STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

RE: Douglas J. W. Bartholomew
Master Case No.: M2011-1023
Document: Statement of Allegations

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH

FILED
FEB 20 2013
Adjudicative Clerk

In the Matter of **DOUGLAS J. W. BARTHOLOMEW** Credential No. MHC.LH.00003582 Respondent	**No. M2011-1023** **STATEMENT OF ALLEGATIONS AND SUMMARY OF EVIDENCE**

The Executive Director of the Mental Health Counselor Program (Program), on designation by the Secretary of Health (Secretary), makes the allegations below, which are supported by evidence contained in case no. 2011-154410. The client referred to in this Statement of Allegations and Summary of Evidence is identitied in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On July 22, 2001, the state of Washington issued Respondent a credential to practice as a mental health counselor. Respondent's credential is currentiy active.

1.2 On or about December 2008, Client A's wife tiled a dissolution decree and protection order against Client A, alleging acts of domestic violence. On or about December 15, 2008, Client A was ordered to undergo a domestic violence risk assessment with Respondent as the appointed evaluator to determine if domestic violence was present and if there was a risk to the child.

1.3 On or about January 13, 2009, Respondent submitted an "Order of Protection Risk Assessment" for Client A (Risk Assessment). In the Risk Assessment, Respondent found that there was risk of future psychological and emotional abuse by Client A that could affect the minor child. Respondent recommended that Client A complete a domestic violence treatment program. Temporary custody of Client A's minor child was subsequently granted to the mother. Client A was granted restricted visitation and ordered to complete a domestic violence treatment program.

1.4 Respondent's Risk Assessment of Client A was below the standard of care, as evidenced by the following:

ORIGINAL

A. The Risk Assessment of Client A contains grammatical and sentence structure errors, including:

1. Reversed pronouns so that the sentence stated the opposite of what Client A reported to Respondent. Instead of documenting the wife's controlling behavior, Respondent attributed the behavior to Client A, with the sentence reading: "...**he** began to censor or try to control many normal activities, such as, getting the mail, how much times **she** spent rushing *(sic)* her teeth and how much time **she** spent on relatively minor activities". (Emphasis added, page 6 Risk Assessment)

2. Incorrect usage of pronouns, such as:

   a. "It is not possible for him to have played no role **I** the pathologies..." (Emphasis added, page 4 Risk Assessment)

   b. "She does not see **yourself** as having poor relationship..." (Emphasis added, page 5 Risk Assessment)

3. Incoherent sentences, for example:

   a. Client A "...has stated often that he loves his son and has **two sons** best interests in mind". (Emphasis added, page 3 Risk Assessment)

   b. "When I asked him directly to tell me what he learned about his contribution to the marital **this function** as a result of all his therapy..." (Emphasis added, page 10 of Risk Assessment)

   c. "I think it's clinically significant that when I asked him if he'd done that, he said he hadn't, and explained that he did." (Page 14 Risk Assessment)

B. The Risk Assessment contains statements and quotes attributed to Client A, that are not supported by the clinical record, for example:

1. Misstated that Client A wanted full custody of his son. (Page 4 Risk Assessment)

2. Misquoted Client A as stating "…our relationship was never able to recover." (Page 7 Risk Assessment)

3. Misquoted Client A as stating "I've been oblivious to (my wife's) feelings." In fact, according to clinical notes, Client A stated "I should have been more sensitive to her needs and feelings." (Page 10 Risk Assessment)

4. Left lists for his wife because it was "the right thing to do." There is no such quote in Client A's clinical records.

5. Respondent claims that in quite a few responses, both verbally and in writing, Client A is "outraged." Respondent continues on to state: "For example when he was "outraged" that she took half of the money…" There is nothing in Client A's clinical notes to support this quotation. (Page 12 Risk Assessment)

6. Misstates that Client A transferred money from a bank account to control his wife and that Client A denied it until confronted by Respondent. In fact, Client A admitted the bank transfer and told Respondent that he had transferred the money at the advice of his attorney. (Page 14 Risk Assessment)

C. Respondent's Risk Assessment of Client A is unprofessional and biased, as evidenced by the following:

1. Information gathering consisted of four (4) to five (5) hours of face-to-face contact with Client A, and only one and a half (1 ½) hours of phone contact with the wife.

2. Dismissed collateral contact information from the couple's former marriage counselor, as "bait and switch" information.

3. Asserts that the wife's claims of physical abuse by Client A were the "tip of the iceberg" with no supporting evidence.

1.5 On or about May 10, 2010, a Parenting Evaluation was submitted, recommending that custody of the minor child be granted to Client A. On or about August 12, 2010, a final dissolution decree and parenting plan were entered, granting

primary custody of the minor child to Client A. In closing statements, the judge stated that the Risk Assessment was "sloppily written" and "rife with inconsistency and bias."

2. SUMMARY OF EVIDENCE

2.1 Complaint Form, dated March 2, 2011. (2 pages)

2.2 Respondent's Order of Protection Risk Assessment for Client A, dated January 13, 2009. (20 pages)

2.3 Respondent's Statement, dated April 8, 2011, in response to Department of Health Letter of Concerns. (13 pages)

2.4 Client A's Health Records, maintained by Respondent. (39 pages)

2.5 December 15, 2008, Order on Family Law Motion Re: Client A. (1 page)

2.6 Jennifer Keilin's Parenting Plan Evaluator's Report, dated May 10, 2010. (34 pages)

2.7 August 12, 2010, Client A's Dissolution Trial Transcript with Court Ruling. (6 pages)

3. ALLEGED VIOLATIONS

3.1 The facts alleged in Section 1, if proven, would constitute unprofessional conduct in violation of RCW 18.130.180(4), and WAC 246-809-035(1)(f) and (g), which provide in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> ... .

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WAC 246-809-035 Recordkeeping and retention.

(1) The licensed counselor or associate providing professional services to a client or providing services billed to a third-party payor, must document services, except as provided in subsection (2) of this section. The documentation includes:

...

(f) Notation and results of formal consults, including information obtained from other persons or agencies through a release of information;

(g) Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy the licensed counselor or associate uses. The associate must provide adequate information about their clinical work to the approved supervisor. This can be in the form of progress notes, case discussions/analysis, or reports from collaborating professionals. The approved supervisor must have an understanding of the clinical work that the associate is doing.

....

4. NOTICE TO RESPONDENT

4.1 The Secretary has determined that this case may be appropriate for resolution through a Stipulation to Informal Disposition (Stipulation) pursuant to RCW 18.130.172(2). A proposed Stipulation is attached, which contains the disposition the Secretary believes is necessary to address the conduct alleged in this Statement of Allegations and Summary of Evidence.

4.2 If Respondent agrees that the disposition imposed by the Stipulation is appropriate, Respondent should sign and date the Stipulation and return it within twenty-eight (28) days to the Department of Health Office of Legal Services at PO Box 47873, Olympia, WA 98504-7873.

4.3 If Respondent does not agree that the terms and conditions contained in the Stipulation are appropriate, Respondent should contact Janet Staiger, Department of Health Staff Attorney, PO Box 47873, Olympia, WA 98504-7873, (360) 236-4743 within twenty-eight (28) days.

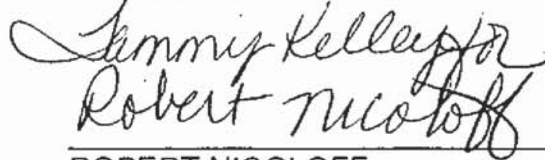
4.4 If Respondent does not respond within twenty-eight (28) days, the Secretary will assume Respondent has declined to resolve these allegations with an informal

Stipulation and may proceed to formal disciplinary action against Respondent by filing a Statement of Charges pursuant to RCW 18.130.172(3).

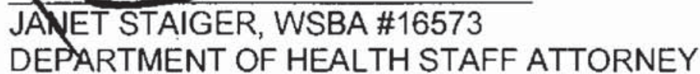
4.5 If the parties cannot resolve the allegations with an informal Stipulation, the Secretary may proceed with a formal Statement of Charges.

DATED: October 29, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH



ROBERT NICOLOFF
EXECUTIVE DIRECTOR



JANET STAIGER, WSBA #16573
DEPARTMENT OF HEALTH STAFF ATTORNEY

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named herein. RCW 42.56.240(1)

Client A: