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**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 REPLY BRIEF

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TABLE OF CONTENTS

I. ARGUMENT		1
A.	This Court Should Not Excuse the Department’s Continued Disregard of Appellate Court Decisions that Properly Constrain its Punitive Powers and Proscribe the Use of Hindsight in a Statutory Neglect Determination.	1
1.	The Department Did Not Apply the Standard of Neglect Articulated in <i>Brown</i> , Requiring Reversal under RCW 34.05.570(3)(d).	3
a.	Hindsight has no place in a neglect analysis, yet the Board’s finding is predicated on it.	5
b.	Ms. Pal’s actions did not create an unreasonable risk of harm.	7
2.	Properly Construed, RCW 74.34.020(16) Does Not Allow the Department to Permanently Ban Ms. Pal from the Caregiving Profession for Not Strictly Complying with an Incomprehensive and Inaccurate Care Plan.	8
3.	Under the Circumstances, Ms. Pal had to Respect Timothy’s Right to Refuse the Care Services They Previously Agreed Upon.	10
B.	The Neglect Finding is Unsupported by Substantial Evidence in Light of the Whole Record, Requiring Reversal Under RCW 34.05.570(3)(e).	12
1.	Neither Timothy’s History of Paranoia Nor Ms. Pal’s Failure to Call Ms. Bournival Supports a Neglect Finding.	13
2.	The Board’s Findings That Contradict the ALJ’s Findings Are Not Supported by the Record.	15
3.	The Review Judge Offered No Valid Basis for Impugning Ms. Bournival’s Integrity.	16
C.	Findings of Fact 23, 28, 44-46, and 49 Are Properly Before This Court, and Portions of Them Are Not Supported by Substantial Evidence.	17

TABLE OF CONTENTS

D. Ms. Pal Did Not Commit Statutory Neglect Because She Took Reasonable Efforts to Ensure Timothy’s Medication Administration Needs Would Be Met While She Was Away.....21

E. Ms. Pal is Entitled to Attorney’s Fees.23

II. CONCLUSION.....24

TABLE OF AUTHORITIES

Cases

<i>Brown v. Dep't of Soc. & Health Servs.</i> , 190 Wn. App. 572, 360 P.3d 875 (2015).....	2, 5, 6, 7, 8, 9, 10
<i>Cowiche Canyon Conservancy v. Bosley</i> , 118 Wn.2d 801, 828 P.2d 549 (1992).....	3
<i>Crosswhite v. Dep't of Soc. & Health Servs.</i> , 197 Wn. App. 539, 389 P.3d 731 (2017).....	5, 8, 15, 23
<i>Kim v. Lakeside Adult Family Home</i> , 185 Wn.2d 532, 374 P.3d 121 (2016).....	4
<i>Language Connection, LLC v. Employment Sec. Dep't</i> , 149 Wn. App. 575, 205 P.3d 924 (2009).....	23
<i>Marcum v. Dep't of Soc. & Health Servs.</i> , 172 Wn. App. 546, 290 P.3d 1045 (2012).....	8
<i>Raven v. Dep't of Soc. & Health Servs.</i> , 177 Wn.2d 804, 306 P.3d 920 (2013).....	9, 11
<i>Ryan v. State, Dep't of Soc. & Health Servs.</i> , 171 Wn. App. 454, 287 P.3d 629 (2012).....	3
<i>Sintra, Inc. v. City of Seattle</i> , 119 Wn. 2d 1, 24, 829 P.2d 765 (1992).....	1
<i>In re Smith</i> , 139 Wn.2d 199, 986 P.2d 131 (1999).....	1
<i>In the Matter of the Dependency of Griffin Lee</i> , 200 Wn. App. 414, 404 P.3d 575 (2017).....	5, 6

State Statutes

Equal Access to Justice Act, RCW 4.84.340-.360	23
RCW 26.44.020(16).....	4
RCW 34.05.464(4).....	15

TABLE OF AUTHORITIES

RCW 34.05.570(3)(d).....3
RCW 34.05.570(3)(e).....12, 15
RCW 74.34.020(16).....8, 11
RCW 74.34.020(16)(b).....4, 10, 24

Regulations

WAC 388-02-0220(2).....2

Other Authorities

<https://www.merriam-webster.com/dictionary/bear%20out>.....5

I. ARGUMENT

This Court must decide whether to excuse the Department's continued disregard of appellate court decisions that properly constrain its punitive powers and proscribe the use of hindsight in a statutory neglect determination. Upholding the Department's erroneous approach in this matter permits it to find neglect in the absence of an unreasonable risk of highly probable and substantial harm or clear and present danger that such harm will occur. It also permits the Department to avoid engaging in a comprehensive analysis of all the surrounding facts and circumstances by making two factors dispositive of a neglect finding: 1) strict compliance with an incomprehensive and inaccurate care plan, and 2) the Department's hindsight speculations about what actions a caregiver should have taken in light of the harm that occurred. The Department offers no authority to support such an extreme outcome.

A. This Court Should Not Excuse the Department's Continued Disregard of Appellate Court Decisions that Properly Constrain its Punitive Powers and Proscribe the Use of Hindsight in a Statutory Neglect Determination.

The Washington Supreme Court has "repeatedly stated it offends the rule of law when agencies of the state willfully ignore the decisions of our courts." *In re Smith*, 139 Wn.2d 199, 203 n.3, 986 P.2d 131 (1999), citing *Sintra, Inc. v. City of Seattle*, 119 Wn. 2d 1, 24, 829 P.2d 765 (1992).

Under its own rules, the Department must apply existing court decisions to its adjudicative decisions. *See* WAC 388-02-0220(2) (“If no department rule applies, the ALJ or review judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, and court decisions.”).

Several appellate court decisions instruct the Department on how to properly evaluate claims of abuse and neglect. *See, e.g.,* App. Br., at 17-20, 23-26. This jurisprudence establishes two foundational points that guide this Court’s decision: 1) the acts or omissions of an individual with a duty of care are to be measured by the surrounding facts and circumstances, not by hindsight; and 2) statutory neglect requires more than just a violation of a duty of care; it requires “serious misconduct”, i.e., an intentional act or omission by an individual with a duty of care to a vulnerable adult, “knowing or having reason to know of facts that would lead a reasonable person to realize that the [caregiver’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”, coupled with clear and present danger such harm will occur. *Brown v. Dep’t of Soc. & Health Servs.*, 190 Wn. App. 572, 590-91, 360 P.3d 875 (2015).

The Department was not free to ignore this jurisprudence and re-define or apply the standard of neglect so as to expand its punitive reach, as it did in this matter. *Cf.* Brief of Respondent (Res. Br.), at 14-15, 20-21.

1. The Department Did Not Apply the Standard of Neglect Articulated in *Brown*, Requiring Reversal under RCW 34.05.570(3)(d).

The Department attempts to shield its disregard of established jurisprudence behind a superfluous statutory construction analysis and a mischaracterization of the Board's use of hindsight as a mere observation of the occurrence of harm. Res. Br., at 14-15, 20.

An agency's interpretation of a statute within its special expertise is entitled to deference, except when that interpretation conflicts with the statute. *See Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 815, 828 P.2d 549 (1992) (citations omitted). "Ultimately, it is for the court to determine the meaning and purpose of a statute." *Ryan v. State, Dep't of Soc. & Health Servs.*, 171 Wn. App. 454, 465, 287 P.3d 629 (2012) (quotation omitted).

The *Brown* court determined the meaning and purpose of statutory neglect, and defined its requisite elements to effectuate its purpose. *See* Appellant's Opening Brief (App. Br.), at 17-19. The review judge therefore had no reason to resort to the dictionary to re-define the elements of neglect. *Cf.*, Res. Br., at 15; App. Br., at 20-22. And the Department

offered no contextual or other analysis that would support the review judge's use of a different interpretation.

The distinctions the Department attempts to draw between *Brown* and this matter are immaterial. Although the *Brown* court interpreted the neglect provision of the Abuse of Children Act (ACA), its relevant portion is nearly identical to the Abuse of Vulnerable Adult Act's (AVAA) neglect provision. *See* RCW 26.44.020(16); RCW 74.34.020(16)(b).

As the Washington Supreme Court explained in *Kim v. Lakeside Adult Family Home*, 185 Wn.2d 532, 543-44, 374 P.3d 121 (2016), both statutes share a “similar structure and purpose”, thus the analysis of the ACA guides a court's analysis of the AVAA. *Kim v. Lakeside Adult Family Home*, 185 Wn.2d 532, 543-44, 374 P.3d 121 (2016). The Court observed:

[P]rior to 1999, some of the AVAA's protections were incorporated in the ACA. *See, e.g.*, former RCW 26.44.010–.020 (1969) (incorporating the protection of mentally disabled adults into the statute); former RCW 26.44.010 (1977) (incorporating the protection of adult developmentally disabled persons into the declaration of purpose). Even after the AVAA was enacted, the ACA continued to provide protection for vulnerable adults. *See, e.g.*, Laws of 1984, ch. 97, §§ 1, 2. ... It was not until 1999 that the legislature removed all reference to adults from the ACA. *See* Laws of 1999, ch. 176, §§ 27–33; *see also* Final B. Rep. on Substitute H.B. 1620, 56th Leg., Reg. Sess. (Wash. 1999) (explaining that this bill consolidated and made uniform the three statutes that required the reporting and investigation of abuse of vulnerable adults).

Kim, at 543-44.

Thus, the *Brown* court’s interpretation of neglect governs the Department’s neglect decisions under the AVAA. *See also, Crosswhite v. Dep’t of Soc. & Health Servs.*, 197 Wn. App. 539, 557, 389 P.3d 731 (2017) (the court looked to *Brown* for guidance in an abuse of a vulnerable adult case). The Department’s conclusory assertion that it applied the standard approved by *Brown* does not make it so. Res. Br., at 13.

a. Hindsight has no place in a neglect analysis, yet the Board’s finding is predicated on it.

Two appellate divisions have disapproved of the Department’s use of hindsight in abuse and neglect determinations. *See Brown*, at 596; *In the Matter of the Dependency of Griffin Lee*, 200 Wn. App. 414, 438, 404 P.3d 575 (2017). Yet, the Department continues to judge the actions of individuals with a duty of care with the clarity of hindsight, rather than by the surrounding facts and circumstances.

The review judge did not merely “[take] note of the actual harm that occurred”, as the Department contends. Res. Br., at 20. His use of the term “as borne out by”, a past participle of bear out (to “confirm or “substantiate”), in conclusion of law 21 (AR 37-8) evidences that his finding is predicated on hindsight. <https://www.merriam-webster.com/dictionary/bear%20out>.

Furthermore, the distinctions the Department attempts to draw between this matter and the *Lee* and *Brown* holdings on hindsight are immaterial as well. *See* Res. Br., at 21-22. In both cases, the courts admonished the Department for basing its neglect findings, at least in part, on events that occurred *after* the allegedly neglectful acts or omissions when those events suggested the earlier acts or omissions might not have been the most prudent or wise. *See Brown*, at 596; *Lee*, at 438-40.

Additionally, that Ms. Pal did not call Ms. Bournival, the DDA case manager, when Timothy took the mediset is irrelevant to whether the *Lee* court's disapproval of hindsight is applicable to this Court's determination of the propriety of the Board's analysis. *Cf.*, Res. Br., at 21. What is more, not only was Ms. Pal not required to call Ms. Bournival, but had she called, Ms. Bournival would have approved of her decision to allow Timothy to retain the mediset for the weekend. RP Vol I 232; AR 279 (Ms. Pal's contract with DSHS provides: "[she] understands she may contact the client's case manager if at any time [she has] any concerns about [her] ability to perform the responsibilities of this contract").

Brown is also indistinguishable on this point. That it involved the Department's impermissible use of both hindsight and a reasonable person standard does not make it inapplicable here. *Cf.*, Res. Br., at 21-22. And factually, like the parent in *Brown*, Ms. Pal made reasonable efforts to

meet Timothy's medication administration needs in light of the surrounding facts and circumstances. *See Brown*, at 594-95. Thus, the fact that substantial harm occurred because Timothy uncharacteristically ingested four doses of medication at once is not determinative of whether Ms. Pal's decision, when she made it, constitutes neglect.

b. Ms. Pal's actions did not create an unreasonable risk of harm.

Contrary to the Department's next assertion, the review judge's finding regarding the occurrence of actual harm does not demonstrate the severity of risk. Res. Br., at 20. The harm that occurred demonstrates only the substantiality of the harm, not the *degree* of risk that it would occur.

The Department fails to explain how the review judge's conclusory finding that, in light of Timothy's self-inflicted harm, Ms. Pal's failure to take drastic measures to retrieve the mediset is an "omission" that meets the elements of serious disregard or clear and present danger. CoL 21, AR 37-38; App Br., at 36-45. The record contains no analysis of, or facts to support, a finding that meets the correct definition of serious disregard:

[K]nowing or having reason to know of facts that would lead a reasonable person to realize that [her] conduct not only created an *unreasonable risk* of bodily harm to the other but also involves a high degree of probability that substantial harm will result to him.

Brown, at 590 (emphasis added).

Although Timothy's retention of his mediset for the weekend presented a possibility of medication mismanagement, it did not, under the circumstances, present an unreasonable risk of mismanagement. *See* App. Br., at 36-43. Nor is there any evidence that under-dosing would lead to substantial harm. Thus, the risk of under-dosing cannot form the basis for a neglect finding. *Cf.*, CoL 21.

2. Properly Construed, RCW 74.34.020(16) Does Not Allow the Department to Permanently Ban Ms. Pal from the Caregiving Profession for Not Strictly Complying with an Incomprehensive and Inaccurate Care Plan.

Ms. Pal does not ask this Court to further narrow the statutory definition of neglect. *Cf.*, Res. Br., at 14-15. Rather, she asks this Court to hold the Department to the standard the *Brown* court articulated because it was correctly based on a strict construction of the identical provision of the ACA. *See Brown*, at 591-93; *see also Crosswhite*, 197 Wn. App. 539, at 557 (This Court “has consistently rejected Department interpretations of statutes that broaden its authority to take punitive action.”); *Marcum v. Dep’t of Soc. & Health Servs.*, 172 Wn. App. 546, 558, 290 P.3d 1045 (2012) (“[R]ules that extend a statute’s punitive reach are an invalid exercise of agency power.”).

Conversely, the Department essentially seeks to broaden its punitive reach to encompass caregiver actions that pose a possibility of risk, rather

than just those actions that pose an unreasonable risk of highly probable and substantial harm coupled with clear and present danger. Only a broad interpretation of statutory neglect would permit the Department to use an alleged lack of strict compliance with an incomprehensive and inaccurate care plan or failure to call a DDA case manager as dispositive bases for a neglect finding. Such a result would effectively lower the standard below what the *Brown* court deemed appropriate, i.e., serious misconduct. *See Brown*, at 588-593; *see also Raven v. Dep't of Soc. & Health Servs.*, 177 Wn.2d 804, 826, 306 P.3d 920 (2013) (“Endorsing DSHS’s view that [a guardian] had a duty to ensure [the VA] accepted the care that was offered sets up an untenable standard for guardians akin to strict liability.”); *see also* RP Vol I, 203 (line 25)–204, ll. 1-3; 211, ll. 12-25 (Ms. Bournival explained that the ISP outlines the care needs, and circumstances often dictate the specific caregiver duties.).

Furthermore, as the *Brown*, *Lee*, *Raven*, and *Crosswhite* decisions demonstrate, the line between perfection and permanent punishment should not be drawn so narrowly as to require individuals with a duty of care to be infallible or to never make a decision that only reveals its imprudence in hindsight. *See* App. Br., at 23-24, 45-46. Nor should the line be drawn so as to ignore the complexities of providing care to individuals with cognitive and mental health disabilities or the tension

between a caregiver's duties and the competing rights of vulnerable adults. Nor should the line be drawn so narrowly as to make a care plan an exclusive benchmark for a neglect finding when the Department does not ensure care plans are precise and exhaustive directives. Only by strictly construing RCW 74.34.020(16)(b) may a court properly balance the AVAA's objective of protecting vulnerable adults from neglect against the risk the Department will unduly punish individuals for actions that do not amount to serious misconduct. *See, e.g., Brown*, at 593.

3. Under the Circumstances, Ms. Pal had to Respect Timothy's Right to Refuse the Care Services They Previously Agreed Upon.

The record shows that Ms. Pal did not "abrogate" her duty of care by yielding to Timothy's repeated rejections of her requests that he adhere to their original medication administration plan. Res. Br., at 17-19. Rather, she made an appropriate alternate plan in light of Timothy's lawful right to retain his medication, his known history, her communications with Ms. Bournival, her understanding of her scope of duty, her nearly daily interactions with him for several months, and his expressed understanding of which medications to take and when. App Br., at 43-46. Despite the Department's repeated assertions, the care plan did not instruct Ms. Pal to maintain absolute control over Timothy's medications. Additionally, Ms. Pal had been trained that she could not lawfully keep his medications from

him or touch them if he did not consent. RP Vol II, 226-27. Thus, under the circumstances, she was not obligated to physically assist him with medications to avoid a neglect finding.

In addition, Ms. Pal does not contend that Timothy's right is absolute and she has no obligation to ever take action to invade that right. *See App. Br., 27 & n.14.* Had Ms. Pal any inclination he might try to overdose, she would have "taken proper measure[]s to prevent" it. AR 343.

Furthermore, the dissimilarities between *Raven* and this case do not support the Department's attempt to dissuade this Court of its applicability to this matter. *Cf., Res. Br., at 18-19.* Properly understood, the *Raven* Court was tasked with considering the interplay between a guardian's duties under guardianship laws and RCW 74.34.020(16) and the difficulties of providing adequate care to an individual who has a right to, and does, resist or refuse care. *See Raven, 177 Wn. 2d 804.* The Court reasoned that the guardian had to honor the ward's expressed wish to remain in her home although doing so put her at substantial risk of self-neglect. *Id., at 817-21.* The Court also determined that although the guardian's actions fell short of some of her duties, these failings were insufficient to warrant a neglect finding. *Id., at 828-31.*

The overall import of *Raven* is that: 1) when making a neglect determination, the Department cannot ignore the role the rights of

vulnerable adults vis-a-vis their personal care plans; and 2) individuals with a duty of care do not have to be infallible.

Contradicting itself, the Department asserts that unlike the ward in *Raven*, Timothy is not “incapacitated”, yet, throughout its brief, it treats him as such to support a heightened duty of care. Res. Br., at 18.

Like the ward in *Raven*, Timothy “has a role in [his] care”. Res. Br., at 19. And like the ward in *Raven*, Timothy lawfully refused to cooperate with a plan of care. *See* App. Br., at 10-11. Thus, like the *Raven* Court, the review judge should have engaged in a reasoned analysis of whether Ms. Pal’s decision to devise an alternate weekend medication plan was appropriate in light of Timothy’s right to refuse and other relevant facts.

B. The Neglect Finding is Unsupported by Substantial Evidence in Light of the Whole Record, Requiring Reversal Under RCW 34.05.570(3)(e).

The record, when viewed in its entirety, lacks substantial evidence to support a neglect finding in light of the totality of the surrounding circumstances. RCW 34.05.570(3)(e). The Department attempts, however, to narrow this Court’s inquiry to a few provisions of the care plan and a term in Ms. Pal’s contract regarding calling the DDA case manager. In doing so, the Department ignores relevant facts negating a neglect finding, and mischaracterizes some material facts and their import to a neglect determination. *See, e.g.*, Res Br., at 5-9, 23, 24.

1. Neither Timothy's History of Paranoia Nor Ms. Pal's Failure to Call Ms. Bournival Supports a Neglect Finding.

Neither Timothy's history of paranoia nor Ms. Pal's failure to call Ms. Bournival supports a neglect finding. *Cf.*, Res. Br., at 8-10, 18. Despite the Department's repeated assertions that Ms. Pal was required to call Ms. Bournival when Timothy took his mediset, both the parties' contract and Ms. Bournival's testimony prove otherwise. *See* AR 279 (notifying Ms. Pal that she "may call" the case manager). Ms. Bournival also testified that she expects a caregiver to call if the caregiver's inability to provide care is going to be long term. RP Vol I, 244. Ms. Pal's failure to call Ms. Bournival in this instance is not a violation of her contract and does not support a neglect finding.

The Department also fails to provide the proper context of the care plan provision regarding paranoia it contends supports a heightened duty of care. *See* Res. Br., at 8, 18. The comment box accompanying the stated need for extensive support with "other serious behavior" provides: "Has been assaultive in the past, but mostly with provocation. Tim continues to struggle with mental health symptoms, mostly with paranoia." AR 239. It does not describe the behavior resulting from paranoia or instruct Ms. Pal on how to prevent paranoia. *Cf.*, RP Vol II, 192, ll. 1-8 (Ms. Bournival verbally instructed Ms. Pal to handle Timothy's paranoia by reassuring

him the cops aren't coming and he is not "getting kicked out").

Other parts of that same section are relevant to a proper consideration of Ms. Pal's understanding of her duty of care and whether she acted with serious disregard of Timothy's safety. Namely, "no support [is] needed" for prevention of "self injury", "suicide attempt" or "agitated/over-reactive behavior". AR 238-39. The record also reveals that, historically, Timothy's paranoia involved fear of being displaced or being chased by the police. RP Vol II, 131-32. When paranoid, Timothy would go to bed with shoes on for fear of being chased. RP Vol III, 86-87.

Thus, the care plan does not support the conclusion that Ms. Pal's efforts to persuade Timothy to return the mediset did not provide the "extensive support" with paranoia that he needed. Res. Br., at 18. Nor does it support the conclusion that Ms. Pal should have known that by leaving the mediset with Timothy, he would deliberately try to hurt himself. The Department belittles Ms. Pal's efforts to persuade Timothy to return the mediset, yet fails to demonstrate how she should have known she needed to spend more time on that endeavor. *See* Res. Br., at 6; *cf.*, RP Vol II, 208 (their discussion was between ten to twenty minutes).

2. The Board's Findings That Contradict the ALJ's Findings Are Not Supported by the Record.

Although Washington's appellate courts do not review an agency's credibility determinations, they review the sufficiency of a review judge's factual findings, even when they are based on a credibility determination. A "review judge may commit an error of law if he...fails to give due regard to findings of the ALJ that are informed by the ALJ's ability to observe the witnesses." *Crosswhite*, at 548; RCW 34.05.464(4). The APA requirement that substantial evidence must exist "in light of the whole record before the court" would be rendered meaningless if an appellate court could not review the substantiality of findings couched in a credibility determination. RCW 34.05.570(3)(e); *Crosswhite*, at 560-61 (the substantiality of evidence is to be based on the entire record, including "the credibility and demeanor findings of the [ALJ].") (quotation and internal quotation marks omitted). Thus, the review judge's contradictory and internally inconsistent findings on Timothy's access to, and control of, his medications when he lived on his own are subject to review. *Cf.*, FoF 48, AR 20; CoL 16, AR 34.

An ALJ's credibility decisions "should not be reversed absent an adequate explanation of the grounds for the reviewing body's source of disagreement." *Crosswhite*, at 561 (quotation omitted). Here, the review

judge did not adequately explain why the ALJ's findings are in error. See CoL 16, AR 34. Additionally, regardless of the review judge's unsupported credibility determinations, a finding that Timothy's medications were always locked up and physically administered to him by someone else is belied by the fact that he has a history of losing and forgetting to take his medications. *See* App. Br., at 42; AR 217 (Timothy explained to the APS investigator that when he lived on his own he would forget to take his medications).

3. The Review Judge Offered No Valid Basis for Impugning Ms. Bournival's Integrity.

The neglect finding is also negated by Timothy's long-term DDA case manager's testimony that had Ms. Pal called her when Timothy took the mediset, she would have advised Ms. Pal to proceed with the alternate weekend medication plan because it was reasonable. RP Vol I, 232. Ms. Bournival has extensive mental health and DDA case management experience, and has been Timothy's case manager for several years. FoF 43, AR 18. Therefore, she is the best person to know the extent of Timothy's care needs and the proper scope of Ms. Pal's duty.

Yet, the review judge ascribed a potentially self-serving motive to her testimony on this issue. *See* Res. Br., at 22, AR 34. The review judge offered no reasonable explanation for impugning Ms. Bournival's

integrity. Despite Timothy's complex needs and challenging behavior she has stuck by him for several years through all kinds of placements. The record does not support a reasonable inference that Ms. Bournival's testimony was motivated more by her desire to avoid responsibility or the task of seeking a new placement for Timothy than by her professional experience and judgment. *Cf.*, AR 34.

C. Findings of Fact 23, 28, 44-46, and 49 Are Properly Before This Court, and Portions of Them Are Not Supported by Substantial Evidence.

Ms. Pal has not waived her assignments of error regarding findings of fact (FoF) 23, 28, 44-46, and 49. Although Ms. Pal did not specify which portions of those findings were objectionable in her assignments of error or cite to FoF 23 and 49 in her discussion, she addressed the objectionable portions in her brief. Many of the objectionable portions of these findings are identical to other findings, some contained within the conclusions of law, that Ms. Pal addressed in her brief. The Department had an opportunity to, and did, respond to Ms. Pal's arguments on those findings. Thus, those findings are properly before this Court.

Finding of Fact 28: In her opening brief, Ms. Pal explained in detail the objectionable portions of FoF 28. *See* App. Br., Section C.2.a., at 37-39. Specifically, Ms. Pal demonstrated the lack of record support for the final finding in FoF 28 that "Timothy was in an agitated paranoid state of

mind, and that the Appellant was aware of this, at the time Timothy took possession of this medications and would not return them.” AR 12.

Ms. Pal’s statement to hospital staff does not suggest, let alone prove, that Timothy was paranoid when he took the mediset and Ms. Pal knew it. The hospital records actually show that Timothy became paranoid after Ms. Pal left. AR 308, Ex. 12. The Department also misquotes Ms. Pal as having testified that “Timothy was feeling paranoid at the time of the incident”. Res. Br., at 23, citing to RP, Vol II, 156, ll. 11-13. The transcript does not contain this statement, but the context of Ms. Pal’s testimony does confirm she told the APS investigator that Timothy was paranoid when he took his medications, as in: when he ingested them, not as in: when he took the mediset. RP Vol II, 155-157.

During that same line of questioning at the hearing, she explained that Timothy “seemed to be doing fine when [she] left”, and that she learned he was paranoid after the fact. *Id.*, at 157, ll. 4-8. Raj Pal’s testimony corroborates Ms. Pal’s testimony. RP Vol II, 41, ll. 3-9.

Additionally, throughout its brief, the Department unduly relies on and mischaracterizes the APS investigator’s notes containing alleged statements of Ms. Pal as “admissions” and facts. Ms. Pal disputed several of the statements that the investigator’s notes attributed to her and explained that some statements were taken out of context. RP Vol II, 154-

59; 223-24. Additionally, there is no evidence in the record to support the review judge's conjecture that when she spoke with the APS investigator Ms. Pal may not have been fully aware of the nature of the investigation. CoL 20, AR 37. Moreover, if, as the review judge opined, her earlier statements have a higher indicia of reliability, then her even earlier statement to the hospital is a more reliable indicator of her understanding of the lack of potential for deliberate self-harm. In response to a nurse's question about whether Timothy has "ever acted this way/took his own meds before", Ms. Pal said, "before he was living on his own doing everything his [sic] self." AR 315.

Finding of Facts 44 and 46: Certain of findings in FoF 44-46, which are identical to or linked with conclusions of law 12, 13 and 20 are fraught with mischaracterization. *See, e.g.*, App Br., at 31-33, 34 (citing FoF 44-46, 59 & CoL 12, 13, 20). For example, the final sentence of FoF 44 suggests that Ms. Bournival intended, i.e., the ISP required, that Ms. Pal would keep and give Timothy his medications like Elahan Place did. *See* FoF 44, AR 18. Ms. Bournival and Ms. Pal both testified, however, that during the assessment meeting, Ms. Bournival verbally explained to Ms. Pal that she and Timothy would need to decide upon a medication administration plan together. App. Br., at 41-43, 31-33, 34.

Next, FoF 46 suggests that the ISP provisions, “Provider gives Tim bubble pack for the appropriate time and shows Tim the correct day to punch”, and “Put medications in lockbox” are instructions that applied to Ms. Pal when, in fact, they applied only to Elahan Place. App. Br., at 31.

Findings of Fact 23 and 45. As Ms. Pal explained in her opening brief, certain of the findings in FoF 45 regarding Timothy’s limitations are erroneous. App. Br., at 34-35. Although when addressing the issue, Ms. Pal cited only to FoF 45, the objectionable portions of FoF 23 regarding whether Timothy’s “ability fluctuates” and the list of limitations are identical to those in FoF 45. The findings are presented as precise statements of Timothy’s limitations, when they are actually a selection of pre-programmed drop-down options, where some, but not all, of the listed limitations may apply. For example, the finding that Timothy’s “ability fluctuated”, is inaccurate. Ms. Bournival testified that this “kind of applies to [Timothy]...overall when I’m using these drop downs I will do anything that...could be a potential. Of the drop-down selections, a case manager chooses “whichever’s closest, if there’s something’s [sic] close.” RP Vol I, 201-02. And, there is no evidence that he cannot see labels.

Finding of Fact 49. The objectionable portion of FoF 49 was the last finding as it is inextricably linked to the Board’s last two findings in CoL 12 and its conclusions in CoL 13, which misconstrue Ms. Bournival’s

testimony on “keeping an eye” on Timothy. *See App. Br.*, at 31, 33 (discussing whether keeping an eye on Timothy was a specific ISP instruction). Although FoF 49 was not designated in the discussion of the review judge’s erroneous conclusions on this issue, Ms. Pal’s brief makes clear that Ms. Pal decided on the original medication administration plan to ensure against Timothy forgetting to take and losing his medications, not because the care plan required her to do so. *See id.* Ms. Bournival did not “admit”, but, rather opined, that Ms. Pal devised the original medication plan to “keep an eye on, you know, making sure that he was taking his medications as prescribed.” RP Vol I, 215.

D. Ms. Pal Did Not Commit Statutory Neglect Because She Took Reasonable Efforts to Ensure Timothy’s Medication Administration Needs Would Be Met While She Was Away.

As explained in the preceding sections, the Department reads requirements into the care plan that are not supported by the record. Its characterization of the facts implies that due to Timothy’s limitations, he needs much more support and supervision than can be done in the 69 hours a month the Department determined, utilizing its care assessment expertise, represented his level of need and capacity for independence. Its attempts to heighten Ms. Pal’s duty of care and portray her actions as an inappropriate regard of Timothy’s safety are belied by: 1) its own

determination of his limited care needs, 2) its determination that Timothy does not need 24-hour supervision or a guardian; 3) Ms. Bournival's extensive knowledge of Timothy's needs and Ms. Pal's corresponding duty of care; 4) Ms. Pal's communications with Ms. Bournival regarding her duties and Timothy's needs; 5) Ms. Pal's nearly daily interactions with Timothy for several months before the incident; 6) Timothy's known history and lack of deliberate overdosing; and 7) Timothy's behavior when he took the mediset. Neither the care plan, given its proper context, nor the situation itself, demanded Ms. Pal do more than she did to try to ensure Timothy's safety.

More simply put, the Department has not shown that Ms. Pal's actions meet the standard of neglect. Rather, the record shows Ms. Pal is a capable, caring and attentive caregiver who took all reasonable efforts to ensure Timothy's needs would be met while she was away. *See, e.g., App. Br., at 10-11, 46.* When Timothy refused to cooperate with the established medication plan, Ms. Pal devised an alternate plan tailored to the risk she could reasonably anticipate: Timothy forgetting to take or losing the medications. *Id.; see also AR 293* ("There has been no indication in the past [seven] years that Tim would take too much medication."). This Court should therefore reverse the Board's order.

E. Ms. Pal is Entitled to Attorney's Fees.

Ms. Pal is entitled to attorney's fees under the Equal Access to Justice Act (EAJA), RCW 4.84.340-.360, because the Department was not substantially justified in issuing a neglect finding. *See* App. Br., at 47-48. To be substantially justified, the Department's action must have "had a reasonable basis in law and fact." *Language Connection, LLC v. Employment Sec. Dep't*, 149 Wn. App. 575, 586, 205 P.3d 924 (2009). Here, the Department had none; it circumvented established precedent that limited its punitive reach and cherry-picked facts to fit a conclusion that Ms. Pal committed neglect.

Contrary to the Department's assertion, *Crosswhite* does not support its missteps in this action. The Department did not rely "on language in Washington cases" that supported its position or a "duly-adopted rule". *Crosswhite*, 197 Wn.App. at 540. The Department actually did the opposite. If the threshold for substantial justification requires only that the Department investigated as it was statutorily required to, regardless of how cursory the investigation or flawed its analysis, the purpose of the EAJA is rendered meaningless.

Finally, an award of attorney's fees will not have a chilling effect on the Department's investigatory efforts. Res. Br., at 29. Rather, it will incentivize the Department to correct its investigatory and adjudicatory

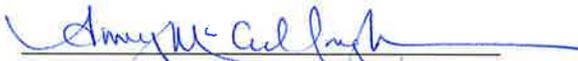
processes, more carefully follow the law, and only issue substantiated findings when warranted.

II. CONCLUSION

This Court should reverse the Board's order and award attorney's fees to Ms. Pal because, contrary to established jurisprudence, the order is based on a neglect analysis that impermissibly lowers the threshold for a neglect finding under RCW 74.34.020(16)(b). Ms. Pal should not be permanently banned from the caregiving profession, volunteering at her children's school, or other work opportunities because she could not preternaturally anticipate or ensure against Timothy's uncharacteristic attempt to harm himself.

RESPECTFULLY SUBMITTED this 9th day of March, 2018.

NORTHWEST JUSTICE PROJECT


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