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

ZAID WOLDEMICAEL,

Appellant,

v.

STATE DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Respondent.

APPELLANT'S REPLY BRIEF

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I. ARGUMENT

A. *Brown v. DSHS, Crosswhite and Raven* are Applicable Law and DSHS Is Not Entitled to Ignore Their Legal Principles.

As discussed at length in Appellant’s Opening Brief, the Court of Appeals has recognized two important principles which together establish a high threshold for a neglect finding based on “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*”, pursuant to RCW 74.34.020(16): (1) the conduct at issue must be well beyond that which amounts to simple negligence; and (2) whether the conduct rises to that level cannot be judged by the gravity of the outcome for the alleged victim, nor by any analysis based on hindsight. *See Brown v. Dep't of Soc. & Health Servs.*, 190 Wn. App. 572, 360 P.3d 875 (2015); *Crosswhite v. Dep't of Soc. & Health Servs.*, 197 Wn. App. 539, 548, 389 P.3d 731 (2017). *See also Pal v. Dept. of Soc. & Health Svcs.*, 2019 Wash. App. LEXIS 489, at 28-29 (March 5, 2019) (unreported decision) (“...the Board improperly relied on hindsight to conclude serious disregard and clear and present danger existed because harm occurred.”); *In re Dependency of Lee*, 200 Wn. App. 414, 438, 404 P.3d 575 (2017) (holding that the trial court's reliance on hindsight to conclude that parents’ rejection of a feeding tube for their medically complex son constituted abuse or neglect was improper)

Further, in *Raven v. Dept. of Soc. & Health Svcs.*, 177 Wn.2d. 804, 306 P.3d 920 (2013), the Supreme Court established that, even if an alleged perpetrator failed – in numerous respects - in her duty to meet applicable professional standards this is not sufficient to prove statutory neglect. 177 Wn.2d at 829-830.

Under its own rules, DSHS 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.”) 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).

In its Respondent’s Brief (hereinafter “Rep. Brief”), DSHS attempts to distinguish *Brown*, *Crosswhite* and *Raven*, citing specific factual variances. Rep. Brief, at 18-20. But these arguments ultimately result in distinctions without differences, since it is not the specific facts but the legal principles of these authorities – which DSHS, the Board of Appeals (“Board”) and the Superior Court here each disregarded – that establish the standard of statutory neglect at issue.

Regarding *Brown*, as was detailed in Appellant’s Opening Brief, although the *Brown* Court interpreted the neglect provision of the Abuse of Children Act (ACA), the relevant definition – that of “negligent treatment or maltreatment” - was nearly identical to the Abuse of Vulnerable Adults Act (AVAA) neglect definition at issue here. *Brown*, 190 Wn. App. at 588-589 (citing former RCW 26.44.020(16))¹. As the Supreme Court explained in *Kim v. Lakeside Adult Family Home*, 185 Wn.2d 532, 374 P.3d 121 (2016), both statutes share a “similar structure and purpose”, and therefore the analysis of the ACA guides a court’s analysis of the AVAA. *Kim*, 185 Wn.2d at 543-44.

In its arguments about *Brown*, DSHS resorts to hyperbole, claiming that “...applying *Brown* to vulnerable adult neglect would result in significantly increased risk to the elderly and disabled citizens of Washington. Doing so would arguably require proof of an intentional omission to meet the ‘serious disregard’ standard.” Rep. Brief, at 20-21. This overdone argument misunderstands *Brown*, which instead held that that the words employed in the definition of “negligent treatment or maltreatment” – specifically including the terms “serious disregard of consequences” and “clear and present danger” - meant that DSHS could not

¹ The same definition of “negligent treatment or maltreatment” is now at RCW 26.44.020(18). See also 2019 c 172 § 5,

invoke a “reasonable person” standard, and could not sanction a person for “neglect” based on conduct amounting to simple negligence. *See Brown*, 190 Wn. App. at 590-593. Interpreting “neglect” to require culpable conduct well beyond simple negligence is hardly tantamount to requiring an “intentional omission.” The ALJ here appropriately found “the analysis of the *Brown* court to be persuasive and because it concerns a substantially identical statute, it is applicable to an analysis of the legal standard in the present case.” CP 164 (Initial Order – APS), CL 5.15. The ALJ’s conclusion was correct, and the Board’s subsequent rejection of the *Brown* analysis was erroneous.

B. Zaid Woldemicael Did Not Neglect Debra.

DSHS’s argument for neglect proceeds upon a misleading series of claims about the known and documented care needs of Debora as of the date of her death, and the way that Ms. Woldemicael went about addressing these needs. While making these claims, DSHS continues to ignore or minimize the testimony of Debora’s own DSHS case manager who created the official DSHS assessment of her care needs. These efforts have the net effect of judging Ms. Woldemicael’s conduct using the benefit of hindsight and based on the tragic outcome of Debora’s death. This is precisely what is forbidden by the authorities discussed above.

1. Appropriate Monitoring and Supervision.

DSHS now argues that Ms. Woldemicael “set a chicken sandwich (quartered) and a bag of chips in front of Debora and then left her alone. . . . During Debora’s dinner, Debora was not monitored for choking. . . .” Rep. Brief, at 17. These disingenuous statements, which imply that that maintaining continuous visual observation of Debora was required in order to safely “monitor for choking”, contradicts the direct testimony at hearing from Debora’s DSHS case manager, Kristina Sherriff:

Q. What was your understanding of Deborah's needs from her caregiver as far as monitoring for choking?

A. It would be kind of what we talked about earlier: line of sight *or earshot*.

RP, Vol. II, at 35-36 (Sherriff testimony; emphasis added). Critically, Debora’s care needs *did not* require that she remain in continuous or uninterrupted line of sight throughout her meal. *Id.*, Vol. II, at 86-87. Ms. Woldemicael monitored Debora from the kitchen adjacent to the dining area, mere feet away from where Debora sat and certainly “within line of sight or earshot,” as required by her DSHS care assessment. *Id.*, Vol. I, at 42. Further, contrary to DSHS’s claim that Ms. Woldemicael “did not. . . cue Debora throughout the meal,” Rep. Brief, at 17, Ms. Woldemicael testified that she “was watching her through -- the whole time she was, uh I was making eye contact, talking to her through the -- like pointing my fingers at

her.” RP, Vol. I, at 142.

DSHS’s investigator ultimately admitted at hearing that Ms. Sherriff was better able to interpret the terms of the assessment and the level of care required than the investigator was. *Id.*, Vol. III, at 47 (Witman testimony). DSHS’s *post hoc* effort to re-interpret the care requirements must be rejected.

2. Adequate Meal Preparation.

As with the standards for protective supervision, DSHS suggests without basis that Ms. Woldemicael’s food preparation was inadequate and in contravention of Debora’s care plan. Ms. Sherriff gave specific testimony that the chicken sandwich, prepared as was it was that day, was consistent with Debora’s assessed needs. RP, Vol. II, at 77-78. During the underlying DSHS investigation, Ms. Witman was also not aware that Debora had regularly eaten a chicken sandwich, prepared in the same way, without prior incident; she admitted that this was a “significant fact”. *Id.*, Vol. III, at 44-45. Ignoring these facts, DSHS instead implies that the size of the food bolus later detected during an autopsy is sufficient to establish the inadequacy of the meal preparation. Rep. Brief, at 8, 17. This is a classic argument from hindsight that cannot form the basis for a neglect finding.

3. Appropriate Emergency Response.

DSHS’s Respondent’s Brief continues its misleading account of the

pertinent events as its “armchair detective” critique of Ms. Woldemicael’s conduct moves into the phase of her emergency response under extreme duress. DSHS’s claim that “[Ms. Woldemicael] did not look in Debora’s mouth or check whether she was breathing” Rep. Brief, at 7, is both false *and* misleading. First, Ms. Woldemicael testified that she *did* check to see if Debora was breathing, RP, Vol. I, at 145. This is also confirmed by the 911 call transcript, which reflects that Ms. Woldemicael told the operator “...she stopped breathing right now.” *See* AR 566². Second, DSHS fails to mention that Ms. Woldemicael had been trained that, during an apparent seizure, a caregiver should not insert hands or objects into the victim’s mouth, owing to the risk of further injury. RP, Vol. V, at 176-177 (Bunch testimony). Since Ms. Woldemicael suspected that Debora could be having a seizure – and her suspicion is again confirmed by the 911 call transcript, it is understandable that she did not look in Debora’s mouth.

DSHS also wantonly suggests that a certain delay between the time of Ms. Woldemicael’s 911 call and her commencing CPR was due to a supposed “failure to follow the operator’s specific instructions, and going to get another person to assist her.” Rep. Brief, at 7. This asserted “failure”

² There were two nearly – but not entirely - identical versions of the Agency Record that were filed with the Superior Court. *See* Clerk’s Papers (CP) 15-16, 120-121. Unless otherwise stated, all references to the Agency Record refer to that filed with the Superior Court in Case No. 18-2-04218-34 on October 3, 2018.

is not at all evident from the call transcript, and Ms. Woldemicael required help to move Debora due to Debora's obesity and partial paralysis from a historical stroke. RP, Vol. I, at 153-154 (7/31/17 Woldemicael testimony). She tried her best to follow the operator's instructions despite feeling, as one would expect, "terrified," and having no prior experience with CPR and only a nursing assistant's medical training. *Id.*, Vol. VI, at 17, 18 (9/21/17 Woldemicael testimony).

C. Zaid Woldemicael Did Not Commit Any Serious Violations of AFH Regulations.

1. WAC 388-76-10670 (Prevention of abuse)

As noted in Appellant's Opening Brief, the Board incorrectly found that Ms. Woldemicael had committed a violation of WAC 388-76-10670 (Prevention of abuse) based entirely upon its related findings regarding neglect. AR 13-14 (Final Order – AFHL), CL 10, 13. As such, Appellant's related arguments against the neglect finding are equally applicable to her objection as to this regulatory violation.

2. WAC 388-76-10020 (Care and services)

As with the foregoing cited violation, the Board incorrectly found that Ms. Woldemicael had committed a violation of WAC 388-76-10020 (Care and services) based entirely upon its related findings regarding neglect. AR 13-14 (Final Order – AFHL), CL 10, 13. As such, Appellant's

related arguments against the neglect finding are equally applicable to her objection as to this regulatory violation.

3. WAC 388-76-10355 (Negotiated care plan)

As with the foregoing cited violation, the Board incorrectly found that Ms. Woldemicael had committed a violation of WAC 388-76-10355 (Negotiated care plan) based entirely upon its related findings regarding neglect. AR 13-14 (Final Order – AFHL), CL 10, 13. As such, Appellant’s related arguments against the neglect finding are equally applicable to her objection as to this regulatory violation.

Notwithstanding the rather cursory findings of the Board on this alleged violation, DSHS’s Respondent’s Brief goes further, now arguing that “[i]f a resident has care needs that are not reflected in the negotiated care plan, the AFH has failed at its responsibility in that regard.” Rep. Brief, at 27. And yet, the cited regulation by no means requires that a care plan’s description of “care needs” be as extensive or detailed as those reflected in the care assessment or “ISP.” As such, it is erroneous to claim that the abbreviated description in the subject care plan as to how Debora “needs assistance with eating” represents a regulatory violation. Further, DSHS does not mention that under the subject regulation a “plan to...[f]ollow in case of a foreseeable crisis due to a resident's assessed needs,” is only required “if needed.” WAC 388-76-10355 (7). In the case of a “foreseeable

crisis” related to choking, one presumes that the “plan” would be to attempt to render first aid, which seems intuitive and obvious. That the care plan did not specifically stipulate first aid in the event of a medical emergency cannot amount to a regulatory violation.

4. WAC 388-76-10220 (Incident Log)

DSHS’s citation for violation of WAC 388-76-10220 (Incident log) is simply incorrect. The February 12, 2017 event was logged by Ms. Woldemicael in AFH records, as is easily demonstrated by document review. *See* AR 273-274 (Resident Log); AR 436 (Incident Log). While DSHS’s investigator denied receiving one of these records even after Ms. Woldemicael faxed it to DSHS, the other record other was admittedly included within a file which DSHS’s investigator reviewed on site. *See* RP Vol. III, P. 51, 52 (Witman testimony). The cited regulation imposes no requirement regarding the specific form of the “log” or its storage location. DSHS’s arbitrary refusal to accept the record that it did observe cannot support the cited regulatory violation.

D. DSHS’s Neglect Finding and Election of Remedies Was Arbitrary and Capricious.

1. Neglect Finding.

In Appellant’s Opening Brief, she provided a detailed explanation as to how DSHS’s neglect investigation and ultimate finding were irreparably

tainted by bias and malfeasance. *See* Op. Brief, at 43-45. Most notably, DSHS failed to abide by its own investigative policy in refusing to interview Ms. Woldemicael regarding her version of events. *Id.*

Rather than address this specific point, DSHS states, without citation to legal authority, “[t]here is no need, or legal basis, for speculating about who was not interviewed, or why some interviews were not longer.” Rep. Brief, at 32. To the contrary, DSHS’s failure to adhere to its own investigative policy and procedure manual constitutes grounds to afford Ms. Woldemicael relief under RCW 34.05.570(3)(c) and (i); and these grounds are separate and apart from the subsection of the same statute regarding a lack of substantial evidence. *See* RCW 34.05.570(3)(e).

2. .Enforcement Remedies.

DSHS’s Response Brief barely meets the merits of Appellant’s arguments in support of her contention that DSHS’s selection of enforcement actions – the harshest possible - was arbitrary and capricious. In evaluating the propriety of revocation, the presiding officer should give consideration to the impact revocation would have on AFH residents and their guardians or family members. *Conway v. Dep’t of Soc. & Health Servs.*, 131 Wn. App. 406, 420, 120 P.3d 130 (2005). License revocation and summary suspension were not in the best interests of the remaining residents of Win AFH.

As was detailed in Appellant's Opening Brief, Debora's guardians, the representatives of other residents, two former residents and others who worked with Ms. Woldemicael each provided compelling testimony at hearing to the detrimental impacts the residents of Win AFH suffered because of DSHS's displacing them from their home and services, as well as their strong desire that the AFH had not been closed so that the residents could have remained there. Op. Brief, at 46-47. Even DSHS's own representatives in the DDA expressed their support for Ms. Woldemicael and her quality of care. *Id.*, at 47.

Most notably, Adina Angle, who had many years of experience working for DSHS with regard to numerous adult family homes, testified as follows:

Q. What was your opinion of that decision?

A. Of the decision to close the home?

Q. Yeah

A. I was very taken back.

Q. Why?

A. Because I have experienced many clients choke and die under the many years I have worked in my role, and other capacities. *And I also didn't think, from my professional vantage point, that the other people were in danger for remaining in the home.*

Q. Are you speaking of the other residents that remained there?

A. Yes, yes. And...yeah.

Q. Would it be your preference given your role that you could continue to place residents at Win Adult Family Home?

A. Yes.

RP, Vol. III, P. 104 (emphasis added).

Q. You testified earlier that you have known about or had experienced many clients choking and dying. Does that include in adult family home settings?

A. Yes. And also I used to work for RCS, and I was the state evaluator for all of our supportive living agencies for five years. So, I read hundreds of records through that period of time and, you know, so from that experience, so, yes, I had a breadth of experience.

Q. So having an adult family home resident choke and die is unfortunate, but not unusual?

A. It's not, no. It's not unusual. It happens.

Id., Vol. III, P. 113.

DSHS's disregard for the opinions and preferences of these many concerned, interested and knowledgeable parties further demonstrates the arbitrary, capricious and harmful nature of its actions.

E. Entitlement to Attorney's Fees and Costs.

In that event that Ms. Woldemicael prevails as to either the neglect finding or the enforcement actions, the Court should authorize an award of fees and costs, including reasonable attorneys' fees pursuant to RAP 18.1 and RCW 4.84.350 for the proceedings before the Superior Court and Court of Appeals.

“To be entitled to an award of attorney fees under the EAJA, a qualified party is deemed to have prevailed if that party obtained relief on a significant issue.” *ZDI Gaming, Inc. v. Wash. State Gambling Comm'n*, 151

Wn. App. 788, 813, 214 P.3d 938 (2009), *aff'd*, 173 Wn.2d 608, 268 P.3d 929 (2012). In *Karanjah v. Dep't of Soc. & Health Servs.*, 199 Wn. App. 903, 401 P.3d 381 (2017), this Court found that an award of fees under the EAJA was appropriate where the Board made an arbitrary and capricious finding of abuse. *Karanjah*, 199 Wn. App. at 926-927.

Ms. Woldemicael disagrees with DSHS's suggestion that she would not be entitled to this award were she to prevail on the enforcement actions, but not the neglect finding. Rep. Brief, at 37-38. As the agency record reflects, the enforcement actions resulted from a series of investigations by Residential Care Services (RCS), while the neglect finding resulted from a separate investigation by Adult Protective Services (APS). It is undisputed that these separate DSHS sub-agencies enforce different laws and have different investigative roles. If their functions were duplicative or redundant, why would DSHS have them both involved in this case, or any case? If Ms. Woldemicael prevails as to either the enforcement actions or the neglect finding, she will have "obtained relief on a significant issue."

II. CONCLUSION

For the reasons discussed above and in Appellant's Opening Brief, this Court should reverse the orders of the Superior Court and the Board of Appeals, and restore the findings of fact and conclusions of law of the ALJ.

DATED this 19th day of June, 2020.

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