior to her death, Ms. Pratt had been assessed for a housing placement in the community outside of Rainier School. The assessment indicated that she could be placed successfully in the community, and planning for her discharge from Rainier School was underway at the time of her death.

40. Had Ms. Pratt survived, she would have been discharged to a housing placement in the community and could have maintained employment in the community for decades.

V. CLAIMS

A. WRONGFUL DEATH

1. Plaintiff re-alleges the above facts and incorporates them below.
2. Defendants negligently failed to provide adequate medical care to Plaintiff, constituting medical malpractice.
3. The negligence of Defendants was the direct and proximate cause of damages to Ms. Pratt as alleged in this Complaint, including her pain and suffering, future earnings loss, and death.

B. NEGLECT OF A VULNERABLE ADULT: RCW 74.34

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1. Defendants owed a duty of care to Plaintiff under RCW 74.34, Washington's Abuse of Vulnerable Adults statute.
2. Defendants breached their duty to Plaintiff by neglecting her while she was in their care, in that:
    a. Plaintiff was a vulnerable adult as defined in RCW 74.34.020(22) by reason of her developmental disability;
    b. Defendants engaged in a pattern of conduct or inaction that failed to provide Plaintiff the goods and services to maintain her physical or mental health, or that failed to avoid or prevent physical or mental harm or pain to Plaintiff; or
    c. Defendants committed an act or omission that demonstrated a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to Plaintiff's health, welfare or safety
3. The actions and/or omissions of Defendants were the direct and proximate cause of damages to Plaintiff as alleged in this Complaint, including pain and suffering, future earnings loss, and death. In addition, Defendants are liable for reasonable attorney's fees and costs.

VI. JURY DEMAND

Plaintiff demands a trial by jury.

VII. RELIEF

Plaintiff requests the following relief:

1. Judgment in an amount to be proven at trial against Defendants.
2. An award of costs and attorney's fees.
3. Such other relief as the court deems just and equitable.

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Date: October 21, 2020.

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