STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 10-2015-LIC-00281
	)	
	)	
[APPELLANT'S NAME]	)	**REVIEW DECISION AND FINAL ORDER**
	)	
	)	
Appellant	)	Adult Protective Services (APS)

I. NATURE OF ACTION

1. The Department of Social and Health Services (Department) Adult Protective Services (APS) received an allegation of neglect an alleged vulnerable adult. After investigation and review, the Department determined the allegation was valid and issued a substantiated initial finding of neglect against the Appellant. The Appellant requested a hearing to contest the Department's substantiated initial finding. Administrative Law Judge (ALJ) Michael Hovey held a hearing on August 31, and September 1, 2016. The ALJ issued an *Initial Order* on October 25, 2016, affirming the Department's substantiated initial finding of neglect of a vulnerable adult by the Appellant.

2. The Appellant requested an extension of time in which to file a petition for review of the *Initial Order* and the deadline was extended to December 15, 2016. The Appellant filed a petition for review of the *Initial Order* with the Department's Board of Appeals (BOA) on December 14, 2016. The Department submitted a response to the Appellant's petition for review on December 22, 2016.

3. Based on the following findings of fact and conclusions of law, the *Initial Order* is **reversed**. The Department's substantiated initial finding of neglect is **reversed.**

[INTENTIONALLY LEFT BLANK]

II. FINDINGS OF FACT

1. On July 6, 2015, the Appellant, a [AGE 1] female, became employed as a Direct Support Professional (DSP) for [BUSINESS NAME 1], a company that provides in-home support for persons with developmental disabilities.

2. The Appellant underwent initial orientation for three hours on July 6, 2015, and began on-the-job-training by following and observing another DSP for a total of twelve hours on July 7 and 8, 2015.[1] The on-the-job-training covered two clients of [BUSINESS NAME 1], [NAME 1] and [NAME 2].

3. DSP's are tasked to support and accompany the clients without impeding their wishes. DSP's assure the safety of the clients, and if unable to, contact appropriate help from [BUSINESS NAME 1] or the police.

4. In 2015, [NAME 2] was a [AGE 2] male. He has been diagnosed with autism, fragile X syndrome, and epilepsy, and has a history of seizures.[2] [NAME 2] was diagnosed as developmentally disabled and is a client of the Washington Developmental Disabilities Administration (DDA). [NAME 2] receives home health services, at his [CITY 1] apartment, [BUSINESS NAME 2], in [CITY 1], Washington.

5. Leslie Cook, a DDA case manager for [NAME 2], performed an annual assessment of [NAME 2]'s needs in November 2014, and documented his assessment in an Individual Support Plan (ISP).[3] The ISP was available to [BUSINESS NAME 1] which described [NAME 2]'s needs and limitations. A copy of the ISP was located in [NAME 2]'s "binder" on a table in his apartment.

6. [NAME 2]'s particular condition involves his inability to appreciate the consequences of his actions. The ISP indicates [NAME 2] is not street safe, will sit down in the middle of the road, will eat/drink very hot items, likes to make himself bleed with sharp items.

[1] Exhibit 12.
[2] Exhibit 7, p.13.
[3] Exhibit 7.

"[NAME 2] has no awareness of personal safety and requires 1:1 supervision."[4] The care plan notes that [NAME 2] will strike himself, cut himself, cause himself to bleed, dig at electrical outlets, and is not safe around sharp objects.[5] He "needs support at all times due to safety issues."[6]

7. The Appellant had seen [NAME 2]'s ISP and was familiar with his needs. She realized the dangers inherent in his being unsupervised, particularly outside of the apartment. The Appellant had experienced some difficulty controlling [NAME 2] while outside of his apartment during her tenure at [BUSINESS NAME 1].

8. The Appellant had been informed that [NAME 2] was "exit seeking" or that he would "bolt," meaning he would attempt to leave his apartment abruptly when he had an opportunity to do so.[7] Another DSP advised the Appellant to place a large sculpture in front of the apartment door to slow him down should he try to leave on his own.

9. The Appellant worked six twelve-hour shifts assisting [NAME 2] prior to August 2015. On August 1, 2015, Appellant was assigned as caretaker to [NAME 2] from 8:00 a.m. to 8:00 p.m.[8]

10. On August 1, 2015, while [NAME 2] observed personal time in his bedroom, Appellant sat in a chair recliner[9] in the apartment's living room and entered information into a laptop computer. From where she was sitting, the Appellant could not see [NAME 2]'s bedroom door, but could see both the kitchen and porch doors leading to the outside. For [NAME 2] to exit the apartment from his bedroom he would have to pass within view of anyone sitting in the chair occupied by the Appellant.[10] The Appellant recalls looking at the clock on the side desk

[4] Exhibit 8, p. 4
[5] Exhibit 7, p. 11.
[6] Exhibit 7, p. 18.
[7] Exhibit 7, p. 7.
[8] Exhibit 12.
[9] *Verbatim Report Of Proceedings* (Tr.), Vol. II, p. 89, lines 19-21.
[10] Tr., Vol. I, p. 285, line 11 through p. 286, line 8.

next to the chair and noting it was 4:45. The next thing she recalls was being awaken by someone she believed was [NAME 3].[11]

11. At 4:50 pm., on August 1, 2015, [NAME 3], a DSP at [BUSINESS NAME 1], was on duty, for [BUSINESS NAME 1], at [BUSINESS NAME 2] when she observed [NAME 2] walking alone outside, unattended. [NAME 2] walked to the gate of the pool area. [NAME 2] was unable to access the swimming pool because it was enclosed by a fence and a locked gate. [NAME 2] did not have a key to the lock on the gate.[12] [NAME 3] kept [NAME 2] there and requested another nearby DSP, [NAME 4], to get [NAME 2]'s support professional.[13]

12. [NAME 4] entered [NAME 2]'s apartment where she found the Appellant asleep in the recliner. [NAME 4] was unable to roust the Appellant by yelling at her.[14] When [NAME 3] was informed of this, she had [NAME 4] watch [NAME 2] and went to wake the Appellant herself. [NAME 3] used one hand to shake the Appellant's arm/shoulder area and the Appellant woke up after the third shake. Upon awakening, the Appellant appeared startled as if she did not know what was going on. [NAME 3] instructed the Appellant to get up and go outside to take care of [NAME 2].[15]

13. The Appellant located [NAME 2]'s seizure medication and went to retrieve him near the pool fence. The Appellant tried but was unable to get [NAME 2] to return to his apartment. Eventually, the police were called, who escorted [NAME 2] back into his apartment.

14. The Appellant was instructed not to return to work on the following day, but to meet with [BUSINESS NAME 1] manager the following Monday. On Monday, August 3, 2015, the Appellant met with the [BUSINESS NAME 1] management and admitted to falling asleep in the chair in [NAME 2]'s apartment. The Appellant was discharged from her position.[16]

[11] Tr., Vol. !, p. 287, line 19 through p. 10.
[12] Tr., Vol. I, p. 292, lines 14-22; Vol. II, p. 100, lines 17-25.
[13] Tr., Vol. II, p. 88, line 9 through p. 89, line 4.
[14] Exhibit 10.
[15] Tr., Vol. II, p. 89, line 10 through p. 90, line 24.
[16] Exhibit 9.

15. [NAME 3] generated an event report.[17] She submitted her comments to the complaint resolution unit and telephoned the program manager and the [BUSINESS NAME 1] after-hours hotline.

16. Information regarding the August 1, 2015 incident with [NAME 2] was received by Adult Protective Services (APS), on August 10, 2015. Subsequently, an Intake Report was created.[18] Department investigator John Graber was assigned to investigate the matter. During the investigation Mr. Graber attempted to contact the Appellant, unsuccessfully. Mr. Graber received no call-back from Appellant. The investigation was completed without input from Appellant.

17. On October 1, 2015, the Department sent the Appellant an Alleged Perpetrator Notification of Neglect of a Vulnerable Adult pursuant to WAC 388-71.[19]

18. The Appellant requested a hearing October 19, 2015.[20]

19. In June, 2015, the Appellant sought out counseling for what would later be diagnosed as depression.[21] She began weekly therapy meetings with [NAME 5], MA, a licensed mental health counselor. [NAME 5] noted the Appellant's mania and anxiety. He noted that he was seeing "a range of things" with the Appellant including "lack of sleep" and "erratic" presentation at the therapy sessions.[22] [NAME 5] thought that the Appellant may be exhibiting Bipolar II symptoms and referred her to [DOCTOR 1], MD for a medication evaluation.[23] [NAME 5] did not inform the Appellant of his beliefs regarding her diagnosis as he wanted her first to be seen by [DOCTOR 1]. In December 2015, [DOCTOR 1] diagnosed the Appellant with Bipolar disorder and prescribed medication for Appellant.[24]

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[17] Exhibit 11.
[18] Exhibit 3.
[19] Exhibit 1.
[20] Exhibit 2.
[21] Tr., Vol. II, p. 19, lines 12-17.
[22] Tr., Vol. II, p. 22, lines 7-14.
[23] Tr., Vol. II, p. 22, lines 18-25.
[24] Exhibit B, p. 13.

20. The Appellant saw [NAME 6] on January 22, 2016, based on a medication referral from [DOCTOR 1]. [NAME 6] is a licensed Psychiatric Mental Health Nurse Practitioner (ARNP) and holds a Doctor of Nursing Practice degree (DNP). On July 19, 2016, [NAME 6] signed a sworn declaration addressing her treatment of the Appellant.[25] The declaration provides:

- [NAME 6] confirmed the Appellant's diagnosis of Bipolar II based on her initial visit with the Appellant and discussions with [DOCTOR 1] and [NAME 5].
- [NAME 6] opined that the Appellant would have been suffering from her bipolar condition for quite some time before her initial diagnosis in late 2015.
- [NAME 6] declared that one element of the Appellant's bipolar condition is an erratic sleep pattern and "strongly" believed that the Appellant was suffering from an episode of hypersomnia during the incident occurring on August 1, 2015. Her opinion is based on training, experience, and the difficulty staff had in wakening the Appellant on that day. [NAME 6] believes that it is "close to absolutely certain" that the Appellant fell asleep due to sleep deprivation stemming from her Bipolar condition.
- [NAME 6] opined that the Appellant's falling asleep unexpectedly and her inability to assess her own abilities is consistent with the Appellant's untreated bipolar condition.

21. Sufferers of Bipolar II will cycle through periods of mania and depression exhibiting symptoms of insomnia and hypersomnia.[26] The Appellant exhibited bouts of rapid cycling.[27] Features of hypersomnia include extreme grogginess and fatigue causing sufferers to fall into a deep sleep suddenly, un-expectantly, and with significant difficulty to roust awake.[28]

22. Based on the medical evidence in the hearing record and the absence of any evidence countermanding this medical evidence, the following finding is made: On August 1, 2015, the Appellant suffered from Bipolar II with rapid cycling causing her to experience hypersomnia during the afternoon of that day. Based on this affliction and its ramifications, the Appellant went into an immediate and deep sleep when she was sitting in a recliner chair entering work related data into a laptop computer. The Appellant had no forewarning or

[25] Exhibit G.
[26] Tr., Vol. II, p. 28, line 23 through p. 29, line 11: Exhibit G, p. 2.
[27] Tr., Vol. II, p. 33, lines 1-12.
[28] Tr., Vol. II, p. 30, line 20 through p. 31, line 24.

foreknowledge that this event would occur. Because of her mental affliction at the time, the Appellant's ability to self-assess her abilities was substantially reduced.

III. CONCLUSIONS OF LAW

Jurisdiction, Standard of Review, and Standard of Proof

1. The petition for review of the *Initial Order* was timely filed and is otherwise proper.[29] Jurisdiction exists to review the *Initial Order* and to enter the final agency decision.[30]

2. In this adjudicative proceeding, the undersigned Review Judge has the same decision-making authority when deciding and entering the *Final Order* as the ALJ had while presiding over the hearing and deciding and entering the *Initial Order*, unless the Review Judge or a provision of law limits the issue(s) subject to review.[31] RCW 34.05.464(4) grants the undersigned Review Judge the same decision-making authority as the ALJ and in the same manner as if the undersigned had presided over the hearing.[32] This includes the authority to make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[33] This is because "…administrative review is different from appellate review."[34] The undersigned Review Judge does not have the same relationship to the ALJ as an Appellate Court Judge has to a Trial Court Judge in terms of the level of deference owed by the Review Judge to the presiding ALJ's findings of fact.[35] The Review Judge's authority to substitute his

[29] WAC 388-02-0560 through -0595.
[30] WAC 388-02-560(1) and -0600(1).
[31] RCW 34.05.464(4), WAC 388-02-0600(1).
[32] *Kabbae v. Dep't of Soc. & Health Servs*., 144 Wn. App. 432, 443 (2008) (invalidating WAC 388-02-0600(2)(e) which has since been repealed).
[33] *See Hardee v. Dep't of Soc. & Health Servs.,* 152 Wn. App. 48, 59 (2009) (referring to the court in *Regan v. Department of Licensing*, which "…held that a reviewing officer has the authority 'to modify or replace an ALJ's findings, including findings of witness credibility' and stated that the statute does not require a reviewing judge to defer to the ALJ's credibility determinations, but rather authorized the reviewing judge to make his or her own independent determinations based on the record"). *See also Regan v. Dep't of Licensing*, 130 Wn. App. 39, 59 (2005).
[34] *Kabbae* note 39 at 441 (explaining that this is because the final decision-making authority rests with the agency head).
[35] *See, e.g., Tapper v. Employment Sec. Dep't.,* 122 Wn.2d 397, 404-05 (1993), *overruled on other grounds by Markam Group, Inc. v. Employment Sec. Dep't,* 148 Wn. App. 555, 562 (2009), and Andersen,

or her judgment for that of the presiding ALJ on matters of fact as well as law is the difference.[36] If the ALJ specifically identifies any findings of fact in the *Initial Order* that are based substantially on the credibility of evidence or demeanor of the witnesses,[37] a Review Judge must give appropriate consideration to the ALJ's opportunity to observe the witnesses when reviewing the ALJ's factual findings and making his or her own determinations.[38]

3. The Washington Administrative Procedure Act directs Review Judges to personally consider the entire hearing record.[39] Because the ALJ is directed to decide the issues *de novo* (as new),[40] the undersigned has also decided the issues *de novo*. Pursuant to RCW 34.05.464(4) and WAC 388-02-0600(1), the undersigned is required to give due regard or consideration to the ALJ's opportunity to observe the witnesses, when applicable.

4. It may help to explain briefly at the outset the unique characteristics and specific limitations of the administrative hearing process. An administrative hearing is held under the auspices of the *executive branch of government* and neither the ALJ nor the Review Judge enjoy the broad equitable authority of a Superior Court Judge within the *judicial branch of government.* It is well settled that administrative agencies, such as the OAH and the Board of Appeals, are creatures of statute, without inherent or common law powers, and, consequently, they may exercise only those powers expressly granted in enabling statutes or necessarily implied therein.[41] It is also well settled that an ALJ's or a Review Judge's jurisdictional authority to render a decision in an administrative hearing is limited to that which is specifically provided for in the authorizing statute(s) or WAC provision(s).[42] This is because ALJs and Review Judges

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The 1988 Washington Administrative Procedure Act – An Introduction, 64 Wash. L. Rev. 781, 816 (1989).
[36] *Id.*
[37] RCW 34.05.461(3).
[38] RCW 34.05.464(4) and WAC 388-02-0600(1).
[39] RCW 34.05.464(5). *See also* WAC 388-02-0560(4).
[40] WAC 388-02-0215(1).
[41] *Skagit Surveyors & Eng'rs, L.L.C. v. Friends of Skagit County*, 135 Wn.2d 542, 558 (1998), and *Taylor v. Morris,* 88 Wn.2d 586, 588 (1977). *See also* WAC 388-02-0216 which provides, "The authority of the ALJ and the review judge is limited to those powers conferred (granted) by statute or rule. The ALJ and the review judge do not have any inherent or common law powers."
[42] *Id.*

must first apply the Department rules adopted in the WAC to resolve an issue.[43] If there is no Department WAC governing the issue, the ALJ and the Review Judge must resolve the issue on the basis of the best legal authority and reasoning available, including that found in federal and Washington constitutions, statutes and regulations, and court decisions.[44] The ALJ and the Review Judge may not declare any rule invalid, and challenges to the legal validity of a rule must be brought *de novo* in a court of proper jurisdiction.[45]

5. "The power of an administrative tribunal to fashion a remedy is strictly limited by statute."[46] The only discretionary authority afforded to ALJs and Review Judges is that which is set forth, either explicitly or implicitly, in statute or agency rule.[47] As a result, the ALJ and the undersigned have extremely limited authority to grant equitable relief in this administrative forum.[48] Equity within the administrative hearing process generally comes from equal application of the law to the supported facts for all who appear before the tribunal. ALJs and Review Judges do not have the same opportunity as Superior Court Judges to fashion an equitable remedy.

6. The applicable regulations address what standard of proof is to be used in an APS hearing providing that, " If the ALJ determines that a preponderance of the evidence in the hearing record supports the substantiated initial finding that the alleged perpetrator abandoned, abused, financially exploited or neglected a vulnerable adult, the ALJ shall uphold the substantiated initial finding."[49] This standard means that it is more likely than not that something happened or exists.[50]

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[43] WAC 388-02-0220(1).

[44] WAC 388-02-0220(2).
[45] WAC 388-02-0225(1).
[46] *Skagit Surveyors & Eng'rs. L.L.C.,* 135 Wn.2d at 558.
[47] WAC 388-02-0216.
[48] WAC 388-02-0495 is the only regulation explicitly providing for an equitable remedy in administrative hearings applying the Department's WAC provisions.
[49] WAC 388-71-01255(1).
[50] WAC 388-02-0485.

7. The undersigned has reviewed the written transcript of the hearing, the documents admitted as exhibits, the *Initial Order*, the Appellant's petition for review, and the Department's response to the petition for review to determine the adequacy and appropriateness of the *Findings of Fact* made by the ALJ in the Initial Order. After review, the undersigned finds that the ALJ's *Findings of Fact,* with amendments and supplements, are supported by substantial evidence based on the entire record. For this reason, the ALJ's *Findings of Fact,* with amendments and supplements, are adopted and incorporated by reference into this decision as set forth above.[51]

8. In her petition for review, the Appellant requests that additional findings be added related to the Appellant's work history; education; participation in continued therapy treatment; desire to work with vulnerable adults and children; and explanation as to why the Appellant was not contacted by the Department investigator during the APS investigation. None of these requested modifications or additional findings are relevant in determining if the Appellant neglected a vulnerable adult.

Applicable Definitional Regulations and Statutes

9. Chapter 74.34 of the Revised Code of Washington (RCW) is titled "Abuse of Vulnerable Adults." The Department implemented chapter 74.34 RCW by adopting chapter 388-71-0100 through –01281 of the Washington Administrative Code (WAC), entitled "Home and Community Services and Programs-Adult Protective Services." Administrative hearings conducted under these regulations are controlled by statutes and regulations found at RCW 34.05 and WAC 388-02, respectively.[52]

10. RCW 74.34 establishes a system for reporting instances of neglect of a vulnerable adult. The first sentence of the relevant regulatory definitions incorporate by

[51] RCW 34.05.464(8).
[52] WAC 388-71-01245.

reference the statutory definitions.[53] The referenced statute defines neglect as "(a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (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."[54] The Department's substantiated initialing finding of neglect is based on a single incident occurring on August 1, 2015. Therefore, only subsection (b) of the statutory definition is applicable.

11. The statute defines "vulnerable adult" to include a person who has a developmental disability as defined under RCW 71A.10.020 or is receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127.[55] The evidence in the hearing record supports the unchallenged findings that [NAME 2] has been diagnosed with a developmental disability and receives services from a home care agency. For these reasons, [NAME 2] is a vulnerable adult as defined by the statute and is entitled to the protections provided therein.

12. RCW 74.34.020(15)(b) requires that a "duty of care" exist between the alleged perpetrator and the vulnerable adult if a finding of neglect was based on a single incident so egregious as to demonstrate 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. Regulations relevant to APS findings define "Person with a duty of care" to include a person providing the basic necessities of life to a vulnerable adult where the person is employed by or

[53] WAC 388-71-0105.
[54] RCW 74.34.020(15).
[55] RCW 74.34.020(21)(c) and (e).

on behalf of the vulnerable adult.[56] The evidence in the hearing record supports the unchallenged finding that the Appellant was employed by a home care agency to provide care for [NAME 2]. For this reason, a duty of care existed between the Appellant and [NAME 2] during her work shift on August 1, 2015. The fact that the Appellant may have been a "non-licensed, non-certified provider of in-home assistance for developmentally disabled adults" does not affect this "duty of care" relationship nor are these alleged facts relevant to resolution of this case. For this reason, the Appellant's request that *Finding of Fact 4.1* be modified to include this information is rejected.

Neglect of a Vulnerable Adult – Clear and Present Danger

13. In her petition for review, the Appellant argues that her unintentional falling asleep during her work shift did not result in the requisite "clear and present danger" to [NAME 2]'s health, welfare, and safety because of the relative safe nature of the area immediately surrounding the apartment complex including the secured swimming pool. In any case involving a substantiated initial finding of negligent where no actual physical harm to a vulnerable adult has occurred requires making certain assumptions and identifying *possible* or *potential* hazards or negative outcomes. This necessary exercise requires a certain level of what some may consider *impermissible speculation,* but is actually positing *reasonable inferences*. Setting forth the potential for harm to an unsupervised cognitively impaired vulnerable adult, due to the possible occurrence of any one of many negative outcomes is not impermissible speculation. The "laws of logic" and the "experience of logical probability" [57] allows the undersigned to make the reasonable and permissible inference that a developmentally disabled person, lacking basic self-preservation and awareness of personal safety, would be in danger when left unsupervised and unattended in the outside public world.

[56] WAC 388-71-0105 **"Person or entity with a duty of care"** (3)(a). *See* WSR 04-19-136, effective October 22, 2004.
[57] *See, Poppell v. City of San Diego,* 149 F.3d 951, 954 (9th Cir. 1998).

14. The evidence in the hearing record supports the findings and conclusions that [NAME 2] required assistance and supervision on an ongoing basis, especially when outside the confines of his apartment. Allowing [NAME 2] some privacy time in his bedroom and possibly during toileting does not diminish the critical need to provide constant supervision in other areas of the apartment and outside of the apartment. Reasonable measures that could be taken within the limited confines of [NAME 2]'s bedroom and bathroom to greatly minimize any potential threat to his safety when he was allowed privacy time, could not realistically be taken in the world outside his apartment, short of providing constant attentive supervision. The evidence in the hearing record aptly supports the findings that [NAME 2] had a propensity to wander and becoming lost; a habit of picking up and putting foreign objects in his mouth; an inability to speak; a lack of proper boundaries; and a lack of safety awareness, including around streets and traffic. The existence of a reduce speed-limit parking lot and driveway before unblocked entry on the public thoroughfare[58]; the existence of a locked fence on the swimming pool; and the possible presence of other residents in these areas may provide a certain safety buffer for [NAME 2] and delayed him from entering a much more dangerous environment, but did not eliminate the critical need for constant supervision when [NAME 2] was outdoors, no matter where he was outdoors.

15. Concluding that a vulnerable adult with [NAME 2]'s cognitive and behavioral issues would not have the ability to fully avoid, or protect himself from, any number of dangerous occurrences brought about possibly by his own indiscriminate behavior is a permissible and reasonable inference in concluding [NAME 2] could not be left alone outside. The provision of adequate supervision and attending care for a DDA resident is a critical core responsibility of an in-home caregiver employed to provide that supervision and care. Based on [NAME 2]'s specific limitations and care needs, the fact that [NAME 2] was left unattended and

[58] *See* Exhibits H and J.

unsupervised outside his apartment did constitute a clear and present danger to his health, welfare, and safety. This conclusion is reached accepting the common language usage for the terms "serious disregard"[59] and "clear and present danger."[60]

Lack of Intent and Knowledge

16. In her petition for review, the Appellant asserts that she had no intention of falling asleep in the midst of her work shift on August 1, 2015, and did not know, nor have any reason to know, that she could fall asleep that day without any warning. It can reasonably be argued that no one *intentionally* or makes a *conscious choice* to fall asleep during a work shift, especially if that work entails close supervision of a vulnerable adult. "Falling asleep" is an event unique to the animal kingdom that could reasonably be compared to the involuntary acts of the heart muscles or digestive system. The actual act of "falling asleep" is, by its very nature, an involuntary action. It would be rare indeed if a person could voluntarily bring about the exact condition of "sleep" at a precise moment. If the Department had to show an *intent* to fall asleep in proving the existence of a "serious disregard of the consequences" in every case where an alleged perpetrator has failed to stay awake on the job, it would be nearly impossible to show neglect under such circumstances. Arguably, the Department could only prevail in those rare cases where the evidence supports the fact that the alleged perpetrator "brushed their teeth, put on their pajamas, and climbed under the bed covers." For these reasons, the Department does not need to show specific intent to "fall asleep" at a specific time to prove neglect in a case where the alleged neglect is based on the failure to stay awake, and thus, the failure to provide adequate supervision while caring for a vulnerable adult. The basis for the neglect allegation in this case is not the volitional or non-volitional act of "falling asleep," but rather the

[59] The term "serious" is defined as: "Grave in disposition, appearance, or manner." Webster's Third New International Dictionary 2073 (1981). The term "disregard" is defined as: "To treat without fitting respect or attention." Webster's Third New International Dictionary 655 (1981).
[60] The term "clear" is defined as: "Without confusion or obscurity." Webster's Third New International Dictionary 419 (1981). The term "present" is defined as: "Now existing or in progress." Webster's Third New International Dictionary 1793 (1981).

"omission" of providing adequate supervision which happened to be brought about in this case by the Appellant's failure to remain awake during a period when that supervision was required.

The Marcum and the Ashley Brown Cases

17. In her petition for review, the Appellant asserts that the Department cannot interpret and apply the statutory definition for "neglect" to create strict liability. *See Marcum v. Department of Social and Health Services,* 172 Wn. App. 546, 559, 290 P.3d 1045 (2012). 42283-2-II, p. 12 (2012). Although the Washington State Court of Appeals Division II vacated the finding of neglect the Department entered against the appellant in *Marcum,* the case was remanded to the BOA to determine if the founded CPS finding of negligent treatment or maltreatment should stand based on the facts without application of a *strict liability* standard. On remand from the Court of Appeals, the BOA re-affirmed the founded CPS finding of negligent treatment or maltreatment against that appellant based on her mistakenly leaving a child unattended. The case was decided on remand not on a *per se* finding of neglect based on lack of supervision, but on a determination that the lack of *adequate* supervision constituted a serious disregard of the consequences to the child of such a magnitude that it created a clear and present danger to the child's health, welfare, and safety. The Appellant did not *intend* to leave the child unsupervised, but rather failed to recognize the young child was not in her group and was inadvertently left behind alone. It was this inadvertent failure to account for the whereabouts of the two-year-old child in her care that *evidenced a serious disregard of consequences* as set forth in 26.44.020(16). Concluding that falling asleep while tasked with the responsibility of providing critical supervision and care for a vulnerable adult does not automatically create strict liability under the statute as long as all relevant circumstances surrounding the incident, as well as the needs of the vulnerable adult are fully considered.

18. The Appellant also cites to the Washington State Court of Appeals, Division III, analysis in *Ashley Brown v. Department of Social and Health Services*, 190 Wn. App. 572, 360

P.3d 875 (2015) in support of the position that the ALJ cannot use an objective reasonable person standard in determining if neglect has occurred. The *Brown* decision addressed what constitutes negligent treatment or maltreatment of a child under RCW 26.44.020(16) when a parent does not immediately obtain medical treatment for an injured child. The Appellant argues that the conclusions reached in the *Brown* case are equally applicable to an APS finding of neglect based on the Washington State Supreme Court decisions in *Kim v. Lakeside Adult Family Home,* 185 Wn.2d 532, 543-44, 374 P.3d 121, 126 (2016). The court's language contained the Appellant's internal page cites addresses the similarities between the Abuse of Children Act (ACA) and the Abuse of Vulnerable Adults Act (AVAA), but does not specifically rule that term "neglect" under the AVAA and the term "negligent treatment or maltreatment" under the ACA are the same and should be interpreted and implemented identically. The Appellant's stronger argument is that the two definitions are similar enough that the conclusions reached in the *Brown* decision should be given some consideration in addressing neglect in an APS case.

19. Even accepting the Appellant's interpretation and application of *Kim*, the facts in the *Brown* case and the case at bar are markedly different. The *Brown* case involved a young mother who was informed by telephone at work that her young son had been scalded in the bathtub at home while under the supervision of her boyfriend. The mother rushed home and, based on her observations of the child's skin as slightly red and after consulting with both her mother and her boyfriend's mother (who worked in a hospital), as well as seeking advice from a pharmacist and the internet, decided not to seek professional medical treatment for the child and to apply burn ointment to the child herself as she had often done with work related burns while working in a sandwich shop. After initial improvement, the child developed blisters and exhibited increased pain. When the burned area began to bleed, the child's mother took him to the hospital. The ALJ in the *Brown* case affirmed the Department's founded CPS finding of negligent

treatment or maltreatment for failure to seek timely medical attention for the child, the BOA affirmed the ALJ, and the Superior Court also upheld the Department's decision. The Washington State Court of Appeals concluded that the specific definition of negligent treatment or maltreatment required more than a showing of mere negligence.[61] The Court of Appeals appeared to be focused on what would have been the results if the mother had immediately sought medical attention for her son and would that medical treatment be any different than what the mother had done to treat the child's burns.[62] The Department representative's inability to adequately answer these questions posed by the Court of Appeals,[63] appeared to have considerable sway in the court's decision that the mother's decision not to immediately seek medical attention and to treat the child herself, under the specific facts in that case, did not rise to the level of an act that evidenced a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare, or safety.

20. The facts in this case can be readily distinguished from the facts existing in the *Brown* case. Here, the Appellant, by her own admission, failed to stay awake, while charged with the responsibility of supervising a critically impaired vulnerable adult with behavioral issues that created a dangerous environment when he was left unsupervised and unattended. Any question by this tribunal or the Court of Appeals as to what difference did the Appellant's failure to remain awake on the job can readily be answered by responding, "The vulnerable adult would not have been placed in a position where he could have wandered off, injured by inattention to his surroundings (traffic), or picked up by a stranger with nefarious intent." While *Ashley Brown*'s medical care decisions for her young child may not have been ideal when viewed in hindsight, it is understandable why the *Brown* court found her actions did not evidence the requisite "serious disregard of consequences" set forth in RCW 26.44.020(16).

[61] *Brown,* 190 Wn. App. at 590.
[62] *Brown,* 190 Wn. App. at 595.
[63] *Brown,* 190 Wn. App. at 584-85.

Defense of Hypersomnia

21. In her petition for review, the Appellant argues that her condition, unbeknownst to her at the time, rendered her totally incapable of preventing her from falling asleep, or even knowing that this would occur. The Appellant asserts that this condition is akin to her having a catastrophic heart attack or epileptic seizure rendering her unconscious or otherwise incapable of supervising [NAME 2], or requesting immediate supervisory aide, through conditions totally beyond her control or fault. Common human experience shows us that the ease or difficulty a person has in falling asleep, when that is desired, varies with each individual and can vary at different times as to that one individual. This is true also with each individual's ability to stay awake, when that is desired or necessary. And finally we each exhibit different depth levels of sleep - from those who are light sleepers and are woken by the slightest change in our environment and those who are extremely deep sleepers who can only be roused by aggressive and repeated actions. Simply because an individual lies within the "difficulty" stratum of the "ability to stay awake" scale and the "extreme deep sleeper" stratum of the sleep depth scale, does not excuse nor relieve that individual of the responsibility of staying awake to provide critical supervision of a vulnerable adult. Nor would such characteristics provide an adequate defense to an allegation of neglect based on failure to provide such supervision, absent some other mitigating circumstances.

22. The Appellant placed into the hearing record medical evidence of the Appellant's condition from three separate sources who had direct contact with the Appellant and had treated her. This evidence came from the sworn testimony of the Appellant's licensed mental health counselor, [NAME 5]; the medical records of the Appellant's primary care physician, [DOCTOR 1]; and the sworn declaration of [NAME 6] , DNP, ARNP. The totality of this medical evidence was consistent within itself and the Department did not provide any evidence to countermand either the medical records or the declaration. The Department's cross

examination of [NAME 5] did not undermine his assertions made under oath during his testimony at hearing. For all of these reasons, the Appellant has proven by a preponderance of the evidence that she suffered from Bipolar II which included the symptoms of hypersomnia on August 1, 2015. Based on this same unchallenged evidence, the Appellant has proven by a preponderance of the evidence that her falling asleep on that day was unpredictable, without warning, and based on a condition beyond her knowledge or control.

23. To prove neglect in this case, the Department must prove three basic elements by a preponderance of the evidence. These elements are: (1) an act or omission by a person with a duty of care; (2) the act or omission demonstrates a serious disregard of consequences; and (3) that such disregard is of such a magnitude to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. As set forth in earlier conclusions above, the Department has proven by a preponderance of the evidence elements (1) and (3). The Appellant's failure to stay awake was an omission and this omission did create a situation placing [NAME 2]'s health, welfare, and safety in clear and present danger. What the Department has failed to prove is that the Appellant demonstrated a "serious disregard of consequences" when she fell asleep due to hypersomnia brought about by her Bipolar II condition unbeknownst to her at the time. The requirement to prove a "serious disregard of consequences" requires some sentient awareness by the Appellant of what was occurring or was going to occur to her during the incident. When the Appellant was render essentially unconscious through no fault of her own, she could not be charged with a "serious disregard of the consequences."

24. When the Department has proven that a caregiver has fallen asleep while charged with the responsibility of supervising and caring for an extremely disabled vulnerable adult who can be seriously harmed without that supervision, absent any viable defense raised by the Appellant, the Department is going to prevail in its allegation of neglect. The

undersigned has some concerns about whether the Appellant was totally unaware of what was happening to her at work on August 1, 2015. Her therapist, himself, testified that hypersomnia is evidenced by extreme grogginess and the undersigned is not completely convinced that the Appellant was not aware, on some level, that she was less than fully capable in providing the necessary care for [NAME 2] that day. If that was true, perhaps in hindsight, the Appellant should have not sat down in a comfortable recliner chair or should have informed her supervisor of her grogginess earlier in the day. However, when an Appellant provides unchallenged evidence that the Appellant's failure to remain awake was brought about by a medical condition unbeknownst to, and outside the control of, the Appellant, neither the ALJ nor the undersigned can ignore or "second guess" this medical evidence. The Department cannot show a "serious disregard" as the Appellant under such rare conditions is incapable of showing any type of "regard," serious or otherwise. The somewhat unique and specific facts of this case create a situation that is akin to where a person has been rendered unconscious through an unknown and unpredictable affliction.

V. DECISION AND ORDER

The *Initial Order* entered on October 25, 2016, is **reversed**. The Department's substantiated initial finding of neglect of a vulnerable adult by the Appellant is **reversed**.

Mailed this 21st day of February, 2017.

JAMES CONANT
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: [APPELLANT'S NAME], Appellant
[NAME 7], Appellant's Representative
Jeremy Haas, Department's Representative; MS: N31-08
Vicky Gawlik, Program Administrator; MS: 45600
Michael Hovey, ALJ, [CITY 2] OAH