

FILED
Court of Appeals
Division II
State of Washington
12/1/2017 9:24 AM
NO. 50000-2-II

**IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II**

MAGDALENE PAL,

Appellant,

v.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

APPELLANT'S OPENING BRIEF

Amy McCullough, WSBA #36401
NORTHWEST JUSTICE PROJECT
500 W 8th Street, Suite 275
Vancouver, Washington 98660
Tel. (360) 693-6130
Appellant MAGDALENE PAL

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION	1
II. ASSIGNMENTS OF ERROR.....	2
III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR	2
IV. STATEMENT OF THE CASE	3
A. Summary of Relevant Facts and Introduction of Impacted Parties and Other Individuals.....	3
B. Procedural History.....	13
V. ARGUMENT.....	14
A. STANDARD OF REVIEW.	15
B. THE BOARD ERRONEOUSLY INTERPRETED AND APPLIED THE STATUTORY DEFINITION OF NEGLIGENCE.....	16
1. The Punitive Nature of a Neglect Finding Mandates a Narrow Interpretation of RCW 74.34.020(16).....	17
2. The Board Broadly Interpreted and Applied RCW 74.34.020(16) by Misdefining “Serious Disregard” and “Clear and Present Danger” and Employing a Hindsight Analysis.	20
3. The Board Improperly Rejected Due Consideration of a Caregiver’s Duty to Not Violate a DDA Client’s Right to Refuse Care Services.....	24
a. <i>The ISP cannot be interpreted to require a guarantee against self-harm.</i>	28
C. THE RECORD LACKS SUBSTANTIAL EVIDENCE TO SUPPORT A FINDING OF SERIOUS DISREGARD, A PRIMARY ELEMENT OF NEGLIGENCE.	29
1. Ms. Pal Did Not Violate Her Duty of Care; Even if She Did, That Violation Did Not Equal Serious Disregard.....	30

TABLE OF CONTENTS

	<u>Page</u>
a. <i>Strict adherence to the original medication administration plan was not mandated or necessary under the circumstances.</i>	33
2. Ms. Pal's Actions Did Not Constitute an Unreasonable Risk of Highly Probable Harm.	36
a. <i>The record does not support the Board's finding that when Timothy refused to return his medications to Ms. Pal, he was paranoid and Ms. Pal knew this.</i>	37
b. <i>The record contains no evidence that Ms. Pal knew about any prior suicidal ideation, overdosing or other self-harm.</i>	39
c. <i>Timothy had access to, and control of, his medications when he lived on his own.</i>	40
D. THE RECORD LACKS SUBSTANTIAL EVIDENCE TO SUPPORT A FINDING OF CLEAR AND PRESENT DANGER, THE FINAL ELEMENT OF NEGLIGENCE.	43
E. THE BOARD'S NEGLIGENCE FINDING RESTS PARTIALLY ON A DISTORTED VIEW OF MS. PAL'S EXPRESSION OF CARE AND REGRET.	45
F. MS. PAL IS ENTITLED TO ATTORNEY'S FEES IF SHE PREVAILS.	46
VI. CONCLUSION	48

TABLE OF AUTHORITIES

	<u>Page</u>
Cases	
<i>Adkisson v. City of Seattle</i> , 42 Wn.2d 676, 685, 258 P.2d 461 (1953).....	18
<i>Aggregate Indus. v. Nat’l Labor Relations Bd.</i> , 824 F.3d 1095, 1100 (D.C. Cir. 2016).....	41
<i>Brown v. Dep’t of Soc. & Health Servs.</i> , 190 Wn. App. 572, 360 P.3d 875 (2015).....	passim
<i>Casterline v. Roberts</i> , 168 Wn. App. 376, 381, 284 P.3d 743, 746 (2012).....	31
<i>City of Redmond v. Cent. Puget Sound Growth Mgmt. Hrg’s Bd.</i> , 136 Wn.2d 38, 46, 959 P.2d 1091 (1998).....	15
<i>Cosmopolitan Eng’g Group, Inc. v. Ondeo Degremonth, Inc.</i> 159 Wn.2d 292, 296-97, 149 P.3d 666 (2006)	46
<i>Crosswhite v. Dep’t of Soc. & Health Servs.</i> , 197 Wn. App. 539, 557, 389 P.3d 731 (2017).....	19, 41
<i>Helman v. Sacred Heart Hospital</i> , 62 Wn.2d 136, 147, 381 P.2d 605 (1963).....	16
<i>In re Dependency of M.S.D.</i> , 144 Wn. App. 468, 481-82, 182 P.3d 978 (2008)	44
<i>In re Elec. Lightwave, Inc.</i> , 123 Wn.2d 530, 542-43, 869 P.2d 1045, 1052 (1994).....	15
<i>In the Matter of the Dependency of Griffin Lee</i> , 200 Wn. App. 414, 424, ___ P.3d ___ (2017).....	19, 43
<i>Karanjah v. Dep’t of Soc. & Health Servs.</i> , 199 Wn. App. 903, 401 P.3d 381 (2017).....	19, 43

TABLE OF AUTHORITIES

	<u>Page</u>
<i>Language Connection, LLC v. Employment Sec. Dep't</i> , 149 Wn. App. 575, 586, 205 P.3d 924 (2009).....	47
<i>Marcum v. Dep't of Soc. & Health Servs.</i> , 172 Wn. App 546, 290 P.3d 1045 (2012).....	18, 20
<i>Pal v. Dep't of Soc. & Health Servs.</i> , 185 Wn. App. 775, 342 P.3d. 1190 (2015).....	13
<i>Plaza Auto Ctr., Inc. v. Nat'l Labor Relations Bd.</i> , 664 F.3d 286, 291 (9th Cir. 2011)	41
<i>Raven v. Dep't of Soc. & Health Servs.</i> , 177 Wn.2d 804, 826, 306 P.3d 920 (2013).....	25, 26, 45
<i>Ruff v. Fruit Delivery Co.</i> 22 Wn.2d 708, 720, 157 P.2d 730 (1945).....	16
<i>Silverstreak, Inc. v. Dep't of Labor & Indus.</i> , 159 Wn.2d 868, 892, 154 P.3 891 (2007).....	47
<i>Tapper v. Employment Sec. Dep't</i> , 122 Wn.2d 397, 403, 858 P.2d 494 (1993).....	15
<i>Tesoro Ref. & Mktg Co. v Dep't of Revenue</i> , 164 Wn.2d 310, 322, 190 P.3d 28 (2008).....	15
<i>Utter v. State, Dep't of Soc. & Health Servs.</i> , 140 Wn. App. 293, 299, 165 P.3d 399 (2007).....	15
 Statutes	
RCW 18.130.055(b).....	20
RCW 18.130.180(24).....	20
RCW 34.05.461(3).....	41
RCW 34.05.570	15

TABLE OF AUTHORITIES

	<u>Page</u>
RCW 34.05.570(1)(a)	14
RCW 34.05.570(3).....	14
RCW 34.05.570(3)(d).....	2
RCW 34.05.570(3)(d),(e)	1, 16
RCW 34.05.570(3)(e)	2, 15
RCW 4.84.340-360.....	46
RCW 4.84.350	2, 48
RCW 4.84.350(1).....	47
RCW 4.84.340(5).....	47
RCW 70.127.170(2).....	20
RCW 74.34.020(12).....	14, 17
RCW 74.34.020(15).....	17
RCW 74.34.020(16).....	17
RCW 74.34.095	3
RCW 9A.42.100	17
 Regulations	
WAC 388-06A-0110	14, 20
WAC 388-113-0030	14, 20
WAC 388-71-01275(2),(3)	20

TABLE OF AUTHORITIES

	<u>Page</u>
WAC 388-76-10120(3).....	14, 20
WAC 388-97-4220(3).....	20
WAC 388-145-1330	20
WAC 388-825-370	26
 Rules	
ER 803(a)(4)	38
ER 803(a)(6)	38
RAP 18.1.....	2

I. INTRODUCTION

Magdalene Pal appeals the Department of Social and Health Services' (DSHS or Department) erroneous finding of neglect against her. DSHS failed to prove the requisite elements of statutory neglect: that Ms. Pal demonstrated a serious disregard of consequences of such a magnitude to constitute a clear and present danger to a vulnerable adult's health, welfare, or safety. RCW 74.34.020(16)(b). In upholding the neglect finding, the DSHS Board of Appeals (Board) engaged in an unsound evaluation of facts and, contrary to existing law, employed a hindsight analysis and found neglect based on the possibility of risk. The Board's finding permanently punishes Ms. Pal, a dedicated and caring caregiver, for not preternaturally anticipating and guarding against a vulnerable adult's uncharacteristic actions.

The Board's approach to a neglect analysis impermissibly lowers the threshold for a neglect finding under RCW 74.34.020(16)(b), thereby expanding the scope of liability for every individual in Washington who owes a duty of care to a vulnerable adult. The Court should reverse the Board's Review Decision and Final Order (Order) because it is based on a misinterpretation of the law and is not supported by substantial evidence. RCW 34.05.570(3)(d),(e).

II. ASSIGNMENTS OF ERROR

1. The Board erroneously interpreted or applied the standard of neglect, entitling Ms. Pal to relief under RCW 34.05.570(3)(d).
2. The Order is not supported by evidence that is substantial when viewed in light of the entire record before the Court, entitling Ms. Pal to relief under RCW 34.05.570(3)(e).
3. Ms. Pal is entitled to attorney's fees and costs pursuant to RCW 4.84.350 and RAP 18.1.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Whether the Board erroneously interpreted and applied the standard of neglect by redefining "serious disregard" and "clear and present danger" and employing a hindsight analysis to reach Conclusions of Law 18 and 20 through 22.
2. Whether the Board erroneously applied the standard of neglect by disregarding a caregiver's obligation to not violate a vulnerable adult's right to refuse care services.
3. Whether the Order is supported by evidence that is substantial when viewed in light of the entire record, as required by RCW 34.05.570(3)(e).
4. Whether findings of fact 23, 28, 44-46 and 49 are supported by substantial evidence when reviewed in light of the entire record.
5. Whether Conclusions of Law 12, 13, and 16 through 22 are erroneous and the findings of fact contained therein are supported by substantial evidence when reviewed in light of the entire record.

IV. STATEMENT OF THE CASE

A. SUMMARY OF RELEVANT FACTS AND INTRODUCTION OF IMPACTED PARTIES AND OTHER INDIVIDUALS.

Magdalene Pal: Ms. Pal was a DSHS-authorized caregiver from 2009 until December 2011, when APS issued a finding of neglect against her. Report of Proceedings (RP), Vol II, 215; Final Order, Finding of Fact (FoF) 65, AR 26.¹ She received caregiver training from DDA. FoF 65, AR 26. Ms. Pal was a caregiver for Timothy, a vulnerable adult, from January 2011 to the end of December 2011.² RP Vol II, 121. Before that, Ms. Pal provided care for another individual with developmental disabilities. FoF 59, AR 24. Ms. Pal lives with her husband, two children, and her mother, Raj Pal. FoF 54, AR 21. At the time of the events at issue, Ms. Pal's children were three years old and three months old. RP Vol II, 121.

Timothy: Timothy is a 34-year-old man with developmental and mental health disabilities. FoF 1, AR 1; AR 241, Ex. 6. Timothy has diagnoses of moderate mental retardation and intermittent explosive

¹ The Clark County Superior Court Clerk's designation of the report of proceedings does not accurately number the pages of the three volumes of transcripts in this matter. For the purpose of clarifying, the Appellant's citations to Report of Proceedings (RP) are to the transcript, sequentially numbered as Vol I, 1-252; Vol II, 1-230; and Vol III, 1-51. The Appellant's citations to the Adjudicative Record (AR) are to the adjudicative record as numbered by the Board of Appeals and submitted to the Superior Court, which contains the admitted exhibits, briefs, and Order.

² Appellant refers to the vulnerable adult by first name only pursuant to RCW 74.34.095.

disorder.³ AR 241, Ex. 6. Timothy also experiences paranoia. As a result of Timothy's medical impairments, he is eligible for 69 hours of paid personal care services per month through Developmental Disabilities Administration (DDA) (formerly Division of Developmental Disabilities). FoF 26, AR 11. Timothy began receiving these services when he was twenty-two years old. FoF 1, AR 2.

Timothy has a twelfth grade education; he took special education classes. AR 336, Ex. 14. Although it is generally accepted that he cannot read, he is able to read some things. RP Vol II, 130, 224. The results of a mini-mental status examination (MMSE) of him on August 25, 2011, showed he was able to read and follow the written instruction: "close your eyes", although he struggled and/or was unable to complete other tasks. AR 336, Ex. 14; FoF 11, AR 5.

Timothy lives in a mother-in-law suite at Ms. Pal's home; he has lived there since January 2011. FoF 54, AR 21; RP Vol II, 121. Just before moving to Ms. Pal's home, Timothy lived at Elahan Place, a mental health residential treatment facility. AR 259, Ex. 6. For at least a year or two, Timothy lived on his own, during which time he had full access to his medications with little caregiver support. FoF 48, AR 20; RP Vol I, 223-24.

³ Timothy has other physical impairments also. AR 241-42, Ex. 6.

Timothy had no known history of overmedication or attempted self-harm. FoF 47, AR 20; RP Vol I, 226, 238. His known limitations regarding medication management were being unable to read medication labels and forgetting to take medications.⁴ AR 235, Ex. 6.

Raj Pal: Raj Pal is Ms. Pal's mother, and lives with Ms. Pal and her family. FoF 54, AR 21. She has been a DSHS authorized caregiver since 2008. *Id.*; RP Vol II, 37. She became Timothy's caregiver in December 2011. Raj, whom Timothy refers to as "sweet grandma", took care of Timothy when Ms. Pal left on August 18, 2011. FoF 54, AR 22. Raj witnessed the events related to the allegation of neglect. *See* FoF 55-57; AR 22-23; RP Vol II, 39-55.

Ricki Bournival: Ms. Bournival is Timothy's DDA case resource manager. By 2011, she had worked with Timothy for nine years. FoF 43, AR 18. As a case manager, her duties include assessing client needs, coordinating services, and assisting clients with mental health needs. *Id.* This entails completing Comprehensive Assessment Reporting Evaluations (CARE assessment, care plan or Individual Support Plan (ISP)). Ms. Bournival has a bachelor's degree in social sciences. *Id.* She had ten years of experience in mental health management prior to

⁴ Timothy has additional functional and cognitive limitations. FoF 20-22, AR 9.

becoming a DDA case manager. *Id.* At the time of the hearing, she had been employed by DDA for twelve years. *Id.* She declared she had no knowledge of any prior overdose by Timothy and “there was no indication that [he] would take all of his medications at once.” FoF 15, AR 7.

Michelle DeLeon: Ms. DeLeon is Timothy’s mother. FoF 51, AR 21. She did not remember each place Timothy lived after moving out of her home when he was 20 years old or what current medications he took. FoF 51, 53, AR 21; RP Vol II, 118. She did not have firsthand knowledge of the August 18, 2011, incident involving Timothy ingesting four doses of medications at once. RP Vol II, 101-118.

To Ms. DeLeon’s knowledge, Timothy had never tried to overdose. RP Vol II, 104, 115. Ms. DeLeon is Catholic and believes that if someone commits suicide, he will not go to Heaven. RP Vol II, 106. She testified that she did not remember telling Max Horn, APS Investigator, that Timothy had tried to harm himself in the past. RP Vol II, 103, 115. Ms. DeLeon testified that she thought that when Timothy lived on his own his previous caregivers administered his medications to him. FoF 52 & 53, AR 21. She also thought there was a medication lock box at each of his apartments, but she could not be certain. FoF 53, AR 21. Ms. DeLeon sometimes has trouble remembering things day to day. RP Vol II, 107.

Max Horn: Mr. Horn is an APS Investigator who investigated the

allegation of neglect in this case. FoF 2, AR 2. Mr. Horn began his investigation on August 22, 2011, concluded it on October 25, 2011, and recommended a substantiated finding of neglect. *Id.* During his investigation, Mr. Horn interviewed Timothy, Ms. Pal, Ms. DeLeon, and Ms. Bournival. He did not interview Raj Pal, Ms. Pal's neighbor or the medical providers who treated Timothy during his hospital stay from August 18-21, 2011. FoF 8, 31, 38, AR 4, 13, 17. Mr. Horn based his finding of neglect on his interviews with Ms. Pal and Timothy, and hospital and DDA records. FoF 3, AR 2.

When Mr. Horn interviewed Timothy, he conducted a mini-mental status exam (MMSE), the results of which Mr. Horn admitted were limited. FoF 11, AR 5. Mr. Horn does not conduct care assessments or create care plans; he has had no training in either. FoF 19, AR 8.

Timothy's Care Assessment and Medication Administration

Plan: In January 2011, Ms. Bournival completed an assessment of Timothy's need for support with activities of daily living. FoF 19, AR 8. This resulted in a determination that his needs could be met with 69 hours of personal care services a month (or 2.3 hours/day). FoF 26, AR 11 (Ex. 6). The ISP summarized Timothy's medical conditions, needs and

caregiver tasks and instructions.⁵ AR230-264 (Ex 6).

When Ms. Bournival completed Timothy's care assessment, she and Ms. Pal discussed Timothy's needs. FoF 59, AR 24. From that conversation, Ms. Pal understood that Timothy forgot to take his medications and lost his medications. RP Vol II, 127; Vol III, 42. Based on her review of the assessment and conversations with Ms. Bournival, she believed she was to remind Timothy to take his meds at the proper times. RP Vol II, 126-128; Vol III, 17. Ms. Pal signed a client service individual provider contract wherein she agreed to assist Timothy with the personal care services included in the care plan. FoF 27, AR 11-12.

When Timothy came to live with Ms. Pal, an Elahan Place staff member dropped him off with garbage bags containing all of his possessions. FoF 60, AR 24. His medications were unorganized. *Id.* There were several bubble packs of his medications in the bags, along with dozens of ibuprofen. *Id.*; AR 339, Ex.15. The bubble packs were not labeled a.m. and p.m. and lacked instructions. FoF 60, AR 24. Ms. Pal asked Timothy if he would like help organizing his medications, and he said he would. RP Vol II, 126. Ms. Pal asked Timothy if she could keep his medications in the same cabinet that she kept her own medications,

⁵ A detailed list of Timothy's care needs is in the ISP. *See* Ex. 6.

and he agreed. *Id.* It was Ms. Pal's policy to keep all medications in a cabinet high in her kitchen because she had two small children in the home. RP Vol II, 43; Vol III, 19.

Timothy explained to Ms. Pal what medications he took and when. RP Vol II, 129, 131. He told her he had been taking the same medications for the past eight years. *Id.* at 130. Timothy's medications are different shapes, sizes and colors. FoF 60, AR 24. Ms. Pal called the pharmacy and verified the accuracy of his instructions. RP Vol II, 131.

Ms. Pal decided the best way to keep Timothy's medications organized was to place them in pill organizers or "medisets" with compartments listing the days and "a.m. and p.m." RP Vol II, 127. Ms. Pal was concerned that if Timothy kept his medication in his suite, he would lose them and she would need to look for them. *Id.* at 127, 145-46, 218. Ms. Pal runs a very organized home and was concerned about how much time this would take. *Id.*, at 145-147.

Ms. Bournival knew of Ms. Pal's and Timothy's agreement that Ms. Pal would keep his medications in the kitchen and hand them to him, although this was not required under the care assessment. RP Vol I, 214-215, 226. Timothy has the right to coordinate care with his providers, and it was within his prerogative to agree or disagree with this arrangement. *Id.* at 214. When Timothy lived on his own, he had custody of his own

medications. FoF 48, AR 20; RP Vol I, 224. A caregiver would come to his apartment to confirm whether he had taken his medications and, if not, remind him to do so. FoF 48, AR 20; RP Vol I, 224-225. This did not occur daily. RP Vol I, 224-225.

Incident at Issue: Two weeks before August 18, 2011, Ms. Pal told Timothy that she was going out of town to visit her in-laws. She told him that Raj Pal was going to provide care services while Ms. Pal was gone. Ms. Pal notified Ms. Bournival about the arrangement, and Ms. Bournival approved it. FoF 61, AR 24-25.

On August 18, 2011, as Ms. Pal was preparing to leave for the weekend trip to her in-laws, Timothy went into Ms. Pal's kitchen and took the mediset that Ms. Pal had put on the kitchen island for Raj Pal to access while she was gone. FoF 55, AR 22. The organizer contained five medication doses, separated into a.m. and p.m. compartments. RP Vol. II, 42. *Id.* Raj Pal tried to persuade Timothy to return the mediset, but he refused. *Id.* Raj Pal then told Ms. Pal what had happened, and she, too, tried to persuade him to return the mediset. Again he refused. FoF 55-56, 62, AR 22-23, 25.

Timothy argued with Ms. Pal and told her he just wanted to hold on to them himself and that he had been in charge of his own meds in the past when he lived in his own apartment. *Id.* He complained that Ms. Pal

and her mother were treating him like a child, that he taught Ms. Pal how to administer his medications, and he knew how to take them. FoF 55, AR 22; RP Vol II 44-45, 140-41, 206.

At this time, Timothy was acting normally. RP Vol II, 149, 206. Ms. Pal and Raj Pal decided, with Timothy's agreement, that Raj Pal would check on him and remind him to take the medications at mealtimes. Ms. Pal explained to Timothy how the pill organizer worked; showing him that the top was his morning dose and the bottom was his evening dose. Timothy "shook his head 'yes' like he already knew." FoF 62, AR 25. Ms. Pal also told him she would call him in the mornings and evenings to confirm he had taken his medications as directed. RP Vol II, 143. She also told him he could call her anytime if he needed anything. RP Vol II, 135.

Later that evening, after Ms. Pal left for her trip, Timothy took two days' worth (or four doses) of his medications.⁶ FoF 14, 57, AR 6, 23. Shortly thereafter, while outside smoking a cigarette, Timothy told his

⁶ During his hospital stay, Timothy offered various reasons for his decision to take his weekend medications all at once. On August 22, 2011, Kristine Simpson, a psychiatric mental health nurse practitioner, stated in her report that Timothy vacillated in reports of whether the ingestion of pills was intentional with the desire of ending his life or accidental. Timothy stated, "I took too many pills and almost killed myself cause I was agitated and upset." AR 307-308, Ex 12.

neighbor he took all his weekend medications, and the neighbor called Ms. Pal. FoF 56, AR 23. Ms. Pal immediately called Raj Pal. *Id.* When Ms. Pal told her the neighbor said Timothy had taken all his medications, Raj Pal went to Timothy's suite to verify. FoF 57, AR 23. Timothy would not tell her where the mediset was. She then found it, empty, under the couch. *Id.* Ms. Pal instructed Raj to call 911, which she did. *Id.*; RP Vol II, 51-53. Timothy was then transported to the hospital by ambulance; Raj Pal followed by car. FoF 57, AR 23. The attending physician told Raj that Timothy was going to be okay, so she left. *Id.*

According to Legacy Salmon Creek Medical Center records, when he arrived at the hospital, Timothy was groggy, but denied being in pain. AR 316, Ex. 12. He then became obtunded (not comatose); a doctor placed him in the Intensive Care Unit (ICU), for treatment and observation. AR 304-6, Ex. 12. One of the medications Timothy took was carbamazepine; the amount he ingested was twice the normal limit. FoF 28, AR 12.

By the next morning, Timothy was up and walking around. FoF 57, RP 23. Before being discharged, Timothy met with a mental health professional, Kristine Simpson, who determined that he did not need psychiatric hospitalization. AR 311, Ex. 12. Timothy told Ms. Simpson, "I took too many pills and almost killed myself cause I was agitated and

upset.” AR 308. Timothy explained he was having an argument with Raj Pal at the time and had received a letter denying his request for medical transportation. *Id.* Based on her interview with Timothy, Ms. Simpson determined “this was a rather impulsive ingestion.” AR 310, Ex. 12.

Timothy returned home on August 22, 2011, and remained in Ms. Pal’s care for four more months. APS did not issue a substantiated neglect finding until December 20, 2011. AR 224, Ex. 4. APS did not initiate a guardianship petition for Timothy. FoF 12, AR 6. To date, with his mother’s approval, Timothy still lives in the mother-in-law suite at Ms. Pal’s home. FoF 43, AR 18. Raj Pal is now his DDA-paid caregiver. *Id.* According to Ms. Bournival, Timothy’s residence at Ms. Pal’s home has been his most successful placement. RP Vol I, 228.

B. PROCEDURAL HISTORY.

After receiving APS’s notice of substantiated finding of neglect, dated December 20, 2011, Ms. Pal requested an administrative hearing with the Office of Administrative Hearings (OAH). OAH denied the hearing request as being untimely filed. Ms. Pal successfully appealed this ruling. On February 3, 2015, this Court reversed the OAH hearing denial and remanded for a hearing. *Pal v. Dep’t of Soc. & Health Servs.*, 185 Wn. App. 775, 342 P.3d. 1190 (2015). On remand, OAH held a hearing on the Department’s finding of neglect on January 8, 21, and 22, 2016. On May

24, 2016, Administrative Law Judge (ALJ) Dickerson issued an Initial Order affirming APS's neglect finding. On June 14, 2016, Ms. Pal sought review of the Initial Order with the DSHS Board of Appeals. On August 4, 2016, Board Review Judge Conant affirmed the Initial Order. Ms. Pal timely filed a Petition for Judicial Review on September 2, 2016. On July 3, 2017, Clark County Superior Court upheld the Final Order. Ms. Pal timely appealed to this Court on July 26, 2017.

V. ARGUMENT

An individual substantially prejudiced by a state agency adjudicative order may seek judicial review and relief from the order. RCW 34.05.570(3). A reviewing court may set aside an agency's final order if the court determines the agency erroneously interpreted or applied the law or the order is not supported by substantial evidence. *Id.* The party challenging an agency decision has the burden of demonstrating the invalidity of the agency's action. RCW 34.05.570(1)(a).

Ms. Pal is substantially prejudiced by the Board's Order. Her name will now be placed on a public abuse registry, which significantly impairs her reputation and employment and volunteer opportunities.⁷ She can never be employed in any position involving unsupervised contact with

⁷ RCW 74.34.068; RCW 74.39A.056(2); RCW 18.130.400; WAC 388-06A-0110; WAC 388-76-10120(3); WAC 388-113-0030; WAC 388-145-1330.

vulnerable adults. She may be denied various licenses, such as becoming a foster care parent. *See* WAC 388-71-01275(3).⁸

A. STANDARD OF REVIEW.

An appellate court applies the standards in RCW 34.05.570 “directly to the record before the agency, sitting in the same position as the superior court.” *Utter v. State, Dep’t of Soc. & Health Servs.*, 140 Wn. App. 293, 299, 165 P.3d 399 (2007) (quotations omitted). Questions of statutory or regulatory interpretation and an agency’s application of the law to the facts are reviewed *de novo*. *Tesoro Ref. & Mktg Co. v Dep’t of Revenue*, 164 Wn.2d 310, 322, 190 P.3d 28 (2008); *Tapper v. Employment Sec. Dep’t*, 122 Wn.2d 397, 403, 858 P.2d 494 (1993).

The facts underlying a neglect finding must be supported by substantial evidence when viewed in light of the entire record. RCW 34.05.570(3)(e); *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hrg’s Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998). Substantial evidence is “evidence in sufficient quantum to persuade a fair-minded person of the truth of the declared premises.” *In re Elec. Lightwave, Inc.*, 123 Wn. 2d 530, 542–43, 869 P.2d 1045, 1052 (1994), as amended on denial of reconsideration (Apr. 28, 1994). Substantial evidence is “more than a mere

⁸ Individuals subject to substantiated findings of abuse or neglect are not able to seek to have the finding removed from the registry during their lifetime. WAC 388-71-01275(3).

scintilla.” *Helman v. Sacred Heart Hospital*, 62 Wn.2d 136, 147, 381 P.2d 605 (1963). It means “that character of evidence which would convince an unprejudiced, thinking mind of the truth of the fact to which the evidence is directed.” *Ruff v. Fruit Delivery Co.*, 22 Wn.2d 708, 720, 157 P.2d 730 (1945).

B. THE BOARD ERRONEOUSLY INTERPRETED AND APPLIED THE STATUTORY DEFINITION OF NEGLIGENCE.

In upholding the Department’s erroneous neglect finding, the Board failed to: 1) strictly construe and apply the definition of neglect, thereby permitting a finding of neglect based on the possibility of risk as evidenced by the occurrence of harm; 2) meaningfully consider a caregiver’s obligation to not violate a DDA client’s rights; and 3) engage in reasoned and balanced fact finding. *See* RCW 34.05.570(3)(d),(e).

The Board’s erroneous finding of neglect is based on a single incident: Ms. Pal agreed to a vulnerable adult’s request to self-administer two days’ worth of medication while Ms. Pal was out of town, and while she was away, the vulnerable adult, with no known history of overdosing or self-harm, took the medication all at once. *See* Section IV.A, at 10-12. As demonstrated below, there is no basis in fact or law for a neglect finding based on this incident.

1. The Punitive Nature of a Neglect Finding Mandates a Narrow Interpretation of RCW 74.34.020(16).

The Abuse of Vulnerable Adults Act (AVAA) defines neglect, in relevant part, as:

(b) 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.

RCW 74.34.020(16)(b) (emphasis added).⁹ The statute does not define “serious disregard” or “clear and present danger”. In 2015, the Division III Court of Appeals defined these concepts and articulated a clear analytical framework for neglect determinations. *See Brown v. Dep’t of Soc. & Health Servs.*, 190 Wn. App. 572, 360 P.3d 875 (2015). In analyzing Washington’s child neglect statute, which mirrors RCW 74.34.020(16)(b), the *Brown* court examined each element of neglect and concluded that more than mere negligence is required to establish neglect. *Id.* First, regarding serious disregard, the court reasoned:

An actor’s conduct is in “reckless disregard” of the safety of another if he or *she intentionally does an act or fails to do*

⁹ When the ALJ issued her initial finding, the definition of “neglect” was found at RCW 74.34.020(15) (effective July 24, 2015). In 2011, “neglect” was at RCW 74.34.020(12), and subsection (b) did not contain the words “a person or entity with a duty of care”. The 2011 version is applicable to the incident at issue. Ms. Pal agrees she had a duty of care and that Timothy was a vulnerable adult.

an act which it is his or her duty to the other to do, knowing or having reason to know of facts that would lead a reasonable person to realize that the actor's conduct not only creates an unreasonable risk of bodily harm to the other but also involves a high degree of probability that substantial harm will result to him or her. Adkisson v. City of Seattle, 42 Wn.2d 676, 685, 258 P.2d 461 (1953). We see no difference between "serious disregard" and "reckless disregard." Reckless and serious disregard signifies a higher degree of culpability than acting unreasonably or affording "negligent treatment."

Id. at 590 (emphasis added).

The *Brown* court clarified that magnitude, defined in part as "greatness of size or extent," must be of a greater level of fault than negligence. *Id.*, at 590 (citation omitted).

Next, the court observed that "clear and present danger," as used in First Amendment jurisprudence, refers to "a serious substantive evil that rises above public inconvenience, annoyance, or unrest." *Id.*, at 591. The court concluded that the Legislature's use of the idiom means "more serious misconduct than mere negligence" is required. *Id.*; *see also, Marcum v. Dep't of Soc. & Health Servs.*, 172 Wn. App 546, 290 P.3d 1045 (2012) (this Court reversed a finding of child neglect that was based on the agency's list of *per se* acts constituting neglect rather than an actual finding of clear and present danger).

Finally, the validity of a caregiver's actions or omissions must not be examined through the lens of hindsight. The *Brown* court rejected the

Board’s use of hindsight as “unbecoming even for a negligence standard.” *Brown*, at 596 (citations omitted). Division I similarly rejected a hindsight review. *In the Matter of the Dependency of Griffin Lee*, 200 Wn. App. 414, 424, ___ P.3d ___ (2017) (reversing and remanding for a determination based on the presenting circumstances).

Adherence to the above analytical framework is critical because of the punitive nature of the AVAA.¹⁰ When a statute has punitive consequences separate and apart from civil liability, the statute must be strictly construed. *See Brown*, at 591; *Karanjah v. Dep’t of Soc. & Health Servs.*, 199 Wn. App. 903, 401 P.3d 381 (2017); *Crosswhite v. Dep’t of Soc. & Health Servs.*, 197 Wn. App. 539, 557, 389 P.3d 731 (2017) (rejecting the Department’s broad interpretation of the AVAA and noting that the court “has consistently rejected Department interpretations of statutes that broaden its authority to take punitive action.”).

A substantiated finding of neglect of a vulnerable adult carries permanent punitive consequences. A substantiated finding results in the placement of the offender’s name on a lifelong public abuse registry, which stigmatizes that individual and permanently precludes her from working or volunteering in positions where she may have unsupervised

¹⁰ The AVAA has both beneficial and punitive purposes. *See, e.g.*, RCW 74.34.005(6); RCW 74.34.068; RCW 74.34.120.

access to vulnerable adults.¹¹ The registry listing and the consequent disqualification from employment is automatic and permanent. A finding also disqualifies an individual from obtaining a number of licenses, including a license for an adult family home or daycare center.¹² A finding is also a basis for denial of any license issued by the Department of Health or a license to become a foster parent. RCW 18.130.055(b); RCW 18.130.180(24); WAC 388-148-1300.

The extraordinary consequences of a neglect finding therefore demand that the definition of neglect be strictly construed and applied only to those instances in which it is undoubtedly warranted.

2. The Board Broadly Interpreted and Applied RCW 74.34.020(16) by Misdefining “Serious Disregard” and “Clear and Present Danger” and Employing a Hindsight Analysis.

Here, the Board departed from the analytical framework established by *Brown* and *Marcum* in three critical ways, resulting in an invalid neglect finding. First, regarding serious disregard, the Board defined *serious* as “[g]rave in disposition, appearance, or manner” and *regard* as “[t]o treat without fitting respect or attention.” CoL 21, RP 38,

¹¹ RCW 74.34.068; RCW 74.39A.056(2); RCW 43.43.832(4); WAC 388-113-0030; 388-06A-0110; WAC 388-76-10120(3); WAC 388-71-01275(2),(3).

¹² RCW 70.127.170(2); WAC 388-76-10120(3)(d); WAC 388-78A-3190 WAC 388-78A-3190; WAC 388-97-4220(3); WAC 388-145-1330.

fn 216. This definition reduces the severity of conduct necessary for a serious disregard finding by removing the essential elements: *an intentional act or failure to act that the individual knew or should have known poses an unreasonable risk of substantial and highly probable harm.* *Brown*, at 590 (emphasis added).

Second, regarding clear and present danger, the Board defined *clear* as: “[w]ithout confusion or obscurity” and *present* as “[n]ow existing or in progress.” CoL 21, AR 38, fn 217. This definition does not incorporate the principle that clear and present danger implies serious misconduct. *Brown*, at 591.

Third, the Board improperly relied on hindsight to conclude serious disregard and clear and present danger existed because harm occurred. A proper determination of the degree of risk, probability of harm, and level of danger associated with an alleged act or omission may only be achieved through an examination of the presenting facts and circumstances.

From these dictionary definitions and the luxury of hindsight, the Board reached Conclusions of Law 21 and 22, respectively:

[T]he Appellant’s failure to take action to insure Timothy did not under-dose or overdose on his medication was an omission that demonstrated a serious disregard of the consequences of such a magnitude as to constitute a clear and present danger to

Timothy's health, welfare, or safety, **as borne out by his overdosing** on his medications during unsupervised self-medication requiring emergency transportation to, and care at, a hospital. This conclusion is reached accepting the common language usage for the terms "serious disregard" and "clear and present danger."

CoL. 21 (emphasis added); and

The Appellant's failure to provide physical assistance to ensure adequate supervision and monitoring of Timothy's self-administration of his medications did constitute neglect...

CoL. 22. Further using post-hoc rationalization, the Board opined that Ms. Pal should have contacted authorities to assist her "[regain] physical control of the medications", taken legal action or physically monitored Timothy round the clock until he relinquished the medications. The latter course of action would mean that Timothy could not toilet or bathe himself privately. CoL 18, AR 36.

The Board's failure to follow the established analytical framework and engage in a rigorous analysis of each element of statutory neglect resulted in an impermissible lowering of the necessary threshold for a neglect finding under RCW 74.34.020(16)(b). This expands the scope of liability of individuals with a duty of care beyond that envisioned or enacted by the Washington State Legislature. Under the Board's approach, a caregiver commits neglect if she does not *guarantee* against the *possibility* of harm as evidenced by the harm later occurring, regardless of how unforeseeable.

Additionally, imposing strict liability on caregivers for any possible harm occurring to a vulnerable adult, regardless of the reasonable steps taken to prevent such harm, is poor public policy and undermines the purpose of home-based care services. It creates a significant disincentive for any person seeking to be a paid caregiver (a much needed skillset and profession), which limits the opportunities for individuals with disabilities to live as independently as possible, i.e., without institutionalization. It is especially poor policy when doing so interrupts a quality placement for a vulnerable adult, which is hard to come by. *See, e.g.*, FoF 48, AR 20 (explaining the difficulty in finding placements for Timothy).

The statutory framework does not hold caregivers to this impossible standard. Both *Brown* and *Lee*, for instance, highlight the imprudence of a hindsight analysis. In *Brown*, the court rejected the Board's use of hindsight to find a parent, Ms. Brown, committed neglect when she did not immediately seek medical attention for her two-year old child's significant burns. *Brown*, at 595-96. Ms. Brown sought treatment several days after the child was burned. A doctor found the child had extensive second and third degree burns. *Id.*, 576-77. The court found that Ms. Brown's actions were not serious disregard so as to constitute a clear and present danger because *when* the child was burned, he was not in distress, and Ms. Brown took reasonable treatment measures under the

circumstances. *Id.*

In *Lee*, the court reversed a hindsight determination that parents committed neglect based on their child's post-hospitalization medical improvement. *Lee*, 200 Wn. App. 414. For several years, the parents refused to consent to a permanent feeding tube for their malnourished child. *Id.* When the child was last hospitalized he was so malnourished he was near death. *Id.* After a feeding tube was inserted, the child began to gain weight. The court remanded for a new determination based on the facts in existence before the child's last hospitalization. *Id.*

This jurisprudence makes sense. Otherwise, to avoid a neglect finding and its consequences, every individual with a duty of care would have to have a preternatural ability to foresee events or be so hyper-vigilant as to take anticipatory protective measures each moment of the day. This Court should therefore do as Divisions I and III did: reject the Board's continued use of a fundamentally flawed approach to neglect determinations.

3. **The Board Improperly Rejected Due Consideration of a Caregiver's Duty to Not Violate a DDA Client's Right to Refuse Care Services.**

The Board improperly rejected Ms. Pal's argument regarding Timothy's right to refuse care services as irrelevant and a self-serving attempt to evade responsibility. CoL 17. A more reasoned analysis of

serious disregard would have included a meaningful consideration of a caregiver's obligation to not violate a DDA client's rights even though he has developmental and mental health disabilities.

What Ms. Pal believed she lawfully could do regarding controlling Timothy's medication was another factor informing her decision and her understanding of her duty of care. This factor is integral to a proper determination of whether her actions constituted serious disregard of such a magnitude as to create a clear and present danger.

The Board's decision reveals a lack of understanding of the inherent difficulties of providing care to individuals who resist or refuse care, but are nonetheless entitled to do so. *See, e.g., Raven v. Dep't of Soc. & Health Servs.*, 177 Wn.2d 804, 826, 306 P.3d 920 (2013); AR 197, Ex. D (Ms. Bournival this case "highlight[s] the incongruence between client choice/rights and provider responsibility"). The Board did not point to any law or standard that required Ms. Pal, under the circumstances presented here, to *guarantee* that Timothy accepted the care she had been providing and had initially arranged for in her short absence.

The Washington Supreme Court's decision in *Raven* is illustrative. There, the Court considered whether a guardian committed statutory neglect by deferring to her client's expressed wishes to live in her home, even though the client's high care needs and lack of cooperation with

caregivers resulted in self-neglect at home. *See Raven*, 177 Wn.2d 804..

The Court rejected the Department’s view that guardians must ensure their wards accept care provided to them as that would create “an untenable standard akin to strict liability.” *Id.*, at 826-27. The Court reversed the neglect finding although the client’s care needs would have been better met in a care facility and the guardian’s failure to ensure better home care for the client fell short of her duty. *Id.*, at 829-31, 833-34.

Similarly, as a DDA-paid caregiver, Ms. Pal must provide Timothy’s personal care in a way that respects his right to live as independently as possible in light of his functional limitations.¹³ *See, e.g.*, RCW 71A.10.011 (the Legislature “recognizes that the emphasis of state developmental disability services is shifting from institutional-based care to community services in an effort to increase the personal and social independence and fulfillment of persons with developmental disabilities[.]”); WAC 388-825-370 (a caregiver must “[p]rovide the services as outlined on the client's plan of care...according to the client's direction, supervision, and prioritization of tasks within the number of hours authorized[.]”); AR 264, Ex. 6 (“participation in all ADSA/DDD

¹³ Adults are presumed to be capable of self-autonomy until a court determines otherwise. *See* RCW 11.88 (guardianship proceedings).

paid services is voluntary and [Timothy has] a right to decline or terminate services at any time”).

Ms. Pal’s education and training informed her that Timothy had a legal right to possess his medications. RP Vol II, 225-26; Vol III, 13; Vol I, 228-29. And neither the ISP, nor Timothy’s case manager, his mother, or Ms. Pal’s interactions with Timothy for the past seven months informed her that Timothy could not exercise that right. RP Vol II, 153. So when he refused to return the mediset containing his weekend medications, she adjusted his medication administration plan consistent with her duty of care and his right of choice, as was appropriate in light of his known history, behavior and expressed understanding of which medications to take and when.

Only clear and present danger could warrant an invasion of Timothy’s rights in the ways the Board speculated were necessary to avoid committing neglect. *See* CoL 18, AR 35-6 (admonishing Ms. Pal for not calling “the necessary resources to aide [sic] her in regaining physical control of the medications which may have included legal action” or constantly monitoring Timothy, which would have meant he would not have been able to toilet or bathe himself privately). Here, no such danger existed.¹⁴ *See* Section D, *infra*.

¹⁴ In support of its contention that a caregiver’s obligation to respect a DDA client’s

a. *The ISP cannot be interpreted to require a guarantee against self-harm.*

In rejecting Timothy's right of choice as irrelevant, the Board further opined that "the ISP cannot be interpreted or applied to abet self-neglect by a vulnerable adult[,] or allow circumstances dangerous to that vulnerable adult's health, welfare and safety."¹⁵ CoL 17, RP 35. Nor may an ISP be interpreted or applied to require a guarantee against every possibility of self-neglect or danger. Timothy's ISP authorized 69 hours of care a month, which is about 2.3 hours a day. This leaves 21.7 hours a day in which DDA determined Timothy could be wholly independent. An ISP that does not authorize or mandate 24-hour supervision inherently poses a possibility of self-neglect or harm. That a vulnerable adult may commit self-harm is not a basis for neglect; there must be an *unreasonable risk* of substantial and probable harm coupled with *clear and present* danger. *Brown*, at 589 (emphasis added).

If the Court accepts the Board's reasoning heightening Ms. Pal's duty of care, the Court would need to conclude that Timothy should not

rights is irrelevant, the Board draws a reductionist and inapt analogy of arguably clear and present danger. CoL 17, AR 35. Had the situation the Board imagines existed here--- i.e., that it was obvious and imminent that Timothy was going to overdose on his weekend medications--Ms. Pal would have chosen differently. AR 343.

¹⁵ To the extent the Board's comment implies that Ms. Pal abetted self-neglect, the record plainly shows otherwise. Abet means to encourage or assist someone take an action, and connotes knowledge and intent. See <https://www.merriam-webster.com/dictionary/abet>. She neither encouraged nor assisted Timothy to take four doses of medication at once.

retain his right to refuse medication assistance or ever be left unsupervised because with his limitations, it is always possible he could engage in self-harm. Yet, APS has not initiated a guardianship for Timothy. FoF 12, AR 6. To date, with DDA's and his mother's approval, Timothy still lives in the mother-in-law suite at Ms. Pal's home, without 24-hour supervision. FoF 43, 64, AR 18, 25-6. According to Ms. Bournival, Timothy's residence at Ms. Pal's home has been his most successful placement. RP Vol I, 228.

C. THE RECORD LACKS SUBSTANTIAL EVIDENCE TO SUPPORT A FINDING OF SERIOUS DISREGARD, A PRIMARY ELEMENT OF NEGLECT.

The Department did not meet its burden of proving, by a preponderance of evidence, the requisite elements of neglect. *See* RCW 74.34.020(16)(b). The element of serious disregard requires that Ms. Pal intentionally acted or failed to do an act which it was her duty to Timothy to do, "*knowing or having reason to know* of facts that would lead a reasonable person to realize her conduct not only created an *unreasonable risk* of bodily harm *but also* involved a high degree of probability that substantial harm would occur." *Brown*, at 589 (emphasis added). In other words, serious disregard requires substantially more than a violation of a duty of care. *See, e.g., Raven*, at 465, 471. The record does not support a finding of serious disregard, under either the correct definition or the

Board's definition.

As demonstrated below, the Board failed to consider substantial evidence regarding Timothy's history and Ms. Pal's belief that her alternate weekend medication plan was reasonable under the circumstances. The Board largely ignored the views of the ISP's drafter when those views did not support a finding of neglect and misconstrued the ISP to require a heightened duty of care. The Board also accepted nearly wholesale a cursory APS investigative report based, in large part, on unexamined hearsay statements and disputed, unverified statements of Ms. Pal and others.¹⁶

1. **Ms. Pal Did Not Violate Her Duty of Care; Even if She Did, That Violation Did Not Equal Serious Disregard.**

Ms. Pal had a duty to assist Timothy with medication management. The Board's erroneous conclusion that Ms. Pal violated that duty by not physically assisting Timothy or pulling out all stops to retrieve his medications from him was based, in part, on a misinterpretation of

¹⁶ The APS Investigator failed to interview Raj Pal, a primary witness to the events before and after Ms. Pal left for the weekend, Ms. Pal's neighbor, or any of the medical providers from whom he received documentation regarding Timothy's hospital stay. FoF 31, 38, AR 13, 17. He did not seek to verify the accuracy or context of any the statements contained within those documents. His note misrepresents Timothy's state of consciousness when hospitalized as "comatosed", although the record shows that upon admission, Timothy was groggy, but denied being in pain. FoF 3, AR 52; AR 316, Ex. 12. He then became obtunded (not comatose). AR 304-6, Ex. 12

Timothy's care plan (ISP). CoL 12, 13, 22, AR 32-33; FoF 44-46, AR 18-19.

Although mislabeled as a conclusion of law, the question of what the ISP required Ms. Pal to do is factual and should be analyzed under the substantial evidence standard. A conclusion of law erroneously described as a finding of fact will be reviewed as a conclusion of law. *Willener v. Sweeting*, 107 Wn.2d 388, 394, 730 P.2d 45 (1986). If a conclusion of law is mislabeled as a finding of fact, the court reviews the conclusion *de novo*. *Casterline v. Roberts*, 168 Wn. App. 376, 381, 284 P.3d 743, 746 (2012) (citation omitted).

Contrary to the Board's finding, the ISP did not specifically require Ms. Pal to keep Timothy's medications locked up, hand him medications, and "keep an eye" on him while he took his medications (CoL 12, 13, 20). The ISP provided only two specific instructions regarding medication management. First, the "Caregiver Instructions" section stated: "Put medications in lockbox, **Remind client to take medications.**" AR 243, Ex. 6 (emphasis added).

Ms. Bournival testified that the first phrase of that instruction applied to Elahan Place, not to Ms. Pal.¹⁷ RP Vol I, 213-14; FoF 15, AR 7

¹⁷ Ms. Bournival also testified Ms. Pal had not taken on the role of an adult family home. RP Vol I, 225-226. Ms. Pal testified that she understood, from her conversations with Ms. Bournival, that she did not need a lockbox. RP Vol II, 189, 190, 201.

(Ms. Bournival's Declaration). Ms. Pal also testified that she understood from her conversations with Ms. Bournival that she did not need a lockbox. RP Vol II, 189-90, 201. The Board misconstrued Ms. Pal's alleged statement to the APS investigator that the medications were "normally locked up." CoL 20, AR 37. Substantial evidence in the record suggests Ms. Pal most likely meant the medications were kept in her kitchen cabinet. FoF 46, AR 19.

The second instruction, in the comment section of Medication Management, was:

Meds at EP are kept in the medication room. Tim goes to the med. Room during med. pass time and is handed bubble pack. *IP will assist Tim with meds. in his new living situation.*

AR 243 (emphasis added). Only the last sentence pertains to Ms. Pal. RP Vol I, 214. Similarly, the ISP's provision, "Provider gives Tim bubble pack for the appropriate time and shows Tim the correct day to punch[,]" referred only to medication management at Elahan Place, not to Ms. Pal. RP Vol I, 197.

Although the needs section indicated that partial physical assistance was needed, the ISP did not instruct Ms. Pal on how that was to be performed.¹⁸ Ms. Bournival told Ms. Pal that she and Timothy would

¹⁸ Ms. Bournival explained that the term "partial physical assistance" means the caregiver needs to "use their body in some way to assist." FoF 49, AR 20. Yet, the

need to decide together how his medications would be administered, which they did. FoF 59, AR 24. That Ms. Pal elected, with Timothy's approval, to keep the medications in her home and to hand them to him at the appropriate time was out of concern for organization, the young children in her home, and the need to ensure he did not forget to take, or run out of, medications, not because the ISP mandated that she do so. RP Vol II, 126-27; 146-47. Ms. Bournival's testimony made clear that "keeping an eye" on Timothy was Ms. Pal's idea, not a specific ISP instruction. RP Vol I, 215.

Finally, the ISP did not specify a need to keep Timothy's medications away from him to prevent intentional self-harm. In fact, the ISP explicitly stated that no assistance was needed with "prevention of suicide attempts" or self-injury. AR 239, Ex. 6; FoF 22, AR 9.

- a. *Strict adherence to the original medication administration plan was not mandated or necessary under the circumstances.*

In any event, whether Ms. Pal strictly adhered to the ISP's "specific requirements" or the medication administration plan established at the outset is not dispositive of whether she committed neglect. Failure to strictly comply with either plan is not *per se* neglect. A caregiver may

instructions under Medication Management states: "Remind client to take medications." AR 243, Ex. 6.

as easily commit neglect by strictly following a care plan as by not following it, depending on the circumstances.

Conceptually, like the Department's list of *per se* violations of child neglect this Court invalidated in *Marcum*, an ISP is not an exclusive benchmark by which an agency may establish a neglect finding. *See Marcum*, at 558-59. Nor can it realistically be. The Board' view ignores the realities of caregiving and of life. Sometimes issues crop up suddenly that require a reasonable adjustment to a given situation, as illustrated by the events here. This is particularly true when, as here, the ISP is not an exhaustive, comprehensive or accurate directive.

In disregarding the testimony of the ISP's drafter, Ms. Bournival, regarding the ISP's requirements, the Board took the ISP out of context.¹⁹ For example, the Board interpreted a pre-populated drop-down selection literally, as a precise description of Timothy's limitations. CoL 18, AR 35-36. This literal interpretation contributed to the Board's miscalculation of the need for absolute external control over Timothy's medication and the corresponding risk of not exercising such control. *See, eg. FoF 44-46, AR 18-19.*

The drop-down selected for client's limitations was: "Complex

¹⁹ The Review Judge disregarded most of Ms. Bournival's statements that did not support a finding of violation of duty of care, but accepted the one he believed did (the need for partial physical assistance). CoL 12, AR 32.

Regimen, Ability fluctuates, Does not follow frequency or dosage, Poor coordination, Forgets to take medications, Unable to read/see labels, Unaware of dosages”. AR 243, Ex. 6. Ms. Bournival testified that, of the drop-down selections, a case manager chooses “whichever’s closest, if there’s something’s [sic] close.” She also explained, for example, “‘ability fluctuates’ *kind of* applies to[Timothy]...overall when I’m using these drop downs I will do anything that...could be a potential.”²⁰ RP Vol I, 201-02.

The Board’s finding also disregards that Ms. Bournival, a professional with several years of mental health management experience and case management oversight of Timothy, testified that had Ms. Pal called her before leaving for the weekend, she would have advised her to proceed with the alternate weekend medication plan.²¹ RP Vol I, 232; FoF 49, AR 20. Hence, even had she done as the Board suggested, the harm would not have been prevented. The Board dismisses this reliable evidence by ascribing a potentially self-serving basis to Ms. Bournival’s testimony. CoL 16, AR 34. The Board reached this conclusion without

²⁰ Ms. Bournival’s testimony comports with Ms. Pal’s testimony that her conversations with Ms. Bournival regarding Timothy’s limitations were different than what was indicated in the ISP. RP Vol II, 190.

²¹ The Board erred in accepting Mr. Horn’s view of the scope of Ms. Pal’s duty of care, rather than Ms. Bournival’s, because Mr. Horn does not conduct care assessments or create care plans and has had no training in either. FoF 19, AR 8.

having seen or heard Ms. Bournival testify. That Ms. Bournival's uncontroverted testimony "may" have been self-serving is not a reasonable inference in light of the entire record. Even if her testimony was self-serving, it was nonetheless accurate.

2. Ms. Pal's Actions Did Not Constitute an Unreasonable Risk of Highly Probable Harm.

The standard by which to judge a caregiver's actions or omissions is not, as the Order implies, whether there is a possibility a vulnerable adult might take all his medications at once, as illuminated by the actual occurrence of self-harm. CoL 21, AR 37-38. The standard is whether Ms. Pal "knew or should have known of facts leading a reasonable person to realize her acts would create an unreasonable risk of substantial and highly probable harm." *Brown*, at 590.

As best can be gathered from the Order, the Board decided that Ms. Pal's alternate weekend medication plan constituted a risk (of an indeterminate level) due to: 1) Timothy's functional limitations, and 2) a specious finding that when Timothy grabbed the mediset and refused to return it, he was feeling paranoid and Ms. Pal knew it. FoF 28, AR 12. The record shows that nothing about Timothy's history or behavior on August 18, 2011, would lead a reasonable person to believe the alternate weekend medication plan created an unreasonable risk of harm.

- a. *The record does not support the Board's finding that when Timothy refused to return his medications to Ms. Pal, he was paranoid and Ms. Pal knew this.*

According to the hospital's attending physician's treatment notes, Timothy became paranoid *after* Ms. Pal left the home:

Patient apparently, per the substitute caretaker [Raj Pal] and nursing, patient took his medications as he normally does when they are given to him, and then this evening patient became significantly paranoid, and with his primary caretaker not there, the mother of the caretaker became somewhat overwhelmed. Patient became paranoid, was somewhat agitated, and decided to take his own medications...

AR 304, Ex. 12. (emphasis added); *see also* FoF 10, AR 5 (Timothy's statement to Max Horn). When Timothy took his mediset and refused to return it, he was acting normally, except for getting frustrated that Ms. Pal and her mother were trying to convince him to return it. RP Vol II 149, 206, 209. He did not want to be treated like a child. *Id.*; FoF 55, AR 22.

The Board's finding to the contrary is based on: 1) Timothy's statement to Kristine Simpson, PMHNP,²² that, "I took too many pills and almost killed myself cause I was agitated and upset[.]" and 2) Ms. Pal's statement to hospital staff that Timothy had informed her "he was feeling really paranoid and wanted to take his own medications" and her alleged statement to Max Horn that Timothy was feeling paranoid at the time of the incident. FoF 28, AR 12. The Board found these three statements were

²² Psychiatric-mental health nurse practitioner.

given for purposes of medical diagnosis and thus, had a high indicia of reliability, citing to ER 803(a)(4) and (6). *Id.* These evidence rules, however, refer to the admissibility, not reliability or weight, of the statements.

First, Timothy's statement to Ms. Simpson does not indicate when he became agitated and upset. Second, Ms. Pal's statement to the hospital reveals that Timothy told her he was feeling paranoid, not that she knew he was feeling paranoid when she was preparing to leave:

rn spoke to pt's caregiver Magdalene who states pt has lived with her since feb. ...Caregiver state pt was **'he said he** was feeling really paranoid and wanted to take his own medication' rn asked if pt has ever acted this way/took his own meds before 'before he was living on his own doing everything his self' ...

AR 315, Ex. 12 (emphasis added). As Ms. Pal testified, Timothy told her about being paranoid when she spoke to him *at the hospital*. RP Vol II, 157.

Third, the Board misquotes and misrepresents Ms. Pal's testimony; she did not inform Mr. Horn that Timothy was feeling paranoid at the time of the incident. FoF 28, AR 12, citing RP Vol II, 156, lines 9-13; *Cf.*, Vol II, lines 23-24, 157, lines 1-8. The record also demonstrates that Timothy made conflicting statements to medical providers and to others about why he took the four doses. And, Max Horn never interviewed hospital staff to determine the context of the above statement or attempted to ascertain

from Timothy or Ms. Pal when Timothy began feeling paranoid or when Ms. Pal learned of it.

What is more, even if, *arguendo*, Ms. Pal knew Timothy was feeling paranoid when he refused to return the mediset, she could not have reliably predicted a single expression of paranoia presented an unreasonable risk of self-harm. Historically, Timothy's paranoia involved fear of being displaced or being chased by police. RP Vol II, 131-32, 190-92. When paranoid, Timothy would not engage in self-harm or take too many medications. He would sleep with shoes on for fear "they were coming for [him]." RP Vol II, 86-87, 190-92; FoF 22, AR 9.

b. *The record contains no evidence that Ms. Pal knew about any prior suicidal ideation, overdosing or other self-harm.*

Not only was Timothy acting normally before Ms. Pal left for the weekend, he had no known history of overmedicating or attempting self-harm.²³ FoF 15, AR 7; RP Vol I, 226, 235; Vol II, 104, 115, 159; Vol III, 17. This is demonstrated by the ISP and testimony of Ms. Pal, Ms.

Bournival and Timothy's mother, Ms. DeLeon. *Id.*

Although Mr. Horn's notes of his conversation with Ms. DeLeon

²³ Ms. Simpson's notes indicate that in 2010, Timothy went to Legacy Salmon Creek with a complaint of suicidal ideation. Apparently, he was "suicidal to get attention and to avoid returning to a care home he was not fond of." AR 308, Ex. 12. Neither Ms. Pal nor Ms. Bournival knew about this event. FoF 15, AR 7; RP Vol II, 159.

state that she said, “He’s done something like this before”, (FoF 13, AR 6), Ms. DeLeon later testified that she did not remember saying that. RP Vol II, 104, 115. Given the extraordinary nature of an attempted suicide by one’s own child, Ms. DeLeon likely would remember such an event. RP Vol II, 104 (“I think that’s something I would know.”).

Ms. Pal had no information that Timothy overdosed on his medication in the past, either deliberately or inadvertently. RP Vol II 159; Vol III, 17. What Ms. Pal learned from Ms. Bournival was that Timothy would lose his medications or forget to them and thus was often under-dosed. RP Vol II, 146-47, 190, 196-197; Vol III, 26.

c. Timothy had access to, and control of, his medications when he lived on his own.

The ALJ correctly found that Timothy had sole access to his medication when he lived on his own and that a caregiver would check his medications to ensure he was taking them. Initial Decision, FoF 4.48, AR 85. Ms. Bournival testified that a caregiver would remind Timothy to take his medications, but this did not always occur daily. RP Vol I, 224-25.

Ms. DeLeon testified, however, that she thought Timothy’s medications were locked up (although she could not be certain), and given to him by caregivers. Initial Decision, FoF 4.52, AR 86; Order, FoF 52, AR 21. The ALJ correctly found that Ms. DeLeon had difficulty remembering from day-to-day. Initial Decision, FoF 4.53, AR 86. The

ALJ essentially found Ms. Bournival’s testimony on this issue more reliable than Ms. DeLeon’s testimony.²⁴

The Review Judge also correctly found that when Timothy lived on his own for a year or two he “had access to his own medications” and an “[a]gency provider would check his medications to make sure he was taking them.” FoF 48, AR 20. Yet, the Board then inexplicably made a contradictory finding in Conclusion of Law 16. CoL 16, AR 34. The Board’s reversal of this finding lacks support in the record. A reviewing officer must “give due regard to findings of the ALJ that are informed by the ALJ’s ability to observe the witnesses.” *Crosswhite*, at 548. And, “when a reviewing officer reverses an ALJ on factual matters, [this Court must] ‘examine the disagreement with a gimlet eye.’” *Id.*, at 560, quoting *Aggregate Indus. v. Nat’l Labor Relations Bd.*, 824 F.3d 1095, 1100 (D.C. Cir. 2016); *accord Plaza Auto Ctr., Inc. v. Nat’l Labor Relations Bd.*, 664 F.3d 286, 291 (9th Cir. 2011) (“Our review is more ‘searching’ in instances where the Board’s findings or conclusions are contrary to those

²⁴ WAC 388-02-0520 requires an ALJ to decide what evidence is more credible if evidence conflicts as well as the weight to be given to evidence. The ALJ must include in the decision an explanation of why the evidence is credible when the facts or conduct of a witness is in question, as well as a discussion of the reasons for the decision based on the facts and the law. RCW 34.05.461(3) also requires that “any findings based substantially on credibility of evidence or demeanor of witnesses shall be so identified.” The ALJ did not follow these directives concerning the testimony of Ms. Bournival and Ms. DeLeon. In *Crosswhite*, the Court held that “where findings were necessarily based on weighing live witness testimony, we will treat them as such even if the order drafting requirements of RCW 34.05.461(3) have not been satisfied.” *Id.* In the instant case, the findings the ALJ made demonstrate that she found Ms. Bournival’s testimony to be more credible.

of the ALJ.”) The Board’s discounting of Ms. Bournival’s testimony on this issue reveals its unsound cherry-picking of facts to support the conclusion that Ms. Pal committed neglect. As Timothy’s case manager for several years, Ms. Bournival was in a superior position to know the details of each of Timothy’s past care assessments and the required frequency of caregiver supervision. Timothy’s history of forgetting to take his medications and losing them alone negates a finding that his medications were always been locked up and physically administered to him twice a day and at any other time as needed.

The Board next speculates that had Ms. Bournival genuinely believed Timothy could safely retain and administer his medications on his own *without any caregiver assistance*, she “would have” and “should have” amended his ISP accordingly. CoL 16, AR 34. First, there is no evidence or argument by either party that *no* caregiver assistance was to be provided. Second, there is no evidence in the record that Ms. Bournival would or should have amended the ISP. She most likely would not have as she did not amend it to reflect Ms. Pal’s original medication administration plan or to remove portions relevant only to Elahan Place. *See, e.g.,* RP Vol I, 239.

Conversely, if Ms. Bournival genuinely believed that Timothy could not safely retain his medications, she more likely would have

explicitly instructed Ms. Pal to maintain control over his medications when drafting the initial ISP as that was the time for determining the right level of assistance and corresponding number of allotted care hours.

Additionally, the MMSE results show Timothy was able to read and follow the written instruction, “close your eyes.” AR 336, Ex. 14. This, along with his twelfth-grade education, support Ms. Pal’s testimony that Timothy could read some things and understood when and which medications to take. RP Vol II, 129-30; 214-16.

In summary, the record lacks substantial evidence to support a finding of serious disregard in light of the surrounding circumstances, including: a) Timothy’s behavior on August 18, 2011; b) Timothy’s known history with medications and lack of attempted self-harm; c) Ms. Pal’s lay education and training; and d) her obligations under the ISP.

D. THE RECORD LACKS SUBSTANTIAL EVIDENCE TO SUPPORT A FINDING OF CLEAR AND PRESENT DANGER, THE FINAL ELEMENT OF NEGLIGENCE.

In addition to proving serious disregard, the Department must prove clear and present danger existed when Ms. Pal modified the medication administration plan. *Brown*, at 590; *Marcum*, 172 Wn. App 546; RCW 74.34.020(16)(b). Like serious disregard, clear and present danger must be viewed in light of the presenting circumstances, not with the clarity of hindsight. *See, e.g., Brown*, at 596; *Lee*, at 424; *see also Karanjah*, at 921

(a review of a caregiver's actions must be based on "the surrounding circumstances"); *In re Dependency of M.S.D.*, 144 Wn. App. 468, 481-82, 182 P.3d 978 (2008) (rejecting the Department's view that a man's past criminal history alone was sufficient to establish clear and present danger under the current circumstances). Here, under either the correct analytical framework or the Board's more simplistic definition, the record shows the danger of an attempted overdose was not obvious, extant or imminent.

Relying solely on hindsight, the Board artificially elevated the severity of the presenting circumstances based on the harm that ultimately occurred (that Timothy was transported to the hospital and placed in in ICU for observation and treatment due to the amount of ingested carbamazepine). CoL 21, AR 37-38. The same facts that negate a finding of unreasonable risk for purposes of serious disregard, however, also negate a finding of clear and present danger. *See* Sec. C. above.

Neither Timothy's history nor his behavior on August 18, 2011, suggested, let alone made obvious, that at some point *after* Ms. Pal left, he would intentionally ingest four doses of medication at once. As explained in Section C, Timothy had control of his medications when he lived on his own and had not, to Ms. Pal's knowledge, ever attempted to overdose. Nor, to her knowledge, had he engaged in any other acts of self-harm.

When Ms. Pal prepared to leave for the weekend, Timothy was

acting normally. RP Vol II, 206, 209. Even a couple hours after Ms. Pal left, around dinnertime, Raj Pal checked the mediset and saw that it still contained the four weekend doses (that evening's dose, to be taken at dinnertime, was missing). FoF 56, AR 22-23. It was only after that, in an apparent response to an argument with Raj Pal and upon learning his request for medical transportation had been denied, that he decided to take his medications all at once. AR 308, Ex. 12.

E. THE BOARD'S NEGLIGENCE FINDING RESTS PARTIALLY ON A DISTORTED VIEW OF MS. PAL'S EXPRESSION OF CARE AND REGRET.

In concluding that the record contains substantial evidence of neglect (CoL 20), the Board mischaracterized Ms. Pal's disputed statement to Mr. Horn that her actions were "a terrible misunderstanding and a mistake" as an admission of neglect. CoL 20, AR 36-37. A statement expressing regret or acknowledging a mistake is not evidence of statutory neglect.

Furthermore, the standard of neglect is not whether an individual with a duty of care makes less than ideal choices or exercises less than ideal judgment in carrying out her responsibilities. *See, e.g., Raven*, at 834 ("it is without question that Raven [a guardian] could have made better decisions in some areas and that she exercised poor judgment in meeting her mandates under professional standards in others. But the evidentiary record here cannot sustain a finding [of] ... neglect..."); *Crosswhite*, at

569 (reversing a finding of verbal abuse although the caregiver “exercised poor judgment in acting on her concerns [for the vulnerable adult’s health] as she did.”).

As explained in the preceding sections, Ms. Pal’s actions showed an appropriate regard for Timothy’s health, welfare and safety in light of the surrounding facts and circumstances. When Timothy refused to return the mediset, Ms. Pal attempted to guard against reasonably foreseeable medication mismanagement: forgetting to take medications or losing them. AR 235, Ex. 6. She could not have deemed the situation to be one necessitating her calling APS, 911, or remaining home for the weekend to physically monitor Timothy round the clock, as the Board opined. *Cf.*, FoF 18 & 19, AR 35-36. And, when she learned Timothy ingested four doses of medication at once, she immediately took protective action to get appropriate medical treatment for him. RP Vol II, 148.

F. MS. PAL IS ENTITLED TO ATTORNEY’S FEES IF SHE PREVAILS.

Ms. Pal is entitled to attorney’s fees and costs in this matter pursuant to Washington’s Equal Access to Justice Act (EAJA), RCW 4.84.340-360.²⁶ The EAJA provides, in relevant part:

Except as otherwise specifically provided by statute, a

²⁶ Attorney’s fees are available to a prevailing party where authorized by “contract, statute, or a recognized ground in equity.” *Cosmopolitan Eng’g Group, Inc. v. Ondeo Degremont, Inc.*, 159 Wn.2d 292, 296-97, 149 P.3d 666 (2006).

court shall award a qualified party that prevails in a judicial review of an agency action fees and other expenses, including reasonable attorneys' fees, unless the court finds that the agency action was substantially justified or that circumstances make an award unjust. A qualified party shall be considered to have prevailed if the qualified party obtained relief on a significant issue that achieves some benefit that the qualified party sought.

RCW 4.84.350(1). Once a court establishes that that an appellant is a "qualified prevailing party," the Department may avoid imposition of attorney's fees only by demonstrating that its action affirming the neglect finding was "substantially justified."

Language Connection, LLC v. Employment Sec. Dep't, 149 Wn. App. 575, 586, 205 P.3d 924 (2009). Substantially justified means justified to a degree that would satisfy a reasonable person.

Silverstreak, Inc. v. Dep't of Labor & Indus., 159 Wn.2d 868, 892, 154 P.3 891 (2007) (quotations omitted). The action must have "had a reasonable basis in law and fact." *Language Connection, LLC v. Employment Sec. Dep't*, at 586.

Here, the necessary requirements for an award of attorney's fees to Ms. Pal are met. If the Court reverses the Board's Order, Ms. Pal will be a prevailing party. She is "qualified" because her net worth did not exceed one million dollars when the initial petition for review was filed. RCW 4.84.340(5). And, the

Department cannot show its action in this matter had a reasonable basis in law and fact.

The Department circumvented existing jurisprudence and based its finding on an erroneous interpretation and application of RCW 74.34.020, despite being on notice of the *Brown* decision, dated October 8, 2015, and the *Marcum* decision, dated Dec. 26, 2012. Additionally, it engaged in a dubious factual determination, including disregarding reliable evidence that supported a finding that Ms. Pal did not commit neglect.

The Court should authorize an award of fees and costs, including reasonable attorney's fees pursuant to RAP 18.1 and RCW 4.84.350.

VI. CONCLUSION

As a result of this neglect finding, Ms. Pal can never work as a DSHS paid caregiver again. She cannot even work as a janitor at an assisted living facility, and may never be able to volunteer at her children's schools. The Legislature intended this severe result only if the Department proves that a caregiver engaged in such serious misconduct to constitute clear and present danger to a vulnerable adult. The Legislature did not intend that a caregiver should be so punished for not guaranteeing against the possibility of self-harm, even if that harm occurs. The Board's Order does just that. Given the life-changing consequences of a neglect

finding, this Court should demand a more rigorous and reasoned analysis of law and evidence by the agency responsible for adjudicating these matters. The Court should therefore reverse the Board's Order and award Ms. Pal reasonable attorney's fees.

Respectfully submitted this 30th day of November, 2017.

NORTHWEST JUSTICE PROJECT


AMY McCULLOUGH, WSBA #36401
Attorney for Appellant

NORTHWEST JUSTICE PROJECT

December 01, 2017 - 9:24 AM

Transmittal Information

Filed with Court: Court of Appeals Division II
Appellate Court Case Number: 50660-2
Appellate Court Case Title: Magdalene Pal, Appellant v. D.S.H.S., State of Washington, Respondent
Superior Court Case Number: 16-2-01694-8

The following documents have been uploaded:

- 506602_Briefs_20171201092138D2743387_3883.pdf
This File Contains:
Briefs - Appellants
The Original File Name was 20171130155602.pdf

A copy of the uploaded files will be sent to:

- RondaG@nwjustice.org
- jodyc@atg.wa.gov
- rsdkenfax@atg.wa.gov

Comments:

Sender Name: Charity Belanger - Email: Charityb@nwjustice.org

Filing on Behalf of: Amy Mccullough - Email: amym@nwjustice.org (Alternate Email:)

Address:
500 W. 8th Street, Suite 275
Vancouver, WA, 98660
Phone: (360) 693-6130

Note: The Filing Id is 20171201092138D2743387