MAINE SUPREME JUDICIAL COURT

SITTING AS THE LAW COURT

Law Court Docket No. KEN-14-192

Maine Department of Health and Human Services

In re: A.P.

On Appeal from the District Court (Augusta)

Brief of Appellee
State of Maine Department of Health and Human Services

Janet T. Mills
Attorney General

Nora Sosnoff
Assistant Attorney General
Maine Bar Registration No. 6872

Martha Hallisey Swift
Assistant Attorney General
Maine Bar Registration No. 8803

6 State House Station
Augusta, ME 04333
(207) 626-8800

Attorneys for State of Maine Department of Health and Human Services

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Statement of Facts

In this consolidated appeal, the mother asks the Law Court to review a Judicial Review Order of the District Court dated April 24, 2014 (Augusta, *Stanfill, J.*) (A. 9-21) and a Jeopardy Order of the District Court dated May 29, 2014 (Augusta, *Stanfill, J.*) (Blue Br. at Supp. Appendix 1-8.) The District Court authorized the Maine Department of Health and Human Services ("Department") to make medical decisions for A.P., including the authority to issue a directive of "Do Not Resuscitate" ("DNR"). (A. 21.)

A.P. was born June 15, 2013. (A. 191.) She was "a previously healthy 6-month-old" (A. 140) until she suffered lethal injuries at the hands of her father. (A. 137; I Tr. 194.)

A.P. cannot see or hear and will never be able to regain those abilities. (I Tr. 60, 167-168.) She is a spastic quadriplegic who will not walk or purposefully move any part of her body ever again. (I Tr. 34, 36.) She persistently arches her torso backwards to such an extent that she nearly touches her back with her head. (I Tr. 57.) A.P. is unable to suck or swallow and requires a gastric feeding tube (G-tube) for nourishment. (I Tr. 33; A. 12.) She feels pain. (II Tr. 141.) She experiences neurological irritability.[1] (I Tr. 91-92.) She is uncomfortable for the great majority of her waking hours despite high doses of pain reducing medication. (II Tr. 132.)

[1] A type of irritability arising from the brain injury, that makes A.P. unable "to tolerate environmental stimulation because there's no processing of it." A.P. does not respond to "the typical techniques that you would use to console a child." (I Tr. 92.)

For her first six months of life, A.P. lived with her mother, seventeen-year-old Mother, and her father, twenty-one year-old Father (II Tr. 202, A. 97, 191.) On the morning of December 21, 2013, the father was alone with A.P. at home. (II Tr. 203.) The father was playing "Call of Duty" on his X-Box. (A. 111, I Tr. 236.) A.P. was fussy. (I Tr. 236.) Interrupted from his X-Box video play, the father went to the baby. (I Tr. 236.) The father was frustrated. (I Tr. 236.) He "lost it...." (I Tr. 236.) The father violently shook the baby. (I Tr. 236, 182.) The baby's eyes rolled back in her head, her back arched and her breathing stopped or became labored. (I Tr. 236.)

The father carried A.P. to his car and drove towards the Augusta Burger King where the mother was working. (I Tr. 226, 227.) The father was stopped by local law enforcement before reaching his destination. (I Tr. 227.) The police officer took the infant to a near-by fire station. (I Tr. 227.) A.P. was transported to MaineGeneral Medical Center (MGMC), and subsequently to Maine Medical Center (MMC). (A. 51.)

A.P. suffered a catastrophic "fatal" brain injury. (I Tr. 33.) Her father's violence caused retinal hemorrhages, subdural and subarachnoid hemorrhages and a cessation of breathing. (I Tr. 28, 29.) Because A.P. at some point stopped breathing, and experienced a loss of oxygen to her brain, she suffered a hypoxic, global injury to her cortex. (I Tr. 30-31; 23-24.) "Her hypoxic injury doubled or tripled the severity of the brain injury for her." (I Tr. 30-31.)

Her "severe diffuse irreversible brain injury" will cause A.P. to "die prematurely from her injuries, and she will never be able to function beyond an

early infantile level." (I Tr. 166, 169.) A.P. will suffer seizures. (I Tr. 34, 170.) "[S]he needs to be fed by a G-tube." (I Tr. 33.) She will likely develop aspiration pneumonia. (I Tr. 33.) A.P. will require multiple orthopedic surgeries due to her severe spasticity. (I Tr. 35.) She will likely "end up in the pediatric intensive care unit on a breathing machine." (I Tr. 33.)

When A.P. initially arrived at the Pediatric Intensive Care (PIC) Unit at Maine Medical Center on December 21, 2013, the father professed to the treating pediatrician that A.P. was wet and accidentally slipped from his hands, hitting the crib rail. (I Tr. 108, 111.) The father reiterated this account to law enforcement that day. (I Tr. 226.) The treating pediatrician did not "consider that an adequate explanation for the severity of the injuries" and made a referral to Lawrence Ricci, M.D., pediatric child abuse specialist. (I Tr. 122.)

Dr. Ricci interviewed the parents on December 22, 2013. (I Tr. 186.) At the outset of the interview, both the father and mother maintained that A.P. slipped accidentally. (I Tr. 186, 190.) Dr. Ricci expressed to them that he was skeptical about their account of events. (I Tr. 190-191, 199.) Approximately five minutes after the meeting ended with Dr. Ricci, the mother returned to Dr. Ricci and disclosed that the father shook their child. (I Tr. 193-194.) The father then admitted the same to Dr. Ricci (I Tr. 194) and confessed to law enforcement. (I Tr. 236.)

The father revealed some version of the truth to the mother before their Dr. Ricci interview, in the early morning hours of December 22, 2013. (I Tr. 239-240.) As far back as September 2013, the mother instructed a daycare

worker that the father could not be left alone with the child because of his anger problem. (I Tr. 175-176.)

Dr. Ricci later found evidence that A.P. had been physically abused before the catastrophic incident. (I Tr. 200.) He found evidence of a prior brain bleed (I Tr. 197-198) and bruising. (I Tr. 200.) The parents had failed to seek medical attention. (I Tr. 200.)

A.P. spent eleven days on the PIC Unit at Maine Medical Center. (I Tr. 118.) Starting on the second day, while comatose, she had frequent, multifocal seizures and she required intubation. (I Tr.113, 164.) A.P.'s treating pediatricians spoke with the parents about A.P.'s code status[2], in light of the treatment plan of removing the breathing tube (extubation). (I Tr. 116-117, 123.) The physicians recommended DNR status. (I Tr.116, 123.) The physicians also made a referral to the Department. (I Tr. 265.)

On December 30, 2013, the Department organized a Family Team Meeting. (I Tr. 265.) Participants included the parents, Department social workers, medical doctors, and family and friends of the parents. (I Tr. 265.) Following that meeting, the parents agreed to a DNR directive. (I Tr. 116, 265.) A.P. was extubated, and survived. (I Tr. 117.) The parents revoked the DNR

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[2] Full code status as used here means "if [the child's] heart stops beating or if [the child] stop[s] breathing or need[s] any medical efforts whatsoever to preserve life, [hospital staff will] do everything for them." DNI status here means "do not intubate. And that's for parents who wish for their child to have other supportive measures, but not ever to have a breathing tube put back in them. " DNR status means "do not resuscitate... in the event that the child stops breathing or their heart stops....[medical staff may] give them medication to make sure they're peaceful and comfortable, but you don't do painful and invasive procedures for them. " Modified code status means the medical professionals "have lots of little things that we can do to tailor at the parent's request."

directive. (I Tr. 117.) A.P.'s treating pediatricians and neurologists continued to recommend DNR. (I Tr. 42, 123.)

A.P. was "horrendously uncomfortable" and "[w]atching what she endured... was traumatic for the nurses that took care of her, [and] was traumatic for the physicians." (I Tr. 80.) A.P. began to arch her torso, and at one point, only her head and feet were touching the crib mattress. (I Tr. 57.) She was inconsolable. (I Tr. 39.)

Dr. Alexa Craig, pediatric neurologist, treated A.P. when she was transferred to the Barbara Bush Unit of MMC on January 4, 2014. (I Tr. 13.) Dr. Craig was "very aggressive" in her management of A.P.'s symptoms. (I Tr. 38-39.)

Even after administering four strong medications to A.P., "her irritability and discomfort [were] so high, we added a fifth drug called [C]lonazepam." (I Tr. 39.) Dr. Craig explained, "[Clonazepam] is a drug that I really don't like to use in children...there wasn't anything else I could do." (I Tr. 39.) Clonazepam is "a long acting medication that can cause excessive sedation [and] adding these five sedating drugs on to one another, increases the risk that she'll have an aspiration event, meaning Pneumonia." (I Tr. 41-42.) Dr. Craig spoke with the parents several times, explaining the infant's poor prognosis and her recommendation that they authorize a DNR directive. (I Tr. 42-43.)

The Department filed a Petition for Child Protection Order on January 17, 2014 (A. 36-42), together with an Affidavit in Support of a Preliminary Child Protection Order (A. 43-45), pursuant to 22 M.R.S. §§ 4032 and 4034(1).

The District Court granted an Order of Preliminary Child Protection the same day, placing A.P. in the Department's custody pursuant to 22 M.R.S. §§ 4034(2) and 4036(1). (A. 33-35.) A.P. was still hospitalized. (A. 58.) On January 28, 2014, the Department moved for an expedited judicial review, pursuant to 22 M.R.S. § 4038(2), requesting authority to give a DNR directive for the child. (A. 46-48.)

The father, meanwhile, was indicted on two counts of Aggravated Assault (Class B) and one count of Assault (Class C) on January 24, 2014. (A. 97-98; I Tr. 240-242.) He was arrested that day and eventually bailed with conditions of no contact with the mother or child. (A. 99-100; I Tr. 243.) The day the father was arrested, the mother told the investigating detective, "if [the father] got a sentence of ten years to jail, she would be there after ten years, waiting for him." (I Tr. 242.) She told a Department caseworker on February 24, 2014 that she hoped the bail conditions would be amended so she could go "home to [him]." (I Tr. 250-251.)

The Department's Motion for Expedited Judicial Review (A. 46-48) came on for hearing on March 7, March 20 and April 8, 2014. (I Tr. 1; II Tr. 1; III Tr. 1.) The trial court heard testimony from fifteen witnesses (I Tr. 3; II Tr. 3; III Tr. 3.) and admitted sixteen documents into evidence. (A. 49-201.)

Four physicians from MMC testified regarding A.P.'s condition and the advisability of a DNR directive: Dr. Alexa Craig, A.P.'s treating pediatric neurologist; Dr. Logan Murray, the pediatric hospitalist who treated A.P. at the Barbara Bush Unit; Dr. Stephen Rioux, A.P.'s pediatric neurologist on the PIC

unit; and, Dr. Eric Gunnoe, A.P.'s critical care pediatrician on the PIC unit. (I Tr. 46, 60, 136-137, 152, 153-154, 169; III Tr. 75.) The Court also heard from a Dr. John Lantos, pediatric bioethicist, who was retained by the parents. (III Tr. 6-68.)

Doctors Craig, Murray, Rioux and Gunnoe all strongly endorsed placing A.P. on DNR status. (I Tr. 46, 60, 136-137, 152, 153-154, 169; III Tr. 75.)

> DNR status..means that we would not perform a code in the event of a respiratory arrest or cardiac arrest. It does not limit other aspects of care. So it would allow antibiotics, it would allow feeds to continue, it would allow pain meds to be administered, or anxiety relieving medications to be administered.

(I Tr. 127.)

The physicians were in agreement that "to do a code on [A.P.] would cause pain, would cause indignity" and cause "additional insult to [the] injury.. sometimes very significant additional injury to the brain from the code." (I Tr. 45-46, 122, 136, 153, 169.) Doctors Gunnoe and Craig described the painful procedures encompassed in a full code status, including chest compressions and intubation. (I Tr. 44-46, 125-126, 136-137.) Besides the extreme pain caused by such procedures,

> bringing somebody back to a quality of life where they're so irritable and experiencing so much pain, to put them through something that's horrendously painful to bring them back to something horrendously [painful] doesn't make sense.

(I Tr. 46.)

Without the DNR directive, Dr. Craig was limited in her ability to employ medications to manage the child's pain and symptoms. (III Tr. 74.) Dr. Craig explained that she was

> in a real bind because on the one hand I want to treat her pain and muscle spasms as effectively as I can and on the other hand I don't want my medical treatment of those symptoms to cause her to have an aspiration even[t] and wind up in more pain because a breathing tube has to be put in.

(I Tr. 42.)

Dr. Craig testified on the first day of hearing on March 7, 2014, and again on the last day, April 8, 2014. (I Tr. 10-104; III Tr. 69-79.) A.P.'s condition deteriorated during that month. (III Tr. 74.) Dr. Craig increased three of the infant's five prescribed medications, because A.P. was

> getting increasingly irritable ... there were only about three to four hours of the day where [A.P.] wasn't crying inconsolably and... appearing ...to be in pain and uncomfortable.

(III Tr. 71, 73.) Dr. Craig told the court that:

> having had another month go by and see that [A.P. is] making no developmental progress and see the level of irritability and discomfort that she's experiencing I really do feel that it's appropriate for me to recommend [DNR status] at this time ... I don't see anything changing in a positive direction for her.

(III Tr. 75.)

The father conceded that he should not participate in the decision about a DNR directive. (I Tr. 187-188.) His conditions of bail prohibited any contact with the child. (A. 99.) The Department of Health and Human Services provided, and continues to provide, reunification services to the mother. (II Tr. 15-20; A. 103-105.) Immediately upon A.P.'s discharge from the hospital, the Department attempted to schedule visits for the mother at the foster home and to arrange for the mother to attend all of the baby's medical appointments. (I Tr. 276; II Tr.13-17.) The mother was permitted to visit A.P. at the foster home

three times weekly, ideally at times when the visiting nurse was present "so she could learn how to care for" her daughter. (II Tr. 17; A. 104.) The Department provided the mother with transportation. (II Tr. 17-18.)

As of the second day of hearing on March 20, 2014, the baby had been discharged for over six weeks, and the mother had visited only five times. (II Tr. 233.) Between March 14, 2014 and the last day of hearing on April 8, 2014, the mother did not avail herself of a single visit with A.P. (III Tr. 96.) The mother explained that she did not visit her baby because it was "not very enjoyable" and "[i]t's hard to go spend two or three hours with her because ... it's a lot of work...." (II Tr. 212-213.)

The Department's caseworker encouraged the mother to attend doctor appointments with her child, and furnished several reminders about specific appointments. (A. 103-105; II Tr. 17, 22-23, 24, 29, 35, 43, 45.) The mother chose not to attend the first and second follow-up appointments with Dr. Craig after A.P.'s hospital discharge. (II Tr. 48; III Tr. 81.) The mother also chose to miss the follow-up appointments scheduled with Dr. Ricci (II Tr. 49.), and with A.P.'s pediatrician. (III Tr. 84.)

A.P. remains in the therapeutic foster home of T.M., where she has resided since her discharge from MMC on January 27, 2014. (A. 58, I Tr. 275; II Tr. 110-111.) T.M. feeds A.P. through a G-tube every four hours and each feeding lasts one hour. (II Tr. 121-123, 125.) At every feeding, A.P. needs to be

"vented"[3] to prevent gastrointestinal distress and ensure she retains her medications, a process that lasts from five minutes to one hour. (II Tr. 117-118.) A.P. must be constantly monitored during feeding to ensure she does not aspirate or cause the G-tube to disconnect. (II Tr. 126-127.)

A.P.'s five different medications must be administered through her G-tube at different times during the day. (A. 106, II Tr. 127-128.) A.P.'s secretions must be suctioned using a machine, because she cannot swallow and is at risk of choking. (II. Tr. 125.) "When [A.P.] is fussy, irritable ...[suctioning] can be constant, like every ten minutes...." (II Tr. 124.)

When A.P. is awake, she is arching her torso backwards "all the time" and her irritability is "pretty much constant...maybe 80, 85 percent of the time...." (II Tr.131-132.) Her foster mother and constant caregiver observed: "She's just miserable....[and] [y]ou can't fix it." (II Tr. 132.)

On April 24, 2013, the District Court issued a Judicial Review Order (A. 9-21) finding "it is in the best interest of the child to give the Department the authority to issue a DNR and to make decisions regarding [A.P.]'s medical treatment as necessary." (A. 21.) The full record of the judicial review hearing was considered for the subsequent jeopardy hearing and some of the findings from that order were incorporated and reiterated in the court's Jeopardy Order dated May 29, 2014. (Blue Br. at Supp. Appendix 1-8.) Based on the evidence presented at the judicial review, the court found

[3] T.M. described the process by which she puts a cylinder in the infant's port for excess formula to come out. T.M. then waits for the formula to slowly go back, ensuring A. receives her medications. (II Tr. 117-118.)

clear and convincing evidence that neither parent is in a position to make medical decisions in [A.P.]'s best interest. ...[The father] has a clear conflict of interest. Should [A.P.] die, he could be subjected to a charge of manslaughter or even murder....

...

[The mother] is not sufficiently involved or informed about [A.P.]'s condition to make the medical decision based on [A.P.]'s needs rather than her own.

...

[The mother] visited with [A.P.] only a handful of times after she was discharged from the hospital...she did not attend [A.P.]'s medical appointments...[The mother] herself acknowledged that a DNR order was probably best, but she could not bring herself to do it.

(A. 18-19.)

Issue Presented for Review

Whether the scope of 22 M.R.S. § 4037 as interpreted by this Court in the case of *In re Matthew W.*, 2006 ME 67, 903 A.2d 333 permits a District Court to authorize the Department of Health and Human Services to issue a "do not resuscitate" directive for a child in its custody.

Standard of Review

This Court reviews "questions of law... de novo." *In re Robert S.*, 2009 ME 18, ¶ 12, 966 A.2d 894.

Summary of Argument

The District Court followed the governing statute, 22 M.R.S. § 4037, as interpreted by this Court in *In re Matthew W.*, 2006 ME 67, 903 A.2d 333 (*overruled on other grounds by In re B.C.*, 2012 ME 140, 58 A.3d 1118), in strict observance of the standards and procedures set forth in *Matthew W.* The mother is asking the Court to change Maine law. No change is warranted.

Argument

The scope of 22 M.R.S. § 4037 as interpreted by this Court in the case of *In re Matthew W.*, 2006 ME 67, 903 A.2d 333 permits a District Court to authorize the Department of Health and Human Services to issue a "do not resuscitate" directive for a child in its custody.

For A.P., a DNR directive means first, in the event of respiratory arrest, medical personnel would not insert an endotracheal tube using "a laryngoscope with a blade on it. It's not sharp, but it is steel. We put it in the mouth and lift up the tongue. It's a noxious feeling, maybe far worse than somebody gagging you with a tongue depressor." (I Tr. 124.)

A DNR directive for A.P. also means that if respiratory arrest were followed by cardiac arrest ("a cardiac arrest on a child always comes after the respiratory arrest. Unlike an adult...." (I Tr. 127)), medical personnel would not do "chest compressions to try to replace ...the cardiac output." (I Tr. 123.) "Chest compressions, when they're done properly, will often fracture ribs or the sternum. Because ... on a child of that age, the most effective way to get good output is to actually mash the heart between the breast bone that you're pushing down, and the ... backbone, the vertebrae behind it." (I Tr. 125.) A DNR directive here also would allow medical personnel, in the event of cardiac arrest, to forego giving epinephrine by way of inserting "essentially a drill bit ... through the tibia, so that we can gain access to the circulation." (I Tr. 124-125.)

Other forms of mitigating, or at least not amplifying A.P.'s suffering, would be permitted. A DNR directive "would allow antibiotics, it would allow

feeds to continue, it would allow pain meds to be administered, or anxiety relieving medications to be administered." (I Tr. 127; I Tr. 123.)

This Court concluded in *Matthew W.* "that 22 M.R.S. § 4037[4] does not authorize the Department to unilaterally approve a DNR except after notice to the parents and, if they object, a right for the parents to be heard." *In re Matthew W.*, 2006 ME 67, ¶ 11, 903 A.2d 333 (*overruled on other grounds by In re B.C.*, 2012 ME 140, 58 A.3d 1118). The Court explained that due process is satisfied when the parents are

> afforded the same procedural protections before approval of a DNR for their child as they are afforded prior to the termination of their parental rights. In a case such as this, when either or both *parents, whose parental rights have not been terminated,* object to a DNR for their child who is in the Department's custody, the court must provide reasonable notice for a hearing, hold the hearing, and determine, by clear and convincing evidence, whether it is in the best interest of the child to give the Department the authority to issue a DNR.

Id. ¶ 12 (emphasis added). This Court also enumerated six factors which, at a minimum, should be considered by the trial court in its assessment of whether

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[4] 22 M.R.S. § 4037 states in pertinent part: "When custody of the child is ordered to the department or other custodian under a preliminary or final protection order, the custodian has full custody of the child subject to the terms of the order and other applicable law."

a DNR directive is in the child's best interest.[5] *Id.*

The mother here does not dispute that the proceedings took place in accordance with Maine law as announced in *Matthew W.* The mother received adequate notice; she was afforded a full opportunity to present evidence during three days of trial; the court had the requisite quantum of evidence on which to make its findings to the clear and convincing standard; and the trial court properly included in its assessment, the six enumerated factors set forth in *Matthew W. See Id.* ¶¶ 7,8,12. (A. 9-10, 14-16.)

The mother argues for changing Maine law to require that the trial court first find parental unfitness sufficient for termination of parental rights under 22 M.R.S. 4055(1)(B)(2)(b).[6] That condition precedent to a court order authorizing the Department to approve a DNR directive for a child in its custody was implicitly, if not explicitly, rejected by this Court when it set forth

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[5] As part of its assessment, the court should, at a minimum, consider: (1) the child's quality of life, including whether the child is in a persistent vegetative state; (2) what life-sustaining treatment would be necessary; (3) the degree of pain the life-sustaining treatment or the withholding of life-sustaining treatment would cause the child; (4) the long-term prognosis for the child; (5) the opinions of medical experts in regard to the foregoing considerations; and (6) the benefit or detriment to the child if the parents participate in the decision making.

In re Matthew W., 2006 ME 67, ¶ 12, 903 A.2d 333 *overruled on other grounds by In re B.C.*, 2012 ME 140, 58 A.3d 1118.

[6] The mother seeks support for her position in the testimony of bioethicist John Lantos. He suggested that barring termination of parental rights, the mother's decision making concerning the child be "scrutinized" and "overridden by the Court" only if "manifestly contrary to the best interest of the baby...." (III Tr. 36.) The court found Dr. Lantos' "testimony was based on the presumption that the parents would in fact be available – physically, emotionally and intellectually – to make decisions when needed. That presumption, however, is not accurate at this time." (A. 20.)

the criteria "[i]n a case such as this, when either or both *parents, whose parental rights have not been terminated*, object to a DNR for their child who is in the Department's custody...." *In re Matthew W.*, 2006 ME 67, ¶ 12, 903 A.2d 333 *overruled on other grounds by In re B.C.*, 2012 ME 140, 58 A.3d 1118 (emphasis added).

A.P.'s "body cannot manage life on its own." (A. 13, I. Tr. 33.) Someone who is capable of acting in the child's best interest must also have the legal authority to do so. "Neither parent can be counted on to be physically or emotionally available to make the necessary informed decisions when needed for [A. P.]" (A. 20.) The father stipulated to that fact. (A. 17.) The court made findings of fact on that point about the mother. (A. 18-19.)

No one disputes the mother's right to direct A.P.'s care, if during A.P.'s lifetime the mother becomes capable of assuming the responsibilities that accompany the right. *See Troxel v. Granville,* 530 U.S. 57, 65, 120 S. Ct. 2054, 147 L. Ed. 2d 49 (2000). Until then, the authority has to vest with someone. The exercise of *parens patriae* authority is all that stands between A.P.'s current condition and additional suffering.

"[A]cting in the role of *parens patriae* ... The Department may ask the court for temporary custody in order to protect the child involved, but it does not assert any right to custody beyond its statutory authority and the necessities of the situation at hand." *In re Higera N.*, 2010 ME 77, ¶ 19, 2 A.3d 265. In A.P.'s case, the "necessities of the situation at hand" were explained by the treating pediatric neurologist, Dr. Alexa Craig:

> If the plan isn't in place, the child codes, they get resuscitated, they experience all of this intervention, and then you take the tube out because you've decided to make them DNR and -- I mean, a court hearing like this, how long did it take this to happen? It can't happen in a timely fashion to respond in a way that would prevent her from experiencing a lot of suffering. So I think it's all in anticipation of the degree of suffering, why it needs to be in place ahead of time .....

(I Tr. 94-95.)

The District Court followed the governing statute, 22 M.R.S. § 4037, as interpreted by this Court in *In re Matthew W.*, 2006 ME 67, 903 A.2d 333 (*overruled on other grounds by In re B.C.*, 2012 ME 140, 58 A.3d 1118), in strict observance of the standards and procedures set forth in *Matthew W.* No more was required. No change in the law is warranted. The judgment commends itself to affirmation.

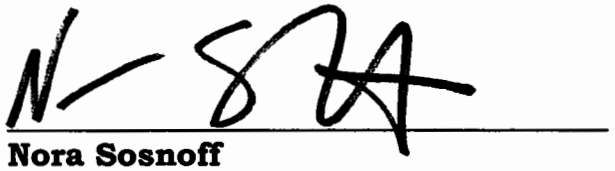
Conclusion

The Maine Department of Health and Human Services respectfully requests that the Law Court affirm the District Court's Judicial Review Order dated April 24, 2014 and its Jeopardy Order dated May 29, 2014, finding it is in the best interest of A.P. to authorize Department of Health and Human Services to issue a Do Not Resuscitate directive and to make other necessary decisions regarding [A.P.]'s medical treatment. (A. 21.)

Respectfully Submitted,

Janet T. Mills
Attorney General

Dated: June 16, 2014



Nora Sosnoff
Assistant Attorney General
Maine Bar Registration No. 6872

Martha Hallisey Swift
Assistant Attorney General
Maine Bar Registration No. 8803

6 State House Station
Augusta, ME 04333
(207) 626-8800

Attorneys for State of Maine
Department of Health and Human Services

Certificate of Service

I, Nora Sosnoff, Assistant Attorney General, hereby certify that I have caused two copies of the foregoing brief of the Appellee, Maine Department of Health and Human Services, to be served upon each of the attorneys and/or parties listed below, by depositing those copies this date in the United States Mail, first-class postage prepaid, addressed for delivery as follows:

Scott F. Hess, Esquire
72 Winthrop Street
Augusta, ME 04330

Newell A. Augur, Esquire
5 Wade Street
Augusta, ME 04330

Melissa Norton, Esquire
28 Ithiel Gordon Road
Mount Vernon, ME 04352

Dated: June 16, 2014

Nora Sosnoff
Assistant Attorney General