STATE OF MINNESOTA | **DISTRICT COURT**
COUNTY OF ANOKA | **TENTH JUDICIAL DISTRICT**

CASE TYPE: CIVIL - OTHER

ANNE QUINER, AS HEALTH CARE AGENT FOR HUSBAND SCOTT QUINER, PATIENT

Plaintiff,

vs.

MERCY HOSPITAL,

Defendants.

EX PARTE TEMPORARY RESTRAINING ORDER

Court File No.: 02-CV-22-104

This matter came before the Honorable Jennifer L. Stanfield, Judge of District Court on Plaintiff's Motion for a Restraining Order.

Based upon the Motion, Affidavit of Anne Quiner, and Affidavit of Plaintiff's Attorney, the Court makes the following:

ORDER

1) Defendant Mercy Hospital is RESTRAINED from turning off Scott Quiner's ventilator.
2) This matter is set for a hearing on **February 11, 2022 at 1:30 PM**. This hearing shall be held via Zoom due to the ongoing pandemic.
3) If Plaintiff does not proceed for a temporary injunction, the Court shall dissolve the Temporary Restraining Order.
4) In preparation for this hearing, both parties shall file Memoranda on the five *Dahlberg* factors pursuant *Dahlberg Bros. v. Ford Motor Co.*, 137 N.W.2d 314, 321–22 (Minn. 1965). Specifically, the parties shall discuss the legal authority for removing an

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individual from life support in Minnesota. These Memoranda shall be due on the following dates:

a. Plaintiff's Memorandum: January 21, 2022 at 4:00 PM
b. Defendant's Memorandum: January 28, 2022 at 4:00 PM
c. Plaintiff's Memorandum on any new issues raised by Defendant's Memorandum: February 4, 2022 at 4:00 PM

Dated: ________________ ________________________________
Hon. Jennifer L. Stanfield
Judge of District Court

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STATE OF MINNESOTA
COUNTY OF ANOKA

DISTRICT COURT
TENTH JUDICIAL DISTRICT

CASE TYPE: CIVIL - OTHER

ANNE QUINER, AS HEALTH CARE AGENT FOR HUSBAND SCOTT QUINER, PATIENT

Plaintiff,

vs.

MERCY HOSPITAL,

Defendants.

AFFIDAVIT OF PLAINTIFF IN SUPPORT OF EX PARTE TEMPORARY RESTRAINING ORDER

Court File No.: ________________

STATE OF MINNESOTA)
)ss
COUNTY OF HENNEPIN)

Affiant Anne Quiner, being duly sworn on oath deposes and states as follows:

1. I am the wife of Scott Quiner, a patient at Mercy Hospital, Defendant herein.
2. I have been appointed by my husband as his Agent to make health care decisions in the event he is unable to do so, via Mionnesota Health Care Directive dated August 28, 2017, a copy of which is attached hereto as **Exhibit A**.
3. My husband is currently on a ventilator. I am in process of finding a new facility to provide medical care for my husband but need more time.
4. Doctors employed by Defendant Mercy Hospital have advised that they intend to take actions on Thursday January 13, 2022 that will end my husband's life. These actions include turning off his ventilator.
5. I have advised the doctors that I vehemently disagree with this action and do not want my husband's ventilator turned off.

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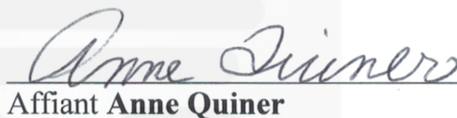
6. Absent an Order from the court restraining Defendant Mercy hospital from turning off the ventilator, my husband will die.

I declare under penalty of perjury that everything I have stated in this document is true and correct. Minnesota Statutes §358.116.

Dated: January 12, 2022



Affiant **Anne Quiner**

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MINNESOTA HEALTH CARE DIRECTIVE

(MEDICAL POWER OF ATTORNEY & LIVING WILL)

I, Scott W. Quiner, understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint Anne Quiner to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: Spouse.

Telephone number of my health care agent: 612-[illegible]483-1808.

Address of my health care agent: 2204 Buffalo Ridge DR, City of Buffalo, MN, State of MN.

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(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint

____________________ to be my health care agent instead.

Relationship of my health care agent to me: ____________________.

Telephone number of my health care agent: ____________________.

Address of my health care agent: ________________________, City of

____________________, State of ____________________.

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

____

____

____

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My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

SO_____ To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

SO_____ To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

____

____

____

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE (I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

____

____

____

My fears about my health care:

____

____

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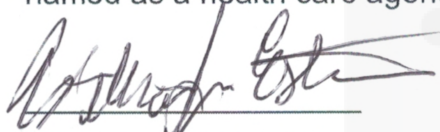
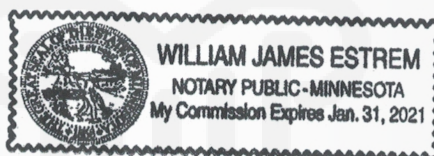
Option 1: Notary Public

In my presence on 8/30/2017 (date), Scott Quiner (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.



(Signature of Notary)

(Notary Stamp)



Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One

(i) In my presence on ________________ (date), ________________ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [_____]

I certify that the information in (i) through (iv) is true and correct.

Witness One Signature: ________________ Date Signed: ________________

Date of Birth: ________________

Address: ____________________, City of ________________, State of

________________.

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My spiritual or religious beliefs and traditions:

Request Prayer from friends + family at bedside

My beliefs about when life would be no longer worth living:

My thoughts about how my medical condition might affect my family:

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE (I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:(Note: You can discuss general feelings, specific treatments, or leave any of them blank)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:

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If I were dying and unable to decide or speak for myself, I would want:

____

____

____

If I were permanently unconscious and unable to decide or speak for myself, I would want:

____

____

____

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

____

____

____

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

____

____

____

There are other things that I want or do not want for my health care, if possible:

____

____

____

Who I would like to be my doctor: ______________________________________

Where I would like to live to receive health care: _____________________________

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Where I would like to die and other wishes I have about dying:

____

____

My wishes about donating parts of my body when I die:

None

____

My wishes about what happens to my body when I die (cremation, burial):

____

____

Any other things:

____

____

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature: [signature] Date Signed: 8/28/17

Date of Birth: 1, 29, 1966

Address: 2204 Buffalo Ridge DR., City of Buffalo, Minnesota

*If I cannot sign my name, I can as someone to sign this document for me:

Anne Quiner

____

*Signature of the person who I asked to sign this document for me:

Signature: [signature] Print Name: Anne Quiner

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STATE OF MINNESOTA
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AFFIDAVIT OF ATTORNEY FOR PLAINTIFF IN SUPPORT OF EX PARTE TEMPORARY RESTRAINING ORDER

Court File No.: 02-CV-22-104

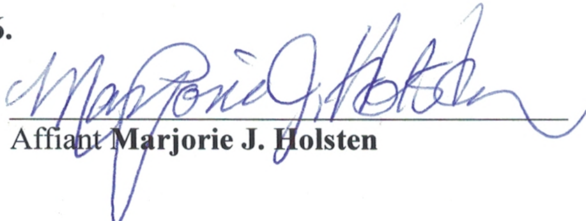
STATE OF MINNESOTA)
)ss
COUNTY OF HENNEPIN)

Affiant Marjorie J. Holsten, being duly sworn on oath deposes and states as follows:

1. I am the attorney for Anne Quiner, wife of Scott Quiner, a patient at Mercy Hospital, Defendant herein.
2. My client was advised by Defendant that they intend to turn off her husband's ventilator at 12:00 p.m. on January 13, 2022. A screenshot from Scott Quiner's "My Chart" is attached hereto as **Exhibit A**.
3. When Defendant came to my office the afternoon of January 12, 2022, I called Defendant and spoke with Heather Whiteis and stated that I was in process of getting an Order temporarily restraining them from taking this action that will cause the death of Scott Quiner.
4. Heather Whiteis called at approximately 4:00 p.m. and advised that she had not yet received a copy of the Order. I said it was still in process. She advised that she was leaving for the day and that as soon as I had the Order I needed to email it to Matthew.hill@allina.com.

I declare under penalty of perjury that everything I have stated in this document is true and correct. Minnesota Statutes §358.116.

Dated: January 12, 2022



Affiant **Marjorie J. Holsten**

MINNESOTA JUDICIAL BRANCH

T-Mobile 6:23 PM 52%

Back S Past Visit Close

Matt H, Beth J and myself called the wife at the agreed upon time today and the agreed upon number, 1230 pm x 2 and nobody answered the phone. Her home phone does not have an ability to leave a message.

We then called her mobile number and left a message stating that we had attempted to reach her at her home number and we were available to discuss the care plan defined yesterday. If she wished to speak with us further she should call the bedside nurse who can then call me directly.

At this time there is no change in the care plan. As defined yesterday, we will plan for cessation of ventilatory support tomorrow (1/13/2022) at noon. Family would be able to be present at the bedside thru the compassionate exception to the no visitor status at this time.

Exhibit 1A

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