Supreme Court No. 101184-9

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

SHANAREL DEMENT
fka SHANAREL ANCHETA,

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

PETITION FOR REVIEW

Court of Appeals No. 82859-2-I

King County Superior Court No. 20-2-16178-1 KNT

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I. IDENTITY OF PETITIONER

Petitioner, Ms. Shanarel Dement fka Shanarel Ancheta, is a Washington State Registered Nurse and the former owner of All Heart Adult Family Home, LLC. While working with FG, Ms. Dement also worked closely with Ms. Beth Newell, FG's Mental Health Counselor (MHC) and with Ms. Baumann, FG's Department-Home Community Services (hereinafter "HCS") case manager.

II. ISSUES PRESENTED FOR REVIEW

Ms. Dement seeks review of the Court of Appeals' decision pursuant to RAP 13.4 based on the following issues:

A. Did the Court of Appeals fail to recognize that Ms. Dement's not calling 911 or Law Enforcement (L.E) was not raised in the Complaint and that adding it later as part of the ruling violates Ms. Dement's due process rights ?

B. Did the Appeals Court consider that RCW 74.34.020 (16) (b) is subject to a variety of interpretations that do not provide notice to an objective reader of measurable acts

to perform or avoid and interpreted of what might happen. Did Ms. Dement's constitutional due process rights suffer because the Department interpreted this law based solely on its opinion and by relying on an unregulated term to conclude that FG was in supervision and in caregiver's line of sight ?

III. COURT OF APPEALS DECISION

Ms. Dement seeks this Court's review of the decision of the Court of Appeals, Division I, in Case No. 82859-2-I, filed on June 13, 2022, affirming that Ms. Dement violated RCW 74.34.020 (16) (b). A copy of the Court of Appeals' decision is appended hereto as Attachment "A". A copy of the order denying petitioner's motion for reconsideration is appended hereto as Attachment "B".

IV. WHY REVIEW SHOULD BE GRANTED

1. Review should be granted when the Court of Appeals and the Superior Court accepted the argument of the Department that Ms. Dement failed to call Law Enforcement even though the Administrative Court and

the DSHS-Board of Appeals has been silent on this issue. In doing so the Court denied Ms. Dement's procedural due process in violation of the Due Process Clause of the Fourteenth Amendment. COA App. Reply Brief Appendix A pg. 21.

2. Additionally, Review should be granted because to do otherwise violates Ms. Dement's Constitutional due process rights to be given proper notice as to the application of RCW 74.34.020(16) (b). The law must be specific, not ambiguous, not misleading and one must know what he can do and what he cannot do. The Court of Appeals ignored Ms. Dement's arguments that RCW 74.34.020 (16) (b) does not provide proper notice or inform the reader of objective measurable acts to perform or refrain from doing. The statue is vague as written and as applied and a vague law is unconstitutional.

V. ARGUMENT I

THE DEPARTMENT'S COMPLAINT

> *"On or about April, a vulnerable adult eloped from your adult family home. You did not follow the vulnerable adult's care plan, which stated the vulnerable adult* ***"is to be within line of sight and supervised when going outside the AFH." You allowed the vulnerable adult to leave the AFH without staff supervision to go to the store several blocks away.*** *The vulnerable adult did not return and became a missing person. Your actions placed the vulnerable adult in clear and present danger." CP 270-272.*

A. The Court of Appeals concluded that Ms. Dement failed to report to the Law Enforcement/911so as to locate and assist FG for 12 hours while FG was out in the community.

This Court overruled the Administrative Law Judge's decision not to hear the issue of calling of 911 or Law Enforcement.

> ***The Court of Appeals affirmed the ruling as follows****: The finding was based on Dement's failure to supervise a resident at her adult family home who left the home unattended and her subsequent failure to contact police*

for nearly twelve hours after she learned of his elopement. The DSHS Board of Appeals applied the proper legal standard and the finding of neglect is supported by substantial evidence. Accordingly, we affirm. Appendix A page 1

***The Court of Appeals** cited, two of Dement's three assignments of error presented in her opening brief to expressly challenge the ruling by the King County Superior Court in affirming the neglect finding. However, Tapper makes clear that we do not review the actions of the Superior Court. Appendix A page 5-6.*

The Court of Appeals further states:
Next, under Washington's Administrative Procedure Act (WAPA), RCW 34.05.570 governs judicial review of the final agency action. "In reviewing administrative action, this court sits in the same position as the superior court, applying the standards of the WAPA directly to the record before the agency." Tapper v. Emp't Sec. Dep't, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). "The WAPA allows a reviewing court to reverse an administrative decision when, interalia: (1) the administrative decision is based on an error of law; (2) the decision is not based on substantial evidence; or (3) the decision is arbitrary or capricious. The party challenging an agency's action must demonstrate that the action was invalid. RCW 34.05.570(1)(a). Appendix A page 5

Ms. Dement's fundamental rights to be given Notice and be heard were trampled by the hearing procedures employed by the Superior Court and the Court of Appeal. Ms. Dement was

not accused of failing to call or report to the Law Enforcement /911. See Complaint CP 270. Ms. Dement argues that the Court of Appeals affirmed the findings of the Superior Court[1] and reversed the Administrative Law Judge's decision in denying calling or reporting issue and by doing so the Appeal Court denied the Constitutional Due Process rights of Ms. Dement to be put on notice and defend herself. "The WAPA allows a reviewing court to reverse an administrative decision when, inter alia: (1) the administrative decision is based on an error of law. Here the decision of the Administrative Law Judge was not based on an error of law, the ALJ was protecting the due process right of Ms. Dement. Tapper makes clear that this court does not review the actions of the Superior Court, but this Court adopted the Order of the Superior Court by concluding that Ms. Dement failed to call or report to the Law Enforcement/911.

[1] June 11,2021 Superior Court hearing Transcript *COA Petitioner's Opening Brief Appendix B pages 21 line 4-14.*

A litigant in civil proceedings is entitled to a fair hearing, imbued with the protections of due process. The due process guarantee expressed in the Fourteenth Amendment to the United States Constitution requires assurances of fundamental fairness during legal proceedings. See U.S. Const. amend. XIV, § 1.

The decision of the Court of Appeals conflicts with a decision of the Supreme Court.

In re Ruffalo, 390 U.S. 544 (1968), the *Court held:* The lack of notice to petitioner, prior to the time he and Orlando testified, that petitioner's employment of Orlando would be considered a disbarment offense deprived petitioner of procedural due process. Pp. 390 U. S. 547-552. Petitioner had no notice that his employment of Orlando would be considered a disbarment offense until after both petitioner and Orlando had testified. Pp. 390 U. S. 550-551.

In this case, Ms. Dement had no notice during the proceeding, the ALJ denied hearing the Department's issue

against Ms. Dement for not calling 911 or the Law Enforcement because it was not in the Complaint, and it deprive petitioner of procedural due process.

Also consider Fuentes v. Shevin, 407 U.S. 67, 81 (1972). At times, the Court has also stressed the dignitary importance of procedural rights, the worth of being able to defend one's interests even if one cannot change the result. In this case, Ms. Dement is defending her right to retain her AFH license and her professional license if found to have violated the RCW 74.3.020 (16) (b). The clause also promises that before depriving a citizen of life, liberty or property, government must follow fair procedures. Thus, it is not always enough for the government just to act in accordance with whatever law there may happen to be. Citizens may also be entitled to have the government observe or offer fair procedures, whether or not those procedures have been provided for in the law on the basis of which it is acting. Action denying the process that is "due" would be unconstitutional.

The Court of Appeals also failed to hold the Department responsible for knowingly and willfully using an incorrect writing knowing the same to contain incorrect statements[2] which led to an improper decision.

Department used the term "in the line of sight" which is outside of the contours of WAC 388-106-0010. This violates the due process rights of Ms. Dement when it modified her duties as to FG. In accepting this term, the Court is enforcing an unenforceable rule. The Department utilizes regulated terms of the ADL[3] Self-Performance Code Definitions of the WAC 388-106-0010. These regulated terms have specific meanings. The regulated terms establish the level of care (LOC) and the daily rate paid to the AFH. Per the Assessment and Negotiated Care Plan, FG was on "supervision and per client request" assistance as the given task for the adult family home (AFH). CP 296, CP 300, COA App. Brief page 6. The "within caregiver's line of

[2] DSHS used the unregulated term " ***"is to be within line of sight"*** in the Complaint.
[3] Activity of Daily Living

sight" concept is applied only during an AFH Emergency Evacuation. CP 300, CP 44 ¶ 26, COA App. Brief pg. 6. The "supervision and be escorted daily at Treatment Mall" was a Western State Hospital (WSH) task. CP 300, CP 387, CP 468.COA App. Brief page 6

The Court appears to have failed to recognize that the Assessment contained tasks that were designed for an entirely different facility and in doing so created the confusion in court.

Here, the Court decided to hear the reporting issue (to LE or 911 of the Department) and concluded that Ms. Dement was tasked to provide a caregiver to supervise FG in the community. The Court also accepted the incorrect or unregulated task demanded by the Department APS but not by the Department of HCS[4], and this led the Court to make the wrong decision. In its decision, the Court failed to protect Ms. Dement's fundamental right to due process.

[4] The creator of FG's assessment.

In Goldberg v. Kelly, 397 U.S. 254 (1970), the Court held as follows: Procedural due process applies to welfare recipients at risk of losing their benefits. Welfare is a statutory entitlement and can be considered property. State officials must conduct an evidentiary hearing prior to ending someone's benefits. Supreme Court, Justice Black wrote that the Court's findings amounted to a decision about what would be "fair and humane procedure" for terminating benefits, rather than an exercise in applying the text of the Constitution or past decisions.

In Dement, Department violated its own WAC 388-76-10330 (1) for not providing Ms. Dement an accurate assessment (the Department mixed the duty of the Western State Hospital and the AFH Assessment for FG). After the escape of FG, the Department filed a Complaint that contains unregulated or inaccurate term to survive the "Neglect Law." This complaint also did not give Ms. Dement notice regarding the Department case issue for failure to call 911/Law Enforcement. The Due

Process Clause of the Fourteenth Amendment reads, "nor shall any State deprive any person of life, liberty, or property, without due process of law." Ms. Dement AFH and professional license are property, she has the right to be given notice. It is necessary for the government to follow the proper process before taking actions that affected a citizen adversely. Unfortunately, the Department chose seemingly to cause to continue its quest for Ms. Dement downfall.

VI. ARGUMENT II

B. RCW 74.34.20(16)(b) utilizes the phrase "demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety" leaving to the reader to grapple with the interpretation of what limits exist to the reader. **Not only the person interpreting the meaning based on his/her experience, but the authority is also to be interpreted based on his/her experience**. This law does not refer to something that may happen. Whatever the danger is

must be "clear and present" as well as be capable of creating harm to something that may happen. Whatever the danger is it must be "clear and present" as well as being capable of creating harm to the clients of such a magnitude as to create a danger to his client's health, welfare, or safety.

THE STATUTE

*RCW 74.34.020 (16) (b) provide as follows: an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW **9A.42.100**.*

Here, the Department -HCS' Assessment was inaccurate which expressly violated the WAC 388-76-10330 (1).[5] The Assessment was created to cover two (2) entirely different types of facility, an unlocked and unguarded Adult Family Home (AFH) and a heavily guarded, locked Western State Hospital. COA App. Brief pg. 2, CP 300, CP 468.

[5] (1) which states that the DSHS is obligated to create an accurate assessment.

The Department-HCS created the Assessment for FG and demanded that Ms. Dement provide assistance as " per client request" only when FG went for a short distance walk because FG was on supervision. COA App. Brief pg. 2-3, CP 296, CP 300. The Department-HCS did not correct the errors in the Assessment that called for FG to be escorted whenever he goes to the treatment mall which has elevators at the Western State Hospital. Due to the vagueness of the statute, Department-APS went far beyond the actual task required for Dement to perform in assisting FG regarding the short distance walk.

The statute can be easily misinterpreted in a variety of ways. The Department-APS interpreted the statute based on its opinion and it used an unregulated term: **" in the caregiver's line of sight"** which means one on one or follow the vulnerable adult everywhere he goes so as to survive the "Neglect" moniker.

The Department APS ignored the true meaning of the term "in line of sight," which was to aid FG on Emergency Evacuation of the AFH. CP 300, CP 44 ¶ 26. Department APS ignored the fact that Ms. Dement's task per the Assessment and NCP was clearly to give assistance "**per client's request** " only. CP 296, CP 300.

The Department's Complaint created a false finding when the Department interpreted RCW 74.34.020 (16) (b) and used an unregulated undefined term in its interpretation of the Law to satisfy the statute. Essentially, the Department had used the unregulated term in all court hearings then on April 21, 2022, at the Court of Appeals Oral Argument, the Department admitted in Court that the Department had "No" level of care known as " in line of sight or one on one."[6] The Court used the sentence " allowed FG into the community unsupervised and

[6] The use of the unregulated term as " in line of sight or one on one." in the complaint and in court is a lack of candor in court designed to mislead the courts.

leaving him there without a law enforcement [7] search for twelve hours" These statements are not supported by evidence.

To be enforceable a law must be written so that the party reading the law clearly understands what limits are being placed on the reader or when a specific task is required (or not required.) No arrangement like this should require an interpretation by the reader. RCW 74.34.20(16)(b) utilizes the phrase "demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety" leaving the interpretation of how this phrase is read to the reader.

RCW 74.34.020 (16) (b) does not provide information that is necessary to give proper notice to the reader regarding measurable acts to be performed or to be avoided, only a method for DSHS to address acts by caregivers for things not covered by Law or the WAC regardless of the outcome. It is based on the opinion of the reader versus the opinion of the

[7] The Court concluded Ms. Dement failed to call, report or inform the Law Enforcer/911

State. see Skidmore v. Swift & Co., 323 U.S. 134 (1944), where the court held as follows.

> *In Skidmore v. Swift & Company it was decided that an agency's interpretation of the law is less important than its expertise and knowledge in a particular area. In other words, an agency's interpretation of the law can be outweighed by its lack of understanding and experience, and therefore, other factors, such as interested parties with expertise, can come into play when deciding how a rule or law is being interpreted. In federal administrative law, this is referred to as the Skidmore deference. The Skidmore deference is when the courts give those with the most expertise in a specific area more weight in the interpretation of the law and do not rely on the agency alone to decide what the law means.*

This case serves as an example. On April 13, 2019, while Ms. Dement was at her church, her caregiver on duty told FG that he couldn't go out because Ms. Dement was not home. As usual FG exercised his right as decision maker in his own right[8] and went out for his short distance walk. CP 345 ¶ 8 and 9, CP

[8] The action of FG is supported by the 2018 Superior Court order that FG is responsible for his own health and safety in the community. The Rights are created because they relate to deeply important issues that are "central to personal dignity"—and about which the Court believes people should be able to make their own decisions without "compulsion of the State". CP 345 ¶ 8 and 9, CP 41

41. At 12:30 P.M, Ms. Dement called and informed the Valley Cities Mental Health Clinic (VCMHC) and Ms. Dement was advised to decide on her own how and when to involve the police because Ms. Newell, MHC was on vacation. CP 428. COA App. Brief pg. 9.

Ms. Dement is an RN and was part of the VCMHC team and she and the VCMHC Team were preparing FG to be released into the community. She had known that FG always came home after his routine walks. Sometimes he would come home late in the day like 10:00 P.M and the MHC was satisfied as to his forward progress. CP 277, 412, 413, 419. COA App. Brief pg. 7. FG also had been making progress as far as trusting Ms. Dement and the Mental Health Team. CP 277, 412-413, 428, CP 54 ¶ 74-77, CP 55 ¶ 78, CP 56 ¶ 81. COA App. Brief pg. 7-8-. The Department was well aware regarding the walking issues of FG and despite this did not change the level of care of FG. CP 277, CP 56 ¶ 81, CP 58 ¶ 88. COA App. Brief pg. 8.

Ms. Dement believed that FG would not leave the home because FG was already close to end of his commitment. COA App. Brief pg. 42. Upon leaving FG also left his backpack and his radio. CP 409, COA App. Brief pg.44. As per Department evidence, Ms. Newell's letter stated that Ms. Dement had called the Valley Mental Health Clinic (VMHC) and Ms. Dement had spoken with the VMHC's staff that informed her that Ms. Newell was out of town. CP 428, COA App. Brief pg. 9. As per Department evidence, Department-HCS candidly admitted she was also informed and that Ms. Dement was following the protocol. CP 425, COA App. Brief pg. 10. Ms. Dement had not only a duty to FG but she has a duty to prevent FG from experiencing a detrimental event that might occur if confronted by the police. Ms. Dement had to consider the behavior of FG that he was sensitive and resistive to authority, Ms. Dement elected to wait for FG and to not immediately involve the police, knowing it would likely become detrimental to FG's mental health treatment. When Ms. Dement was not able to find

FG, she drove to the police station and reported. CP 436, CP 50 ¶ 54, COA App. Brief pg. 9. After 2 months FG was found in Oregon intoxicated and was taken to the Oregon Hospital where he was examined by a medical professional, and it was determined that there was nothing wrong and was released in the community of Oregon. CP 407, 410. COA App. Brief pg. 44.

Ms. Dement believes that there was no neglect as defined by this statute but a neglect elsewhere because the statute does not specifically guide or inform the reader what the person supposed to do and not to do. See Skidmore v. Swift & Co., 323 U.S. 134 (1944).

Frankly, the Court's finding did not support the evidence. The Court found that Ms. Dement neglected FG based on its opinion and how the Department presented this case is based on the unregulated term used to task Ms. Dement.

The Court accepted the claim of the Department-APS that Ms. Dement had to provide an extra caregiver to supervise FG in the community where the Department-HCS did not demand as much because the Department-HCS chose not to fund the claim on the complaint of the Department-APS. The Department-HCS made an error in the assessment when it started that the WSH must provide an extra caregiver to supervise FG while he was in the treatment mall and the mistake by the Department-HCS was never corrected. This error became a task for Ms. Dement when FG left happened on April 13, 2019, by the Department-APS. This demonstrate that the Department is not willing to accept its error and instead leave the problem to Ms. Dement to deal with.

Ms. Dement argues that the RCW 74.34.020 (16) (b) is silent and ambiguous with respect to the specific issue at hand. A silent or ambiguous or a catch-all statute is unconstitutional.

Another example : Placing prison inmates or Western State Hospital's patients in Ms. Dement's Adult Family Home,

1) without sufficient financial support to allow for extra caregiver or changing the assessment knowing FG was on " per client request" only, 2) without providing an accurate assessment to address the level of care issues because the Assessment was created for two (2) very different facilities, and 3) without considering the impact of assisting FG in getting a large amount of money without a designated payee this only a few weeks before his commitment was to end while Ms. Dement and the Mental health Team were preparing to release FG into the community **such as expressed here is neglect as defined in this statute but not a neglect by the opinion of the State**. see Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984):

The Supreme Court, in an opinion by Justice John Paul Stevens, upheld an interpretation put forth by the EPA. A two-part analysis was born from the Chevron decision (called the "Chevron two-step test") in which a reviewing court first determines whether Congress has directly spoken to the precise

question at issue. If the intent of Congress is clear, that is the end of the matter because the court and the agency must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, and the statute is silent or ambiguous with respect to the specific issue, the court does not simply impose its own construction on the statute but determine whether the agency's answer is based on a permissible construction of the statute.

Despite its language, RCW 74.34.020 (16) (b) does not provide the reader with sufficient information to obtain an accurate picture of what actions need to take or avoided in order to comply with the law. In Chevron U.S.A states "The court does not simply impose its own construction on the statute but determine whether the agency's answer is based on a permissible construction of the statute." In this case, the Department-APS interpreted the law based on its opinions using unregulated term not funded and approved by the

Department HCS on its Complaint that put Ms. Dement in neglect situation.

Ms. Dement interpreted the Statute based on what she knows based on the benefits of FG and the conclusion of the court appointed MHC and Department-HCS case manager because the statute does not give her a notice had to be done and not to be done to not violate the statute. The Court accepted the erroneous findings of the Department-APS. Ms. Dement Constitutional Due Process right was violated because of the ambiguous RCW 74.34.020 (16) (b).

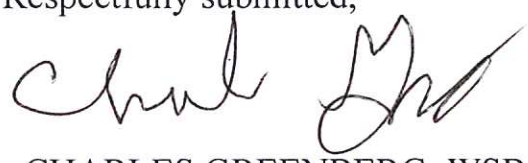
VII. CONCLUSION

Here, the Division I failed to protect Ms. Dements' fundamental rights to notice, hearing, and defense. As a result of a misinterpretation of the statute, and the failure of the Department to add and file its reporting issue in the Complaint, Ms. Dement is asking this court to determine if the RCW

74.34.020 (16)(b) is silent and ambiguous. The silence and ambiguity of the statute cost Ms. Dement her business and soon could cause her to lose her professional license if she is found by this Court to have been neglectful. As such, the Review is merited. RAP 13.4(b)(1), (b) (4). This Court should reverse the Court of Appeals and Costs on appeal should be awarded to the petitioner.

DATED this 17th day of August 2022.

Respectfully submitted,



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DECLARATION OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington that on August 17, 2022, I electronically filed with the Court the foregoing document and appendix and served the same by email upon the following:

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APPENDIX TO PETITION FOR REVIEW

BY THE WASHINTON STATE SUPREME COURT

APPENDIX PAGE NUMBERS	DESCRIPTION
Appendix A 1- 9	Unpublished Opinion in Division I of the Court of Appeals in Washington State Department of Social and Health Services vs. Shanarel Dement in the Court of Appeals Division One Case No. 82859-2-I, filed June 13, 2022
Appendix B 1	Order denying the Petitioner's Motion for Reconsideration, filed on July 18, 2022.

RESPECTFULLY SUBMITTED on August 17, 2022

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APPENDIX A

FILED
6/13/2022
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

SHANAREL DEMENT f/k/a SHANAREL ANCHETA, Appellant, v. STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	No. 82859-2-I DIVISION ONE UNPUBLISHED OPINION

HAZELRIGG, J. — Shanarel Dement appeals the review decision and final order of the Department of Social and Health Services (DSHS) Board of Appeals, which affirmed the substantiated finding by DSHS Adult Protective Services that she had neglected a vulnerable adult. The finding was based on Dement's failure to supervise a resident at her adult family home who left the home unattended and her subsequent failure to contact police for nearly twelve hours after she learned of his elopement. The DSHS Board of Appeals applied the proper legal standard and the finding of neglect is supported by substantial evidence. Accordingly, we affirm.

FACTS

F.G. was a vulnerable adult who was placed in Shanarel Dement's adult family home (AFH) in December 2018 pursuant to a least restrictive alternative plan. F.G. was nearing completion of a 180-day commitment under the involuntary treatment act when the least restrictive alternative plan was authorized and he was transferred to the AFH from Western State Hospital, where he had originally been committed. F.G. had a history of schizophrenia, failure to take prescribed medication, drug use, and convictions for numerous violent felonies, including attempted murder. The "Comprehensive Assessment Reporting Evaluation" (CARE) plan included this history, as well as other behavioral concerns. The CARE plan for F.G. required "supervision" with "locomotion outside of immediate living environment to include outdoors." (Capitalization omitted). The caregiver was to "[t]ake client to store," and "[d]rive client to appointments." Dement was instructed in the negotiated care plan she signed that "[care giver] will let provider know if F.G. wants to go outside so [care giver] can take him. [Care giver] should ensure that [F.G.] shouldn't go far to prevent wandering." If F.G. left the AFH without supervision, Dement's facility was to call F.G.'s case manager to decide whether law enforcement should be contacted.

The record indicates F.G. had left the AFH numerous times while under Dement's care without any calls to the case manager. However, F.G.'s case manager was called on April 10, 2019 when he went to the store without supervision and did not return for more than 90 minutes. Then on April 13, 2019, F.G. left the AFH around 10:30 a.m. and did not return. Dement became aware of

F.G.'s elopement by 12:30 p.m., however she did not contact F.G.'s case manager or law enforcement until 10:43 p.m. F.G. was not located for nearly two months. When F.G. was eventually found, he was in a state of mental health crisis in the middle of a road in Oregon and was taken to a local hospital for evaluation and treatment.

Based on F.G.'s elopement from the AFH, leading to his status as missing for nearly two months and serious decompensation of his mental health, DSHS Adult Protective Services (APS) investigated. APS ultimately entered a substantiated finding of neglect of a vulnerable adult against Dement on June 27, 2019. On July 1, 2019, Dement requested a review of that finding by the Office of Administrative Hearings (OAH).[1] In April 2020, an administrative law judge (ALJ) conducted a two-day hearing during which Dement and DSHS presented testimony regarding the incident with F.G., the APS investigation, and the resulting finding of neglect. On June 29, 2020, the ALJ issued a written decision, the initial order, upholding the June 2019 APS finding of neglect of a vulnerable adult.

On July 8, 2020, Dement sought review of the initial order by the DSHS Board of Appeals (BOA). She also filed a motion for a temporary restraining order, expressly seeking to "prevent the DSHS or any other program or sub-party of the [DSHS] from placing [Dement's] name in the [Background Registry System (BRS)]."[2] On October 22, 2020, the BOA review judge denied Dement's request

[1] The initial order entered by the ALJ after the April 2020 hearing indicates that Dement's request for review was dated July 10, 2019, but based on the documents contained in the administrative record, this appears to be a typographical error.

[2] RCW 74.39A.056(2) prohibits employment as a care giver for, or other unsupervised access to, vulnerable adults if the provider is included in any state registry based on a finding of neglect or abuse of a vulnerable adult.

for stay of entry into the BRS and issued a review decision and final order (the final order), which affirmed the initial order of the ALJ.

Dement next sought judicial review of the final order in King County Superior Court and again filed a motion for a temporary restraining order and injunction to prevent DSHS from placing her name in the state BRS based on the substantiated neglect finding.[3] After considering briefing and oral argument of the parties, the superior court judge affirmed the final order of the BOA review judge. Dement timely appealed to this court.

ANALYSIS

I. Scope and Standard of Review for Administrative Appeals

Though Dement raises claims regarding other sanctions imposed by the State as a result of F.G.'s elopement, and assigns error to the superior court's ruling, we limit our review to the October 22, 2020 final order as that is the only decision properly before this court. The other sanctions[4] she discusses in her

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In briefing to this court, Dement relies on this fact to claim that the substantiated neglect finding, and resulting registration requirement, violates the prohibitions on excessive fines and cruel and unusual punishment contained in the 8th Amendment to the United States Constitution. However, she fails to engage with the proper constitutional tests for such challenges. Accordingly, we decline to consider those arguments.

[3] The record transmitted on appeal does not contain Dement's October 30, 2020 motion for temporary restraining order and injunction and supporting memorandum. However, briefs opposing and supporting the motion were submitted and the parties appear to agree as to the procedural facts regarding this aspect of the proceedings.

The same is true for a second motion for temporary restraining order and injunction and supporting memorandum apparently filed by Dement on November 23, 2020. The record before us does not contain any rulings on these motions by the superior court.

[4] Dement also complains of the imposition of a civil fine and conditions on her license to operate an AFH. However, those sanctions are not properly before us. As a preliminary matter, Dement must exhaust all administrative remedies as to each sanction prior to judicial review. RCW 34.05.534. There is nothing in the record to suggest that she appealed those other sanctions or sought consolidation of the various penalties for purposes of her appeal here.

briefing are outside the scope of this appeal; the only question for us to consider is whether the finding of neglect is supported by substantial evidence.

Next, under Washington's Administrative Procedure Act (WAPA),[5] RCW 34.05.570 governs judicial review of the final agency action. "In reviewing administrative action, this court sits in the same position as the superior court, applying the standards of the WAPA directly to the record before the agency." Tapper v. Emp't Sec. Dep't, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). "The WAPA allows a reviewing court to reverse an administrative decision when, inter alia: (1) the administrative decision is based on an error of law; (2) the decision is not based on substantial evidence; or (3) the decision is arbitrary or capricious." Id. The party challenging an agency's action must demonstrate that the action was invalid. RCW 34.05.570(1)(a).

This court will grant relief from an agency order when the agency has erroneously interpreted or applied the law. RCW 34.05.570(3)(d). "We will defer to an agency's factual findings, but we ultimately review its conclusions of law de novo." Herman v. State of Wash. Shorelines Hr'gs Bd., 149 Wn. App. 444, 458, 204, P.3d 444 (2009). "This standard is highly deferential to the administrative fact finder." Motely-Motley, Inc. v. State, 127 Wn. App. 62, 72, 110 P.3d 812 (2005).

Two of Dement's three assignments of error presented in her opening brief expressly challenge the ruling by the King County Superior Court affirming the neglect finding. However, Tapper makes clear that we do not review the actions

[5] Ch. 34.05 RCW.

of the superior court. As such, we turn our attention to her third challenge that addresses the BOA final order upholding the APS finding of neglect.

II. Substantiated Finding of Neglect of a Vulnerable Adult

We review cases involving neglect of a vulnerable adult under RCW 74.34.020(16)(b). This was recently clarified in Woldemicael v. DSHS, wherein this court provided the specific standard for neglect findings as to vulnerable adults. 19 Wn. App. 2d 178, 494 P.3d 1100 (2021). Woldemicael expressly disavowed use of the child neglect standard articulated in Brown v. Department of Social & Health Services in cases involving allegations of neglect of vulnerable adults. Id. at 181 (citing Brown, 190 Wn. App. 572, 360 P.3d 875 (2015)). While her briefing advocated for application of the Brown standard, Dement conceded at oral argument before this court that Woldemicael controls. As such, there is no dispute between the parties that the ALJ and BOA utilized the proper neglect standard under RCW 74.34.020(16)(b) in reaching the determination affirmed in the final order. There was no error as to the proper legal standard here.

We then turn to a substantial evidence review of the Board's finding. Neither party disputes that F.G. is a vulnerable adult or that Dement owed him a duty of care. In actuality, Dement does not argue the facts found by the BOA are not supported by substantial evidence, but rather urges this court to reweigh those facts to determine if they could support another conclusion. However, that is not how this court engages in appellate review of agency decisions. See Hanh v. Dep't of Ret. Sys. of State of Wash., 137 Wn. App. 933, 939–40, 155 P.3d 177 (2007).

We need only determine whether the evidence of Dement's actions or omissions supports the findings of neglect in the final order. The final order contains two particularly key conclusions:

> 17. This Appellant's failure to follow F.G.'s Negotiated Care Plan and CARE Assessments, and to provide F.G. with the adequate supervision necessary to keep him from eloping from her adult family home, demonstrated a serious disregard of potential consequences to F.G.'s health and welfare. This Appellant knew that F.G. required supervision outside of the AFH, knew that F.G. wanted to go to Oregon, and knew that F.G. had a lengthy criminal history in six (6) states, as well as a history of suicide attempts, substance abuse, and attempted assault. In spite of this knowledge, the Appellant failed to require caregiver supervision of F.G., whenever he left the AFH. Based on the Appellant's knowledge at the time of the incident, allowing F.G. to leave the AFH unsupervised demonstrated a serious disregard of potential consequences to F.G.'s health and welfare.
>
> 18. This Appellant's failure to follow F.G.'s December 13, 2018, Treatment Plan, and to timely notify Valley Cities Mental Health of F.G.'s elopement also demonstrated a serious disregard of potential consequences to F.G.'s health and welfare, and to the health and welfare of others. This Appellant waited nearly twelve (12) hours before notifying Valley Cities Mental Health of F.G.'s elopement. This delay demonstrated a serious disregard of F.G.'s safety, and the health and safety of other individuals that happened to encounter F.G. Additionally, the delay allowed F.G. more time in which to make his ultimately successful "escape." Based on the Appellant's knowledge at the time of incident, waiting nearly twelve (12) hours before notifying Valley Cities Mental Health of F.G.'s elopement demonstrated a serious disregard of potential consequences to F.G.'s health and welfare.

Each of these conclusions is rooted in undisputed evidence and support the finding for neglect, therefore the ultimate substantiated finding under RCW 74.34.020(16)(b) was sufficiently supported. The final order utilized the correct definition of negligence under the statute and, as DSHS succinctly puts it in briefing, "The Final Order properly reviews the evidence of the functional limitations for F.G. in determining that what Ms. Dement did in allowing him into the

community unsupervised and leaving him there without a law enforcement search for twelve hours was neglectful."

Though Dement asserts that the final order was based on an improper reading of the F.G.'s plan of care, this argument is irrelevant as to her actions, particularly given that the final order primarily relies on the CARE report and negotiated care plan to establish F.G.'s limitations and inability to safely function on his own. Accordingly, these documents demonstrate that Dement was aware of and did create a risk by leaving F.G. in the community unsupervised for such an extended period of time without contacting his case manager or law enforcement. Further, he was ultimately missing for two months and found in the middle of a road in a neighboring state. First responders concluded that F.G. was in a sufficiently deteriorated mental state that they detained and transported him for immediate care, which included holding him for a mental health assessment. This was precisely the sort of risk that the supervision requirements contained in the negotiated care plan sought to avoid. Finally, we decline to reach Dement's unsupported claims that the investigation was biased or did not follow proper procedure, as outside the record on appeal. DSHS utilized the correct statutory definition of neglect in considering the evidence presented and reaching the decision contained in the final order.[6]

[6] Dement also seeks an award of attorney fees under the equal access to justice act, RCW 34.05.570(3)(i). However, because she does not prevail in her appeal, her request is denied.

Affirmed.

WE CONCUR:

APPENDIX B

FILED
7/18/2022
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

SHANAREL DEMENT f/k/a SHANAREL ANCHETA, Appellant, v. STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	No. 82859-2-I DIVISION ONE ORDER DENYING MOTION FOR RECONSIDERATION

The appellant, Shanarel Dement, filed a motion for reconsideration of the court's opinion filed on June 13, 2022. A majority of the panel having determined that the motion should be denied; now, therefore, it is hereby

ORDERED that the motion for reconsideration be, and the same is, hereby denied.

For the Court:

Judge

TRIAD LAW GROUP

August 17, 2022 - 3:50 PM

Filing Petition for Review

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