STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	Docket No. 05-2009-L-2089
[ADULT FAMILY HOME 1] **/[APPELLANT 1]** Appellant	Adult Family Home
[APPELLANT 1] Appellant	Docket No. 11-2009-L-0552 Resident Client Protection Program
[APPELLANT 2] Appellant	Docket No. 11-2009-L-0555 Resident Client Protection Program
[APPELLANT 3] Appellant	Docket No. 11-2009-L-0556 Resident Client Protection Program
	REVIEW DECISION and **FINAL AGENCY ORDER**

I. NATURE OF ACTION

1. The Department of Social and Health Services' Aging and Disability Services Administration (ADSA) served [APPELLANT 1], owner of [ADULT FAMILY HOME 1], with notice of its decision to issue a Summary Suspension, Stop Placement of Admissions, and Revocation of License regarding [ADULT FAMILY HOME 1] (AFH). The Appellant (the Appellant) objected to this decision and requested an administrative hearing. The Office of Administrative Hearings assigned Docket No. 05-2009-L-2089 to this appeal.

2. The Department of Social and Health Services' Resident and Client Protection Program (RCCP) served [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3] with notice of its findings that each neglected a vulnerable adult. In addition, it advised [APPELLANT 3] of its finding that she had abused a vulnerable

adult. The Appellants (the Appellants) each objected to these decisions and requested an administrative hearing. The Office of Administrative Hearings assigned Docket Nos. 11-2009-L-0552 ([APPELLANT 1]), 11-2009-0555 ([APPELLANT 2]) and 11-2009-L-0556 ([APPELLANT 3]), to these appeals.

3. Administrative Law Judge (ALJ) Bill Gales conducted a prehearing conference on July 6, 2009, in Docket No. 05-2009-L-2089, and mailed a Prehearing Conference Order on July 6, 2009, scheduling the hearing for September 1, 3, and 4, 2009. On October 16, 2009, the Department filed a motion to stay the hearing until after the appeals were heard in Docket Nos. 11-2009-L-0552 and 11-2009-L-0555. The Department asked the Office of Administrative Hearings not to consolidate Docket No. 05-2009-L-2089 with the appeals of Docket Nos. 11-2009-L-0552 and 11-2009-L-0555. On October 29, 2009, the Appellant responded and asked that all of the matters be considered in one consolidated hearing. By Prehearing Conference Order mailed November 12, 2009, ALJ Gales consolidated the four matters (including Docket No. 11-2009-L-0555.) The matters were heard on February 11-12, 2010, February 16, 2010, April 20-21, 2010, April 23, 2010, April 30, 2010, June 7, 2010, and June 22, 2010. Post hearing closing arguments were filed, and the record was closed on September 15, 2010. ALJ Gales mailed an Initial Order on February 4, 2011. The ALJ decided that [APPELLANT 1] did not violate the regulations cited in the Department's Notice of Summary Suspension, License Revocation and Stop Placement Order; [APPELLANT 1] did not neglect a vulnerable adult(s); [APPELLANT 2] did not neglect a vulnerable adult(s); and [APPELLANT 3] did not neglect or abuse a vulnerable adult(s).

4. This Final Order incorporates the Petition for Review and Response for the easy reference of the reader.[1] The Department timely filed a Petition for Review on March 11, 2011.[2] The Petition states:

> The Department of Social and Health Services ("Department") petitions the Board of Appeals ("BOA") for review of the initial order in the case of *In re [ADULT FAMILY HOME 1]/ [APPELLANT 1], [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3],* Docket Nos. 05-2009-2089, 11-2009-L0552, 11-2009-L-0555, and 11-2009-L-0556. A hearing was held in the above matter February 11, 12, and 16; April 20, 21, 23, & 30, 2010; and June 7 & 22, 2010, before Administrative Law Judge (ALJ) Bill Gales. [APPELLANT 1], [APPELLANT 2] and [APPELLANT 3] were represented by attorney, Gary Preble. The Department is appealing the initial order from this hearing which reversed the Department's revocation of [APPELLANT 1]'s adult family home license, and overturned findings of neglect and/or abuse against [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3].
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> **I. PROCEDURAL BACKGROUND**
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> This matter was brought before the Office of Administrative Hearings (OAH) on consolidated appeals by [APPELLANT 1], doing business as [ADULT FAMILY HOME 1], and [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3], in their individual capacities. The Department of Social and Health Services' (Department or DSHS) revoked [APPELLANT 1]'s adult family home license, and also made individual findings of neglect, and a finding of verbal abuse.
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> [APPELLANT 1] has operated an adult family home since April 12, 2005, at [ADDRESS 1], [COUNTY 1], Washington (hereafter referred to as [ADULT FAMILY HOME 1]) under adult family home license *[NUMBER 1]*. Exhibit (Ex.) Dept. 1[3]. On April 30, 2009, the Department's Residential Care Services' facility practices' personnel (RCS) concluded the on-site portion of an investigation regarding allegations of failed practices at [ADULT FAMILY HOME 1]. Ex. Dept. 7. On May 1, 2009, RCS issued a Stop Placement Order prohibiting admissions pending the completion of an investigation.[4] Ex. Dept. 9. On May 6, 2009, RCS completed a written Statement of Deficiencies. Ex. Dept. 6. The following day, RCS issued a

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[1] The content of these documents is replicated without comment or correction, with the exception of the footnotes which are numbered consecutively throughout this Review Decision and Final Order.
[2] The Department was granted an extension on its time to file by order dated February 11, 2011.
[3] Reference to "Exhibit (Ex.) Dept" is referring to exhibits submitted by the Department into the hearing record at the administrative hearing.
[4] The stop placement of admissions is effective immediately and is not stayed pending an appeal. RCW 70.128.160(3); WAC 388-76-10980(2)-(3).

Notice of Summary Suspension and Revocation based on the violations cited in the Statement of Deficiencies. The Notice and the Statement of Deficiencies cited violations of the adult family home licensing regulations under WAC 388-76-10020, Ability to provide care and services; WAC 388-76-1-620(2)(a)(c), Resident rights and Quality of life; WAC 388-76-10670(1-4), Prevention of Abuse; and WAC 388-76010673 (2)(a)(b), Abuse and neglect reporting -- Mandated reporting to the Department -- Required. Ex. Dept. 10.

[APPELLANT 1] timely appealed the revocation of her adult family home license. Ex. Dept. 11. Subsequently, [APPELLANT 1], her [RELATIVE] [APPELLANT 2], and her caregiver, [APPELLANT 3] were investigated by the Department's Resident and Client Protection Program (RCPP).

On October 1, 2009, RCPP issued preliminary findings against both [APPELLANT 1] and [APPELLANT 2] for neglect of a vulnerable adult pursuant to RCW 74.34. Exs. Dept. 23 & 27. On October 1, 2009, RCPP also issued a preliminary finding of neglect and a preliminary finding of mental abuse against [APPELLANT 3]. Ex. Dept. 31. [APPELLANT 1 & 2] and [APPELLANT 3] appealed those findings by letters dated October 9, 2009. Ex. Dept. 26, 30 & 34. The appellants requested a consolidated hearing and that motion was granted.

The ALJ reversed the Department's revocation of the adult family home license and overturned the findings of neglect and abuse. The Department now appeals to this tribunal because some of the ALJ's findings of fact were erroneous and the conclusions of law were flawed and not based on the facts in the record.

II. STANDARD OF REVIEW

Pursuant to WAC 388-02-0600(2)(a), a review judge has the same decision-making authority as the ALJ when reviewing initial orders in licensing cases, but must consider the ALJ's opportunity to observe the witnesses. Additionally, pursuant to WAC 388-02-0600(3), a review judge may change the hearing decision in a Resident Client Protection Program case if:

(a) There are irregularities, including misconduct of a party or misconduct of the All or abuse of discretion by the All, that affected the fairness of the hearing;
(b) The findings of fact are not supported by substantial evidence based on the entire record;
(c) The decision includes errors of law;
(d) The decision needs to be clarified before the parties can implement it; or
(e) Findings of fact must be added because the All failed to make an essential factual finding. The additional findings must be supported

> by substantial evidence in view of the entire record and must be consistent with the ALJ"s findings that are supported by substantial evidence based on the entire record.[5]

A review of the record will reveal that the there were errors in findings of fact and conclusions of law. Furthermore, additional findings are supported by the record.

III. FACTS[6]

[APPELLANT 1] and [APPELLANT 2] moved to the state of Washington in 1989 with their then [AGE]-year-old [RELATIVE], [NAME 1], who has Down syndrome and qualifies for state services based upon a developmental disability. Initial Decision, Finding of Fact (FF) 1. A short time later, [APPELLANT 1] began working as a social services provider in various capacities. For a time she provided in-home child care and also served as a foster parent. From 2001 to 2006 she worked in residential and group homes with an agency called [BUSINESS 1] ([BUSINESS 1]). During her time with that agency she ran a 24-hour, secure community protection home which housed several residents with sexual deviancy problems. While working with [BUSINESS 1] she learned about the adult family home concept and decided to apply for a license to operate her own adult family home. *Id.*

On April 12, 2005, [APPELLANT 1] was granted a license to operate an adult family home at [ADDRESS 1], Washington, in [COUNTY 1], for up to five developmentally disabled adults. Initial Decision, FF 2. In order to obtain the license she completed the training required of all licensees, which including training on the fundamentals of care giving and the obligations of mandatory reporters. *Id.*

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[5] Pursuant to the Washington Administrative Procedure Act, the "reviewing officer shall exercise *all the decision-making power that the reviewing officer would have had to decide and enter the final order had the reviewing officer presided over the hearing."* RCW 34.05.464(4) (emphasis added). The reviewing officer "shall give due regard to the presiding officer's opportunity to observe the witnesses." *Id.* But because the ALJ has the authority to enter findings of fact, "the review judge 'has the power to make his or her own findings of fact and in the process set aside or modify the findings of the ALJ"' *Kabbae v. Dep't of Soc. & Health Servs.,* 144 Wn. App. 432, 442-43 (2008) (quoting *Tapper v. Employ. Sec. Dep't,* 122 Wn.2d 397, 404 (1993)) (invalidating WAC 388-02-0600(3)(e), which attempts to limit a Board of Appeals review judge's authority to revise initial orders). The Washington State courts have clarified that a review officer can "substitute his own findings of fact for that of the ALJ," even if those facts are not essential. *Id.* at 443. And, of course, the review judge may change an Initial Order if there were irregularities, findings of fact not supported by substantial evidence based on the entire record, and/or errors in law. WAC 388-02-0600(3).

[6] The Office of Administrative Hearings provided counsel with audio recordings of the proceedings which were used for reference. Where there are quotes, independent of the initial order, every effort was made to reproduce the testimony given at the hearing verbatim. There is no transcript of this hearing available to the undersigned.

The adult family home [APPELLANT 1] operated was called [ADULT FAMILY HOME 1] and was a spacious, multi-level house which also served as the [APPELLANT 1 & 2]'s residence. In 2009, [APPELLANT 1] and [APPELLANT 2] lived in the home with their [RELATIVE] [NAME 1], and also with [APPELLANT 3], who worked for her as a caregiver at [ADULT FAMILY HOME 1]. Initial Decision, FF 3. [NAME 1] was approximately [AGE] years old at the time of the investigations and the [APPELLANT 1 & 2]'s were providing [NAME 1] with in-home state funded care. *Testimony of [APPELLANT 1];* Initial Decision, FF 1. Throughout the time that [APPELLANT 1] has had an adult family home license, many different residents have resided in their adult family home. There were five developmentally disabled residents living at [ADULT FAMILY HOME 1] in February 2009: [NAME 2], [AGE]; [NAME 3], [AGE]; [NAME 4], [AGE]; [NAME 5], [AGE]; and [NAME 6], [AGE]. Initial Decision, FF 3. The residents lived in the basement with [NAME 2] and [NAME 6] sharing a bedroom and the rest in individual bedrooms. [APPELLANT 2] and [APPELLANT 1], [NAME 1], and [APPELLANT 3] lived upstairs. *Id. Testimony of [APPELLANT 1].* Meals for everyone were prepared and served upstairs in the kitchen area. Most of the residents had part-time jobs outside the home, except for [NAME 6], who had more serious physical problems and did not work. *Id.*

On February 22, 2009, [APPELLANT 1] left town on a previously scheduled trip to [LOCATION 1] with other members of her family and she delegated the running of [ADULT FAMILY HOME 1] to her [RELATIVE] [APPELLANT 2] and [APPELLANT 3]. Initial Decision, FF 4.

Just before lunch that Monday, February 23, 2009, [NAME 4] came upstairs from the basement and told [APPELLANT 3], who was in the kitchen, that something inappropriate was, or had been, going on downstairs between [NAME 2] and [NAME 1]. Initial Decision, FF 5. [APPELLANT 3] went to talk to [APPELLANT 2], who was also upstairs but in a different part of the house, about [NAME 4]'s report. They decided that [APPELLANT 2] would talk to [NAME 1] and [APPELLANT 3] would talk to [NAME 2] to find out what, if anything, had happened. [APPELLANT 3] went downstairs to talk to [NAME 2] and sent [NAME 1] upstairs to talk to his [RELATIVE]. *Id.*

In their investigation of [NAME 4]'s report on February 23, 2009, [APPELLANT 3] and [APPELLANT 2] were told by [NAME 4], [NAME 2] and/or [NAME 1] that [NAME 2] had rubbed his private parts against [NAME 1], either while they were dancing or under other circumstances, in a manner that could be described as "dry humping" or mock intercourse. The contact did not appear to involve any touching with the hands or any contact under the clothing or skin-to-skin. Initial Decision, FF 8. The contact does not appeared to have been forced, although a

question was raised by the Appellants themselves as to whether [NAME 1] was capable of consenting to any sexual contact, if that is in fact what had occurred. It is also not clear whether this type of incident was an isolated incident or had happened between them in the past. Both [APPELLANT 1] and [APPELLANT 3] made statements to other witnesses, such as [NAME 7] and Ms. Hochreiter that it had occurred before, although it was not clear what exactly had occurred before. *Id.* Neither [APPELLANT 2] nor [APPELLANT 3] reported this incident to the Department's hotline, to anyone who worked for the Department or with the residents, or to law enforcement. Initial Decision, FF 10. Both [APPELLANT 2] and [APPELLANT 3] were aware that as staff of the adult family home, they were mandatory reporters. [APPELLANT 2] at one point stated to a witness that he did not want to report what [NAME 2] had done because he felt that a report of sexual misconduct would create problems for [NAME 2] in the future and that he thought that he had dealt with the incident by telling [NAME 2] that such behavior would not be tolerated in their home. *Id.* [APPELLANT 3] told a Department investigator that she did not think that the incident needed to be reported because both [NAME 2] and [NAME 1] had their clothes on at the time. *Id.* [APPELLANT 1] did not learn of the incident until she returned from [LOCATION 1] on February 27, 2009, when she talked to her [RELATIVE] and [APPELLANT 3] about how things had gone in her absence. Initial Decision, FF 11. [APPELLANT 1] followed up on the information by scheduling an appointment for [NAME 2] with [BUSINESS 2]; a community mental health agency. She also did not report the incident to the Department's hotline or to Adult Protective Services (APS) or law enforcement. *Id.*

A month later, on March 27, 2009, [NAME 2] was scheduled for an intake interview with [BUSINESS 2], and was taken to the appointment by [APPELLANT 3]. [APPELLANT 1] had intended to go herself, but had to be with another client that day. Initial Decision, FF 11. The interview was conducted by [NAME 9], a mental health professional, who conducted the interview with [NAME 2] using the agency's 14-page intake form. [APPELLANT 3] sat in during the entire interview and contributed some information from time to time. During the part of the interview dealing with possible criminal conduct, [APPELLANT 3] told [NAME 9] that "[NAME 2] manipulated another person into sexual unsavory things - he is 'humping' him. We don't feel comfortable with other [or others] being alone with [NAME 2]." Initial Decision, FF 11; Ex. Dept. 20, p. 4. As part of her recommendations, [NAME 9] wrote that [NAME 2] may need an evaluation for sexually inappropriate behavior and suggested that someone should talk to [APPELLANT 1] to see if his behavior should be reported to APS. *Id,* p. 15.

More than a month and a half after the February 23, 2009, incident, on April 14, 2009, [NAME 2] met with [BUSINESS 2] therapist [NAME 7]. This time, [APPELLANT 1] accompanied [NAME 2] to the meeting and sat in on the session. Initial Decision, FF 12. In a private conversation, before or after the session, [APPELLANT 1] told [NAME 7] that they had caught [NAME 2] and her [RELATIVE] [NAME 1] engaging in sexually inappropriate conduct. [NAME 7] recalled that [APPELLANT 1] had used the term "dry humping" to describe the conduct. She also mentioned an incident between [NAME 2] and another female resident who was no longer in the home although the nature of that incident was not specified. *Id.* [APPELLANT 1] said that since the February incident they had not allowed [NAME 1] to be alone with [NAME 2]. She also said they were not concerned about the other residents since they were older, bigger and functioned at a higher level and thus were not at risk in their view. Initial Decision, FF 12; Ex. Dept. 3. Shortly after the session, [NAME 7] reported the incident to APS, which forwarded the report to Residential Care Services (RCS). *Id.* [NAME 7] also made an appointment for [NAME 2] with a doctor for a psychosexual evaluation. Ex. Dept. 22. [NAME 7] also told [APPELLANT 1] she would be reporting the incident and that [NAME 2] would, as a result, be removed from her home pending an investigation. Initial Decision, FF 12.

After the meeting with [NAME 7], [APPELLANT 1] talked with [NAME 2]'s case manager Wesley Fullerton about the session and told him that [NAME 7] felt that [NAME 2] could not continue living at their home. Initial Decision, FF 13. On April 15th, [APPELLANT 1] also met with an attorney who helped her write a 30-day eviction notice which they served on [NAME 2]. As a reason for the eviction, [APPELLANT 1] stated, that they were concerned for the safety or health of individuals in the home because of [NAME 2]'s "inability to control his impulses." Initial Decision, FF 13; Ex. Dept. 4. The following day, April 16, 2009, [NAME 7] filed a critical incident report with [FACILITY 3] based on what [APPELLANT 1] had told her. Initial Decision, FF 13; Ex. Dept. 6.

As a result of the reports to APS and RCS, a referral was made to local law enforcement. Initial Decision, FF 14. On April 21, 2009, [DETECTIVE 1] and [DETECTIVE 2][7] interviewed [APPELLANT 1] and [APPELLANT 2] at [ADULT FAMILY HOME 1] about the incident which had been reported to APS and RCS. [APPELLANT 1] essentially confirmed that [NAME 2] had be caught "humping" [NAME 1] and that he "owned up to it" when confronted by [APPELLANT 2] and [APPELLANT 3]. Initial Decision, FF 14; Ex. Dept. 13. She denied that there had been any similar incidents in the past. The Detectives tried to interview [NAME 4] but he said he didn't remember the incident. [DETECTIVE 1] tried to talk to [NAME 1] but didn't feel qualified to conduct the interview given [NAME 1]'s disabilities. The

[7] [citation omitted].

police did not interview [NAME 2] or any other resident. The police investigation ended at that point based upon a lack of evidence of a crime. *Id.*

On April 23, 2009, adult family home licensing complaint investigator Robbie Hochreiter began her investigation of the incident with a home visit to [ADULT FAMILY HOME 1]. She returned to [ADULT FAMILY HOME 1] on April 29 and 30, 2009, to complete her investigation. She was accompanied on at least one of those days by her supervisor Roberta Crawford, who assisted her in the investigation. Initial Decision, FF 15. Between them, they interviewed [APPELLANT 1], [APPELLANT 2], [APPELLANT 3], three of the residents ([NAME 2], [NAME 4], and [NAME 6]) and [NAME 2]'s [RELATIVE]. As to the reported incident, [APPELLANT 3] said that [NAME 2] admitted to her that he rubbed his genitals against [NAME 1] in mock intercourse. [APPELLANT 2] said that [NAME 2] told him he got these impulses and couldn't help acting on them. Neither [APPELLANT 2] nor [APPELLANT 3] reported the incident. *Id.* [APPELLANT 1] told Ms. Hochreiter that she learned of the incident when she returned from [LOCATION 1] and immediately contacted [BUSINESS 2] for an appointment for [NAME 2]. *Id.*

When [NAME 2] was interviewed by Ms. Hochreiter, he claimed [NAME 1] was the instigator of the incident and that he told staff that, but that they didn't believe him. [NAME 4] did not confirm this version of the incident even though he complained about [NAME 1]'s sometimes "sexually inappropriate" behavior, the exact nature of which was never explained, although it may have been his loose and revealing clothing and his dancing style, which was described by another resident, [NAME 6], as "lap dancing." Initial Decision, FF 16. The Appellants also talked about [NAME 1]'s love of music and dancing and that he liked to dress up as Elvis Presley and imitate him. They also said that [NAME 1] could be socially intrusive and had a problem respecting boundaries, which was likely an aspect of his developmental delay and the Down syndrome. *Id.*

Ms. Hochreiter broadened her investigation beyond the reported incident as a result of her interviews with residents [NAME 2], [NAME 4], and [NAME 6], who complained to her about the food and also about being yelled at and verbally abused by [APPELLANT 2] and [APPELLANT 3]. As to the complaints about the food, the chief complaint appeared to be the [APPELLANT 1 & 2] placed limits on availability of milk and sugar. Initial Decision, FF 17.

On April 30, 2009, the Department completed its adult family home licensing investigation and Ms. Hochreiter wrote a 7-page Statement of Deficiencies. Initial Decision, FF 19; Ex. Dept. 7. A copy of the SOD was given to [APPELLANT 1], or the contents discussed with [APPELLANT 1],

on April 30, 2009. Initial Decision, FF 20. [APPELLANT 1], at the urging or upon the recommendation of Ms. Crawford, called the Department's hotline later that day reporting an allegation of non-consensual sexual touching involving a resident. She also possibly called to report an allegation of verbal abuse of a resident by a staff member. *Id.*

On May 1, 2009, the Department issued a Stop Placement Order prohibiting any new admissions to the home pending completion of their investigation. Initial Decision, FF 21; Ex. Dept. 9. That same day, [APPELLANT 1] wrote a letter to Ms. Crawford informing her that [APPELLANT 2] and [APPELLANT 3] would be relieved of all caregiving responsibilities at [ADULT FAMILY HOME 1] until the allegations of verbal abuse were resolved. Initial Decision, FF 21; *Ex. Dept. 5.* On May 7, 2009, The Department personally served [APPELLANT 1] with a Notice of Summary Suspension, License Revocation, and Stop Placement Order Prohibiting Admissions referencing the attached Statement of Deficiencies as the basis for the action. Initial Decision, FF 21; *Ex. Dept. 10.*

[APPELLANT 1] elected to participate in the Informal Dispute Resolution (IDR) process offered by the Department in this regulatory area. Initial Decision, FF 23. On May 12, 2009, [APPELLANT 1] wrote a letter to the IDR program manager requesting IDR in which she admitted' that the incident that occurred in their home on February 23, 2009, "most likely" involved resident [NAME 2] rubbing himself, "including his private parts," on her [RELATIVE] [NAME 1]. She went on to say that they did not report the incident because they felt that while what had occurred was inappropriate it did not constitute sexual abuse, or assault. She denied the allegation that they limited access to milk or other food choices except when advised to do so by medical staff. She also denied allegations of yelling by [APPELLANT 2]. The IDR session was held on June 8, 2009, and resulted in some changes in the SOD, the only significant change involving the removal of the finding that law enforcement should have been contacted by the home about the incident on February 23, 2009. *Ex. Dept. 8 and 15.* However, no change to the enforcement action was recommended or made. Initial Decision, FF 21. On the May 12, 2009, [APPELLANT 1] also wrote a letter to the Office of Administrative Hearings (OAH) requesting an administrative hearing to contest the Department's May 7, 2009, enforcement action. *Ex. Dept. 11.*

On June 19, 2009, the Department's Resident and Client Protection program (RCPP) began its own investigation of the individuals working at the [ADULT FAMILY HOME 1] as to the allegations of verbal abuse and neglect reported to the Department Complaint investigator Gloria Morrison interviewed all five residents who had been at [ADULT FAMILY HOME 1] shortly before it was closed. Initial Decision, FF 25. [NAME 4] told Ms.

Morrison he didn't remember the incident and [NAME 6] refused to talk to her. Therefore, Ms. Morrison used statements they made to the licensing complaint investigators in April 2009 in her report. Residents [NAME 5] and [NAME 3], who had not previously been interviewed, had positive things to say about [ADULT FAMILY HOME 1] and their time there. [NAME 2] repeated his allegation that [NAME 1] had been the instigator of the incident in February and said that [NAME 1] had pulled him down on the ground and started humping on him and wouldn't let him up for some time. *Id.*

Ms. Madison also interviewed the Appellants and Wesley Fullerton, [NAME 7], and [DETECTIVE 1], all of whom repeated the substance of their previous statements. At the conclusion of her investigation, Ms. Morrison wrote three reports summarizing the results of her investigation. These reports were submitted to a RCPP panel on September 28, 2009, which recommended findings of neglect of vulnerable adults against [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3], and an additional finding of mental abuse against [APPELLANT 3]. Initial Decision, FF 26.

Upon the conclusion of the hearing and despite the ALJ issuing a credibility finding in favor of the Department, *See* Initial Decision, FF 7, the ALJ reversed the Department's revocation of [APPELLANT 1]'s adult family home license, and overturned findings of neglect and/or abuse against [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3].

IV. ERRONEOUS FINDINGS OF FACT

The Department takes exception to the following findings of fact which are clearly erroneous in light of the entire record: Findings of Fact 3, 8, 17, 18, 22, and 25. Furthermore, Conclusions of Law 7 and 8 contain independent, incorrect factual assumptions.

A reasonable review of the record leads to the following conclusions regarding erroneous findings of fact:

1. Finding of Fact 3: This age directly conflicts with Finding of Fact 1, which states that [NAME 1] was born in 1989. The testimony and record at hearing supports a finding that [NAME 1] was at least [AGE] years old at the time of the "incident", and was developmentally disabled such that he functioned at a much lower cognitive level than his chronological age. [APPELLANT 1] also testified at hearing that, when [NAME 1] turned [AGE], she became his legal guardian. The ALJ's finding of fact that [NAME 1] was [AGE], and any conclusions of law that are based on [NAME 1] being a minor or a child, are unsupported by the record.

2. Finding of Fact 8: Finding of Fact 8 states "a question was raised by the Appellants themselves as to whether [NAME 1] was capable of consenting to any sexual contact." This finding of fact misstates the record. The Appellants testified unequivocally that [NAME 1] could not consent to sexual contact.

Also, Ms. Crawford testified that she asked [APPELLANT 2] and [APPELLANT 1] if [NAME 1] could consent to any sexual touching or any sexual activity during the course of the licensing investigation. *Testimony of Roberta Crawford.* This conversation regarding consent was what prompted [APPELLANT 2] to report that he had changed [NAME 1]'s diaper up until the time he was 7 or 8 years old, and he indicated with his finger that he had never seen [NAME 1] have an erection. *Id.* Ms. Crawford testified further that [APPELLANT 2] was adamant in saying that [NAME 1] could not consent and that he had the mental age of an 8 year old and was "asexual". *Id.* [APPELLANT 2] also told Ms. Hochreiter that [NAME 1] said he did not like [NAME 2] rubbing himself on him. *Testimony of Robbie Hochreiter.* Furthermore, [NAME 7] stated that [APPELLANT 1] told her that "[NAME 1] was at the cognitive age of 8" and [NAME 2] was functioning at a higher level and this was a great concern for [NAME 7] regarding sexual contact. *Id.*

3. Finding of Fact 17: Finding of Fact 17 states that there were no food restrictions. This Finding of Fact is not supported by the record. The residents complained to Department investigators about access to food and food choices. Ms. Hochreiter testified that [NAME 2], [NAME 4] and [NAME 6] all complained that they wanted milk for lunch and dinner but were not allowed. *See Testimony of Roberta Hochreiter.* The residents also told Ms. Hochreiter that they could not have sugar on their cereal and that if they did not like what was being served, they could not have anything else. *Id.* Roberta Crawford testified that she saw [APPELLANT 3] make Peanut Butter and Mayonnaise sandwiches and that they all got water. *See Testimony of Roberta Crawford.* Roberta Crawford testified that the residents were not offered a choice of sandwich or any other drinks. *Id.*

Ms. Hochreiter testified that [NAME 2]'s [RELATIVES], [NAME 8] and [NAME 10] were interviewed and they complained about [NAME 2] not being allowed milk at lunch and dinner and that he was not allowed to have cereal. *Id.* They told Ms. Hochreiter that one time [NAME 2] did not like what was being served for dinner so he got out a bowl of cereal and he was chewed out for it. *Id.*

Ms. Hochreiter testified that [NAME 4] also complained he could not have milk for, lunch or dinner, and that no sugar was allowed. *Id.* Further, [NAME 4] complained about being given a raw hamburger and

when he mentioned it, [APPELLANT 2] "nuked it until it was dry and tasteless". *Id.* [NAME 4] also told Ms. Hochreiter that he asked for milk with lunch and [APPELLANT 3] said yes but then [APPELLANT 2] said no. *Id.*

Ms. Hochreiter testified that [APPELLANT 1] and [APPELLANT 2], said that they do not keep sugar on the table but they keep it put away in the cupboard. *Id.* They said that sugar is bad for the residents and they only serve unsweetened cereal. *Id.* [APPELLANT 2] told Ms. Hochreiter that the milk drinking was out of control and that they only let the residents have milk at breakfast. *Id.* If they wanted it at other times they had to buy it themselves. *Id.* Ms. Hochreiter testified that the times she was at the home, she did not see food being made available for the residents. *Id.*

[APPELLANT 3] testified that [NAME 2] had ADHD and was not allowed to have sugar. *Id.* She said they made it a rule that clients could not go into the pantry unless they asked. *Id.* [APPELLANT 3] said that they did have problems with [NAME 2] not having control and taking things out of the pantry. *Id.* Wesley Fullerton, [NAME 2]'s case manager testified that [NAME 2] was a rather slim guy and that his access to food and snacks should not be limited. *Id.* Mr. Fullerton further testified that if there was some issue with [NAME 2]'s taking food or accessing food, that should have been discussed as part of his assessment. *Id.* Gloria Morrison testified that [NAME 2] reported he could never have seconds if he was still hungry. *Id.*

[APPELLANT 1] admitted that water was offered at dinner because, "Most of the residents were on a fiber supplement and the only way I could get them to drink enough water was to serve it at dinner time". *Id.* [APPELLANT 1] also admitted that they restricted [NAME 6]'s access to milk. Id. She was questioned about that on cross examination:

> Q: You also testified that you had a written directive from [NAME 6]'s doctor about Milk?
> A: Yes
> Q: Was that part of his written assessment?
> A: Yes, it is in his negotiated care plan.
> Q: But it is not part of his current annual assessment right?
> A: No, it is not in the assessment.
> Q: Your testimony earlier was that you use these assessments to create the negotiated care plans right?
> A: Yes.

Former resident [NAME 11] corroborated the residents complaint when he testified that he could take what he wanted out of the refrigerator "if it was

his" if they were "his groceries" that he bought. *Id.* [NAME 11] also very clearly and adamantly testified that the "dry closet was off limits—you needed permission from the administrator or his [RELATIVE] to go in there". *Id.* He also clearly stated he "never went into the freezer". *Id.* He also stated he could "sometimes get food" and that "food was served at certain times". [NAME 4]'s [RELATIVE], [NAME 12], also corroborated the residents complaints testifying that she was aware of and okay with the fact that the "providers were limiting food access". *Id.* There is ample evidence in the record, corroborated by consistent and similar reports from current and former residents, as well as their family members, to support a finding that access to food was unreasonably restricted by the appellants

4. Finding of Fact 18: Finding of Fact 18 states that there was no yelling or belittling in the home. This finding is not supported by the record. During the course of the investigations regarding the incident of unreported sexual abuse, allegations of verbal abuse, resident rights violations, and quality of life violations came to light from the residents. *Id.* Roberta Crawford testified that she was concerned enough about the verbal abuse allegations to require an immediate safety plan. *Id.* That plan resulted in [APPELLANT 2] and [APPELLANT 3] being removed from all duties with the residents. *Id.*

During the hearing, Gloria Morrison testified that she made the recommendation of verbal abuse against [APPELLANT 3] based on reviewing Roberta Hochreiter's notes and based upon her own subsequent and independent interviews with [NAME 2] and [NAME 4]. Id. [NAME 2] told Ms. Morrison that [APPELLANT 3] was really nasty to everyone and to him and that he saw [APPELLANT 3] chastise [NAME 6] about his laundry and she got mad at [NAME 2] when he tried to help him with the laundry, and that she would call him a liar and she would not believe him. Id. [NAME 2] stated that this is why he would not talk to her. Id. [NAME 2] reported to Ms. Morrison that he was happy that he was no longer at the home because of [APPELLANT 3]. *Id.*

Ms. Morrison also testified that [NAME 4] reported he dropped a bottle or something like that, breaking it and [APPELLANT 3] got really angry and yelled at him and he went downstairs and she followed him continuing to yell at him, criticizing him and when he started to cry she called him a baby. *Id.* [NAME 4] said that when he talked to his [RELATIVES] on the phone he would cry and then [APPELLANT 3] would tell him he was putting on a good show for them and acting like a baby. *Id.* [NAME 4] said [APPELLANT 3] yelled at [NAME 1] and that she also treated [NAME 4] just like the down-syndrome boy. *Id.* [NAME 4] told Ms. Morrison that he never knew what [APPELLANT 3] would do and that she "scared the wits" out of him. *Id.* Ms. Morrison testified that [APPELLANT 3] admitted to her that she would tell the residents to stop crying. *Id.* Ms. Hochreiter

testified that [NAME 4] said he was afraid to tell [APPELLANT 2], [APPELLANT 1] and [APPELLANT 3] anything, including the fact that [APPELLANT 3] was keeping him up all night with her squeaky chair. *Id.* He was afraid he would get yelled at if he told them or asked them anything. *Id.* He was afraid to ask about his medications and he had been yelled at for asking in the past. *Id.* [NAME 4] reported to Ms. Hochreiter that he heard [APPELLANT 2] and [APPELLANT 3] yelling at [NAME 6] for having "poop on his bed". *Id.* This upset [NAME 4] to the point he had to put headphones on and go outside. *Id.* When [NAME 4] told Ms. Hochreiter about this incident he cried. *Id.*

[NAME 6] confirmed to Ms. Hochreiter that [APPELLANT 2] and [APPELLANT 3] "got into his face" and yelled at him about the "poop on his bed". *Id.* [NAME 6] said that [APPELLANT 3] told him that if he was "going to act like a baby she was going to treat him like a baby". *Id.* [NAME 6] said that this was upsetting to him. *Id.* Ms. Hochreiter further testified that [NAME 6] was described getting into "scuffles" with [APPELLANT 2] and [APPELLANT 3] and that he was afraid of [APPELLANT 2] because he would get very upset and not be able to calm down and that further that [APPELLANT 3] would remind them that they were living in the [APPELLANT 1 & 2]'s home and then [APPELLANT 2] was always right and would never back down and that, the he did not have a voice, he wanted to move out so he could be his own man and be himself. *Id.*

[APPELLANT 1] addressed this incident in her IDR notes, Ex. 14:

> The incident referred to as a "scuffle" by [NAME 6] began with him leaving feces smeared on his bed. [...] At first [NAME 6] was angry and verbally abusive to staff. This was a very animated discussion.

Id. The version in her IDR letter, Ex. 12, is slightly different:

> [NAME 6] is a resident with spina bifida. He is incontinent and wears adult diapers. However, he also messes his bed on occasion. He got [NAME 2] to clean it up, and to do his laundry. We told [NAME 6] that he could not get others to clean his feces, and he was angry about it. He is able to clean it up on his own. This is a significant health and hygiene issue, and my [RELATIVE] was emphatic about it. This discussion was animated, and my [RELATIVE] is a big man, hard of hearing, and speaks loudly.

Id. [APPELLANT 1] was asked about this event during the hearing:

Q: Moving on to the second page of Exhibit 14, at the bottom of the first page, you say there was an animated discussion and [NAME 6] was angry and verbally abusive to staff. Were you present?
A: Yes.
Q: In what way was [NAME 6] angry and verbally abusive to staff?
A: He was yelling and he was using foul language and yelling at staff.
Q: What did you mean by this was a very animated discussion?
A: Because of his behavior.
Q: [NAME 6]'s behavior?
A: Yes.
Q: What about [APPELLANT 3]'s behavior?
A: Hers was ... she did very well dealing with him . . . she said they were just having a discussion about this.
Q: Was [APPELLANT 2] present for that animated discussion?
A: No.
Q: Was [APPELLANT 3] animated?
A: No.
Q: Were you animated?
A: No.
Q: Was [NAME 6] animated?
A: Yes.

Id. In her letter to the IDR, [APPELLANT 1] admits that [APPELLANT 2] was present and involved in this "scuffle" or event, however, at the hearing she testifies that [APPELLANT 2] was not even there during that event. *Id.* On direct examination, [APPELLANT 1] testifies that the first time she ever heard about allegations of yelling and ridiculing of the residents was not until she read the SOD and up until that time she never heard that there were these allegations. *Id.* On cross examination she was asked if that could actually be correct, and she changes her testimony:

Q: You testified that the first you heard about a verbal abuse allegation was when the SOD came out on May 7th, is that correct?
A: The verbal abuse? No.
Q: When was the first time you heard about verbal abuse?
A: When Ms. Crawford called me and told me that I needed to report it, that it had been reported to her, I believe that was on April 30th.
Q: Are you changing your testimony then? Earlier you said that the first you heard about the verbal abuse was on May 7th when the SOD came out.

A: The verbal abuse? No, because I said . . . no I didn't say that, because Roberta Crawford said I had to call it into the CRU that was on the 30th of April and write the letter relieving my staff.

Q: Did you call the CRU?

A: I did.

Q: On what day?

A: That same day, the 30th I believe.

Q: What did you report to the CRU?

A: that Ms. Crawford told me to call in and report verbal abuse.

Q: Did you report sexual abuse to the CRU?

A: yes

Q: On what day?

A: I believe it was the same day.

Q: Was it at the same time as the verbal abuse phone call or a separate phone call?

A: I believe it was separate.

[APPELLANT 1] testified that she did not hear [APPELLANT 2] tell [NAME 2] that he found a home for [NAME 2] full of criminals. *Id.* [APPELLANT 1] claims that they were helping another friend move out of that type of situation and that [NAME 2] was there during that discussion. *Id.* [APPELLANT 1] did testify that [APPELLANT 2] told [NAME 2] he had better be careful where he was going to move because he could end up in a situation like their friend was in. *Id.* [APPELLANT 2] admitted during the hearing that [NAME 2] was excluded from activities, "He would be rude to "[NAME 1]", he was not nice, so sometimes there was a reason to exclude [NAME 2]." *Id.*

The appellants' versions of the facts which gave rise to the finding of verbal abuse were inconsistent and not credible. In contrast, residents [NAME 6], [NAME 4], and [NAME 2] all consistently related similar corroborated reports to both investigators Ms. Hochreiter and Ms. Morrison on separate occasions.

5. Finding of Fact 22: Finding of Fact 22 states that "there was no history of significant, repeated or uncorrected deficiencies" at the adult family home. This finding of fact completely ignores the essence of the licensing action in this case.

The Department was so concerned with the lack of mandatory reporting and the violation of the licensing requirements in this case, the Department summarily suspended the adult family home license so that residents had to be removed from the home immediately. At the time of the licensing action, the licensee had failed to report suspected sexual abuse for more than *two months.* Residents were also suffering from

verbal abuse and resident rights violations. *Testimony of Roberta Crawford.* Furthermore, [APPELLANT 2], [APPELLANT 1], and [APPELLANT 3] all admitted to the mental health professionals at [BUSINESS 2], or during the hearing, that there had been *previous* instances where [NAME 2]'s sexualized behavior had concerned them but they had not reported anything. *See Testimony of [NAME 7], [APPELLANT 3], [APPELLANT 1], and [APPELLANT 2].*

6. Finding of Fact 25: Finding of Fact 25 states that [NAME 2] "gave a much more elaborate description of the incident than he had given earlier" when he was interviewed by Gloria Morrison for the RCPP investigation. Any suggestion that a more elaborate statement from [NAME 2] is inaccurate is not supported by the record and erroneous.

Ms. Hochreiter testified that she interviewed [NAME 2] during the licensing investigation. *See Testimony of Roberta Hochreiter.* [NAME 2] told Ms. Hochreiter that he was not the "instigator" and that [NAME 1] was the one that did "lap dances" on him. [NAME 2] said that he tried to tell [APPELLANT 1] and [APPELLANT 2] about it but that nobody would listen to him. *Id.* [NAME 2] reported to Ms. Hochreiter that [APPELLANT 2] told him "what he did was criminal", and that he felt like [APPELLANT 2] and [APPELLANT 1] were blaming him for everything that happened. *Id.* [NAME 2] felt like [APPELLANT 2], [APPELLANT 1], and [APPELLANT 3] were all treating him badly and [NAME 1] continued to come downstairs after the incident. *Id.* Ms. Hochreiter also interviewed [NAME 2]'s [RELATIVE], [NAME 8] who said that [NAME 2] told him he did not initiate the sexual incident and that [APPELLANT 2] and [APPELLANT 1] would not believe him. *Id.* [NAME 2]'s previous reports are corroborated later by what he told Ms. Morrison during her separate and independent investigation. This rendition of what happened is consistent with what [NAME 2] told Ms. Morrison: [NAME 1] had been the instigator of the incident in February and [NAME 1] had pulled him down on the ground and started humping on him and wouldn't let him up for some time. Initial Order, FF 22.

If anything, the record supports that this finding should be supplemented to reflect that [NAME 2] no longer was living at the AFH when Gloria Morrison was interviewing him, and, to the extent there was any elaboration, that was a specific product of follow-up questions that Gloria Morrison asked him. *Testimony of Gloria Morrison.*

7. Conclusion of Law 7: Conclusion of Law 7 contains two factual assumptions that conflict with other findings of fact. The first incorrect assumption is that [NAME 1] is a child. As described in Finding of Fact 1, and the correction to Finding of Fact 3 above, [NAME 1] is not a child. He

is a developmentally disabled individual who was at least [AGE] years old on February 23, 2009.

The second incorrect assumption in Conclusion of Law 7 is that there was no evidence presented regarding consent. Even as currently written, Finding of Fact 8 states "a question was raised by the Appellants themselves as to whether [NAME 1] was capable of consenting to any sexual contact." This finding of fact clearly indicates consent was an issue at the hearing. As stated above, the Department's position is that the appellants did more than "question" [NAME 1]'s ability to consent, they unequivocally told Department staff that [NAME 1] could not consent. Furthermore, there was testimony from several witnesses that [NAME 2] did not indicate that he consented to sexual contact with [NAME 1]. Rather, [NAME 2] characterized [NAME 1] as the aggressor and instigator of the sexual contact. *Testimony of Gloria Morrison and Robbie Hochreiter.*

8. Conclusion of Law 8: Conclusion of Law 8 states that there was no evidence presented at hearing that other residents in the home were in any real danger because the other residents were older than [NAME 2]. This factual assumption is inaccurate, shortsighted, and not supported by the record.

Regardless of whether the current residents were experiencing problems with the sexualized behaviors at the home, at any time, a new resident could be admitted to the home that does not meet the resident profile that the ALJ considered to be "safe." [8] Also, the record supports a finding that the sexualized behavior in the home was causing problems for other residents, not just [NAME 1] and [NAME 2]. When [APPELLANT 1] issued a discharge notice to [NAME 2] after April 14, 2009, that notice stated: "We have found that [NAME 2] is unable to control his impulses, and has action out issues with other clients in a manner that affects the safety and heal of individuals within our home." *Ex. Dept.* 4. The discharge notice is an admission on the part of [APPELLANT 1] that she had reason to believe other residents were at risk.

Furthermore, [NAME 7] also testified that reading the intake report which incorporated statements from [APPELLANT 3] including: "[NAME 2] is humping him", [NAME 7] had reason to believe sexual inappropriate touching had occurred. *Id. See also,* Ex. Dept. 22, p. 4. Also, after speaking with [APPELLANT 1] on April 14, 2009, [NAME 7] informed [APPELLANT 1] that [NAME 2] would have to be removed from the home to ensure the safety of the *other members of the home,* and that process would be triggered after [NAME 7] made her mandatory report. *Id.*

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[8] There is no evidence on the record that there was an evaluation of either [NAME 1] or [NAME 2] about what type of individuals they would be sexually "safe" around

There is also testimony on the record that other residents of the adult family home viewed the sexualized behaviors as problematic. [NAME 4] was interviewed by Ms. Hochreiter. *Id.* Ms. Hochreiter testified that [NAME 4] admitted that he had told [APPELLANT 3] that "something inappropriate" was going on down in the basement. *Id.* He reported that [NAME 1] could be "sexually inappropriate", and [NAME 1] would come downstairs wearing boxer shorts and was always touching himself and adjusting himself. *Id.* [NAME 4] said that [NAME 1] would sit in a manner that would make him "see things he did not want to see". *Id.*

Ms. Hochreiter clarified that both of the words "sexually inappropriate" were the exact words used by [NAME 4]. *Id.* [NAME 4]'s [RELATIVE], [NAME 12], testified at the hearing. *See Testimony of [NAME 12].* She stated that [NAME 4] was "truthful" and was an accurate reporter of sexual abuse. *Id.* She also testified, "[NAME 4] knows the difference between appropriate and inappropriate touching." *Id.* [NAME 12] also testified that "[NAME 1] had a habit of touching his private parts", "like when he was dancing". *Id.* Ms. Hochreiter also testified that [NAME 6], another resident, also told her that he had seen [NAME 1] do a "lap dance" on [NAME 2]. *Id.*

V. ADDITIONAL FINDINGS OF FACT

The record supports the following additional findings of fact:

1) [APPELLANT 1] was providing in-home care services to her [RELATIVE], [NAME 1]. [NAME 1] received these services based on his disability. *Testimony of [APPELLANT 1].*

2) There was a delay of a month and a half between the incident on February 23, 2009 and when [NAME 2] was taken to the mental health provider on April 14, 2009, which finally triggered the mandatory report of sexual abuse to the proper channels. *See* Initial Decision, FF 10, 11, and 12.

3) There was a delay of over two months before [APPELLANT 1] reported nonconsensual sexual touching to the proper authorities and she only did so at the direction of the Department. Initial Decision, FF 11and 20.

4) The record at hearing supports the finding of fact that [APPELLANT 2], a mandatory reporter, never called the hotline to report suspected sexual abuse.

5) The record at hearing supports the finding of fact [APPELLANT 3], a mandatory reporter, never called the hotline to report suspected sexual abuse.

6) The appellants failed to protect the adult family residents from sexual abuse. [APPELLANT 1] and [APPELLANT 2] told the adult

family home complaint investigator that they protected [NAME 1] by keeping him upstairs when [NAME 2] was in the house. *Testimony of Robbie Hochreiter.* It is uncontested that the appellants took no actions to protect the other residents in the home. There was also mixed testimony regarding whether [NAME 1] and [NAME 2] were kept apart after the incident. At times, the appellant's stated that [NAME 1] and [NAME 2] were kept apart. Other times, the appellants claimed that [NAME 1] was not barred from going downstairs, he was simply encouraged to stay upstairs to keep from being teased. *See Testimony of [APPELLANT 2].*

VI. INCORRECT CONCLUSIONS OF LAW

The ALJ made errors in the following conclusions of law: Conclusions of Law 7, 8, 9, 10, 11, 15, and 17. These conclusions were premised upon a misapplication of the law to the facts, or based on facts that are not supported by the record, as identified above and below.

VII. THE RECORD SUPPORTS THE DEPARTMENT'S ACTIONS IN THIS CASE

Individuals who reside in adult family homes are often totally dependent upon the adult family home. The extreme vulnerability of adult family home residents has led to the development of requirements that are designed to protect and promote the physical, mental, and emotional well-being of residents. The provider was cited for multiple violations of adult family home licensing requirements as well as having findings of neglect and abuse made against all of the caregivers in the home.

The hearing record in this case is unnecessarily complicated, in large part, because the appellants continued to change their story of what happened in the adult family home throughout the hearing process. Throughout the licensing investigation, the informal dispute resolution process, the RCPP investigation, and the hearing process, their stories evolved and even flatly contradicted earlier statements and they contradicted one another. The variation in the appellant's testimony was acknowledged by the administrative law judge when he made a credibility determination that supported the Department's witnesses because, with ample opportunity to hear the testimony of the witnesses presented by both sides, he determined the evidence supported a finding that the statements attributed to the Appellants by Department witnesses were made and were accurately documented. Initial Decision, FF 7.

Based on this determination, the ALJ's findings of fact support that: In the original adult family home complaint investigation, [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3] admitted that they knew there was inappropriate, non consensual sexual contact between an adult family

home resident and their developmentally disabled adult [RELATIVE], for whom they also provide care for in the home. Once they knew about the sexual contact, they failed to report it to the proper authorities, and did not take any steps to protect the other residents in the home from the risk of sexual abuse. Furthermore, they attempted to enroll the resident involved into a therapy program for inappropriate sexual behaviors, even though there is some question as to who was actually the aggressor in the "incident."

[APPELLANT 1], [APPELLANT 2] and [APPELLANT 3] interacted with several professionals prior to the licensing complaint investigation, including a police officer, mental health therapists, and a Department case worker. During their interactions with these professionals, the appellant's stories stayed fairly consistent: There was inappropriate, non consensual sexual contact between [NAME 1] and [NAME 2], they had not reported this contact to the proper authorities, they did not protect the other residents, and they sought mental health counseling for the resident [NAME 2], but not for their [RELATIVE]. Once the adult family home license was revoked, the appellants' stories started to drastically change so that they suddenly had no idea why everyone thought there was a sexual incident in the adult family home. They each testified at hearing that they had no idea the underlying allegations prompting the Department investigations and the police investigations involved possible sexual abuse. This evolving story is unbelievable and was not believed by the ALJ.

The ALJ's credibility determination supporting the Department's witnesses, as well as issuing findings of fact that support the basic premise of the Department's case, makes the ultimate decision in this case, that all the Department's actions were overturned, perplexing. The information that [APPELLANT 1], [APPELLANT 2] and [APPELLANT 3] admitted in the course of the adult family home licensing investigation amply supports the Department's positions in this case. Furthermore, the ALJ's own findings of fact, with the correction of the erroneous findings of fact cited to above, require a reversal of the initial order in this case.

A. The Adult Family Home Licensing Action

1. [APPELLANT 1] Lacks The Understanding Necessary To Operate An Adult Family Home

[APPELLANT 1]'s violated WAC 388-76-10020, which requires that an adult family home provider must have the understanding suited to meet the personal and special care needs of vulnerable adults. The provider demonstrated this lack of understanding when she failed to understand

the need to report sexual abuse to the department and also did not protect her residents from verbal abuse. *Ex.* 8, pp. 3-4.

At the time of the licensing investigation, the provider admitted that she had knowledge of an incident of unwanted sexual contact between [NAME 2] and her [RELATIVE], [NAME 1]. *Testimony of Robbie Hochreiter.* Furthermore, both her [RELATIVE] and her caregiver knew about the sexual contact, and they did not report it either. *Id.* The provider and [APPELLANT 2] also told the adult family home complaint investigator that they protected [NAME 1] by keeping him upstairs when [NAME 2] was in the house. *Id.* No one took actions to protect the other residents in the home from [NAME 2], or from [NAME 1] for that matter.[9] Instead, [APPELLANT 1] contacted a mental health clinic to get [NAME 2] into counseling, with an appointment more than one month after the incident.

The residents were also subjected to verbal abuse on several occasions, including when they were called a "baby" by one staff, insulted about being incontinent, and intimidated by "scuffles" with the provider's [RELATIVE]. These statements are supported by the consistent and corroborated reporting by the residents involved to more than one investigator and on separate occasions, as well as collaterally supporting information from the appellants and the other witnesses at hearing.

The provider's inability to appropriately deal with these incidents of sexual and mental abuse demonstrate that she does not possess the understanding to operate an adult family home.

2. The Adult Family Home Did Not Prevent Mental Abuse At The Home

WAC 388-76-1000 defines "Mental abuse" as "a willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriate isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." WAC 388-76-1000. The provider is required to ensure that abuse does not occur in her home. WAC 388-76-10670. *Ex. 8, pp. 5-7.*

The appellant admitted during the hearing that the home isolated [NAME 2]. [APPELLANT 1] admitted during the hearing that [NAME 2] was excluded from activities, "He would be rude to [NAME 1], he was

[9] There was mixed testimony regarding whether [NAME 1] and [NAME 2] were kept apart after the incident. However, the provider and her staff have consistently stated that neither [NAME 2] nor [NAME 1] were kept separate from the other residents of the home. In fact, [APPELLANT 2] told Ms. Hochreiter that the other residents didn't need protection because they were not [NAME 2]'s type. They are older and "wouldn't put up with that." *Testimony of Robbie Hochreiter.*

not nice, so sometimes there was a reason to exclude [NAME 2].” Testimony of [APPELLANT 1].

Additionally, [NAME 4], [NAME 6], and [NAME 2] all reported similar verbal confrontations or belittling behavior by either [APPELLANT 2] or [APPELLANT 3]. These complaints were consistently reported to both the adult family home complaint investigator and the RCPP investigator. As the adult family home provider, [APPELLANT 1] had a responsibility to protect her residents and prevent these types of interactions between residents and staff. Her failure to do so constitutes a violation of the minimum licensing requirements.

3. The Provider Failed To Report Abuse

WAC 388-76-10673(2)(a) requires that providers must report suspected abuse, neglect or exploitation to the toll free phone number provided by the Department. The provider failed in meeting this requirement because she did not report sexual abuse to the appropriate authorities when she became aware that it occurred. Furthermore, even after a mental health provider and Department staff told her to report the abuse, and a police officer had been to her house investigating sexual assault, she still did not report the abuse. Even after the Department’s Field Manager requested that she call in a complaint, the provider did not report the abuse in a timely manner.

At the time of the adult family home complaint investigation, [APPELLANT 1] admitted that she did not report sexual contact between [NAME 2] and her [RELATIVE] as soon as she knew about it. Instead, she reported that she enrolled the adult family home resident in counseling, but did not report it. Both of her staff were also aware of the incident and did not report it, even though they knew that there had been a sexual incident on the day that it occurred, and also knew that the resident was attending counseling because of it. *Testimony of Robbie Hochreiter, Ex. 8, pg. 7.*

Even after three separate investigations, one by licensing, one by the police, one by RCPP, her own participation in IDR where she made a number of admissions, and then after listening to multiple days of testimony at the hearing, [APPELLANT 1] steadfastly refused to believe she had any reason to report anything at all, and she absolutely and adamantly refused to admit that there was even a *possibility* that sexual abuse could have happened. During the hearing, [APPELLANT 1] was questioned on cross examination about her IDR letter, Exhibit 12, page 1, where she wrote:

> Q: “We became aware that [NAME 2] most likely rubbed himself including his private parts on our [RELATIVE]

[NAME 1] as if they were dancing or goofing around" your testimony earlier was that you took that information from the SOD, is that correct?

A: That is correct.

Q: Isn't it true that the SOD doesn't say anything about them dancing or goofing around?

A: No, it doesn't say that.

Q: So, where does the dancing or goofing around come from if you took that information from the SOD?

A: It came from me.

Q: How did you know they were dancing or goofing around.

A: It was reported that music was playing and that is what they did.

Q: So it is possible that [NAME 2] did "most likely rub himself on your [RELATIVE] [NAME 1]" while they were dancing, or goofing around? Is that true?

A: No.

Q: Why is that not true?

A: Nothing was reported like that.

Q: So, if it wasn't reported, it didn't happen?

A: I had no reason to believe that anything happened.

Q: But is it possible that [NAME 2] rubbed himself on your [RELATIVE] [NAME 1] while they were dancing or goofing around downstairs?

A: I can't answer that.

Q: Why not?

A: because I don't think it is possible.

Q: Why don't you think it is possible?

A: I never seen any indication of that, we were right there in the house the house is very open.

Q: Can you see downstairs where the guys listen to music when you are upstairs?

A: No, if you go down a few steps you can.

Q: Are you with the guys 24 hours a day 7 days a week?

A: Pretty much, unless there are appointments, I am there at the house.

Q: On February 23, 2009, is it your understanding that one of your staff was downstairs with the guys the entire day?

A: No.

Id. This position of [APPELLANT 1] is insupportable by the evidence and is of grave concern to the Department.

[APPELLANT 1] and her staff failed to report suspected abuse. This failure is a violation of the minimum licensing requirements.

4. The Provider Did Not Protect Resident Rights

The provider failed to allow residents to make choices about food and drink. This is a violation of WAC 388-76-10620 which requires:

> (2) Within reasonable home rules designed to protect the rights and quality of life of residents, the home must ensure the resident's right to:
>
> (a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and negotiated care plan;
>
> (c) Make choices about aspects of his or her life in the home that are significant to the resident;

As described in the fact section above, in addition to verbal abuse, the residents complained about access to food and food choices. These complaints were consistent. Other witnesses corroborated the resident's complaints. For example, former resident [NAME 11] testified that he could take what he wanted out of the refrigerator "if it was his" and if they were "his groceries" that he bought. *Id.* [NAME 11] also testified that the "dry closet was off limits—you needed permission from the administrator or his [RELATIVE] to go in there". *Id.* He also clearly stated he "never went into the freezer". *Id.*

[NAME 4]'s [RELATIVE], [NAME 12], also corroborated the residents complaints testifying that she was aware of and okay with the fact that the "providers were limiting food access". *Testimony of [NAME 12].* Furthermore, admissions from the provider, and her staff, at the time of the complaint investigation supported that there were limitations on both sugar and milk. There was no evidence provided that these limitations were officially sanctioned, part of any negotiated care plan, supported by any doctor's orders, or necessary and the resident's care assessments do not justify and such restrictions.

5. Upholding Every Citation Is Not Necessary In Order To Uphold The Department's Decision To Revoke The Appellant's License.

A Decision-maker need not affirm all citations in the statement of deficiencies in order to uphold the Department's decision to revoke the Appellant's license. This position is supported through statute, rule, case law and policy.

DSHS licenses and regulates adult family homes under chapter 70.128 RCW, the rules adopted under chapter 388-76 WAC, and related statutes and regulations. The Department is authorized to suspend or revoke a license when an adult family home provider has failed or refused to comply with minimum licensing requirements. RCW 70.128.160(1)(a),(2)(d); WAC 388-76-10940(4)-(5), WAC 388-76-10960(14)(b), (16). DSHS may suspend admissions to the adult family home by imposing stop placement. RCW 70.128.160(2)(e).

When a provider is cited for failing or refusing to comply with minimum licensing requirements, the Department may impose a licensing remedy. WAC 388-76-1040. A remedy must be imposed when the violations pose a serious risk, or are recurring or uncorrected. WAC 388-76-10945. These standards do not require DSHS to prove actual harm in order to impose any of the remedies available. The Department is expressly allowed to consider the severity of the potential harm and which remedy is likely to improve resident outcomes. The purpose of the adult family home regulations is to require that providers meet certain minimum licensing requirements to ensure that vulnerable adults have their care needs met. *Williams-Batchelder v. Quasim,* 103 Wn. App. 8, 16, 19 P.3d 421, 425 (2000). In balancing the needs of vulnerable adults and the interests of even well-meaning caregivers, DSHS must give priority to the safety of the residents. RCW 70.128.005; *Bond v. Dep't of Soc. & Health Servs.,* 111 Wn. App. 566, 575, 45 P.3d 1087, 1092 (2002). In doing this balancing test, and in looking at what other options the department had for remedies, the Department decided that the appropriate remedy was revocation. *Testimony of Roberta Crawford.*

B. Resident Client Protection Program Findings

A finding of either neglect or abuse prohibits an individual from being employed in a capacity that would allow him or her to have unsupervised access to vulnerable adults. RCW 74.39A.050(8). Authority for findings of abuse or neglect against the [APPELLANT 1 & 2] and [APPELLANT 3] is Chapter 74.34 RCW, the statute that deals with the protection of vulnerable adults.[10] The investigations of the adult family home and the individual are distinct, and the focus is different.

Any individual who has access to a long-term care facility is eligible for a finding of abuse, neglect, exploitation, or financial exploitation to be made against them, regardless of whether the individual is a licensed provider. WAC 388-76-11000 - 11040. In an adult family home, this includes the ability to make findings against a provider, an employee of the adult family

[10] Authority for an adult family home licensing action is Chapter 70.128 RCW, the adult family home licensing statute.

home, an entity representative, anyone affiliated with a provider, and a caregiver. WAC 388-76-11000. The ability to make these types of findings against an adult family home provider makes sense because adult family home providers, including [APPELLANT 1], serve multiple roles when working in an adult family home. One role is that of a licensee, where there is an obligation to meet the minimum standards for being licensed as an adult family home. The other role is as a person with access to vulnerable adults. It is in this second role that the Department makes a finding of neglect in this case against [APPELLANT 1], [APPELLANT 2], and [APPELLANT 3] and a finding of abuse against [APPELLANT 3].

1. [APPELLANT 1], [APPELLANT 2] and [APPELLANT 3]'s Actions Constitute Neglect

RCW 74.34.020(11) defines "neglect" as:

> "Neglect" means (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 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.

In this case, when the appellants failed to report sexual contact to the proper authorities, and did not take any steps to protect the other residents in the home, they failed to provide services that maintain the physical and mental health of the vulnerable adults in their care. Failing to report sexual behaviors means that those behaviors cannot be properly handled with appropriate supervision or intervention, and investigated. Furthermore, failing to take any measure to protect the other residents in the adult family home from sexual abuse, is an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to a vulnerable adult's health, welfare, or safety. On multiple levels, the [APPELLANT 1], [APPELLANT 2] and [APPELLANT 3] conduct is neglect.

2. [APPELLANT 3]'s Actions Constitute Abuse

The term "abuse" is defined in RCW 74.34.020(2) as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult." Abuse includes sexual abuse, mental

abuse, physical abuse, and exploitation of a vulnerable adult. RCW 74.34.020(2); *see also* WAC 388-76-10000. "Mental abuse" is "a willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriate isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." WAC 388-76-10000.

In this case, residents consistently reported that [APPELLANT 3] yelled at them. Yelling is, by definition, mental abuse. One resident also reported that she belittled him by saying she was going to treat him like a baby if he did not change his behavior. These belittling comments are ridiculing and intimidating which is also, by definition, mental abuse. [APPELLANT 3] actions with the residents are mental abuse and, as such, a finding is appropriate.

VIII. CONCLUSION

The ALJ should have upheld the Department's revocation of the provider's adult family home license and the findings of neglect and abuse against the appellants. The record supports the Department's action in this case.

5. The Appellants filed a response to the Petition for Review on April 13, 2011, and argued as follows:

A. INTRODUCTION

The issue of failure to report known or suspected sexual behavior has dominated this case. The other allegations tend to stand or fall depending on that issue. Virtually the entire case centers around what the Initial Decision calls an "alleged incident". FF 4 Though the ALJ's credibility ruling caused him to use almost exclusively the testimony of the State's witnesses on the "alleged incident" and what followed, FF 7, the ALJ nevertheless concluded the state had not met its burden of proving the Appellants were aware of and did not report non-consensual sexual contact between household members.[11] CL 7 The ALJ also found the Appellants had not abused or neglected the vulnerable adult residents and the ALJ reversed all findings and actions of the Department. Thus, though the Appellants strongly disagree with the ALJ's findings about them and the issue of sexual contact in their Adult Family Home, they are in agreement with the ALJ's Decision that resulted.

However, the Appellants believe the response to the State's petition is best addressed by making their case that there was no sexual contact in

[11] The ALJ's favoring the state's testimony over that of the Appellants was rather like a summary judgment or a dismissal at the close of the plaintiff's case.

their home - even consensual. In making that case there are several critical points. One is the fact that all testimony can be traced back to the use of one word in the AFH, the word “hump”. The second is the eager willingness of counselor [NAME 7] to imagine sexual abuse had occurred. The third is the existence of willing accomplices to [NAME 7] in confirming her imagination.[12] Fourth is the inartful IDR letter written by [APPELLANT 1] on May 12, 2009, Exhibit 12. Fifth is the testimony of [NAME 6] refuting the statements that the investigator misquoted him as saying. Exhibit E Sixth is the statement of [NAME 4]'s [RELATIVE] that he was misquoted or misunderstood and that he did not witness sexual behavior at [ADULT FAMILY HOME 1]. Exhibit H Seventh is the acknowledgment of Roberta Hochreiter that it was necessary for her to define slang language in order to convey its meaning. And finally there is the character of [APPELLANT 1] herself, for whom breaking the rules was inconsistent with not only her past actions in working with disabled people, but was inconsistent with the manner in which she acted during the investigation itself.

In addressing these points, Appellants do not intend to address every Finding of Fact with which they take issue for the simple reason there are so many, which would be costly and time-consuming. Moreover, most if not all of the Findings objected to, flow directly from the ALJ’s rather draconian credibility Finding, FF 7. However, the Findings objected to are laid out in chart form in Attachment A, with some comments on the side. Because the Department’s and the Appellants’ positions are so clearly opposed to each other, answering the points in the preceding paragraph will meet both the credibility Finding and the other resulting Findings.

In addition, also attached as attachments are excerpted transcripts of primarily the cross-examinations of the following state witnesses: [DETECTIVE 1], **Attachment C**; [NAME 7], **Attachment D**; Roberta Hochreiter, **Attachment E**; Wesley Fullerton, **Attachment F**; and Gloria Morrison, **Attachment G**.[13]

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[12] In fact, the Department was so intent on its objective of shutting down [ADULT FAMILY HOME 1] they were willing to emotionally abuse the residents by an extremely stressful an unprepared for mass removal of the residents from the home that can best be described as jerking them out. The ALJ heard some testimony on the extreme trauma visited on the residents in their removal, but he refused to admit Appellants’ proposed Exhibits A and B. Appellants believe they are relevant to show the lengths the Department workers went to accomplish their biased objectives. In fact, RCPP investigator Gloria Morrison - in disregard of [NAME 4]’s family, proposed Exhibit A, Exhibit H, and his mental health therapist’s explicit request, proposed Exhibit B - interviewed him anyway. As a result, [NAME 4]’s behaviors decompensated and he ended up in [FACILITY 1]. Though the review process is one where the Department tends to uphold Department actions, granting the Department’s petition in this case will serve to reward investigators who should instead be punished for the harm they did to the [ADULT FAMILY HOME 1] residents they were purportedly helping.

[13] The transcript excerpts were transcribed for the undersigned by the Appellants, and he has found them to be very accurate. Transcribing is a difficult task and it is easy to miss minor words or punctuation. However, the location of each testimony excerpt on the CD’s of the various hearing dates are clearly marked in the transcripts and it is an easy thing to check the accuracy against the audio itself.

1. Theories of the Case

a. ALJ Initial Decision

The ALJ decision determined that there was a conflict of evidence presented.

> There is a clear conflict in the evidence presented at hearing as to what [APPELLANT 2] and [APPELLANT 3] were told by [NAME 4], [NAME 2], and [NAME 1] as to what had happened that day. At the hearing, [APPELLANT 2] and [APPELLANT 3] testified that after talking to [NAME 2], [NAME 1], and [NAME 4], they concluded that nothing significant appeared to have happened between [NAME 2] and [NAME 1], at least nothing more than the type of disagreements that they often had. This contrasts with earlier statements made by the Appellants to others, including [BUSINESS 2] employees [NAME 9] and [NAME 7], Department investigators Robbie Hockreiter (sic), Roberta Crawford, and Gloria Morrison, and [COUNTY 1] police detective [DETECTIVE 1]. It also is inconsistent with statements made by [APPELLANT 1][14] in a letter to the Department as part of the Informal Dispute Resolution (IDR) process in June 2009, which took place after the home had been closed. Exhibit Dept-12. In their testimony at the hearing, Appellants denied making any statements showing that they were aware that something of a sexual nature had occurred and maintained that the statements attributed to them by others were either never made or were gross distortions of what they had said.

FF 6.[15] He stated he would accept the state's version of events and rely on the state's witnesses as to what had been said to them by the Appellants.

> Credibility of Witnesses. During the course of the hearing, I had ample opportunity to hear the testimony of the witnesses

[14] At the beginning of the hearing, [APPELLANT 1] indicated through counsel that she preferred to be referred to as [APPELLANT 1]. While it might be expected the state would not wish to accommodate [APPELLANT 1]'s wish, it is unclear why she is referred to as [APPELLANT 1] throughout the Initial Order.

[15] The Appellant's here quote the actual language of the Order, identifying it clearly as such by formatting. To avoid waste of time, the reviewing officer can completely disregard pages 5B11 of the State's Petition for Review because, though they leave out some words not supportive of their claim and make some style changes to the language of the order, they repeat findings 5, 8, 10 - 17, 19 - 21, and 23 - 26 almost verbatim, yet without quotation.

presented by both sides and to assess their credibility. As part of that assessment I considered a number of exhibits admitted into the record which included contemporaneous records of statements made and the later investigative reports from the Department and law enforcement. Based upon the totality of the evidence, I have determined that the evidence supports a finding that the statements attributed to the Appellants by Department witnesses were made and were accurately documented. The following findings are primarily based the statements made by the Appellants to the Department witnesses.

FF 7. However, the ALJ found no evidence (or no sufficient evidence) of the lack of consent:

> Nor is it at all clear that the incident was one involving sexual abuse, since sexual abuse as defined requires the sexual contact be nonconsensual. WAC 388-76-10000. There was almost no evidence presented on the issue of consent. [NAME 2] did allege that [NAME 1] was the aggressor and that he had forced him to the ground, but that version of events was never corroborated by [NAME 4] or anyone else and is suspect given that it was only made months after the incident had occurred.

CL 7. Appellants do agree with the State as to Conclusion of Law 7 insofar as it incorrectly relies on the erroneous finding that [NAME 1] was a minor. FF 1 shows clearly that [NAME 1] would have been [AGE] in June, 2009, though FF 3 incorrectly states it as [AGE]. Nevertheless, the remainder of CL 7 is accurate as quoted above.[16]

As to the ALJ's findings on yelling and withholding of food from the residents, the Appellants believe the ALJ accurately found FF 17 and 18, as well as CL 9, 10 and 15 - 17 (and any other references to those parts of the Initial Decision other that those regarding the allegations surrounding sexual conduct).

b. Department:

The department's theory of the case is that [APPELLANT 1] and [APPELLANT 2] and [APPELLANT 3] were aware of and condoned sexual

[16] But because Appellants believe the ALJ overlooked significant points in the record and took only the testimony of the State's witnesses, Appellants believe the erroneous conclusion of [NAME 1]'s age is supportive of their position that the Reviewing Officer should review the entire record - including the supporting statements of others submitted by the Appellants for not only evidence of the Appellants' consistency and credibility but for evidence of the State's witnesses' inconsistency, bias and inaccuracy.

activity in the home. The department's position is stated as follows: [APPELLANT 1 & 2] were aware of and condoned unwanted sexual contact by [NAME 2] against their adult [RELATIVE], [NAME 1], who has Down Syndrome and resides with the [APPELLANT 1 & 2] in the home. The three appellants were also oblivious to the fact that unwanted sexual contact was a violation of the WAC's.[17] [APPELLANT 3] told [BUSINESS 2] at [NAME 2]'s intake -- in [NAME 2]'s presence -- that "[NAME 2] manipulated another person into sexual unsavory things - he is 'humping' him . . ."[18] The department's theory then must be that after the state investigated and wrote the report outlining the appellants' deficiencies, the appellants colluded together and came up with a plan to lie to the ALJ. They would claim that it was all a misunderstanding. They would claim that instead of telling [BUSINESS 2] and the investigators that [NAME 2] was "dry humping" [NAME 1], they would concoct the story that they used the term "the hump" from a dance that was similar to [NAME 1]'s gyrations in doing Elvis impersonations. Even though they were not smart enough to know how to lie to [BUSINESS 2] and the investigators in the first place, they thought they would be able to pull one over on the ALJ. The Department's theory must also include the idea that the appellants -- who had done so well with their residents, who had expressed and exhibited such concern for them individually,[19] and who had the loyal support of those family members of the residents who actively participated in the residents' lives -- would have no problem violating the WAC's when it came to disregarding the safety of their own [RELATIVE].

c. Appellants:

i. The theory.

Appellants' theory of the case is that a very minor incident which occurred at [ADULT FAMILY HOME 1] was misunderstood as sexual by mental health workers who then manifested confirmation bias, took words innocently said, and reported them as indicative of unreported sexual

[17] Logically, the state could also claim the [APPELLANT 1 & 2] and [APPELLANT 3] knowingly allowed such conduct which was a violation of the WAC's. However, the state would have to also believe the appellants knew they were doing wrong and yet spoke freely and without hesitation to the state investigators about the wrong. Such a position would be highly unlikely on its face; it would certainly be unlikely in light of the appellants' obvious desire to continue running an adult family home, not to mention the [APPELLANT 1 & 2]'s [RELATIVE] concern for the welfare of their disabled adult [RELATIVE], [NAME 1].

[18] See discussion, infra, regarding the implications of the presence of [NAME 2] while [APPELLANT 3], according to the hearsay of Exhibit 20, purportedly told [NAME 9] he was sexually abusive.

[19] *See*, testimony of [NAME 13] who drove the two hours to testify in person because of how much the [APPELLANT 1 & 2] had done for his [RELATIVE]; testimony of [NAME 12], whose [RELATIVE] [NAME 4] had done so well at [ADULT FAMILY HOME 1] and who decompensated rapidly and ended up in [FACILITY 1] after the Department jerked him out of the [APPELLANT 1 & 2]'s care; testimony of [NAME 11], the only resident who was not mentally disabled; and testimony of [NAME 14], a professional who had observed the home and the care provided.

abuse in the adult family home. As a result of reports to law enforcement and the department, investigations were begun in which a number of people used various words to describe a number of sexual acts that had occurred, many of which had their origin in the mental health workers. See Attachment B, Origin of Sexual Words Used According to State's Witnesses.

In short, just as the old children's party game of "telephone" exemplifies the human propensity to distort what one has heard when relaying it to another, resulting in an entirely different story when it returns to the initial speaker -- which propensity is the reason for the hearsay rule in litigation and is likely the reason that gossip is morally and/or socially frowned upon -- so the government witnesses in this case distorted what had been heard. And because everyone believed sexual abuse had taken place the phenomenon of confirmation bias enhanced the hearsay process, with the result that people heard and reported what would support their belief that sexual abuse had occurred, willing to believe mentally disabled adults with conflicting stories rather than competent adults with knowledge of the adult family home.

Because sexual abuse had not in fact occurred, Appellants' legal obligation to report abuse of a vulnerable adult had therefore not arisen. But the government believed sexual abuse had occurred and claimed the legal obligation to report had arisen and been violated, requiring the immediate closure of the home and the abrupt removal of the residents from their home.

ii. The incident.[20]

On February 23, 2009, [APPELLANT 2] and [APPELLANT 3] were caregivers at [ADULT FAMILY HOME 1] while the provider, [APPELLANT 1], [APPELLANT 2]'s [RELATIVE], was in [LOCATION 1] with her [RELATIVE]. While [APPELLANT 3] was making lunch in the kitchen and [APPELLANT 1] was working nearby in the office, each being on the main floor of the home, their new resident, [NAME 4], came up the stairs. As he entered the kitchen, he commented to [APPELLANT 3], "Something inappropriate is happening down there," referring to the finished daylight basement where the five residents lived. Immediately behind [NAME 4] was [APPELLANT 2] and [APPELLANT 1]'s Down syndrome adult [RELATIVE], [NAME 1], who lived upstairs with his [RELATIVES] and [APPELLANT 3]. [NAME 4] was new in the house and the caregivers were not familiar with his personality traits, and they were therefore

[20] The following is from the testimony of the Appellants, which will appear to the reviewing judge to be almost completely different from the findings of the Initial Order because they were disregarded wholesale.

uncertain as to what he would likely mean by such a comment. [APPELLANT 3] told [NAME 1] to go talk to his [RELATIVE] and let [APPELLANT 2] know what [NAME 4] said and that she was going downstairs.

[APPELLANT 2] asked [NAME 1] what was going on downstairs and [NAME 1] said he was dancing and [NAME 2] was "helping" him. [NAME 1], who has a cheerful disposition, did not indicate to his [RELATIVE] that anything troubling or out of the ordinary had occurred. [NAME 1] does an Elvis impersonation, has an Elvis costume and performs for various events. Around the house he likes to dance and enjoyed going downstairs and listening to music and dancing by himself in the residents' main room. [APPELLANT 2] refers to [NAME 1]'s dancing as the "Hump", after a song of the 1960's by the Invictas, which led to a dance by the same name.

While [APPELLANT 2] was speaking with [NAME 1], [APPELLANT 3] went downstairs to speak with [NAME 2], the only other resident downstairs at the time, and asked him what was going on. ([NAME 2] was higher functioning than [NAME 1].) Using a common expression of his, [NAME 2]'s first response was, "Who ratted me out?" He then told [APPELLANT 3] that nothing had happened.

After lunch [APPELLANT 2] and [APPELLANT 3] spoke together about the matter, concluding that nothing of concern had happened, except what [APPELLANT 2] had surmised. Specifically, [APPELLANT 2] knew [NAME 2]'s style and that he would probably not be helping [NAME 1]. Rather, [NAME 2] would mock [NAME 1] by doing various things, including pretending he was interested in dancing along with [NAME 1] to the music -- when in fact he would just be just mocking him. [APPELLANT 2] had spoken to [NAME 2] before about his making fun of [NAME 1]. [APPELLANT 2] also spoke with [NAME 2] after lunch, and [NAME 2] told him nothing had happened. [APPELLANT 2] expressed that he didn't want [NAME 2] making fun of [NAME 1]. At that point, it appeared to both [APPELLANT 2] and [APPELLANT 3] that the matter had been resolved. [NAME 4] said nothing further about his comment or what had appeared to him to have been "inappropriate", and they never heard anything further about it from any of the other residents or [NAME 1]. In particular, neither [APPELLANT 2] or [APPELLANT 3] had received any impression that whatever had happened was anything remotely of a sexual nature. Nor had they ever seen evidence of any other thing of a sexual nature among the current residents or [NAME 1]. The thought never crossed their minds, therefore, that something of a sexual nature had or would have occurred.

When [APPELLANT 1] returned from [LOCATION 1] several days later, they reviewed with her the event and issues that had occurred in her

absence. They mentioned to her [NAME 4]'s comment and the results of their conversations with [NAME 2] and [NAME 1], the primary point of interest being understanding the personality and style of their new resident, [NAME 4].

iii. [BUSINESS 2]

[NAME 2] was referred to [BUSINESS 2] by [APPELLANT 1] in mid-February, 2009. See Appendix to Appellants' Response to Petition, 2009 Chronology of Events, the substance of which was testified to by [APPELLANT 1]. The reason for setting the appointment was that his primary care physician indicated he should see a psychiatrist for his medication management; and he could only see the psychiatrist if he was referred by a counselor. [APPELLANT 1] set the appointment for February 27 but [BUSINESS 2] called the day before the appointment because [NAME 9] was sick. After returning home and learning that the [BUSINESS 2] appointment had been canceled, [APPELLANT 1] called [BUSINESS 2] on March 5 for March 20 at 8:15 a.m. That time was not acceptable to [NAME 2] as too early, so the appointment was set over a week for March 27.

The intake occurred on March 27, when [NAME 2] was interviewed by [NAME 9]. Ex 20. [APPELLANT 1] was busy so [APPELLANT 3] took [NAME 2] to the intake. She sat through the entire session with him, offering her input from time to time. [APPELLANT 3] apparently used the word "hump" when speaking with [NAME 9], intake worker and supervisor of [NAME 7] at [BUSINESS 2], when she and [NAME 2] spoke together with [NAME 9] for [NAME 2]'s intake on March 27, 2009. Ex. 20, "Page 4".

2. The investigation.

a. Confirmation bias.

The investigation in this case is a good example of what psychologists refer to as "confirmation bias." See R. Nickerson, "Confirmation Bias: A Ubiquitous Phenomenon in Many Guises," 2 Rev. of Gen. Pscych., 175, 177 (1998) (explaining that people tend to seek information that they consider supportive of favored hypotheses or existing beliefs and to interpret information in ways that are partial to those hypotheses or beliefs; conversely, they tend not to seek and perhaps even to avoid information that would be considered counterindicative with respect to those hypotheses or beliefs and supportive of alternative possibilities (Koriat, Lichtenstein, & Fischoff, 1980)); D. Rothman, California Judicial Conduct Handbook, 3rd Edition (California Judges Association), pp. 56-59 (describing the dangers of "cognitive illusions" of judgment caused by "scenario fulfillment" where there is an unconscious attempt to make available evidence fit a preconceived scenario).

b. Sexual words.

From the one word "hump" spoken casually no doubt by [APPELLANT 3] in [NAME 2]'s intake with the empty chair witness, [NAME 9], the state employees managed to build a house of cards. In **Attachment B** is listed a chart showing 38 words or phrases with sexual words or connotations -- in addition to the words hump, humped and humping -- that the Department's witnesses used in their testimony or their reports in this case. The source for almost half of them was [NAME 7]. The Appellants were the source of none of the other words (though Hochreiter is all over the board as to whether [APPELLANT 2] said "dry humping"). And this is not claimed to be an exhaustive list.

The amazing thing is how these people fed on each other. And they kept saying it so many times and in so many different ways that they even fooled themselves. And it is this proliferation of gossip and misinformation that led the ALJ to conclude the state's witnesses were more credible because there has to be something to it if all these professionals say it is.

c. Assumptions.

Unfortunately, the Department investigators, and ultimately the ALJ confused assumption with fact and ended up -- assuming no malice -- confusing themselves. The only one who generally escaped the whirlpool of gossip was [DETECTIVE 1], who was first to interview people in the home.[21] He readily concluded that no crime had been committed. At 2:54:00 on February 16, 2010, is this:

> GP: Now Ms. Hochreiter indicated to you that [NAME 2] had started this two weeks after moving in, did she indicate to you what the this was?
> [DETECTIVE 1]: No, she did not specifically define that.
> GP: So, what we really don't know what Ms. Hochreiter was meaning to say there, correct, regarding what [APPELLANT 1] had said to her?
> [DETECTIVE 1]: Not beyond assumptions.

He recognized what Ms. Hochreiter failed to recognize -- that just as one can never weave silk purses from a sow's ear, so one can never weave facts from from assumptions.

[21] He pointed out to [NAME 7] that she had failed to report to law enforcement as required by law. For some reason, in light of the unrelenting attack on the [APPELLANT 1 & 2] for their supposed failure to report up to and including the current Petition for Review, no one seems to care that [NAME 7] violated the law as well.

i. Even [DETECTIVE 1] fell prey to some assumptions.

Notwithstanding his better grasp of forensic validity, he, too, fell prey to some assumptions. He assumed [APPELLANT 1] meant something sexual by the use of "humping". And at 2:43:20 he stated he had been affected by the reports he received:

[DETECTIVE 1]: The incident had been defined in my mind by their reports previously.
GP: By their - whose reports?
[DETECTIVE 1]: Reports received by the Sheriff's Office.
GP: Okay - from Larry Davis and Wesley Fullerton?

However, when it came down to it, [DETECTIVE 1] did not jump beyond what he knew, which he makes clear at 02:41:12:

GP: [APPELLANT 1] also stated that [NAME 2] revealed what occurred to her. So what occurred could be something that did not include sexual abuse. Isn't that correct?
[DETECTIVE 1]: Yes.
GP: So this statement that "[APPELLANT 1] also stated that [NAME 2] revealed what occurred to her" does not - you can not say that she said that [NAME 2] revealed her that sexual abuse occurred, correct?
[DETECTIVE 1]: Correct.

And at 03:22:58, [DETECTIVE 1] acknowledged he couldn't say [APPELLANT 1] knew what he was talking about.

GP: You were asked about your general summarization of the complaint for [APPELLANT 1] and what you believed you were there for, what did [APPELLANT 1] believe you were there for, do you know?
[DETECTIVE 1]: What did she believe?
GP: Yes, what did she believe you were talking about, do you know?
[DETECTIVE 1]: No

And [DETECTIVE 1] stated that [APPELLANT 2] never reported anything sexual, at 02:19:10:

GP: Did [APPELLANT 2] indicate to you that he thought that sexual contact had occurred?
[DETECTIVE 1]: No, I don't recall that.

ii. [APPELLANT 1] pointed out inaccuracies in the police report.

[APPELLANT 1] was asked about the police report, Ex 13, and she said there were inaccuracies, including the last paragraph on page 5,which states that [NAME 4] observed "[NAME 2] humping on [NAME 1]". She testified that [NAME 4] reported "inappropriate" behavior, not "humping" and that she did not use the word "humping" with the detectives. She said she told the detectives she was not there when the incident occurred, that she was in [LOCATION 1], and that when she came back the staff informed her that [NAME 4] stated there had been "inappropriate behavior".

Appellants all testified they used the word “the hump” as a noun not a verb, referring to the dance of that name. All the investigators added -ed, -ing, and “dry” to the word “hump” used by appellants -- as their confirmation bias led them to do after having heard the term from [NAME 7] -- and after the various players in the matter creatively enhanced and embellished the details with the 38 sexual words and phrases set forth in **Attachment B**.[22]

iii. Ms. Hochreiter treated her assumptions as facts.

Unlike [DETECTIVE 1], however, Ms. Hochreiter relied on assumptions and was not even aware when they wrapped her around the axle of truth. The following exchange occurred at 04:16:03 on February 11, 2010:

GP: And [NAME 4] was the one who said something about verbal abuse?
RH: He was one of them, yes.
GP: Who else?
RH: [NAME 2] and [NAME 6] – [NAME 6].
GP: And what was the verbal abuse?
RH: The verbal abuse was [APPELLANT 3] and [APPELLANT 2] yelling. One of the instances was them yelling at [NAME 6] for the poop on his bed.
GP: And how loud did they yell?
RH: I don’t know.
GP: What did they say?

[22] Such sexual words include thrusting, grope, genital contact, rubbed his genitals, touching of private areas, some sort of inappropriate sexual contact, inappropriately touched, sexually inappropriate, preys on vulnerable people out in the community, rape, mock intercourse, mock sex with clothes on, intercourse, touched in genital area, hands on [NAME 1]’s genitals/hands on [NAME 1]’s pants, sexualized impulses, sexualized behavior, sexual, sexual assault, rubbed on back, touched through pants, no hands involved, rubbed with hips, no bodily penetration, from behind, lap dance.

RH: They said, if you act like a baby I'm going to treat you like a baby.
GP: All of them said that?
RH: [APPELLANT 3] said that.
GP: Did you ask [APPELLANT 3] about that?
RH: No.
GP: You did not give her the opportunity . . .
RH: She wasn't in the home after my first visit.
GP: Excuse me, if I can finish my question first. You didn't give her the opportunity to respond to that allegation, did you?
RH: That's not correct.
GP: Oh, you did give her an opportunity?
RH: She was unavailable .
GP: Did you know how to contact her?
RH: No.
GP: Did you have a number for the adult family home?
RH: Yes I did.
GP: So you knew how to contact [APPELLANT 2] and [APPELLANT 1], correct?
RH: Yes.
GP: Did it occur to you that they might know how to contact [APPELLANT 3]?
RH: It didn't, I didn't need to go any further than what I was reporting. What is important was what the residents told me.
GP: Okay, so it doesn't matter what the truth is . . .
RH: No.
JG: Objection.
GP: If I could finish my question.
ALJ: Go on.
GP: It doesn't matter what truth is, what matters is what the resident thinks happened, is that correct?
RH: No.
GP: Okay, so then I misunderstood your last answer.
RH: The truth is that the residents were upset by how they were treated in the home. That's the truth. They told me they were upset.

The amazing thing is that a person who could engage in the tautological sophistry reflected in the foregoing dialogue is entrusted with authority to represent the government. When the questioner asked if she had attempted to obtain both sides on a particular point by asking [APPELLANT 3]'s side of the story, she first said she gave [APPELLANT 3] an opportunity because she stopped by when [APPELLANT 3] was not at home. (Huh?) She then said she didn't know how to contact her, and when she saw she would be forced to admit she knew the AFH would

know how to get hold of her, she side-stepped by saying she didn't need to speak with [APPELLANT 3] again because what was important was what the residents told her.

That response led logically to the question of whether the truth was unimportant or just what the resident thought had happened. She first attempted to avoid being boxed in a logical corner by interrupting. She then said the truth was that they were upset, having confused objective truth with objective feelings. In the end it appears she was unaware of the vacuity of her answers, thinking perhaps that smugness could triumph over logic merely by being expressed.

3. The ALJ found the state presented almost no evidence on the issue of consent as to any sexual contact. FF 7

In FF 7, the Initial Decision states in relevant part as follows:

> Nor is it at all clear that the incident was one involving sexual abuse, since sexual abuse as defined requires the sexual contact be nonconsensual. WAC 388-76-10000. There was almost no evidence presented on the issue of consent. [NAME 2] did allege that [NAME 1] was the aggressor and that he had forced him to the ground, but that version of events was never corroborated by [NAME 4] or anyone else and is suspect given that it was only made months after the incident had occurred.

[NAME 2]'s later statements were made to investigator Gloria Morrison, claiming that [NAME 1] was the aggressor. As to the comparative character of [NAME 2] and [NAME 1], [NAME 14] testified on cross examination by the Department in her role as a behavioral specialist that [NAME 2] lies. She had been the therapist for both [NAME 1] and [NAME 2].

JG: And what about [NAME 2], do you think [NAME 2] was truthful?

[NAME 14]: [NAME 2] at times was definitely not truthful. We had a meeting with [APPELLANT 1], [APPELLANT 3] and [APPELLANT 2] and [NAME 2]'s [RELATIVE] and [RELATIVE] and during that time at the meeting he denied some things that had actually happened and I remember his [RELATIVE] actually saying, "[NAME 2] that's not true."

JG: What things did [NAME 2] deny in that meeting?

[NAME 14]: Well, at first he wouldn't admit that he had given his check to his [FRIEND] or whether it was his [FRIEND],

> the young woman that he liked; and I remember talking with him and I remember it took about 20 minutes of talking for him to say yes, that he had given the check to her. So that was one situation that I can remember. I remember his [RELATIVE] asking him the same question and he wouldn't look at her or answer the question and that's when I stepped in and it took me quite a while for him to say that he'd actually given the check to her.

B. CRITICAL POINTS

As noted above, there are a number of critical points that were not considered by the ALJ, the failure of which led to his credibility finding in FF 7, and which led him to find the state's witnesses credible and to disregard the Appellants' witnesses.

1. All testimony can be traced back to the use of one word in the AFH, the word "hump", which was apparently taken down by [NAME 9] in [NAME 2]'s intake on March 27, 2009, based on a comment from [APPELLANT'S NAME 3].

[NAME 2] was not taken to [BUSINESS 2] for any issue of sexual misconduct. In the first place, the appointment had been originally set in mid-February, prior to the "incident" on February 23, 2009 that "something inappropriate" was occurring in the basement living area. He was taken to the Intake by [APPELLANT 3], who remained in the session and took an active part in providing information.

a. Areas of inquiry

Ex 20, page 2, asks for the "Presenting Issues". [NAME 2] himself said he likes to "instigate stuff". [APPELLANT 3] said:

> He has some behavioral issues. He doesn't change. He is disruptive. He isn't happy & he brings the others down. He wants to have his own way and he gets really disruptive.

When asked if he had ever harmed or attempted to harm another person, [NAME 2] said he had punched his [RELATIVE] and at 14 had "destroyed" her house; [APPELLANT 3] said, "He takes advantage of others - people less able." *Id*. at page 5. When asked about his ability to get along with others and/or his social life, [APPELLANT 3] said, "He has problems." *Id.* at 9. As to major events that impacted his life, he said he broke the rules in his family home and had to move out. as to family/friends' concerns regarding his safety, he said. "They don't like me getting angry." *Id*. at 11. When asked if he was currently experiencing any controlling or violent behavior in his "domestic relationship" (which included "physical abuse,

intimidation and threats, . . . emotional abuse, . . . sexual coercion/abuse), [NAME 2] checked "No." In addition, [APPELLANT 3] provided no information as she did at other points. *Id.* at 12. At page 13, where the is a list of all areas where the client has needs to be addressed, the only boxes checked were "Symptom Management" and "Medications". "Social/ Recreational" and "Other" were not checked.

b. General functioning.

As part of the intake, [NAME 9] went over various characteristics of [NAME 2]. *Id.* at 14. His attitude was "impatient". His affect was "appropriate". His thought process was "concrete" and his ability to abstract was: "limited". He was oriented as to person, time and place. His immediate, recent and remote memory were all intact. His insight was poor. His judgment was "poor" and "poor impulse control". His behavior was "poor eye contact" and "suspicious". And verbally, he "interacts, initiates, and interrupts".

c. Diagnostic Summary.

The Diagnostic summary on Exhibit 20, pages 1 - 1a, contains nothing whatsoever regarding sexual concerns. [NAME 2]'s "presenting issues" were his "mood swings and disruptive behavior . . . showed little insight and had poor impulse control". And this is exactly what the Appellants have each testified. It was stated, "The client did show a lack of remorse for his aggressive behavior and had little insight into why people would find such behavior inappropriate." The only specifics identified by [NAME 2] was his treatment of his [RELATIVE]. The therapist thought he might have intermittent explosive disorder, but couldn't be sure. It was stated "He is at risk for losing housing because of his aggression and his aggressive puts others at risk of harm."

d. Sexual issues.

The Intake assessment has two references to sexual issues. The first is on page 4, where [APPELLANT 3] is the source for the following:

> [NAME 2] manipulated another person into sexual unsavory things - he is "humping" him. "We don't feel comfortable w/others being alone with [NAME 2]."

The other reference is on page 15 and states under "Additional recommendations":

> Possibly will need evaluation for sexually inappropriate behavior. Monitor behavior to see if assessment is appropriate. Talk to [APPELLANT 1] (owner of [ADULT

FAMILY HOME 1]) to see if behavior necessitates call to
APS & report if needed.

e. Observations and conclusions regarding Intake Assessment.

- [APPELLANT 3] knew more than [APPELLANT 2] or [APPELLANT 1] about the “incident”. Thus she was in the best position to convey the most information available if there had been sexual acting out on [NAME 2]’s part.

- It is not clear what information [APPELLANT 3] provided to [NAME 9], whom the state chose not to call as a witness and therefore was not available to be cross-examined. It is not clear what was meant by “sexual unsavory things”. This term was not in quotes and was thus the words of [NAME 9]. [APPELLANT 3] testified there had been a few incidents with sexual overtones of which she was aware regarding [NAME 2], including where a younger [RELATIVE] had taken off her clothes when she was with [NAME 2]. Since [APPELLANT 3] could not remember what she said, and since she would not use the term “sexual unsavory things”, it can’t be concluded that term refers to anything current.

- There is nothing in the term “humping” that would necessarily mean sexual behavior. This is particularly true since -- with the best information available through [APPELLANT 3] -- [NAME 9] was not able to conclude there was any sexual abuse. In addition, rather than seeing a definite need for a sexual evaluation, [NAME 9] said only “possibly” will he need one.

- [NAME 9] was a mandated reporter and yet made no report. She thus did not have “reasonable cause to believe that” abuse or sexual assault had occurred, for she did not make a report, either to the Department or to law enforcement as required by RCW 74.34.030, which requires such reports to be made “immediately”.

- Since [NAME 9] had no reasonable cause to believe [NAME 2] had sexually assaulted or abused [NAME 1] in particular, it is most likely that [APPELLANT 3] use of the word “hump” or a variation was not clear to [NAME 9]. This means [NAME 9] either did not inquire of [APPELLANT 3] as to the meaning of the term, or that [APPELLANT 3]’s explanation of what had happened was not indicative of a reportable event.

- [NAME 9] thus most likely either assigned, as did others,

sexual meaning to [APPELLANT 3]'s use of the term "hump" or "humping" or [APPELLANT 3] explained what she and [APPELLANT 2] expected had occurred and it was not abusive, as they have both testified.

- Finally, notwithstanding the comments regarding possible sexual behavior, the diagnostic summary has nothing in it regarding any sexual problems of [NAME 2].

- Thus the testimony of the Appellants is corroborated that the reason [NAME 2] was taken to [BUSINESS 2] was exactly as they testified: mood swings, disruptive behavior and poor impulse control -- but not sexual impulses or sexual behavior. This also corroborates the Appellants' testimony that the term "hump" referred in their minds to a dance.

f. The department's position is wrong in suggesting the Intake Assessment reflects that the Appellants knew [NAME 2] had sexually abused [NAME 1].

The Department's theory must also include that [NAME 2] sat quietly and said nothing to [NAME 9] as he heard [APPELLANT 3] tell her he had been "humping" another male, Ex 20, page 4 and page 2 ("(Client accompanied by caregiver - [APPELLANT 3])"). Yet [NAME 9] noted in the intake that [NAME 2] was oriented as to person, time, and place; his immediate, recent and remote memory was all intact; and he was able to verbally interact, initiate and interrupt. *Id*. at page 14.

Since he had no problem telling Ms. Hochreiter he did not instigate inappropriate sexual behavior, Ex 8, p. 6, the most reasonable explanation is that if he had heard himself accused of sexually assaulting [NAME 1]. he would have initiated verbal interaction and interrupted [APPELLANT 3] as she spoke to [NAME 9]. One would have thought [NAME 2] would have complained that [APPELLANT 3] had "ratted him out", using his common expression. After all his memory was good and he would have known that [APPELLANT 3] was accusing him of abusing [NAME 1]. And he had no problem promoting his perceived self-interest when he later accused [NAME 1] in speaking to Ms. Hochreiter.

The better explanation for [NAME 2]'s sitting quietly when [APPELLANT 3] made her comments is that [NAME 2] was familiar with [APPELLANT 2]'s habit of calling [NAME 1]'s dancing the "hump". What had happened was not sexual, it was mockery. It was not mock intercourse, it was mock [NAME 1].

1. [APPELLANT 1]'s May 1, 2009 letter to IDR.

[APPELLANT 1]'s IDR letter can be seen as not inconsistent with Appellants' theory of the case, that whatever occurred in the "incident" was a result of [NAME 1]'s doing the "hump" as he often did, coupled with [NAME 2]'s "helping him" as [NAME 1] said, or mocking him, as [APPELLANT 2] suspected. Their own investigation at the time by [APPELLANT 3] and [APPELLANT 2] was sufficient to let them know there was nothing else.

a. Appellants consistently maintained that no sexual assault occurred.

Appellants learned when the investigators started asking questions that the issue of sexual misconduct was on the table, but they had no idea what it was because none of them had observed or been told that anything of a sexual nature had occurred. [APPELLANT 1]'s strong statement that "no assault, or abuse, sexual or otherwise occurred".

b. Appellants took seriously the results of the investigation once they received the SOD.

Though they had had no evidence that [NAME 2] rubbed himself on [NAME 1] until the SOD. And while they remained skeptical, they nevertheless acknowledged the SOD findings when they said [NAME 2] "likely rubbed himself, including his private parts, on our [RELATIVE] [NAME 1], as if they were dancing or goofing around." By this statement, they honored the SOD by saying "likely" -- that is, they were taking the state's word for what they had no proof of. Secondly, they maintained a consistent position regarding what had actually happened. [NAME 2] and [NAME 1] had been goofing around.

c. The IDR letter was in artful.

In the second paragraph, [APPELLANT 1] said, "After we became aware of this issue we made an appointment with [BUSINESS 2] to see if [NAME 2] would qualify for mental health services." The question is, what was "this issue". The construction of the letter suggests the antecedent of the pronoun "this" was the allegation of sexual misconduct. However, that could not be the case because they set up the appointment with [BUSINESS 2] *before* the incident on February 23. However, the Intake Assessment corroborates what the "this" refers to -- it refers to [NAME 2]'s problem with impulse control, one of the presenting problems listed at the beginning of the Diagnosis Summary. Ex. 20, page 1. The absence of sexual issues in the Diagnosis Summary is further evidence that "this issue" was not sexual but was impulse control. The IDR letter is thus completely consistent with what the Appellants have maintained all along.

d. The Appellants position in the IDR letter is also consistent with the [APPELLANT 1 & 2]'s interest in the welfare of their [RELATIVE] [NAME 1]

One of the more poignant moments in the hearing was when [APPELLANT 2] pointed out that nobody had asked the question of how would he and [APPELLANT 1] knowingly allow one of their residents to molest their own disabled [RELATIVE]. The Credibility Finding of FF 7 is thus inconsistent with the [APPELLANT 1 & 2]'s own personal interest in the best interests of [NAME 1]. Their love for their [RELATIVE] was obvious in the hearing; and for the credibility determination to be accurate, one would have to say that the [APPELLANT 1 & 2] were despicable people in that they did not care for their own [RELATIVE] and were content to let him be the sexual plaything of a predator -- and that they did not mind having an active sexual predator in their own home. The kind of people who would garner the personal support the [APPELLANT 1 & 2] have are not the despicable people who would disregard the safety and welfare of their Down Syndrome [RELATIVE]. *See*, Exhibits D, E, F, G, H, I, and proposed Exhibits A and B.

2. [NAME 7]'s active imagination, misguided actions and plain arrogance are critical to understanding how this case came to be where it is.

One of the problems with a well-spoken, poised and arrogant witness, such as [NAME 7], is that the poise and articulateness masks the arrogance. But an objective reading of her transcript will leave only the taste of arrogance when her testimony is seen for what it is.

a. [DETECTIVE 1] recognized [NAME 7] for who she is.

GP: [NAME 7] was very definite in her presentation of the facts, wasn't she?
[DET 1]: Yes
GP: And she appeared very precise, isn't that correct?
[DET 1]: Yes.
GP: And she appeared to have no doubt as to what she was talking about, isn't that Correct?
[DET 1]: Yes
GP: How would you describe her attitude toward you or as she was reporting the facts as she understood them?
[DET 1]: Reluctant and offended.
GP: About you?
[DET 1]: Yes.

b. Everyone except [NAME 7] knew [APPELLANT 1] was in

[LOCATION 1] when the incident occurred, and everyone knew it was [APPELLANT 3] who went downstairs to speak with [NAME 2] after [NAME 4] said something inappropriate was happening.

[NAME 7] lied about what [APPELLANT 1] told her. The proof is seen in [NAME 7]'s testimony that [APPELLANT 1] said she herself caught [NAME 2] and [NAME 1]. It is enjoyable as an attorney to cross-examine an arrogant liar like [NAME 7], as the following excerpt shows, February 12, 2011, 03:35:48. Not realizing [APPELLANT 1] was in [LOCATION 1] at the time of the incident, [NAME 7] was an easy mark.

GP: You said that [APPELLANT 1] told you that she had caught [NAME 2] and her [RELATIVE] [NAME 1] in sexually inappropriate behavior, correct?
[NAME 7]: Uh huh.
GP: Is that a yes?
[NAME 7]: Yes
GP: Can you please tell me more of the details of how she caught them?
[NAME 7]: I, I can not recall the detail of how she caught them they are not stated in my notes.
GP: That's a pretty significant thing to have caught a resident and a family member in sexual activity, correct?
[NAME 7]: I would imagine so, yes.
GP: You were, you were, well you said that you were particularly concerned about that regarding [NAME 2], correct?
[NAME 7]: And the other person involved, yeah.
GP: And so why is it that you didn't say that she had caught them?
[NAME 7]: More than likely I summarized what I could in the amount of time that was allotted to me. I do about 60 of these unscheduled event activity logs every day. They're very brief summary and statements of what is going on and unfortunately at least sometimes some information does not make it in. And I try to insure the most important information gets into the log.

She sounds so believable. But there's more, at 03:38:00.

GP: So, um, did [APPELLANT 1] tell you where she had caught [NAME 2] inappropriately touching, excuse me, where she had caught him in

sexually inappropriate behavior with [NAME 1]?

[NAME 7]: I can not recall at this time.

And there is yet more at 03:42:00.

GP: You could be mistaken that [APPELLANT 1] caught them, couldn't you?
[NAME 7]: I don't believe I am mistaken in that.
GP: You could be mistaken that she walked in on them or came in?
[NAME 7]: I didn't state that she walked in on them; I was using that as a definition for the word caught.
GP: I see, but you could be mistaken that it was [APPELLANT 1] who caught them?
[NAME 7]: I don't believe that I am mistaken because that is what [APPELLANT 1] reported to me and that is what I documented.
GP: Okay, and you're, you're good at documenting things, correct?
[NAME 7]: I am fairly good at documentation.

[NAME 7] also told [DETECTIVE 1] that [APPELLANT 1] caught [NAME 2] and [NAME 1]. Ex 13, page 8. And at 03:45:17

GP: Do you think its important, referring to these records, do you think it's important to make accurate records?
[NAME 7]: It is very important to me to make accurate records and I have to say that since this situation has come about I definitely been even more diligent in my record keeping.
GP: But you were diligent then weren't you?
[NAME 7]: Yes, I was.

So [NAME 7] is very definite about [APPELLANT 1] reporting to her that [APPELLANT 1] caught [NAME 2] and [NAME 1] engaging in sexually inappropriate behavior. As [DETECTIVE 1] agreed, *supra*, [NAME 7] was very definite and precise in her testimony. The trouble for the state is that she was definitely and precisely wrong. [APPELLANT 1] was in the [LOCATION 1] when the incident occurred. [APPELLANT 1] could not have caught [NAME 2] and [NAME 1].

There is only one conclusion.[23] [NAME 7] lied when she said "that [she caught [NAME 2] and [NAME 1] engaging in sexual behavior] is what [APPELLANT 1] reported to me and that is what I documented.". And she lied about her record keeping as well to buttress her other lies.

c. [NAME 7] also lied in the Critical Incident Report when she said that [NAME 2] had committed rape.

On April 16, 2009, [NAME 7] filed a Critical Incident Report with APS claiming there was an "Allegation of rape" against [NAME 2]. Ex 6, page 1. She also had the option of selecting "Allegation of Sexual Assault". It is difficult to see how, if as she claims, [APPELLANT 1] used the term "dry humping" with her how "dry humping" became rape. It would appear we see a clear case of escalation by [NAME 7]. She already escalated from "inappropriately touched" in Exhibit 3 to "dry humping". In that case she took [APPELLANT 1]'s word and "upgraded" it, as it were. But here she is even taking her own word of "dry humping" and escalating it to "rape". She testified regarding her rape claim on February 12, 2009, at 03:55:46:

GP:	Now lets turn of to page 1 of exhibit 6. Tell me about the rape that occurred in the [ADULT FAMILY HOME 1].
ALJ:	I'm sorry, could you repeat that.
GP:	Tell me about the rape that occurred in the [ADULT FAMILY HOME 1].
[NAME 7]:	That was the box that my supervisor suggested that I check, considering that we had very few details on the exact situation and my job is not to investigate them and so she suggested that I check that box.
GP:	Given what you knew, did you believe that rape had occurred?
[NAME 7]:	I didn't know what had occurred.
GP:	Did you believe that rape had occurred? Excuse me, did you believe that rape might have occurred?
[NAME 7]:	... ...I believe that at that time someone had been taken advantage of, yes.
GP:	Well, you just said earlier, your, your supervisor

[23] Actually, there could be another explanation. [APPELLANT 1] could have lied to [NAME 7] and told her that she caught [NAME 2] and [NAME 1]. It appears [NAME 7] has not only committed the crime of failure to report to law enforcement, she has probably also committed the crime of false swearing, RCW 9A.72.040. (*See*, RCW 9A.72.080: "Every unqualified statement of that which one does not know to be true is equivalent to a statement of that which he knows to be false.") While the "[APPELLANT 1] lied" defense might fly in criminal court, under the preponderance burden in the present case, it is certainly more likely than not that it was [NAME 7], and not [APPELLANT 1], who lied.

	told you to check rape because you did not know what had happened, correct? You weren't sure what the extent of what happened, correct?
[NAME 7]:	That is correct.
GP:	So from that point you had reason to suspect that rape had occurred, correct?
[NAME 7]:	That is what I, we decided to use in filing the form, yeah.
GP:	Was that a yes to my question?
[NAME 7]:	Yes

[NAME 7] seems to claim a defense that was popular in post-WWII Germany: "I was just following orders." Actually, since APS is a public servant, [NAME 7] may have committed an additional crime of Making a false or misleading statement to a public servant. RCW 9A.76.175 And [NAME 2] would have a defamation suit against her for falsely accusing him of rape. Attachment B lays out all the sexual imaginations of the state's witnesses. We can now see how [NAME 7] is at the center of so much of it -- the truth is not important to her.

d. [NAME 7] backpedaled when questioned about her notes in Ex 3.

We have seen how [NAME 7] claimed to be a diligent record keeper, supra at page 22. Yet Exhibit 3, [NAME 7]'s purported notes of her conversation with [APPELLANT 1], does not contain any reference to rape or even "dry humping". In light of what we have seen of her lies, this case, like the house of cards, should fall of its own weight once the [NAME 7] card is removed. [NAME 7] testified she only spoke with [APPELLANT 1] on one occasion, which she memorialized in her notes in Ex. 3. At 03:38:00, she was asked as follows:

GP:	Did she tell you that that was humping or did she use the words sexually inappropriate or do you recall what she said?
[NAME 7]:	I, I can honestly say that cannot recall that conversation. It was almost a year ago.
GP:	And I think you said earlier the word sexually inappropriate was your own word, your own language?
[NAME 7]:	Yes, it is not even in my notes that it says sexually inappropriate it says inappropriately touched a member of the household. So earlier today when I said sexually inappropriate, yes that was my own wording.

GP:	Okay. And "inappropriate touched" so for example [NAME 2] was slapping members of the household on the back and they did not like it, is that correct?
[NAME 7]:	I ...I ... I don't recall I mean I can't recall the specific behaviors that [NAME 2] was ah displaying at that time.
GP:	Okay. So, it could have, you don't say sexual there, do you in your typewritten notes?
[NAME 7]:	No, I just... it says inappropriately touched.
GP:	Okay. Slapping someone on the back is inappropriately touching isn't that right if they don't like it, isn't that correct?
[NAME 7]:	That is correct.
GP:	In fact inappropriately touching can have a, a great variety of meanings that do not include sexual behaviors, isn't that correct?
[NAME 7]:	That is correct.

e. Because [NAME 7] is wrong on [APPELLANT 1]'s being there at the incident and she is wrong about accusing [NAME 2] of rape, none of her information is trustworthy

3. The existence of willing accomplices to [NAME 7] in confirming her imagination.

Throughout the testimony, [NAME 7] is not only the source of the complaint, she is one of the first people that the investigators spoke with. It was true for Roberta Hochreiter, and it was true for Wesley Fullerton. And Fullerton and Hochreiter talked to [DETECTIVE 1]. Ex 13, pages 6 - 10, including conversation with [NAME 7]. *Id.* at 8. As set forth in Attachment 2, the impact of [NAME 7]'s willingness to create her own version of events was significant. As [DETECTIVE 1] stated, *supra* at page 10, incident had been defined in his mind by their reports previously. Attachment 2 sets forth in significant detail how the language used by [NAME 7] to spin the story led directly to the others using those same or similar words.

The result of [NAME 7]'s impact on the investigation also affected the residents. Both [NAME 6] and [NAME 4] felt they had been misquoted by the investigators, [NAME 6] very strongly. It was thus just not the Appellants who were misquoted.

4. [NAME 6] refuted the statements that the investigator misquoted him as saying.

These are the things that [NAME 6]'s [RELATIVE] said, Exhibit E, which also [NAME 6] signed:

> . . . he refutes every single statement that you attribute to him as untrue; He did not use the words "lap dance" when referring to the dancing that [NAME 1] did; he had never seen anything "sexual" happen in the home; he did not state he gets into "scuffles" with [APPELLANT 2]; he said at no time did the staff "yell" at him; he never felt "verbally abused" in any way; . . .

5. [NAME 15] and [NAME 12], [NAME 4]'s [RELATIVES], said that their [RELATIVE] was misquoted or misled and that he did not witness sexual behavior at [ADULT FAMILY HOME 1].

[NAME 15] and [NAME 12] stated in Exhibit H: [NAME 4] feels the interviewers suggested things to him. [NAME 4] is easily swayed by suggestion. [NAME 4] was very happy there. [NAME 4] was treated as a family member and not just stuck in a room with a T.V. [NAME 4] said that [APPELLANT 2] never yelled at him; we were impressed with the progress the [APPELLANT 1 & 2] had made with [NAME 4] in such a short time; [NAME 4] needs dental work and [APPELLANT 1] had him scheduled with [FACILITY 2] Dental School to get work done; [NAME 1] was not "lap dancing," as was suggested by the report, but was only giving his interpretation of Elvis Presley, whom he pretends to be on a regular basis; [NAME 4] realizes this is not sexual behavior, but just [NAME 1] being [NAME 1]; [NAME 4] told us that [NAME 6] and [NAME 2] wanted to be kicked out of [ADULT FAMILY HOME 1] on several occasions for personal reasons; we feel [NAME 4] was manipulated over this issue, he was intimidated by the interviewer, he was scared, and he didn't know what they wanted him to say . . .

As with [NAME 6]'s refutation of Hochreiter's report, [NAME 4]'s statements also show that Hochreiter was not accurate in her investigation. Again, confirmatory bias appears to have affected the reliability of this investigation.

6. Roberta Hochreiter acknowledged it was necessary for her to define the slang term "dry humped" language in order to convey its meaning

Throughout her investigation, Roberta Hochreiter heard people used the term "dry humping" which came from [NAME 7]. Hochreiter said she never asked anyone what they meant by the term. However, when it came time to write her SOD, Roberta Hochreiter realized she had a

problem. This term that was at the center of the investigation was a slang word and when she wrote it in the report she had to be sure people understood what it meant. So Hochreiter made up some new terms and attributed them to the appellants. It is no doubt this essential dishonest with words that elicited [NAME 6]'s strong response. Exhibit E. Ms. Hochreiter's creative word smithing is found at 04:08:55 on February 11, 2010.

GP: Now Staff A, who is staff A?
RH: [APPELLANT 3]
GP: She said that Resident 1 told her that he had rubbed his genitals against [NAME 1] in mock intercourse. Did you find "rubbed his genital" in your notes regarding [APPELLANT 3]?
RH: No
GP: It wasn't was it?
RH: No, not that term.
GP: That's your term, isn't it?
RH: That's the term we wrote in the statement of deficiencies to avoid saying the words "dry humping".
GP: It's your term or it's Roberta Crawford's term?
RH: I wrote that report, I wrote that. I changed it from "dry humping" into something that was a little more ...
GP: Explicit?
RH: Not explicit, that wasn't, um, sanitized or that's not the right word. It didn't say "dry humping" but it described what dry humping was.
GP: In your own mind.
RH: And in the minds of pretty much everyone I talked to.
GP: Although you didn't ask them what it meant -
RH: I didn't ask any one what do you mean by "dry humping".
GP: And again, I think that you testified that "mock intercourse" was your term, correct?
RH: Yes that was the term that I wrote in there to describe dry humping.
GP: And none of my three clients had used that word with you?
RH: Which term?
GP: "Mock intercourse".
RH: No
GP: Or "intercourse" for that matter?
RH: No

7. The character of [APPELLANT 1] herself, for whom breaking the rules was inconsistent with not only her past actions in working with disabled people, but was inconsistent also with

the manner in which she acted during the investigation itself.

There is a difference between good character and good reputation. The former is inherent in who a person is and will necessarily produce the latter. The latter, on the other hand, can exist for a time without the former. But deficiency of character in a person will ultimately sully their good reputation. The good reputation that [APPELLANT 1] has enjoyed derives from her good character. And it was reflected in the type of home [ADULT FAMILY HOME 1] was, in the activities, in the social options, and in the good care provided by the [APPELLANT 1 & 2] and [APPELLANT 3].

a. What people think of [ADULT FAMILY HOME 1]/[APPELLANT 1]

i. Residents

The proof in this case is clear. The residents who lived at [ADULT FAMILY HOME 1] improved their situation because they were cared for with respect, dignity and the assistance to excel where they could in their own lives. Every resident who has been relevant to this case found their life improved for having lived at [ADULT FAMILY HOME 1]. [NAME 4] thrived there. He looked on [APPELLANT 1] as a second [RELATIVE] and he and [APPELLANT 2] had become pals. Ex H. [NAME 6] was able to live on his own after living there because he was able to overcome personal limitations regarding his own hygiene. Ex. E; Testimony of [NAME 13]. [NAME 2] had people who cared for him and who would not be satisfied with his making problems for himself. Like [NAME 4], he wished he could go back. Ex H. [NAME 11] found a peaceful place to recuperate. Ex D.

ii. Family

[NAME 13] testified he drove two hours so he could testify on behalf of [APPELLANT 1 & 2] and [ADULT FAMILY HOME 1]. With tears he told of what they had done for his [RELATIVE], [NAME 6]. [NAME 15] wrote and [NAME 12] testified about how well [NAME 4] did in their care.

iii. Colleagues and Professionals

[NAME 14] had had several clients at [ADULT FAMILY HOME 1] and spoke well of [APPELLANT 1 & 2] and their care for their residents. [NAME 16] had been a co-worker with [APPELLANT 1] and had seen her in several different capacities. He wrote of her things that come obviously from the heart:

> [APPELLANT 1] is one of the most consummate professionals I have had the pleasure of working with. She is an extremely committed person in her approach to all those under her care, morally, ethically and is deeply concerned for the well being and quality of life she helps provide for those under her care. I would not hesitate to have [APPELLANT 1] be in charge of my own [RELATIVES] if circumstances were to dictate, and that is not a statement I take lightly. To put any doubt on her ability to provide excellent care for anyone under her watch is irresponsible., ill-informed and demonstrates a total disregard for the vulnerable people who depend on [APPELLANT 1] to give a safe and positive environment in which to live.

Exhibit G. [NAME 17], a graduate student in counseling psychology, worked as a cleaning woman for [ADULT FAMILY HOME 1] for over three years. She was always impressed with the quality of care [APPELLANT 1 & 2] provided to their residents, as well as the safe and comfortable family atmosphere they created. Ex. I.; Ex. C.

b. [APPELLANT 1]'s response to rules.

It is perhaps [APPELLANT 1]'s immediate response to rules that caused her some trouble, especially coupled as it used to be with a respect for the opinions of professional. When [NAME 7] told her [NAME 2] should leave the house, she gave him the eviction notice the next day. Ex. 4. When Roberta Hochreiter found that the temperature was 0.4 degrees off and an incontinent man's room smelled like urine, she correct those issues. When Roberta Crawford told her she needed to call in an abuse complaint she did. When Roberta told her not to have [APPELLANT 2] and [APPELLANT 3] work with the residents, she complied immediately. Ex 5. Erroneously thinking she was dealing with people of good faith in the department, she cooperated fully with their incompetent and predetermined investigations. In the past she had called in complaints as a mandatory reporter when necessary. When [APPELLANT 2] had a question about [NAME 2]'s paycheck he tracked down the check and resolved the situation with common sense and concern for the innocent girl to whom [NAME 2] had given his check. [APPELLANT 3] also showed the personal concern for the rules and the welfare of the residents.

c. Contrast between [APPELLANT 1] and Investigators

i. Character

The contrast between the exemplary character of [APPELLANT 1] and her accusers could not be clearer. [NAME 7] has shown herself to be a liar,

supra at 21, 22, 23, who violates the laws herself, *supra*, at pages 23, 24. Roberta Hochreiter has shown herself to be an investigator who lacks common sense, reason, and the recognition of proper investigating, *supra*, at 12, 13, 14.

ii. Effect on Residents' lives.

In an irony that is no doubt lost on most if not all people involved with the department's case, there couldn't be a stronger contrast between how [APPELLANTS 1 & 2] and [APPELLANT 3] treated the residents than how the department employees have done. Not addressing the inadequate investigations, all one has to do is look at the lives of those residents who were ripped out of [ADULT FAMILY HOME 1] for their own welfare. [NAME 4] was sent alone in a taxi to a home where he begged his parents to get him out. Ex. H. He finally decompensated to the point he was hospitalized at [FACILITY 1]. [NAME 4] was also distressed by Ms. Hochreiter's investigation. Ex H. Gloria Morrison, against the wishes of [NAME 4]'s family and therapist, went ahead and interviewed him alone anyway. Ex H, Proposed Exhibits A and B. Ms. Morrison may well have been the final straw cause of [NAME 4]'s decompensation. Proposed Ex. B. And [NAME 7] falsely slandered one of her own clients, [NAME 2] with a rape accusation, forcing him to leave the home where he had been accepted and cared for.

d. Credibility determination

As this writer has reviewed the record, the error of the credibility determination has become abundantly clear. There was no reason to make such a determination. And holding the credibility of Hochreiter and Bills in particular up to the light, one can see that their credibility does not exceed that of the Appellants; rather their credibility is significantly less.

C. PARTICULAR POINTS

1. One of the underlying assumptions of the ALJ's credibility determination in FF 7 is that the Appellants knew why the investigation was being conducted. The Appellants, on the other hand said they were not aware of the details

The following testimony of Roberta Hochreiter on cross examination on February 12, 2010, 04:30:30, illustrates that although Ms. Hochreiter says she informed [APPELLANTS 1 & 2] about the investigation, in reality she told them nothing remotely specific.

GP: Had [APPELLANT 1], the provider, ever been told by [NAME 6] these things that he told you?
RH: I don't know.
GP: You didn't check?
RH: No.
GP: You didn't check with [NAME 6]?
RH: Check?
GP: You didn't ask [NAME 6] whether he had told [APPELLANT 1]?
RH: No.
GP: You didn't check with [APPELLANT 1] whether she had heard?
RH: No.
GP: Wouldn't you say that its appropriate to. . .
RH: Let me restate my answer
GP: Okay.
RH: I did talk to them about . . . we do not reveal to the provider when the residents are still in the home . . . especially when we think when we have concerns there could be abuse . . . we don't tell them who said what because we're trying to prevent retaliation.
GP: So in other words . . .
RH: In general I did discuss with them we had some complaints from residents of verbal abuse.
GP: So in other words, my client really never gets a fair opportunity to respond.
RH: No, that's not true.
GP: What are scuffles with [APPELLANT 2]?
RH: That is the term that [NAME 6] used.
GP: I understand that; you testified to that earlier. What does that mean?
RH: I would say it meant, in my mind, I thought he was referring to argumentative interactions with [APPELLANT 2].
GP: About what? Did you ask him?
RH: No. He mentioned the incident of the poop on his bed; he gave that example and an example of how he was spoken to about the state of his room.

Continuing at 04:33:15:

GP: And what did [APPELLANT 2] say about any problems he had with [NAME 6]?
RH: Can I see my notes?
GP: You don't recall as you sit there, right?
RH: I don't recall if he said he had. I don't remember, that's why I want to look at my notes.

GP: Did you give him a chance to tell you?
RH: Yeah
GP: And how did you give him a chance to tell you?
RH: All during the investigation we are letting the providers know, that would be [APPELLANT 2] and [APPELLANT 1], kind of what we were finding and the problems we were seeing and I did talk to them about the complaints the residents had made.
GP: Did you talk to them about scuffles?
RH: I did not - no - not that word - I did not use that word.
GP: Did you ask if he had problems with any resident, asking by name one by one?
RH: I'm sorry.
GP: Well, for example, did you ask [APPELLANT 2], do you have problems with [NAME 2], do you have problems with [NAME 6], do you have problems with [NAME 4]. Did you ask question like that?
RH: No
GP: Did you ask [APPELLANT 3] or [APPELLANT 1] questions like that?
RH: No. I don't recall that I specifically sat down and talked with them like that.
GP: Did you ask them as to each resident so that you wouldn't identify any of them?
RH: I asked about the issues not the residents because I don't want to give away who said what at the time of the investigation.
GP: Let me finish my question then you might be able to answer it. Did you ask [APPELLANT 2] and [APPELLANT 1] and [APPELLANT 3] as to each client so as not to give away that any particular client said anything, of whether they had heard problems from that client as to how they were being treated? Do you understand my question?
RH: I think you are asking me if I asked them specific question about specific residents.
GP: No. Let me try again.
RH: Okay
GP: Let me give you a hypothetical - if I - no I won't make it a hypothetical. [NAME 6] said, "I have scuffles with [APPELLANT 2]." Now if you asked him starting with [NAME 2], has [NAME 2] ever complained to you that you had done anything to hurt him or bother him -- then you go on any say, has [NAME 6], and then you say has [NAME 2], and then you say has [NAME 4] and then you say the fifth guy -- in other words asking the same

question as to each person so that my client would not be on notice which if any person had said anything.

JG: Objection, I don't think there was a question there and if there was it seem to be compound and vague -

ALJ: It seems to me he's asking if she ever used the technique -- if her concern was not revealing individual residents complaints -- did you sort of use the approach of asking the staff as to whether each resident in turn had any complaints, not revealing that a particular one had a particular complaint.

RH: I did not ask in that fashion.

ALJ: Okay, it just seemed like an interviewing technique question.

GP: Thank you, your honor.

ALJ: Is that correct?

GP: That is fully correct.

GP: So for a lot of these things that you are talking about my clients don't have the opportunity to address them until they show up in your report, is that correct? The specifics.

RH: I don't know. I don't think so. We talk to them, not in specifics. We talk to them in general.

GP: Right, but my question went to specifics.

RH: I don't talk specifically about residents.

GP: Okay

RH: I talk about specific complaints without a resident attached to it.

GP: So, okay, then did you then ask about scuffles?

RH: No I did not.

GP: But that was a specific complaint, right?

RH: Yes

GP: Did you ask about [APPELLANT 2]'s temperament, not knowing how to calm himself? Did you ask [APPELLANT 2] about that?

RH: No

GP: Did you ask [APPELLANT 3] about that?

RH: No. I didn't know about that when I talked to her.

GP: Did you ask [APPELLANT 1] about that?

RH: No

GP: Did you ask [APPELLANT 3] about [NAME 6] pooping on his bed?

RH: I didn't know about it when I first talked with her.

GP: Did you talk with [APPELLANT 2] about that?

RH: I think he brought it up.

GP: What did he say?

RH: [Pause] I don't [pause] I just have stated in here from [APPELLANT 1] and [APPELLANT 2] that no one yells at the residents; [APPELLANT 2] is hard of hearing and [APPELLANT 2] says his own voice is naturally loud. He did not know of anyone coming over and yelling.
GP: My question had to do with [APPELLANT 2]'s temperament and not knowing how to calm himself.
RH: No
GP: You did not ask him about that?
RH: No, I did not.

2. The ALJ incorrectly stated in FF 10 that [APPELLANT 2] chose not to report [NAME 2] for something that was reportable.

[APPELLANT 2] at one point stated to a witness that he did not want to report what [NAME 2] had done because he felt that a report of sexual misconduct would create problems for him in the future.

The ALJ confused a non-reportable incident that had occurred in the past perhaps as an indication of [APPELLANT 2]'s lack of credibility. The details of the actual incident, in which [NAME 2] gave his check to a girlfriend, however, reveals there was nothing to report and [APPELLANT 2] acted appropriately. [APPELLANT 2] explicitly did not suspect sex abuse and exploitation. He doesn't immediately think about sexual issues like many of the state's witnesses. Nor does he immediately presume evil from events, as the state's witnesses have done. The state's innuendo during hearing reveals one of the fundamental flaws in the entire process -- the statist idea that individual citizens are incapable of making decisions for themselves and that the government must be involved in every aspect of people's lives.

> SECTION 32 FUNDAMENTAL PRINCIPLES. A frequent recurrence to fundamental principles is essential to the security of individual right and the perpetuity of free government.

WA Const., art 1, sec. 32. Demanding that [APPELLANT 2] report to the government every time a problem arises would create a number of difficulties.

The first is to trammel on a citizen's right to make decisions for oneself. Even Ms. Hochreiter admitted this when she testified that, for the obligation to report to arise, "There has to be a reasonable belief that something happened." February 12, 2010 following 02:33:55. If [NAME 2]'s right to self-determination is to be honored, then he has a right to give his money away to a girlfriend. For [APPELLANT 2] to honor that right,

he cannot presume, as would the state, that someone harmed [NAME 2] financially; he would have to inquire before reporting, which would necessarily include considering the abilities and the personalities of the residents.

The same applies to [APPELLANT 2]. He has the right to determine for himself whether he has a reasonable belief that something reportable happened to [NAME 2]. The data received by [APPELLANT 2] raised a question of why [NAME 2] did not have his paycheck, but it did not in itself provide a reasonable basis to believe that [NAME 2] had been harmed. Rather, believing in his freedom as a citizen to act without the government's intervention, and having no reason to believe his obligation to report had been activated, and desiring to enable [NAME 2] to make his own decisions, [APPELLANT 2] looked into the matter and found there was no evil and there in fact had been no reason to believe harm had occurred to [NAME 2] from a third person. In order to help[24] [NAME 2] from making further bad decisions, [APPELLANT 2] reported the matter to [NAME 2]'s DDD case manager, Wesley Fullerton, who arranged for [NAME 14] to assist in a behavior plan for [NAME 2]. *See*, [NAME 14]'s testimony, *supra*, at page 14. Implicit in the reporting statute is the objective reasonable person standard. In this case, though confirmation bias may guide the government agents, the reasonable person would ask questions first to make sure they clearly understood.

A third significant concern, which the state would probably not think of and might not even be able to fully understand, is that by reporting the matter, [APPELLANT 2] would have subjected an unfortunate girl to being investigated by government agents as a sexual abuser and financial manipulator. Just as [NAME 2] lied to [NAME 14], [APPELLANT 2], and his [RELATIVE] about what happened to the check, he may well have lied about how the girl got the check, especially if he perceived he had been "ratted out" and might be in trouble. Just as investigator Gloria Morrison -- in an inherently leading manner -- demonstrated "humping" for [NAME 2], February 12, 2010 at 01:31:55, so another government agent asking leading questions might end up having criminal charges pressed against the girl. One has only to look back over the last 17 months of this case to realize such a possibility is not out of the question.

A fourth concern of having to report to the department each time "as soon as they were told anything that could be possible sexual abuse," Ms. Hochreiter February 12, 2010, 05:52:25, would be the staggering burden

[24] In light of the state's suggestion at the hearing that [APPELLANT 2]'s actions in this matter of the paycheck were inappropriate, it may not be the right thing to say [APPELLANT 2] "helped" [NAME 2], since the government witnesses might draw unwanted conclusions from the conjunction of acting "inappropriately" and "helping" [NAME 2].

on at least the DSHS, attorney general and law enforcement budgets. For under RCW 74.34.035(1) the provider is mandated to call not only the department but the police. There would also be a significant social impact as law enforcement found itself incapable of adequately protecting its citizens from criminals because they had to investigate every complaint that some [NAME 2] touched some [NAME 1] in every adult family home in the area. The same would be true for the department. Instead of protecting vulnerable adults in true need, agency investigators would be investigating and writing reports at every utterance of the phrase "A touched B"[25] in every adult family home in the state.

3. Ms. Hochreiter said [APPELLANT 1] said [NAME 2] admitted he had been "doing this" since two weeks after he moved into the home.

The type of behavior that [APPELLANT 1] was referring to was [NAME 2]'s impulsiveness without any concern for the consequences. The "two weeks" comment refers to the discussion [APPELLANT 1] had with Ms. Hochreiter about how a new resident is usually on their best behavior for the first two weeks after moving into a new setting.

4. [APPELLANT 1] also told Ms. Hochreiter that [NAME 2] "preyed on people in the community".

In Ms. Hochreiter's testimony of February 11, 2010, beginning at 5:42:30 she is forced to acknowledge after reviewing her notes that the words she attributed to [APPELLANT 1] -- purporting to be based on Ms. Hochreiter's interview with [APPELLANT 1] -- are in fact based word for word on Ms. Hochreiter's notes of her conversation with [NAME 7]. 5:52:45 What [APPELLANT 1] actually told her was that [NAME 2] took advantage of those less developmentally advanced. Caught in confirmatory bias by her own words, in 5:42:30 -- 5:52:45, she refused to admit what was obvious -- that in her mind she had attributed the more damning words of [NAME 7]

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[25] Multiply this by the many permutations of other words and phrases that possibly indicate sexual abuse and the calls to the department become endless. A few statements that come to mind, each of which could easily have a non-sexual meaning, are as follows:

> [NAME 2] touched [NAME 1]. [NAME 2] brushed against [NAME 1]. [NAME 2] rubbed [NAME 1]'s leg. [NAME 2] poked [NAME 1]. [NAME 2] had his thing out. [NAME 2] was smelling [NAME 1]. Something is dirty down there. [NAME 2] is talking dirty to [NAME 1]. [NAME 2] scratched [NAME 1]. They're dancing funny. They're dancing together. [NAME 1] was doing something bad to [NAME 2]. [NAME 2] is being like a dog. [NAME 1] is afraid of what [NAME 2] is doing.

Any parent with more than one child under the age of 10 would know how to handle any such statement effectively and quickly. It is nonsensical to require adult family home providers and caregivers to report each of these statements to DSHS and to law enforcement -- not because they refer to any sexual behavior, but because they each could be an indicator of "possible sexual abuse".

-- 'preys upon", which carries with it the implication of sexual misconduct -- to [APPELLANT 1]. Ms. Hochreiter's weak defense was that she knew [APPELLANT 1] or [APPELLANT 3] had said "preys upon", she just didn't write it down in her notes even though at 5:44:15 she said that it was an "important statement". Her most honest statement, perhaps inadvertent in the context, was at 5:44:43: "I know that somebody told me that. I know that I was told that." But she refused to "rat out" her true source -- and in fact the source for virtually every one of the state's witnesses -- [NAME 7].

5. Ms. Hochreiter reluctantly had to acknowledge that the term "dry humping" did not come from [APPELLANT 2] but from [NAME 7].

Ms Hochreiter routinely attributes damaging words to the Appellants without documentation when in fact the existence of sexual meaning comes from her own mind. [APPELLANT 2] testified he was explaining the "hump" and didn't want Ms. Hochreiter to attribute a sexual connotation to the dance and then use it against [NAME 2]. He gave her and testified to an example where a teacher had said his [RELATIVE] [NAME 1] was inappropriately touching himself in class, when in fact [NAME 1] was simply scratching a severe fungus on the inside of his thighs.[26] [APPELLANT 2]'s explanation better fits the statements and circumstances than Ms. Hochreiter's presumption of sexualized behavior.

Again, Ms. Hochreiter refuses to admit that she had first heard the words "dry humping" and "genitals" from [NAME 7] until she was shown her notes of her interview with [NAME 7] on the morning of April 23, 2009.[27] She was also forced to admit that her notes of her subsequent interview with [APPELLANT 2] that afternoon did not show [APPELLANT 2] as having used the word "dry" with the word "humping". At 03:38:40:

GP: Who used the word "hump" with you first?
RH: Without looking at my notes I don't know if I could . . . say that accurately, I'm not sure.
GP: Who used the word "genitals" with you first?
RH: I don't recall that without looking at my notes. I don't think I heard anybody use the word "genitals".
GP: That was [NAME 7], wasn't it?

[26] Perhaps that same teacher subscribed to the same school of thought that seems to be manifested in this case where one is pre-disposed to draw conclusions that behavior is sexually motivated.
[27] While Ms. Hochreiter clearly and repeatedly reflects throughout her testimony her confirmation bias (which as a psychological phenomenon would appear to be more of an unconscious behavior), at some point the question cannot be avoided as to whether Ms. Hochreiter is overtly biased against [APPELLANTS 1 & 2]. This is suggested by her consistent failure to remember until she is forced to admit what is written in her own notes.

RH: Without looking at my notes I don't, I can't answer that.
GP: I am handing you your 9:10 a.m. conversation with [NAME 7] on the 23rd, in fact she used the word "genital contact", didn't she?
RH: Yes.
GP: And she used the word "dry humping", didn't she?
RH: She did.

Of course, the appellants' theory of the case is that just as Ms. Hochreiter attributes the word "preys" to [APPELLANT 1] and the word "dry" to [APPELLANT 2], so her confirmation bias caused Ms. Hochreiter to hear [APPELLANT 2] say "humping" -- as she had first heard the same morning from [NAME 7] who spoke of "dry humping" --rather than "hump" as [APPELLANT 2] actually testified.

In fact, Ms. Hochreiter's testimony changes on what word [APPELLANT 2] actually used. At 3:39:53 she admitted, "I don't know if he used the word 'dry'," and then asserts, "but he definitely used the word 'humping'." (Emphasis added.) But when directed to her notes, she was forced to admit that [APPELLANT 2] had in fact used the word "humped", 3:40:31, 3:40:43. And she clarified that he did not say "dry humped":

GP: And did you notice in your interview with [APPELLANT 2] whether he used the word "dry humping"?
RH: Um, I don't know if he used the word "dry", but he definitely used the word "humping".
GP: 'Kay. Would you like to review his notes again . . .
RH: Sure.
GP: . . . on that?
. . .
RH: Okay tell me the question again.
GP: Did he use the word "dry humping"?
RH: [Looks through notes] He said "humped".
GP: 'Kay.
RH: Wait, um, sorry. That was [APPELLANT 3]. He used the word "humped".
GP: Not "dry humped", right?
RH: No.

This last admission makes [APPELLANT 2]'s testimony all the more credible, for it is easier to mistake the sound of the word "humped" for "hump" than it would be to mistake the sound of the word "humping" for "hump". Even more telling is the exchange that immediately follows (repeating two lines):

GP: Not "dry humped", right?

RH: No.
GP: [NAME 7] had used that already with you, hadn't she?
RH: Yes.
GP: And that's what stuck in your mind?
RH: No.
GP: You want to continue on and check the other pages?
RH: What would I be checking for? Who used the word "dry hump"?

Notice her confusion in the foregoing exchange of the terms "hump", humped" and "humping". She was first asked about the first use of the word "hump" but she couldn't say who used it first. Then she admitted her notes said [NAME 7] used the term "dry humping". Then she said [APPELLANT 2] definitely used the word "humping" (but could not say he had said "dry humping"). Then she admitted [APPELLANT 2] had used the word "humped" but not "dry humped". Then, when asked to continue checking her notes, she asked if she should look for "dry hump" -- not "dry humped" or "dry humping". She then went through her notes of the two interviews she had with [APPELLANT 2] and found no other notes regarding his use of the words.

But, notwithstanding her questionable denial that what [NAME 7] had told her in the morning ("dry humping", according to her notes) did not stick in her mind, and notwithstanding that her notes of her interview with [APPELLANT 2] do not include the word "dry" -- Ms. Hochreiter nevertheless remains fixated on the idea of "dry humping". Even after the testimony had established her admission that the word "dry" was not used by [APPELLANT 2], like a broken record her confirmatory bias would not allow her to quote [APPELLANT 2] accurately, as seen at 03:44:30:

GP: Now as you understand from [APPELLANT 2], did he think that [NAME 1] had done something to [NAME 2] or that [NAME 2] had done something to [NAME 1]?
RH: He told me that it was reported to him that [NAME 2] did something to [NAME 1].
GP: So, um, and what is it exactly that it was reported to him that [NAME 2] . . .
RH: That . . .
GP: . . . did to [NAME 1]?
RH: . . . [NAME 2] dry humped [NAME 1].
GP: But you just told me that the word "dry humped" does not show up in your interview with [APPELLANT 2], correct?
RH: I didn't write the word "dry humping", no.

Forced to admit her notes say one thing, Ms. Hochreiter relentlessly follows [NAME 7] into focusing on sex, her cognitive dissonance having

kicked in and protecting her from the need to do any true investigation. Throughout her testimony she fails to ask questions and, "knowing" already that there was sexual misconduct, finds it unnecessary to learn from people what their words mean. We have already seen this, *supra*, at pages 12, 13 regarding her confusion of subjective feelings with objective truth. Another example is at 03:45:52:

> GP: And [APPELLANT 2] was pissed, right?
> RH: He told me he was pissed.
> GP: About what?
> RH: About the incident.
> GP: Okay. And he said that [NAME 2] gets impulses, right?
> RH: He said that [NAME 2] told him that he gets impulses.
> GP: Impulses about what?
> RH: Sexual impulses that he has to act on.
> GP: It doesn't say that here, does it?
> RH: No.
> GP: It just says that "[NAME 2] gets impulses", correct?
> RH: Correct.
> GP: In fact, he said that [NAME 2] was impulsive and verbally abusive, correct?
> RH: Correct.
> GP: But that he is better now, didn't he say that?
> RH: That is what he said.

Again, Ms. Hochreiter, because she came at the matter believing that sexual abuse had occurred, injects sex into the Appellants' explanations even though Ms. Hochreiter's own notes do not include sexual words from them. When [APPELLANT 2] mentioned impulses, Ms. Hochreiter's mind was ready to add the word "sexual". But it didn't daunt her when that was pointed out. She merely explained away her notes as not having included the words specifically indicating sexual behavior. Thus, as to whether [APPELLANT 2] used the word "dry humping", Ms. Hochreiter claimed she just hadn't written the word in: "I didn't write the word 'dry humping', no."

But at 3:39:42 she acknowledged that [NAME 7] used the word "dry humping". Again we see Ms. Hochreiter's confirmation bias confirming what she had first heard from [NAME 7].

From 3:38:40 - 3:46:53, Ms. Hochreiter shows how entrenched she was in her opinion that [APPELLANT 2] spoke of sexual matters. First she had to admit [NAME 7] was the first from whom she heard "dry humping". Then she had to admit that nowhere in her notes is it reflected that [APPELLANT 2] used the word "dry". At 3:45:10, after having admitted that [APPELLANT 2] had never used the word "dry" in conjunction with "hump", when she was asked "exactly" what was reported to [APPELLANT

2] that [NAME 2] had done to [NAME 1], she stated immediately, “That [NAME 2] dry humped [NAME 1].” Her confirmation bias appears to be transitioning into actual denial. She is so fixated on the existence of sexual behavior that as soon as she is not forced to admit what her notes actually said, she automatically reverts again to what they specifically did not say.

Another example of this is Ms. Hochreiter’s spin on [NAME 2]’s impulsive behavior. She testified at 3:46:12 that [APPELLANT 2] said [NAME 2] gets impulses. When asked, “Impulses about what?” She immediately responded, “Sexual impulses that he has to act on.” But she then had to admit that her notes do not say that [APPELLANT 2] mentioned “sexual” impulses. In fact, at 3:46:38 she admits that what [APPELLANT 2] actually said was “[NAME 2] was impulsive and verbally abusive”. So how did the impulses become sexual? From [NAME 7] and, by confirmation bias, from Ms. Hochreiter.

6. Ms. Hochreiter demonstrated during the hearing, and then explained on the record, that [APPELLANT 2] “gyrated his pelvis and thrusted it in a sexual way” calling it “dry humping”.

[APPELLANT 2] testified he demonstrated the dance the “hump” while sitting in the chair. Ms. Hochreiter testified to the same demonstration. The difference between the two accounts is that Ms. Hochreiter was thinking sex while [APPELLANT 2] was thinking about a dance which is descriptive of [NAME 1]’s Elvis routine. Contrary to Ms. Hochreiter’s treatment of the residents’ feelings were the truth, [APPELLANT 2]’s explanation of what he was demonstrating was not the truth. Only her perception of sex was the truth buttressed by her cognitive dissonance that was always able to quote [APPELLANT 2] -- contrary to her notes regarding his comments -- as using the term “dry humping” as an explanation.

7. Ms. Hochreiter’s attributions of statements to [NAME 4] is suspect in light of the fact that [DETECTIVE 1] spoke to him first and could get nothing out of him.

[DETECTIVE 1] said [NAME 4] remembered nothing, 01:10:00,

> ACM: What did you learn from [NAME 4]?
> [DETECTIVE 1]: I did not learn any additional information from [NAME 4] and speaking with him briefly ... it appeared that he had either forgotten or had ... um too much knowledge assigned to him that wasn’t the case. So I did not have anything of note - any information gained from [NAME 4].

even about [NAME 2] and [NAME 1]. 02:32:44:

> GP: You spoke to [NAME 4], your notes from [NAME 4] are at the top of page 2 of number 2.
> [DETECTIVE 1]: Yes.
> GP: He did not remember anything regarding [NAME 2] and [NAME 1], correct?
> [DETECTIVE 1]: Yes.
> GP: You said he apologized multiple times and he repeated that he did not remember anything - did you ask him many questions?
> [DETECTIVE 1]: No, not many because it quickly became clear that he did not remember anything so there was no point in pushing the issue, but he apologized with almost every response.

This of course is consistent with what [NAME 4] told his [RELATIVE], Exhibit H, who stated:

> As far as the sexual problem that occurred at the house, we feel it was blown totally out of proportion. [NAME 1] was not "lap dancing," as was suggested by the report, but was only giving his interpretation of Elvis Presley, whom he pretends to be on a regular basis. [NAME 4] realizes this is not sexual behavior, but just [NAME 1] being [NAME 1]!! . . . We feel [NAME 4] was manipulated over this issue, he was intimidated by the interviewer, he was scared, and he didn't know what they wanted him to say.

8. Misuse of the word "inappropriate".

Ms. Hochreiter stated the obligation to report arises when she stated that the obligation to report to the Department existed upon the uttering by [NAME 4] in [APPELLANT 3]'s hearing of that something Ainappropriate" was occurring downstairs. February 12, 2010 following 05:52:25.

> They would have had an obligation to report as soon as they were told anything that could be possible sexual abuse. So that point would have been when [NAME 4] came upstairs and told [APPELLANT 3] there's something going on in the basement inappropriate.

Interestingly, the Appellants' witness, [NAME 14], reflects the same problem, for she initially presumed that the word "inappropriate" means "sexually inappropriate", underscoring the very problem (seen in

[BUSINESS 2]) that led to this case and (seen in the government agents) that has perpetuated it. Specifically, there appear to be unconscious presumptions among the adult care industry which lead the individuals involved to make statements and draw conclusions that evade the light of reason. This is the essence of confirmation bias. Providers, such as the appellants, and residents, such as [NAME 4] who ended up in [FACILITY 1], are the victims of this error. In addition, those who are truly in need of protection are victims as well because to the degree the state is wasting its time and resources in pursuing cases built on presumption, to that degree it incapable of pursuing cases built on fact.

[NAME 14]'s testimony on the subject of "inappropriate" began as follows on April 21, 2010:

> GP: If a resident of an adult family home came to one of the staff and said, 'Something inappropriate is happening in another room,' would that, in itself, be a reportable incident?
> [NAME 14]: It would be.
> GP: Why?
> [NAME 14]: Because if there's any kind on an allegation that there is something going on in the other room that's inappropriate, they can go in and ask questions and say, you know, "Did this occur?" or, you know, "What happened?" And if there's any question in their mind that it could have occurred then they're required to report it.

Caught off-guard by her answer and believing she had misunderstood the question, Mr. Preble attempted to clarify her answer but was met by an objection from Ms. Giles. He then asked at 03:44:22, "What does inappropriate mean?" At that point, [NAME 14] testified to the meaning of the word "inappropriate", which led to her being able to correct her previous incorrect answer based upon her incorrect presumption.

> [NAME 14]: It can mean a number of things. It could mean that somebody did something that another person thought was not okay. It could be that someone took another persons tablet or pencil. It could mean that the person was inappropriate by being rude. It could mean a person was inappropriate because they did something sexually or aggressive. It could be that someone came in and kicked their door open and they were inappropriate. Inappropriate is a broad term. [It could also include belching.]
> GP: . . . For example, if somebody belches, could somebody say that is inappropriate?
> [NAME 14]: Definitely.

GP: If somebody belched in the adult family home, would that
be reportable?
[NAME 14]: No.
GP: If somebody came upstairs and said something inappropriate happened in another room, and the staff member went and inquired and found out that somebody had belched, would that be reportable?
[NAME 14]: No.
GP: Okay. And so I'm wondering why -- and I'm not sure I understood you correctly before, or you me -- okay, I'm wondering why the very fact that a person said that something inappropriate had occurred in the other room would be in itself reportable?
[NAME 14]: I think that I answered that question based on the way
the question was asked. I was under the understanding that it was, I
was being asked if something occurred inappropriately sexually in
another room, would that be reportable; and in that case I would say,
"Yes".
GP: Okay. I would like the record to reflect that my question did
not include the word "sexually". Let me re-ask the question, if I might. If a resident came to a staff member and said, 'Something
inappropriate is occurring downstairs,' would that statement, in itself,
be reportable by that staff member?
[NAME 14]: No.

It is not clear whether Ms. Hochreiter would agree with [NAME 14]'s correction that the uttering of the word "inappropriate" in connection with some unknown thing happening does not alone invoke the obligation to report. It is true that Ms. Hochreiter had earlier testified on February 12, 2010, following 02:33:55, "There has to be a reasonable belief that something happened." However, it would appear from her later statement following 05:52:25 that Ms. Hochreiter believes the word "inappropriate" necessarily means "sexually inappropriate". If that is in fact the case, the appellants' license was doomed from the moment that Ms. Hochreiter read or heard the word "inappropriate" in this case. With her confirmation bias on autopilot, her investigation, such as it was, led to its ineluctable result.

9. The food was good at [ADULT FAMILY HOME 1] and was not withheld from the residents.

> Former resident [NAME 11], a restauranteur for many years, and the only resident without mental or developmental disabilities, testified on April 20, 2010 regarding the food at [ADULT FAMILY HOME 1]: "Meals were served at a certain time. If you didn't like the entre, there were always other choices that you could make. Fruit and snacks were always available." 03:29:00. He never heard anyone complain about the food that was served. 03:30:20. *See also*, Ex D, where he stated the food was excellent and plentiful and that [ADULT FAMILY HOME 1] took pride in the quality of the food it served.
>
> [NAME 6] also said, "[ADULT FAMILY HOME 1] food was good and plentiful." Exhibit E. And Wesley Fullerton, who had three DDD clients at [ADULT FAMILY HOME 1] in April, 2009, testified that he "did not receive any direct complaints from them about food."
>
> **D. CONCLUSION**
>
> A great injustice has been done to [APPELLANTS 1 & 2] and [APPELLANT 3]. A greater injustice perhaps has been done to their former residents. And a great injustice has been done to the state of Washington because an adult Family Home of the caliber of [ADULT FAMILY HOME 1] has been taken out of commission.
>
> For all the above reasons, the Appellants ask the Reviewing Board to provide them all the relief it can, make a new credibility determination in their favor, with concomitant findings, and deny the state's Petition for Review.

6. The Department filed an objection to the Appellant's response to the petition for review on April 13, 2011. The Department objected that the response was filed late, and that the Appellant attempted to appeal findings of fact and conclusions of law that were not appealed by the Department. The Department filed a more extensive Renewed Objection to Timeliness and New Issues Raised on April 21, 2011.

7. The Appellant filed a response to the Department's Renewed Objection to Timeliness on May 2, 2011.

II. FINDINGS OF FACT

The undersigned has reviewed the written transcript of the hearing, the reconstructed record of the first part of the morning of April 23, 2010, the documents admitted as exhibits, the Initial Order, the Department's petition for review and the Appellant's response to the petition to determine the adequacy and appropriateness of the Findings of Fact made by the ALJ in the Initial Order. After review, the undersigned left unchanged those Findings of Fact supported by substantial evidence based on the entire record. Where findings were not supported by substantial evidence based on the entire record they have been stricken or amended. Where additional findings are necessary, they have been added or adopted findings supplemented.[28]

1. [APPELLANT 1] and [APPELLANT 2] moved to the state of Washington in 1989 with their then [AGE]-year-old [RELATIVE] [NAME 1], who has Down syndrome and qualifies for state services based upon a developmental disability. A short time later, [APPELLANT 1] began working as a social services provider in various capacities. For a time, she provided in-home child care and also served as a foster parent. From 2001 to 2006, she worked in residential and group homes with an agency called [BUSINESS 1]. During her time with that agency she ran a 24-hour, secure community protection home which housed several residents with sexual deviancy problems. While working with [BUSINESS 1] she learned about the adult family home concept and decided to apply for a license to operate her own adult family home.

2. On April 12, 2005, [APPELLANT 1] was granted a license to operate an adult family home at [ADDRESS 1], for up to five developmentally disabled adults under

[28] RCW 34.05.464(8).

adult family home license [NUMBER 1].[29] In order to obtain the license she completed the training required of all licensees, which included training on the fundamentals of care giving and the obligations of mandatory reporters.

3. The adult family home [APPELLANT 1] operated was called [ADULT FAMILY HOME 1] and was a spacious, multi-level house which also served as her family's residence. In 2009, [APPELLANT 1] and [APPELLANT 2] lived there with their [RELATIVE] [NAME 1], who was then [AGE] years old, and [APPELLANT 3], who worked as a care giver at [ADULT FAMILY HOME 1]. When [NAME 1] turned [AGE], [APPELLANT 1] became his legal guardian. [APPELLANTS 1 & 2] were providing [NAME 1] with in-home, state funded care.[30] There were five developmentally disabled residents living there in February 2009: [NAME 2], [AGE]; [NAME 3], [AGE]; [NAME 4], [AGE]; [NAME 5], [AGE]; and [NAME 6], [AGE]. The residents lived in the basement with [NAME 2] and [NAME 6] sharing a bedroom and the rest in individual bedrooms. [APPELLANTS 1 & 2] and [APPELLANT 3] lived upstairs. Meals for everyone were prepared and served upstairs in the kitchen area. Most of the residents had part-time jobs outside the home, except for [NAME 6], who had more serious physical problems and did not work.

4. On February 22, 2009, [APPELLANT 1] left town on a previously scheduled trip to [LOCATION 1] with her [RELATIVE]'s family. She delegated the running of [ADULT FAMILY HOME 1] to her [RELATIVE] and [APPELLANT 3].

5. The incident which is at the center of this case took place on Monday, February 23, 2009. [NAME 4] had just moved into [ADULT FAMILY HOME 1] the

[29] Exhibit Dept. 1.
[30] Transcript Vol. 9 p. 187.

preceding week and was in the process of adjusting to his new living situation. [NAME 4] had been living on his own before developing problems which led to a brief period of hospitalization and then placement at [ADULT FAMILY HOME 1].

6. Just before lunch that Monday, [NAME 4] came upstairs from the basement and told [APPELLANT 3], who was in the kitchen, that something inappropriate was or had been going downstairs between [NAME 2] and [NAME 1]. [APPELLANT 3] went to talk to [APPELLANT 2], who was also upstairs but in a different part of the house, about [NAME 4]'s report. They decided that [APPELLANT 2] would talk to [NAME 1] and she would talk to [NAME 2] to find out what, if anything, had happened. [APPELLANT 3] went downstairs to talk to [NAME 2] and sent [NAME 1] upstairs to talk to his [RELATIVE]. [NAME 2] asked [APPELLANT 3]: "who ratted me out?" [31]

7. [APPELLANT 3] and [APPELLANT 2] were told by [NAME 4], [NAME 2], and/or [NAME 1] that [NAME 2] had rubbed his private parts against [NAME 1], either while they were dancing or under other circumstances, in a manner that could be described as "dry humping" or mock intercourse. The contact did not appear to involve any touching with the hands or any contact under the clothing or skin-to-skin. The contact does not appear to have been forced, although the Appellants testified that [NAME 1] could not consent to any sexual contact.[32] [NAME 1] could not consent to any sexual contact. [APPELLANT 2] testified that [NAME 1] had the mental age of an eight-year-old child and was "asexual." [APPELLANT 2] also told Ms. Hochreiter that [NAME 1] said he did not like [NAME 2] rubbing himself on him. It is also not clear

[31] Transcript Vol. 6 p. 12.
[32] Transcript Vol. 3 p. 32.

whether this type of incident was an isolated incident or had happened between them in the past. Both [APPELLANT 1] and [APPELLANT 3] made statements to other witnesses, such as [NAME 7] and Ms. Hochreiter that it had occurred before, although it was not clear what exactly had occurred before.

8. Neither [APPELLANT 2] nor [APPELLANT 3] reported this incident to the Department's hotline, to anyone who worked for the Department or with the residents, or to law enforcement.[33] Both [APPELLANT 2] and [APPELLANT 3] were aware that as staff of the adult family home they were mandatory reporters. Because [NAME 1] was a vulnerable adult, their reporting responsibility would extend to any allegation of sexual abuse of [NAME 1].

9. [APPELLANT 1] learned of the incident when she returned home on February 27, 2009, and talked to her [RELATIVE] and [APPELLANT 3] about how things had gone in her absence.[34] [APPELLANT 1] followed up on the information by keeping [NAME 1] upstairs when [NAME 2] was home, and by scheduling an appointment for [NAME 2] with [BUSINESS 2], a community mental health agency.[35]

10. [APPELLANT 1] did not report the incident to the Department's hotline, or to Adult Protective Services (APS), or law enforcement until April 30, 2009.

11. [NAME 2] was scheduled for an intake interview at [BUSINESS 2] on March 27, 2009, and was taken to the appointment by [APPELLANT 3]. [APPELLANT 1] had intended to go herself, but had to be with another client that day. The report of that appointment is Exhibit Dept. 20. The interview was conducted by [NAME 9], an

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[33] Transcript Vol. 7 p. 144-145.
[34] Transcript Vol. 6 p. 16.
[35] Transcript Vol. 3 p. 51.

MHP, who conducted the interview with [NAME 2] using the agency's 14-page intake form. [APPELLANT 3] sat in during the entire interview and contributed some information from time to time. During the part of the interview dealing with possible criminal conduct, [APPELLANT 3] told [NAME 9]: "[NAME 2] manipulated another person into sexual unsavory things -- he is 'humping' him. We don't feel comfortable with other [or others] being alone with [NAME 2]."[36] During her testimony, [APPELLANT 3] denied making this statement, but it is more likely than not that she did make this statement.

12. As part of her recommendations, [NAME 9] wrote that [NAME 2] might need an evaluation for sexually inappropriate behavior, and suggested that someone should talk to [APPELLANT 1] to see if his behavior should be reported to APS. [37]

13. On April 14, 2009, [NAME 2] met with [BUSINESS 2] therapist [NAME 7]. [APPELLANT 1] accompanied him to the meeting and sat in on the session. In a private conversation, before or after the session, [APPELLANT 1] told [NAME 7] that they had caught [NAME 2] and her [RELATIVE] [NAME 1] engaging in sexually inappropriate conduct. [NAME 7] recalled that [APPELLANT 1] had used the term "dry humping" to describe the conduct. She also mentioned an incident between [NAME 2] and another female resident who was no longer in the home, although the nature of that incident was not specified. [NAME 7] misunderstood at least some of what [APPELLANT 1] told her, since [APPELLANT 1] was out of state on the day [NAME 4] came upstairs to tell [APPELLANT 3] of the interaction between [NAME 1] and [NAME 2]. [NAME 7] thought [APPELLANT 1] had said that she walked in on [NAME 1] and

[36] Exhibit Dept. 20, page 4.
[37] Id. page 15.

[NAME 2] while the contact was taking place. The remainder of her testimony is consistent with what the Appellants told the Department witnesses. Exhibit Dept. 3 is [NAME 7] unscheduled activity log for April 14, 2009. It notes that she spoke to [APPELLANT 1] at 2:50 in the afternoon, after her counseling session with [NAME 2]. She notes [APPELLANT 1]'s words: "[NAME 2] inappropriately touched members of the household." [38] [NAME 7] told [APPELLANT 1] that it was her duty as a mandated reporter to report this to the authorities.[39] [APPELLANT 1] said that since the February incident they had not allowed [NAME 1] to be alone with [NAME 2].[40] She also said: "He hasn't done it with the guys who are bigger or more functioning than him." [41] They were not concerned about the other residents since they were older, bigger, and functioned at a higher level, and thus were not at risk in their view.[42] Ms Hochreiter testified that even if [NAME 1] was not allowed to go downstairs when [NAME 2] was at home, there was still a concern about the other four residents, and an obligation to protect them from sexual abuse. This is one of the reasons that the Department decided [APPELLANT 1]'s license should be summarily suspended.[43] Exhibit Department. 9 is the Stop Placement Order that Ms. Crawford requested pending completion of the investigation of the home.[44]

14. Shortly after the session, [NAME 7] reported the incident to Adult Protective Services, which forwarded the report to Residential Care Services. [NAME 7]

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[38] Id. p. 120.
[39] Id.
[40] Id. p. 121.
[41] Id. p. 141.
[42] Exhibit Dept. 3.
[43] Transcript Vol. 1 p. 205.
[44] Transcript Vol. 3 p. 15.

based her report on information that she received from [APPELLANT 1].[45] She made her report about 43 minutes after she spoke to [APPELLANT 1].[46] Wesley Fullerton, [NAME 2]'s case manager, requested a psychosexual evaluation of [NAME 2].[47] [NAME 7] made an appointment for [NAME 2] with a doctor for a psychosexual evaluation.[48] She also told [APPELLANT 1] she would be reporting the incident and that [NAME 2] would, as a result, be removed from her home pending an investigation.

15. After the meeting with [NAME 7], [APPELLANT 1] talked with Wesley Fullerton about the session and likely told him that [NAME 7] felt that [NAME 2] could not continue living at their home. On April 15, [APPELLANT 1] met with an attorney who helped her write a 30-day eviction notice which was served on [NAME 2]. As a reason for the eviction, [APPELLANT 1] stated that they were concerned for the safety or health of individuals in the home, language likely taken from the applicable regulation, because of [NAME 2]'s "inability to control his impulses."[49] The following day, April 16, 2009, [NAME 7] filed a critical incident report with [FACILITY 3] based on what [APPELLANT 1] had told her.[50]

16. Mr. Fullerton is a case resource manager in the Department of Developmental Disabilities. He performs assessments for his clients, and helps provide services to his clients that meet their health and welfare needs.[51] He is a mandatory reporter. If a client tells him of an instance where they have been abused, neglected, or exploited, or if he believes that they have been, he is required to report to the Complaint

[45] Transcript Vol. 2 p. 169.
[46] Id. p. 172.
[47] Transcript Vol. 2 p. 123.
[48] Exhibit Dept. 22.
[49] Exhibit Dept. 4
[50] Exhibit Dept. 6.
[51] Transcript Vol. 3 p. 125.

Resolution Unit (CRU.)[52] He is not an investigator. He has been the case resource manager for four clients at [ADULT FAMILY HOME 1], [NAME 2], [NAME 5], [NAME 3], and [NAME 18].[53]

17. On April 14, 2009, [APPELLANT 1] called Mr. Fullerton and told him that [NAME 2] needed to move from her home. [APPELLANT 1] mentioned an incident to him, and said that the incident occurred between [NAME 2] and her [RELATIVE] [NAME 1]. The incident described was that [NAME 2] had humped [NAME 1] with their clothes on.[54] She said [NAME 2] had groped [NAME 1] through his clothing, and had rubbed his genitals against him.[55] He heard the word "humped" from [APPELLANT 1].[56] [APPELLANT 2] used the term "dry humping" to indicate what [NAME 2] had done to [NAME 1].[57] Mr. Fullerton contacted [APPELLANTS 1 & 2] again of April 15, and learned the following:

> . . . the incident was described by the adult family home " provider and mental health therapist by a telephone interview during separate calls on April 14, 2009. The incident was reported after the perpetrators first visit with a mental health therapist on 4-14. Provider was originally informed of the incident by their AFH resident and the victim at the end of February. Description of the incident. Client one, [NAME 2], allegedly touched the genital area of client two in the home in attempted mock intercourse with him in some fashion." "Mock intercourse" is my language. "Both perpetrator and victim are clothed at the time of the incident and no bodily penetration occurred. The victim did not consent to this act. The victim claims that the perpetrator – the victim claims that the perpetrator did not use his hands to touch his genital area, but rather rubbed him with his hips." That information I got from – on the 15th clarifying what had taken place with [APPELLANT 1] [[APPELLANT 1]] and [APPELLANT 2] [[APPELLANT 2]].[58]

[52] Id.
[53] Id. p. 126.
[54] Id. p. 140.
[55] Id. p. 141.
[56] Id.
[57] Id. p. 142.
[58] Id. p.147.

18. When Mr. Fullerton asked them to clarify what had happened, [APPELLANT 2] told him it was dry humping. “Dry humping” was [APPELLANT 2]’s phrase.[59] [APPELLANT 1] told Mr. Fullerton that the incident between [NAME 2] and [NAME 1] happened in February. He was surprised to learn that it did not happen a day or two prior to when [APPELLANT 1] told him about it.[60] She also told him that after the incident they would not leave [NAME 1] alone with [NAME 2].[61] Mr. Fullerton contacted the CRU, and filled out an incident report based on what he was told by [APPELLANTS 1 & 2].[62]

19. As a result of the reports to APS and RCS, a referral was made to local law enforcement. The basis of the referrals was [APPELLANT 1]’s reports to complainants that [NAME 4] had reported [NAME 2] humping on [NAME 1].[63] On April 16, 2009, [DETECTIVE 1] was assigned to the case.[64] On April 21, 2009, [DETECTIVES 1 & 2] interviewed [APPELLANT 1] and [APPELLANT 2] at [ADULT FAMILY HOME 1] about the incident which had been reported to APS and RCS. They told [APPELLANT 1] that someone had called in a report of sexual assault in their home.[65] [APPELLANT 1] essentially confirmed that [NAME 2] had been caught “humping” [NAME 1] and that he “owned up to it” when confronted by [APPELLANT 2] and [APPELLANT 3]. This is discussed in the Detective’s report, Exhibit Dept. 13. During the hour that [DETECTIVE 1] was at the adult family home, he does not recall

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[59] Id. p. 168.
[60] Id. p. 164.
[61] Id. p. 152.
[62] Id. p. 145.
[63] Transcript Vol. 3 p. 81.
[64] Transcript Vol. 3 p. 40.
[65] Transcript Vol. 8 p. 102.

any mention of Elvis.[66] [APPELLANT 1] told [DETECTIVE 1] that [NAME 4] said that he saw [NAME 2] humping on [NAME 1].[67] She told him that [NAME 1] was no longer allowed downstairs when [NAME 2] was at home.[68] She denied that there had been any similar incidents in the past. The detectives tried to interview [NAME 4] but he said he didn't remember the incident. [DETECTIVE 1] considered talking to [NAME 1] but, didn't feel qualified to conduct the interview given [NAME 1]'s disabilities. [DETECTIVE 1] left three blank statements, and asked [APPELLANT 2] to fill one out, and to have [APPELLANT 3] and [APPELLANT 1] fill one out. The Appellants did not fill out the forms and return them to the detective. [DETECTIVE 1] spoke to a person at [BUSINESS 2]. He learned that the information they had obtained was not from a client, but from [APPELLANT 1].[69] [NAME 7] was asked by [DETECTIVE 1] why she had failed to report the incident. She appeared to feel threatened by the question, and did not have a good response.[70] The detectives did not interview [NAME 2] or any other resident. The law enforcement investigation ended because there was not clear evidence of sexual assault.[71]

20. On April 23, 2009, [APPELLANTS 1 &2] sent a letter to Mr. Fullerton giving notice that [NAME 2] must be transferred out of their home "as soon as possible, but in no event more than 30 days from now." [72] The letter explained: "We have found

[66] Transcript Vol. 3 p. 116.
[67] Transcript Vol. 2 p. 94.
[68] Transcript Vol. 3 p. 42.
[69] Id. pp. 49-51.
[70] Id. pp. 77-78.
[71] Id. p. 53.
[72] Exhibit Dept. 4 p.1.

that he is unable to control his impulses, and has acting out issues with other clients in a manner that affects the safety and health of individuals within our home."[73]

21. There were three complaints that came in on three consecutive days in April regarding contact between [NAME 2] and [NAME 1] in February 2009.[74] The second complaint came in April 2009 from [NAME 2]'s [RELATIVE] [NAME 8] concerning how his [RELATIVE] was being treated after the incident between [NAME 2] and [NAME 1].[75]

22. Roberta Hochreiter has been a registered nurse for 36 years. She is a certified case manager for DSHS Residential Care Services (RCS). She investigates licensing complaints regarding adult family homes and boarding homes. She has performed two licensing complaint investigations of [ADULT FAMILY HOME 1].[76] Ms. Hochreiter's training included how to interview people, and how to determine whether people were telling the truth. She took a class in investigative procedures with the police department and attorneys.[77] She has been trained in talking with all kinds of populations of people, which would include developmentally disabled people, people with Alzheimer's, and people with dementia.[78] In her nurse's training she has had training on how to interview and assess people who are non-verbal.[79]

23. On April 23, 2009, Ms. Hochreiter began her investigation of the incident with a home visit to [ADULT FAMILY HOME 1]. She returned to [ADULT FAMILY HOME 1] on April 29 and 30, 2009, to complete her investigation and was accompanied

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[73] Id.
[74] Transcript Vol. 1 p. 32.
[75] Id. p. 33.
[76] Id. p. 32.
[77] Id. p. 109.
[78] Id. p. 110.
[79] Id.

on April 29 by her supervisor Roberta Crawford who assisted her in the investigation. Between them, they interviewed [APPELLANT 1], [APPELLANT 2], [APPELLANT 3], three of the residents ([NAME 2], [NAME 4], and [NAME 6]) and [NAME 2]'s [RELATIVE]. At the hearing, [APPELLANT 1] could not recall whether Ms. Hochreiter asked her questions.[80] She then testified that Ms. Hochreiter interviewed her once, on either April 23 or April 29.[81] Ms. Hochreiter's Statement of Deficiencies indicates that [APPELLANT 1]: ". . . stated in interview on 4/29/09 she found out about the incident when she returned to the AFH on 2/27/09. She stated her [RELATIVE] (Staff B) had taken care of the situation. She contacted a mental health clinic to get Resident 1 [[NAME 2]] into counseling." [82]

24. Roberta Crawford has been a registered nurse for 35 years. She has a BA in Nursing and a certificate of Gerontology from the Institute on Aging.[83] Both Ms. Hochreiter and Ms. Crawford work for RCS. RCS is the licensing and regulatory department in DSHS that does the licensing for adult family homes, boarding homes, and nursing homes.[84] Ms. Crawford is Ms. Hochreiter's supervisor. She hand delivered the summary suspension notice to [APPELLANT 1] on May 7, 2009.[85] She discussed the Statement of Deficiencies, what the notice entails, and what appeal rights were available with [APPELLANT 1].[86]

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[80] Transcript Vol. 8 p. 20-21.
[81] Id. p. 22-24.
[82] Exhibit Dept.7 p. 3.
[83] Transcript Vol. 3 pp. 8-9.
[84] Id.
[85] Id. p. 18.
[86] Id.

25. Ms. Crawford interviewed [APPELLANT 3].[87] As to the reported incident, [APPELLANT 3] said that [NAME 2] admitted to her that he rubbed his genitals against [NAME 1] in mock intercourse. [APPELLANT 3] told Ms. Crawford that [NAME 4] had come upstairs and told her an incident was occurring downstairs. She went over and called [NAME 1] up from downstairs and asked [NAME 1] what had occurred. [APPELLANT 3] was told: "[NAME 2]'s humping [NAME 1]," [88] The word "humping" was [APPELLANT 3]'s word, not Ms. Crawford's word. [APPELLANT 3] then called [NAME 2] upstairs, and [NAME 2]'s comment to her was "did [NAME 1] rat me out?" [89] [APPELLANT 3] told [NAME 2] that it was inappropriate, and then she told [APPELLANT 2] what had happened.[90] Ms. Crawford asked [APPELLANT 3] why she did not report the incident to the CRU 1-800 number. [APPELLANT 3] responded that both men were fully clothed, so she did not think it constituted sexual assault.[91] [APPELLANT 3] did not use the words "mock intercourse" – she used the words "dry humping." [92] Ms. Hochreiter testified that it would be sexual abuse whether they have clothes on or not.[93]

26. Ms. Hochreiter interviewed [APPELLANT 2] at the adult family home. He told her that when he found out about the incident between [NAME 2] and [NAME 1] he got pissed.[94] "Pissed" was [APPELLANT 2]'s word. [APPELLANT 2] told Ms. Hochreiter that he did not want to report what [NAME 2] had done because he felt that a

[87] Transcript Vol. 3 p. 25.
[88] Id. p. 26.
[89] Id.
[90] Id.
[91] Id.
[92] Id. p. 45.
[93] Id. p. 203.
[94] Id. p. 70.

report of sexual misconduct would create problems for [NAME 2] in the future,[95] and that he thought that he had dealt with the incident by telling [NAME 2] that such behavior would not be tolerated in their home. He said he told [NAME 2]: "This is complete bullshit."[96] He told Ms. Hochreiter that he had taken protective actions after [NAME 2] disclosed the dry humping incident. The protective actions were: (1) he did not allow [NAME 1] to go downstairs when [NAME 2] was home; (2) he told [NAME 2] that his impulses had to stop; and (3) he had a talk with "the guys" about inappropriate touching.[97] [APPELLANT 2] used the words "dry humping." [APPELLANT 2] did not tell Ms. Hochreiter what he meant by dry humping, but he showed her.[98] Dry humping as he used it is thrusting the pelvis forward as if in intercourse, and that is what [APPELLANT 2] told Ms. Hochreiter that [NAME 2] had done to [NAME 1].[99] He demonstrated, including bodily contact with another person.[100] Ms. Hochreiter never heard anyone mention Elvis.[101]

27. [APPELLANT 2] said that [NAME 2] told him he got these impulses and couldn't help acting on them. Neither [APPELLANT 2] nor [APPELLANT 3] reported the incident. Both [APPELLANT 2] and [APPELLANT 3] told Ms. Hochreiter that there was physical contact between [NAME 1] and [NAME 2].[102] Ms. Hochreiter knew from their use of the term "dry humping" and [APPELLANT 2]'s imitation of dry humping, and [APPELLANT 2]'s demonstration of an erection (using his finger) that [APPELLANT 2]

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[95] Id. p. 46.
[96] Id. p. 70.
[97] Id. p. 51.
[98] Transcript Vol. 1 p. 114, 115.
[99] Id. p. 116.
[100] Id. p. 119.
[101] Id. p. 114.
[102] Id. p. 142.

and [APPELLANT 3] were talking about a sexual instance.[103] [APPELLANT 2] told her that he had changed [NAME 1]'s diaper until he was seven or eight years old, and he had never seen his [RELATIVE] have an erection[104] ([NAME 1] was [AGE] at the time of the incident.) [APPELLANT 1] told Ms. Hochreiter she learned of the incident when she returned from [LOCATION 1] and immediately contacted [BUSINESS 2] for an appointment for [NAME 2]. At the hearing [APPELLANT 1] testified that there was nothing going on.[105] This conflicts with her earlier statements.

28. On April 29, 2009, Ms. Crawford asked [APPELLANT 1] for her incident log. [APPELLANT 1] did not maintain an incident log for [ADULT FAMILY HOME 1].[106]

29. When Ms. Hochreiter interviewed [NAME 2], he told her that [NAME 1] continued to come downstairs and come into his room. He also told her that he was not the instigator. He told her that [NAME 1] did lap dances on him and nobody would listen to him.[107] [NAME 2] used the term "lap dance."[108] According to Ms. Hochreiter, the same problems existed if [NAME 1] was the instigator because there was unwanted sexually inappropriate behavior going on in the home.[109] [APPELLANT 1] understood that she had the same reporting responsibility as to [NAME 1] as she did to the paying residents of her adult family home.[110]

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[103] Id. p. 151.
[104] Transcript Vol. 3 p. 32.
[105] Transcript Vol. 8 p. 51.
[106] Transcript Vol. 3 p. 36.
[107] Transcript Vol. 1 p. 52.
[108] Id. p. 53.
[109] Id. p. 220.
[110] Transcript Vol. 9 p. 187.

30. Ms. Hochreiter was concerned that the Appellants did not seem to understand that they needed to report the sexual incident to the Department.[111] [APPELLANT 2] and [APPELLANT 3] would have had an obligation to report as soon as [NAME 4] came upstairs and told [APPELLANT 3] that there was something going on in the basement.[112] In Ms. Hochreiter's opinion the Appellants could not have reasonably concluded at the end of their investigation that there was no reason to suspect that sexual abuse occurred.[113] She was also concerned that [APPELLANT 1] told her that [NAME 2] "preys on vulnerable people out in the community," but did not report his behavior.[114]

31. Ms. Hochreiter also interviewed resident [NAME 4]. He told her that [NAME 1] can be sexually inappropriate. He said [NAME 1] would come downstairs wearing boxer shorts, and was constantly adjusting himself, touching himself and his shorts. There was conflicting testimony regarding whether [NAME 1] wore boxer shorts, or basketball shorts. It does not matter which he wore, what matters is that [NAME 1] was exposing his genitals to [NAME 4], and [NAME 4] did not want to see that.[115] He would sit on a chair in [NAME 4]'s room and his shorts would gape open and [NAME 4] would see things he did not want to see.[116] Ms. Hochreiter testified that "sexually inappropriate" were [NAME 4]'s actual words.[117] Resident [NAME 6] told Ms. Hochreiter that "once in a while he [[NAME 1]] does a lap dance, did it to [[NAME 2]]." "Lap dance" were [NAME 6]'s actual words. According to [NAME 6]'s [RELATIVE], [NAME 6] had

[111] Transcript Vol. 1 p. 206.
[112] Id. p. 204.
[113] Id. p. 220.
[114] Id. p. 209.
[115] Id. p. 143.
[116] Id. pp. 53-54.
[117] Id. p. 54.

spent a lot of time in bars in his past, and he knew what a lap dance was.[118] Ms. Hochreiter had three residents describe to her the sexual behavior that occurred more than once, and verbal abuse. All three told her basically the same thing, but in their own words.[119]

32. [NAME 4] also told his [RELATIVE] that [NAME 1] would dance around and touch himself-- touch his privates.[120] [NAME 4] felt that [NAME 1]'s touching himself was inappropriate.[121]

33. Ms. Hochreiter interviewed [NAME 8], [NAME 2]'s [RELATIVE], on April 23, 2009. [NAME 8] told her that [NAME 2] told him that he did not initiate the sexual incident that occurred with [NAME 1]. And that [APPELLANTS 1 & 2] would not believe him.[122]

34. The Appellants testified at hearing about [NAME 1]'s love of music and dancing, and that he liked to dress up as Elvis Presley and imitate him. They also said that [NAME 1] could be socially intrusive and had a problem respecting boundaries, which was likely an aspect of his developmental delay and the Down syndrome. The adults in the home ([APPELLANT 1], [APPELLANT 2], and [APPELLANT 3]) were telling Ms. Hochreiter different stories on different days.[123] [APPELLANT 1] first told Ms. Hochreiter that [NAME 2] had been behaving in sexually inappropriate ways since

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[118] Transcript Vol. 4 p. 182.
[119] Transcript Vol. 1 p. 59.
[120] Transcript Vol. 5 p. 54.
[121] Id. p. 87.
[122] Transcript Vol. 1 p. 56.
[123] Id. pp. 144-145.

two weeks after he came to the facility.[124] At the time of the incident that is the focus of this proceeding, [NAME 2] had been in the home for about a year.[125]

35. Ms. Hochreiter broadened her investigation beyond the reported incident as a result of her interviews with residents [NAME 2], [NAME 4], and [NAME 6], who complained to her that they did not have their personal preferences honored for choice of food.[126] One complaint was that [APPELLANTS 1 & 2] did not allow them to put sugar on their breakfast cereal, another was that they were only allowed to drink milk at breakfast. [APPELLANT 2] testified that the sugar was available on the kitchen counter, and that they tried to discourage excessive sugar use for health reasons.[127] The three residents told Ms. Hochreiter that they were not allowed to go into the refrigerator and get food.[128] They also said that when [APPELLANT 2] cooked breakfast on Sundays they were not allowed to have anything else.[129] [NAME 4] told Ms. Hochreiter that when he asked [APPELLANT 3] at lunch to have a glass of milk, she said yes, and [APPELLANT 2] came up and said no, he could not have it.[130] [NAME 4] told his [RELATIVE] that he the residents were not allowed to have seconds.[131] [APPELLANTS 1 & 2] told Ms. Hochreiter that they did not keep sugar on the table, because the residents would eat it all of the time if it was out. They told her that the residents have one glass of milk in the morning because their drinking of milk was out of control. “Out

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[124] Id. p. 145.
[125] Id. p. 146.
[126] Id. p. 69.
[127] Transcript Vol. 7 p. 69.
[128] Transcript Vol. 1 p. 178.
[129] Id. p. 62.
[130] Id. p. 64.
[131] Transcript Vol. 5 p. 61.

of control" was [APPELLANT 2]'s phrase.[132] The residents also told Ms. Hochreiter that they were told they could have milk if they bought it themselves. The Appellants denied this, although they admitted trying to limit the quantity consumed by [NAME 6] for health reasons. On April 29, Roberta Crawford observed [APPELLANT 3] making lunch for the residents. She made a couple of peanut butter and mayonnaise sandwiches, and explained that they were [NAME 3]'s favorite.[133] Former resident [NAME 11], and [NAME 6]'s [RELATIVE] [NAME 13], testified that the food provided at the home was of high quality and that milk and sugar were provided and that resident's food preferences were considered. [NAME 11] testified that he could go into the refrigerator to get things that were his "as long as it was mine."[134] [NAME 11] testified that he would go into the dry storage closet if he was asked to get something that was in there, but that it was off limits and he needed to have permission from the administrator or his [RELATIVE] to go in there.[135] He never went into the freezer. There was always fruit on the kitchen table for a snack.[136] [APPELLANT 3] was asked if the residents could go into the pantry. Her response was that there was a problem with [NAME 2] going in there a lot, so "we" made a rule that "they" could not go in there unless they asked.[137] [APPELLANT 1] denied the allegation that they limited access to milk or other food choices except when advised to do so by medical staff.[138] There is ample evidence in the record, corroborated by consistent and similar reports from current and

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[132] Transcript Vol. 1 p. 65.
[133] Id. p. 61.
[134] Transcript Vol. 4 p. 122.
[135] Id. p. 123.
[136] Id. p. 124.
[137] Reconstructed Record of the first part of the morning of April 23, 2010, page 4. The ALJ recorded over a portion of the audio record, so he transcribed his notes. All parties agreed that these notes could be used as the record of that portion of the proceedings. See, transcript Vol. 8 p. 8.
[138] Exhibit Dept. 12 p. 2.

former residents, as well as their family members, to support a finding that access to food was unreasonably restricted by the Appellants

36. [NAME 2], [NAME 4], and [NAME 6] also complained about being yelled at and verbally abused by [APPELLANT 2] and [APPELLANT 3]. [APPELLANT 2] and [APPELLANT 3] both denied yelling at the residents or verbally abusing them or belittling them. [NAME 4] told Ms. Hochreiter that [APPELLANT 2] and [APPELLANT 3] yelled at [NAME 6] for having poop on his bed.[139] The yelling upset [NAME 4] so much that he put his headphones on and walked outside. [NAME 4] began crying when he told Ms. Hochreiter about the yelling. Three residents told Ms. Hochreiter there was yelling at the residents. All three of them named the same two people – [APPELLANT 2] and [APPELLANT 3] – as the ones who yelled.[140] [APPELLANT 3] testified that she raised her voice to speak with [NAME 2] in order to get his attention.[141] Raising her voice is yelling. She also testified that she explained to [NAME 4] that he was living in [APPELLANTS 1 &2]'s house.[142]

37. According to [NAME 4], [APPELLANT 3] at one point told [NAME 6]: "If you are going to act like a baby, I will treat you like a baby," a statement she denies making. The context may have been an instance when he soiled his bed. As to that incident, [APPELLANT 2] and [APPELLANT 3] testified that they were not concerned that [NAME 6] soiled his bed, which was an occasional problem he had because of his condition, but that he left the mess for [NAME 2] to deal with and that [NAME 2] had not used gloves while cleaning it up. Both [APPELLANT 1] and witness [NAME 14] denied

[139] Transcript Vol. 1 p. 156, 161.
[140] Id. p. 172.
[141] Reconstructed Record of the first part of the morning of April 23, 2010, page 3.
[142] Id.

witnessing or hearing about any verbally abusive behavior towards residents by either [APPELLANT 2] or [APPELLANT 3]. [APPELLANT 1] said that [APPELLANT 2] had a hearing problem and often talked in a loud voice which could be misinterpreted as yelling. [NAME 2] also complained about his treatment by staff after the incident and after receiving the eviction notice. [NAME 6] told Ms. Hochreiter that he got into scuffles with [APPELLANT 2] and [APPELLANT 3]. "Scuffles" was the word used by [NAME 6].[143] He said that [APPELLANT 2] gets very upset and does not know how to calm himself.[144]

38. On April 30, 2009, the Department completed its adult family home licensing investigation and Ms. Hochreiter wrote a 7-page Statement of Deficiencies (SOD).[145] The Statement of Deficiencies found violations of four adult family home licensing regulations: WAC 388-76-10020 (License - Ability to provide care and services), WAC 388-76-10620 (Resident rights -Quality of life - General), WAC 388 -76-1067 (Prevention of abuse), and WAC 388-76-10673 (Abuse and neglect reporting - Mandated reporting to department -Required).

39. A copy of the SOD was given to [APPELLANT 1], or the contents discussed with [APPELLANT 1], on April 30, 2009. [APPELLANT 1] called the Department's hotline later that day reporting an allegation of non–consensual touching involving a resident. She also made a separate call to the CRU to report that [APPELLANT 2] and [APPELLANT 3] were verbally abusing residents of the home.[146]

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[143] Transcript Vol. 1 p. 69.
[144] Id.
[145] Exhibit Dept. 7.
[146] Transcript Vol. 8 p. 35.

At the hearing she claimed that she did this because Ms. Crawford told her to do so.[147] [APPELLANT 1] also relieved [APPELLANT 2] and [APPELLANT 3] from duty until the investigation was done.[148] Again, at the hearing, she claimed that she did this following directions from Ms. Crawford.[149] Ms. Crawford was concerned enough about the verbal abuse allegations to require an immediate safety plan. That plan resulted in [APPELLANT 2] and [APPELLANT 3] being removed from all duties with the residents.

40. [APPELLANT 1] was asked at the hearing when she first heard that anyone was thinking about sex in this matter. Her response was: "It's such a blur now." [150] She could not recall if Ms. Crawford advised her to report anything about sex.[151] Yet, [APPELLANT 1] called the CRU on April 30, 2009 to report non-consensual touching involving a resident.[152] Her report to the CRU is more credible than her testimony at hearing.

41. On May 1, 2009, the Department issued a Stop Placement Order prohibiting any new admissions to the home pending completion of their investigation.[153] That same day, [APPELLANT 1] wrote a letter to Ms. Crawford informing her that [APPELLANT 2] and [APPELLANT 3] would be relieved of all caregiving responsibilities at [ADULT FAMILY HOME 1] until the allegations of verbal abuse were resolved.[154]

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[147] Id.
[148] Id. p. 37.
[149] Id.
[150] Id. pp 45-46.
[151] Id.
[152] Transcript Vol. 9 p. 173.
[153] Exhibit Dept. 9.
[154] Exhibit Dept. 5.

42. On May 7, 2009, the Department personally served [APPELLANT 1] with a Notice of Summary Suspension, License Revocation, and Stop Placement Order Prohibiting Admissions referencing the attached Statement of Deficiencies as the basis for the action. Exhibit Dept 10. The Notice summarized the key findings as:

> **Serious Deficiencies Determined To Be**
> **An Imminent Danger To Resident's Health, Safety, Or Welfare:**
>
> WAC 388-76-10020 License – Ability to provide care and services.
> The licensee demonstrated a lack of understanding of how to protect five residents from verbal and sexual abuse. This placed all residents at risk of emotional and physical harm and a diminished quality of life.
>
> WAC 388-76-10620(2)(a)(c) Residents rights – Quality of life – General.
> The licensee failed to allow three residents to make choices about food and drink. Failure to allow three residents to have some control over food choices placed them at risk for diminished quality of life.
>
> WAC 388-76-10670 (1-4) Prevention of abuse.
> The licensee failed to ensure residents in the Adult family Home were free from abuse. Failure to ensure residents were not ridiculed and yelled at resulted in emotional distress for three residents.
>
> WAC 388-76-10673 (2)(a)(b) Abuse and neglect reporting – Mandated reporting to department – Required.
> The licensee failed to report an allegation of sexual abuse between one resident and a Household Member (HM). This failure placed residents at risk of continued abuse.

43. In addition to the deficiencies cited in the SOD, the Notice cited a history of significant, repeated and/or uncorrected violations that demonstrated the home's inability or unwillingness to provide care and services to residents as required by law, although no specific history was detailed. *Id.* There was evidence presented at the hearing that there had been a few prior investigations but no evidence that any

deficiencies noted were uncorrected or repeated. Nor was there any evidence that the Department had taken any enforcement action against the home or licensee in the past.

44. [APPELLANT 1] elected to participate in the Informal Dispute Resolution (IDR) process offered by the Department in this regulatory arena. On May 12, 2009, [APPELLANT 1] sent a letter to the IDR program manager requesting IDR in which she admitted that the incident that occurred in their home on February 23, 2009, "most likely" involved resident [NAME 2] rubbing himself, "including his private parts," on her [RELATIVE] [NAME 1].[155] She wrote that the incident was reported to [APPELLANT 3] by resident [NAME 4].[156] She went on to say that they did not report the incident because they felt that while what had occurred was inappropriate it did not constitute sexual abuse or assault. She stated: "After we became aware of this issue, we made an appointment with [BUSINESS 2] to see if [NAME 2] would qualify for mental health services, and made an appointment for him." [157] [APPELLANT 1] wrote: "It is my opinion that neither abuse nor criminal assault occurred, however this incident does constitute inappropriate behavior between residents/household members. . . . However, in the future we will report matters of this nature to APS.[158] [APPELLANT 1] was asked about this statement during the hearing. When she was asked: "matters of what nature?" she replied: "I don't recall."[159] [APPELLANT 1] also wrote: "From the time we became aware of this incident, we also took vigorous steps to separate [NAME 1]

[155] Exhibit 12 p. 1.
[156] Id.
[157] Id. At the hearing [APPELLANT 1] testified that [NAME 2]'s meeting with the mental health therapist was set before she went to [LOCATION 1]. Transcript Vol. 8 p. 58. This is in direct conflict with what she wrote in her letter which is Exhibit 12.
[158] Id. p. 2.
[159] Transcript Vol. 8 p. 89, 90.

from [NAME 2] until [NAME 2] moved out."[160] [APPELLANT 2] testified at the hearing that they took no special steps after February 23, 3009, as a result of the incident.[161] [APPELLANT 1] also testified to this.[162] This directly contradicts what she wrote in Exhibit 12.

45. Exhibit Dept. 14 is a copy of the notes that [APPELLANT 1] brought with her to the IDR meeting. She supplied a copy of the notes to the IDR during their meeting on June 2, 2009. The middle of page one of the Exhibit reads in part: "I was in the process of having [NAME 2] seen by a mental health professional, on his [RELATIVE]'s recommendation for other behavior items he was dealing with. The incident was brought up during his appointment with [NAME 7], Mental Health Therapist."[163] When asked by her attorney what "incident" she was talking about, [APPELLANT 1] answered: "I don't recall." [164]

46. [APPELLANT 1] also denied allegations of yelling by [APPELLANT 2]. She referred to an instance where [NAME 6] had soiled his bed and asked [NAME 2] to clean up his bedding, and do his laundry.[165] She wrote that [NAME 6] was angry, and: "This is a significant health and hygiene issue, and my [RELATIVE] was emphatic about it. This discussion was animated, and my [RELATIVE] is a big man, hard of hearing, and speaks loudly. You need to hear him to understand that he is loud without yelling." [166] Emphatic, animated, loud speaking is yelling.

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[160] Id. p. 2.
[161] Transcript Vol. 7 p. 131.
[162] Transcript Vol. 8 p. 72.
[163] Exhibit Dept. 14 p. 1.
[164] Transcript Vol. 9 p. 97.
[165] Id. p. 3.
[166] Id. p. 2.

47. The IDR session was held on June 8, 2009, and resulted in some changes in the SOD, the only significant change involving the removal of the finding that law enforcement should have been contacted by the home about the incident on February 23, 2009.[167] However, no change in the enforcement action was recommended or made.

48. On May 12, 2009, [APPELLANT 1] also wrote a letter to the Office of Administrative Hearings (OAH) requesting an administrative hearing to contest the Department's May 7, 2009, enforcement action.[168]

49. On June 19, 2009, the Department's Resident and Client Protection Program (RCPP) began its own investigation of the individuals working at the [ADULT FAMILY HOME 1] as to the allegations of verbal abuse and neglect reported to the Department. Complaint investigator Gloria Morrison has been a nurse for 30-plus years. She has a BA in Psychology.[169] She does investigation of allegations of abuse or neglect in facilities that are certified and licensed by the Department. She was assigned to investigate allegations of possible abuse or neglect of clients in the [ADULT FAMILY HOME 1].[170] Ms. Morrison interviewed all five residents who had been at [ADULT FAMILY HOME 1] shortly before it was closed. [NAME 4] told her he didn't remember the incident and [NAME 6] refused to talk to her. Ms. Morrison used statements they had made to the licensing complaint investigators in April 2009 in her report. Residents [NAME 5] and [NAME 3], who had not previously been interviewed, had positive things to say about [ADULT FAMILY HOME 1] and their time there.

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[167] Exhibits Dept. 8 (Amended Statement of Deficiencies) and Dept. 15 (Statement of Deficiencies.)
[168] Exhibit Dept. 11.
[169] Transcript Vol. 2 p. 9.
[170] Id. p. 11.

50. [NAME 2] told Ms. Morrison that [NAME 1] had been the instigator of the incident in February, and said that [NAME 1] had pulled him down on the ground and started humping on him and wouldn't let him up for some time. [NAME 2] told her:

> [NAME 1] grabbed him, pulled him down and started humping him. He wouldn't let [NAME 2] up and just kept going and going. [NAME 1] did that to [NAME 2] one more time. [NAME 2] told [APPELLANT 1] but she said her [RELATIVE] never does that. [NAME 1] snuck up behind [NAME 2] in the downstairs area of the home when it happened. [NAME 2] thought [APPELLANT 1] was more concerned for [NAME 1] than for [NAME 2]. [APPELLANT 3] went downstairs and told [NAME 2] that [NAME 1] said [NAME 2] was "raping" him. [NAME 2] told [APPELLANT 1] about [NAME 1] "humping" him before [Ms. Hochreiter's] visit to the home on 4/23/09. [NAME 2] also told [APPELLANT 2] but did not tell [APPELLANT 3] because "she thinks I lie." [171]

According to their assessments, [NAME 1] weighed 162 pounds,[172] and [NAME 2], although taller, weighed only 135 pounds.[173] "Raping" and "humping" were words that [NAME 2] used.[174] Ms. Morrison asked for clarification of what [NAME 2] meant by "humping." She said: "[NAME 2], when you say humping, do you mean that [NAME 1] came up to you, grabbed your body with his hands and held it against you, and thrust into you like this?" Ms. Morrison had her arms out and gyrated her body, including her pelvis. And [NAME 2] said "yes." [175] [NAME 2]'s [RELATIVE] [NAME 8] was present during the interview.[176] [NAME 2] said that on at least one occasion, probably more than one occasion, [NAME 1] had snuck up behind him and started humping him.[177]

51. Ms. Morrison also interviewed the Appellants and Wesley Fullerton, [NAME 7], and [DETECTIVE 1], all of whom repeated the substance of their previous

[171] Exhibit Dept. 25 page 3 of 7.
[172] Exhibit Dept. 17 p. 13.
[173] Exhibit Dept. 16 p. 12.
[174] Transcript Vol. 2 p. 18.
[175] Id. p. 19.
[176] Id.
[177] Id.

statements. At the conclusion of her investigation, Ms. Morrison wrote three reports summarizing the results of her investigation regarding [APPELLANT 1],[178] [APPELLANT 2],[179] and [APPELLANT 3][180], and an additional finding of mental abuse against [APPELLANT 3]. These reports were submitted to a RCPP panel on September 28, 2009, which recommended findings of neglect of vulnerable adults against [APPELLANTS 1 & 2], and findings of neglect and mental abuse against [APPELLANT 3].

52. In her testimony at the hearing, [APPELLANT 1] denied making most of the statements attributed to her by Ms. Morrison in Exhibit Dept. 25.[181] It is more likely than not that she made the statements attributed to her by Ms. Morrison. [NAME 2] left [ADULT FAMILY HOME 1] at the end of April. [APPELLANT 1] received the Statement of Deficiencies on May 7. [APPELLANT 1] testified that she did not have any knowledge that there was an allegation of sexual contact between [NAME 1] and [NAME 2] until she received the Statement of Deficiencies.[182] Yet she told Department representatives that she kept [NAME 2] and [NAME 1] apart after she learned of the incident. This statement only makes sense if [APPELLANT 1] learned of the allegations before [NAME 2] left the home.

53. On October 1, 2009, the Department issued a Notice of Preliminary Finding letters to each Appellant, which were served on them by certified and regular mail.[183] If there is a final finding of abuse, neglect, or exploitation the individual against

[178] Exhibit Dept. 25.
[179] Exhibit Dept. 29.
[180] Exhibit Dept. 33.
[181] Transcript Vol. 9 p. 120-137.
[182] Id. p. 155.
[183] Exhibits Dept 23, 27 and 31.

whom the finding is made cannot have unsupervised access to vulnerable adults in Department licensed or certified settings.[184]

54. [APPELLANT 1] was informed that the Department had found that she had neglected vulnerable adults. Ms. Morrison recommended the finding because when [APPELLANT 1] learned of the sexualized behavior between [NAME 2] and [NAME 1], she did not report it to the Complaint Resolution Unit. She did not report it to the case manager. She did not make an effort to assure that all of the clients in her home were safe from any kind of sexual predatory behavior.[185] The stated basis for the finding was:

> **After a Resident and Client Protection Program investigation, the Department of Social and Health Services has found that you neglected vulnerable adults.**
> **. . .**
> <u>The Incidents</u>
> You were the licensed provider of [ADULT FAMILY HOME 1], an Adult Family Home. Between about February 23, 2009 and April 30, 2009 you demonstrated a pattern of neglect to five vulnerable adults who were residents at the home. You failed over time to take any of several opportunities to notify the authorities of an allegation of inappropriate sexual conduct including: immediately upon learning about it, when told of your obligation by a mental health counselor, when told the incident was reportable by a department resource case manager. For over two months you demonstrated a pattern of neglecting the vulnerable adults' health, wellbeing and safety by not putting protections in place concerning unwanted sexual contact or asking for help from department staff.

55. [APPELLANT 2] was also found to have neglected vulnerable adults. Ms. Morrison recommended the finding of neglect because when [APPELLANT 2] learned that there had been a sexualized event in his home on February 23, 2009, no report was made to the Department's hotline. No report was made to law enforcement. And

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[184] Transcript Vol. 4 p. 95.
[185] Transcript Vol. 2 p. 29.

no consistent implementation of interventions to protect the residents from further potential sexual behavior was made.[186] The stated basis for the finding was:

> **After a Resident and Client Protection Program investigation, the Department of Social and Health Services has found that you neglected vulnerable adults.**
> **. . .**
> <u>The Incidents</u>
> You were a caregiver at [ADULT FAMILY HOME 1], an Adult Family Home. Between about February 23, 2009 and April 30, 2009 you demonstrated a pattern of neglect to five vulnerable adults who were residents at the home. You failed to take any of several opportunities to report an allegation of inappropriate sexual contact to the Department's complaint hotline and to law enforcement per mandatory reporting law and by not putting protections in place to protect other vulnerable adults from unwanted sexual contact. This inaction left the vulnerable adults at potential risk of abuse.

56. [APPELLANT 3] was found to have neglected and abused vulnerable adults. Ms. Morrison recommended the finding of neglect because was based on [APPELLANT 3]'s failure to report when she became aware of the allegation on sexual abuse on February 23, 2009.[187] The finding of verbal abuse was based on [NAME 2] telling her that [APPELLANT 3] was really nasty to everyone, including him.[188] That he saw [APPELLANT 3] chastise [NAME 6] about his laundry, and express anger at [NAME 2] when he tried to help [NAME 6] with his laundry. That [APPELLANT 3] called [NAME 2] a liar.[189] [NAME 4] told Ms. Morrison that when he dropped something and it broke, [APPELLANT 3] became very angry at him and told him to go downstairs. And she followed him downstairs and continued to criticize him. When he cried, she called him a baby.[190] [NAME 4] told Ms. Morrison that [APPELLANT 3] yelled at him, and that

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[186] Id. pp. 32-33.
[187] Id. p. 36.
[188] Id. p.41.
[189] Id.
[190] Id. pp 41-42.

she "scares the wits out of me." [191] The stated basis for the finding was:

> **After a Resident and Client Protection Program investigation, the Department of Social and Health Services has found that you neglected vulnerable adults.**
> **. . .**
> The Incidents
> You were a caregiver at [ADULT FAMILY HOME 1], an Adult Family Home. Between about February 23, 2009 and April 30, 2009 you demonstrated a serious disregard for the health, well-being and safety of five vulnerable adults who lived at the adult family home by failing to notify the authorities of allegations of inappropriate sexual contact. The inaction left the vulnerable adults at potential risk of abuse. Sometime between July 1, 2008 and April 30, 2009, you verbally and mentally abused three vulnerable adults by ridiculing them and yelling at them.

57. On October 9, 2009, each Appellant requested an administrative hearing to contest the Department's finding against them.

58. [NAME 14] is a behavioral consultant for [BUSINESS 3].[192] She has worked in the field of developmental disabilities for 25 years.[193] She first met [APPELLANTS 1 & 2] when she was asked to do some consultation for [NAME 1] about three years before the hearing.[194] She worked with [NAME 1], another young man, and then with [NAME 2].[195] If [NAME 1] told her that someone touched him inappropriately, she would believe him.[196] If [NAME 2] told her that someone touched him inappropriately, she would believe him.[197] [NAME 14] is a mandatory reporter.[198] She would report those statements.[199] In her experience, developmentally delayed or

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[191] Id. p. 42.
[192] Transcript Vol. 5 p. 91.
[193] Id.
[194] Id. p. 94.
[195] Id.
[196] Id. p. 133.
[197] Id.
[198] Id. p. 103.
[199] Id.

developmentally disabled adults can be sexual beings.[200] Based on her experience working with [NAME 1], she believes he is a sexual being.[201] It is also her opinion, after working with [NAME 2], that [NAME 2] is a sexual being.[202] If [NAME 2] touched [NAME 1] sexually without consent, that would meet [NAME 14]'s definition of a sexual assault.[203] If [NAME 1] touched [NAME 2] sexually without consent, that would also meet her definition of sexual assault.[204] If a resident in an adult family home told her that another resident was being sexually inappropriate, she would report that. If someone told her that there was humping going on she would report that.[205] If a resident told her that a resident was doing lap dances to another resident she would report that.[206] If a resident told her that a resident was rubbing his genitals on another resident, she would report that.[207]

59. There is a clear conflict in the evidence presented at hearing as to what [APPELLANT 2] and [APPELLANT 3] were told by [NAME 4], [NAME 2], and [NAME 1] had happened on February 23, 2009. At the hearing, [APPELLANT 2] and [APPELLANT 3] testified that after talking to [NAME 2], [NAME 1], and [NAME 4], they concluded that nothing significant appeared to have happened between [NAME 2] and [NAME 1], at least nothing more than the type of disagreements that they often had. This conflicts with earlier statements made by the Appellants to others, including [BUSINESS 2] employees [NAME 9] and [NAME 7], Department investigators Robbie

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[200] Id.
[201] Id.
[202] Id. p. 94.
[203] Id. p. 137.
[204] Id.
[205] Id. p. 138-139.
[206] Id. p. 139.
[207] Id. p. 139-140.

Hochreiter, and Roberta Crawford, and [COUNTY 1] [DETECTIVE 1]. After [APPELLANT 1] received the Statement of Deficiencies, the Appellants' stories began to change. By July 9, 2009, when they were interviewed by Ms. Morrison, and in their testimony at the hearing, the Appellants denied making any statements showing that they were aware that something of a sexual nature had occurred on February 23, 2009, and maintained that the statements attributed to them by others were either never made or were gross distortions of what they had said. They also began to talk about [NAME 1] doing a dance called "the hump" and doing Elvis impersonations. Neither a dance called "the hump" nor Elvis impersonations were given as explanations for [NAME 1]'s conduct in the earlier stages of the Department's investigation.

60. **Credibility of Witnesses**. During the course of the hearing, the ALJ had ample opportunity to hear the in-person testimony of the witnesses presented by both sides and to assess their credibility. As part of that assessment he considered a number of exhibits admitted into the record which included contemporaneous records of statements made, and the later investigative reports from the Department and law enforcement. Based upon the totality of the evidence, he determined that the evidence supports a finding that the statements attributed to the Appellants by Department witnesses were made and were accurately documented. The Review Judge agrees with this assessment, based on her independent review of the evidence, and giving due consideration to the ALJ's opportunity to view the demeanor of the witnesses. The findings in this order are primarily based the statements made by the Appellants to the Department witnesses.

61. The statements made by the Appellants were not hearsay. Some were made closer in time to the incident, some were made during the time period when the Department alleges the Appellants should have reported contact between [NAME 1] and [NAME 2], and these statements were more credible than their later, conflicting, testimony. As told by the Appellants at the outset of the investigation, there was an instance of sexual contact between [NAME 1] and [NAME 2] on February 23, 2009. [APPELLANT 2] and [APPELLANT 3] learned of it that day. They told [APPELLANT 1] of the incident when she returned from a trip on February 27, 2009. In response to the incident, [APPELLANT 1] scheduled a counseling appointment for [NAME 2], and [APPELLANT 2] made the three responses outlined in Finding of Fact 26. [APPELLANT 3] told [NAME 9] of the incident on March 27, 2009. By the time of the RCCP investigations in July, the Appellants had determined on a course of denying that the incident occurred. This meant that they had to deny the follow-up precautions they made. This meant that they had to deny statements they made to others verbally and in writing. At hearing, this meant that they "forgot" a number of conversations, even while "remembering" contemporaneous conversations. Their initial statements, both verbal and written are more credible than their later denials.

III. CONCLUSIONS OF LAW

1. **Jurisdiction.** The Department's petition for review was timely filed and is otherwise proper. Jurisdiction exists for the undersigned Review Judge to issue the Department's Final Decision in this consolidated matter.[208]

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[208] WAC 388-02-0560 to -0600.

2. The Appellants' response to the petition for review was not timely filed. The Department objects to consideration of this response by the Board of Appeals. WAC 388-02-0590(5) provides:

> (5) If you ask for more time to respond, the time period provided by this section for responding to the review request, including any extensions, does not count against any deadline, if any, for a review judge to enter the final order. A review judge may accept and consider a party's response even if it is received after the deadline.

The undersigned is authorized by this rule to accept and consider the Appellants' response, even though it was filed late. The Department is correct that the Appellants cannot appeal any additional findings of fact and conclusions of law in the Initial Order, and may only respond to those challenged by the Department. The portion of the Appellants' response that responds to the Department's challenges to Initial Findings of Fact is accepted and has been considered. To the extent that the Appellants seek to appeal any aspect of the Initial Order, that appeal needed to be filed in compliance with the timelines in WAC 388-02-0570.

3. In an adjudicative proceeding regarding adult family home licensing or resident and client protection program cases the undersigned has the same authority as the ALJ to enter Findings of Fact, Conclusions of Law, and Orders.[209] The Washington Administrative Procedure Act also states that 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

[209] WAC 388-02-0600(1) and WAC 388-02-0217(3). *See also* RCW 34.05.464(4); *Tapper v. Employment Security*, 122 Wn.2d 397 (1993); and *Northwest Steelhead and Salmon Council of Trout Unlimited v. Washington State Dept. of Fisheries,* 78 Wn. App 778 (1995).

the Review Judge or a provision of law limits the issue subject to review.[210] 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.[211] This includes the authority to make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[212] This is because "…administrative review is different from appellate review."[213] The undersigned Review Judge does not have the same relationship to the ALJ as an Appellate Court Judge has to a Trial Court Judge or that a Trial Court Judge has to a Review Judge in terms of the level of deference owed by the Review Judge to the presiding ALJ's findings of fact.[214]

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[210] RCW 34.05.464(4). *See also* WAC 388-02-0600(1).

[211] *Kabbae v. Dep't of Soc. & Health Servs*., 144 Wn. App. 432, 443 (2008) (citing RCW 34.05.464(4) as the basis for invalidating WAC 388-02-0600(2)(e)—now repealed—which purported to limit the scope of the undersigned's decision-making authority when reviewing certain types of cases).

[212] *See Hardee v. Dep't of Soc. & Health Servs.,* 152 Wn. App. 48, 59 (2009), *aff'd,* 172 Wn.2d 1 (2011) (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) and *Hardee v. Dep't of Soc. & Health Servs.,* 172 Wn.2d 1, 18-19 (2011) (stating that When reviewing the factual findings and conclusions of an ALJ,

> "The reviewing officer shall exercise all the decision-making power that the reviewing officer would have had to decide and enter the final order had the reviewing officer presided over the hearing. In reviewing findings of fact by presiding officers, the reviewing officers shall give due regard to the presiding officer's opportunity to observe the witnesses."

Tapper, 122 Wn.2d at 404 (emphasis omitted) (quoting RCW 34.05.464(4)); *see also* WAC 170-03-0620 (providing the Department's own definition of the review judge's authority). Regardless of whether "[i]t would perhaps be more consistent with traditional modes of review for courts to defer to factual findings made by an officer who actually presided over a hearing," the legislature chose otherwise. *Tapper*, 122 Wn.2d at 405. "[I]t is not our role to substitute our judgment for that of the Legislature." *Id.* at 406. The findings of fact relevant on appeal are the reviewing officer's findings of fact – even those that replace the ALJ's. *Id.* Here, the review judge meticulously reviewed the evidence, as well as the ALJ's factual findings, and appropriately substituted her own findings when warranted. (footnote omitted)).

[213] *Kabbae*, 144 Wn. App. at 441 (explaining that this is because the final decision-making authority rests with the agency head). *See also Messer v. Snohomish County Bd. of Adjustment*, 19 Wn. App. 780, 787 (1978) (stating that "[t]he general legal principles which apply to appeals from lower to higher courts do not apply to administrative review of administrative determinations").

[214] *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

The Review Judge's authority to substitute his or her judgment for that of the presiding ALJ on matters of fact as well as law is the difference.[215] However, 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,[216] a Review Judge must give due regard to the ALJ's opportunity to observe the witnesses when reviewing those factual findings by the ALJ and making his or her own determinations.[217] This does not mean a Review Judge must defer to an ALJ's credibility findings, but it does require that they be considered.[218] In this matter the Review Judge has adopted the ALJ's credibility findings as her own.

4. Review Judges must personally consider the whole record or such portions of it as may be cited by the parties.[219] Consequently, the undersigned has considered the adequacy, appropriateness, and legal correctness of all Initial Findings of Facts, Conclusions of Law, admitted evidence, any previous proceedings and orders, regardless of whether any party has asked that they be reviewed. Because the ALJ is directed to decide the issues *de novo*,[220] the undersigned has also decided the issues *de novo*.[221] In accordance with RCW 34.05.464(4) and WAC 388-02-0600(1), the undersigned has given due regard to the ALJ's opportunity to observe the witnesses, but has otherwise independently decided the case.

Andersen, *The 1988 Washington Administrative Procedure Act – An Introduction,* 64 Wash. L. Rev. 781, 816 (1989).

[215] Id.

[216] RCW 34.05.461(3).

[217] RCW 34.05.464(4) and WAC 388-02-0600(1).

[218] *Hardee*, 152 Wn. App. at 59 (stating that RCW 34.05.464(4) permits a Review Judge to make his or her own independent credibility determinations and need not defer to the ALJ's as long as the ALJ's credibility findings are duly contemplated).

[219] RCW 34.05.464(5). *See also* WAC 388-02-0560(4).

[220] WAC 388-02-0215(1).

[221] RCW 34.05.464(4) and WAC 388-02-0600(1). *See also Hardee*, 152 Wn. App. at 59.

5. **Standard of Proof.** The Appellants argued in their post-hearing memorandum that the appropriate standard of proof in this case should be clear, cogent, and convincing evidence rather than the less demanding preponderance of the evidence standard.

The Department hearing rules, chapter 388-02 WAC, which apply to these proceedings state that the applicable standard of proof in Department hearings is a preponderance of the evidence "unless the rules or law states otherwise." WAC 388-02-0485. The Appellants did not argue that there is an administrative rule or statute which requires a higher standard of proof in adult family home licensing or resident and client protection program cases, but relied on case law that has recognized that due process requires a higher standard than a preponderance of the evidence in certain administrative proceedings.

The cases cited by the Appellant, *Ongom v. Department of Health*, 159 Wn.2d 132, 148 P.3d 1029, (2006) and *Nguyen v. Department of Health*, 144 Wn.2d 516, 29 P.3d 689 (2001), involved administrative disciplinary hearings under the Uniform Disciplinary Act, chapter 18.130 RCW, as to a licensed nursing assistant and a licensed medical doctor. The courts there held that because the proceedings in question involved professional licenses and were quasi-criminal in nature, due process required a standard of proof higher than a preponderance of the evidence. Those courts did not hold that all administrative actions involving licenses required that higher standard of proof. The *Ongom* case was overruled in *Hardee v. Dep't of Social & Health Servs.,*172 Wn.2d 1; 256 P.3d 339 (2011) which held that a day care license revocation was not invalid because the state was not required to prove its case by clear and convincing

evidence. Rather, at an administrative hearing, constitutional due process required no more than a preponderance of the evidence. Likewise, as to the adult family home licensing or resident and client protection program cases, there is no case law supporting such an extension. In fact, the preponderance standard has specifically been upheld in a case where mental abuse of a vulnerable adult under RCW 74.34 was alleged. *Kraft v. Dep't of Social & Health Servs.,* 145 Wn. App 708 (2008). Therefore, the applicable standard of proof in both the adult family home licensing and resident and client protection program cases will be a preponderance of the evidence.

6. **Evidence.** Review Judges decide "…whether or not to admit a proposed exhibit into the record…" and determine "…the weight (importance) of the evidence."[222] When deciding whether to admit evidence, the ALJ or Review Judge considers "…if it is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs."[223] This may include evidence that would be inadmissible in a civil trial, such as hearsay evidence,[224] which is defined as "…a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."[225] Findings of Fact may not be made solely "…on such inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence."[226] The applicable procedural rule in this matter states more narrowly "[t]he

[222] WAC 388-02-0425(1) (granting ALJs this authority, as well as Review Judges via WAC 388-02-0600(1)). *See also* WAC 388-02-0475(6) (stating that the ALJ—and the Review Judge, via WAC 388-02-0600(1)—decides what evidence is more credible if evidence conflicts and decides the weight to be given to the evidence).
[223] RCW 34.05.452(1). *See also* WAC 388-02-0475(2).
[224] *Id.* and RCW 34.05.461(4).
[225] ER 801(c). *See also* WAC 388-02-0475(3).
[226] RCW 34.05.461(4).

ALJ may only base a finding on hearsay evidence if the ALJ finds that the parties had the opportunity to question or contradict it."[227]

7. In this case, the Department presented out-of-court statements from the Appellants, the alleged victims, Roberta Hochreiter, complaint investigator, Gloria Morrison, complaint investigator, [NAME 7], therapist, Roberta Crawford, field manager, [DETECTIVE 1], police detective, Wesley Fullerton, case manager, and Paula Sanz, program manager, and others describing the adult family home licensing violations, and neglect and abuse by the Appellants. The question to determine admissibility is whether a reasonable person would rely on statements of an alleged victim, the AFH and RCCP investigators, and statements health care providers in chart notes to determine whether the adult family home has had licensing rule violations, and the resident and client protection program has established that the victims are vulnerable and have been abused or neglected. The only possible answer to this question is yes. This is the type of evidence that any reasonable person would use to determine whether adult family home licensing violations or abuse or neglect of a vulnerable adult has occurred.

8. Further, written summaries of referrals and subsequent investigative reports by Department investigators are also the kind of records kept in the normal course of Department business that are relied upon by reasonably prudent persons in conducting adult family home licensing and resident and client protection program business. Law enforcement reports are kept in the general course of police business. The out-of-court statements found in the Department case notes satisfy the reasonable

[227] WAC 388-02-0475(3).

person test for admissibility and were correctly admitted in full at the hearing. Even if these statements may not have been admissible in a civil proceeding, they were admissible in this administrative proceeding. This does not mean that the statements contained in these documents are persuasive, sufficient, or necessary to support a finding of fact. It simply means that the statements are unquestionably admissible in a Department administrative proceeding. However, the undersigned has found that many of the statements are persuasive and sufficient to support the Findings of Fact in this Review Decision and Final Order

9. The statements of the Appellants to the Department investigators are not hearsay, and are fully admissible. ER 801(d)(2). The Appellants each testified on his or her own behalf and gave testimony to refute information in Department reports. The Appellants' had the opportunity to question the Department witnesses about the statements in their reports, which would make most statements in those reports not hearsay and admissible under ER 801(d)(1). The Appellant had ample opportunity to rebut, question, and contradict what hearsay evidence there was, pursuant to both RCW 34.05.461(4) and WAC 388-02-0475(3).

10. Because (1) the Appellants had the opportunity to contradict the hearsay evidence at the hearing, (2) out-of-court statements were reliable and corroborated by other evidence, and (3) the Appellants did not object to admission of any of the hearsay statements, the undersigned concludes, pursuant to RCW 34.05.452, RCW 34.05.461(4), applicable case law, and WAC 388-02-0475(3), that it is appropriate to make Findings of Fact in this case based on the hearsay statements presented as evidence at the hearing.

11. **Findings of Fact.** The Department challenges Initial Findings of Fact 3, 8, 17, 18, 22, and 25. The Department also challenges what it claims as independent, incorrect factual assumptions in Initial Conclusions of Law 7 and 8. The Department also seeks to have the record supplemented with six additional findings of fact. These will be discussed below.

12. The Department challenges the statement in Initial Finding of Fact 3 that [NAME 1] was [AGE] years old at the time of the incident, and states that he was [AGE] years old at the time. The Appellants agree with this, and the Final Finding of Fact includes the correct age.

13. The Department challenges the statement in Initial Finding of Fact 8: "a question was raised by the Appellants themselves as to whether [NAME 1] was capable of consenting to any sexual contact." It argues that both [APPELLANTS 1 & 2] testified unequivocally that [NAME 1] could not consent to sexual contact. Final Finding of Fact 7 includes the fact that the Appellants testified that [NAME 1] could not consent to any sexual contact.

14. The Department challenges the statement in Initial Finding of Fact 17 that there were no food restrictions in the home. The Appellants respond that the ALJ accurately found Initial Finding of Fact 17. The Appellants cite to testimony by [NAME 11], [NAME 6], and Wesley Fullerton. Final Finding of Fact 35 supplements the Initial Fact Finding, and includes the Appellants' statements about food at the home and the limitations they admitted. Access to food was unreasonably restricted by the Appellants.

15. The Department challenges the statement in Initial Finding of Fact 18 that there was no yelling or belittling in the home. The Appellants respond that the ALJ accurately found Initial Finding of Fact 18. Final Findings of Fact 36, 37, and 46 establish that there was yelling and belittling by [APPELLANT 3] and [APPELLANT 2].

16. The Department questions the statement in Initial Finding of Fact 22: "there was no history of significant, repeated or uncorrected deficiencies" at the adult family home. The Department cites to the seriousness of the mandatory reporting and other licensing violations in this case. The Appellant do not respond. While the Department is correct that there were serious violations in this case, and that the failure to report found in this case extends back to previous instances where [NAME 2]'s sexualized behavior had concerned the Appellants, but had not been reported, there are not any previous findings against [ADULT FAMILY HOME 1] or the licensee. This is reflected in Final Finding of Fact 41.

17. The Department questions the statement in Initial Finding of Fact 25 that [NAME 2] "gave a much more elaborate description of the incident than any he had given earlier" when he was interviewed by Ms. Morrison. The Department is concerned that this statement implies that the statement is inaccurate because it is more detailed. This implication is not something that is apparent—the review judge has taken his statement at face value, and relied on it in making findings of fact.

18. The Department asks that the following additional findings of fact be included in the Final Order:

1) [APPELLANT 1] was providing in-home care services to her [RELATIVE], [NAME 1]. [NAME 1] received these services based on his disability.

2) There was a delay of a month and a half between the incident on February 23, 2009 and when [NAME 2] was taken to the mental health provider on April 14, 2009, which finally triggered the mandatory report of sexual abuse to the proper channels.

3) There was a delay of over two months before [APPELLANT 1]'s reported nonconsensual sexual touching to the proper authorities and she only did so at the direction of the Department.

4) The record at hearing supports the finding of fact that [APPELLANT 2], a mandatory reporter, never called the hotline to report suspected sexual abuse.

5) The record at hearing supports the finding of fact that [APPELLANT 3], a mandatory reporter, never called the hotline to report suspected sexual abuse.

6) The appellants failed to protect the adult family residents from sexual abuse. [APPELLANT 1] and [APPELLANT 2] told the adult family home complaint investigator that they protected [NAME 1] by keeping him upstairs when [NAME 2] was in the house. *Testimony of Robbie Hochreiter.* It is uncontested that the appellants took no actions to protect the other residents in the home. There was also mixed testimony regarding whether [NAME 1] and [NAME 2] were kept apart after the incident. At times, the appellant's stated that [NAME 1] and [NAME 2] were kept apart. Other times, the appellants claimed that [NAME 1] was not barred from going downstairs, he was simply encouraged to stay upstairs to keep from being teased.

Each of these facts is proven by substantial evidence in the hearing record, and each is included in the Findings of Fact.

19. The Department also challenges certain factual assumptions made in Initial Conclusions of Law 7 and 8. In Initial Conclusion of Law 7 the Department challenges the statements that [NAME 1] is a child, and that there is a question as to whether [NAME 1] is capable of consenting to any sexual contact. The final findings of

fact reflect that [NAME 1] was [AGE] years old at the time of the incident, that [NAME 1] was a sexual being, and that [NAME 1] was not able to consent to sexual contact.

20. Initial Conclusion of Law 8 states that there was no evidence presented at hearing that other residents of [ADULT FAMILY HOME 1] were in real danger because the other residents were older than [NAME 2]. The Department argues that this factual assumption is inaccurate, shortsighted, and not supported by the record. The Appellants do not respond. Regardless of whether the current residents were experiencing problems with the sexualized behaviors at the home, at any time, a new resident could be admitted to the home that does not meet the resident profile that the ALJ considered to be "safe." Also, the record supports a finding that the sexualized behavior in the home was causing problems for other residents, not just [NAME 1] and [NAME 2]. When [APPELLANT 1] issued a discharge notice to [NAME 2] after April 14, 2009, that notice stated: "We have found that [[NAME 2]] is unable to control his impulses, and has action out issues with other clients in a manner that affects the safety and heal of individuals within our home." The discharge notice is an admission on the part of [APPELLANT 1] that she had reason to believe other residents were at risk.

21. **Applicable Law.** ALJs and Review Judges must first apply the Department rules adopted in the WAC to resolve an issue.[228] If there is no Department WAC governing the issue, the ALJ and the Review Judge must resolve the issue based on the best legal authority and reasoning available, including that found in federal and Washington constitutions, statutes and regulations, and court decisions.[229] The ALJ and the Review Judge may not declare any rule invalid, and challenges to the legal validity of a

[228] WAC 388-02-0220(1).
[229] WAC 388-02-0220(2).

rule must be brought *de novo* (anew) in a court of proper jurisdiction.[230]

22. **Conclusions of Law: Licensing.** Adult Family Home licensees against whom the Department has imposed a remedy have an administrative hearing right to challenge the Department's decision to impose a remedy.[231] The Department alone has the authority to decide what remedy is appropriate to impose against a licensee.[232] Individuals who reside in adult family homes are often totally dependent on the adult family home. The vulnerability of adult family home residents has led to the development of detailed requirements that are designed to protect and promote the physical, mental, and emotional well-being of residents. The adult family home provider is responsible for complying with all of the requirements at all times. The adult family home regulations are not suggestions or guidelines, they are mandatory minimum requirements that must be complied with. The Department's obligation is to prove that the Appellant did in fact fail or refuse to comply with those regulations it claimed she violated in its notice. If the Department meets its burden of proof, then the ALJ's and Review Judge's obligation is to affirm the Department's decision to impose a remedy. If the Department fails to meet its burden of proof, then the ALJ's and Review Judge's obligation is to reverse the Department's decision to impose a remedy.

23. The Department, in Ex. 10, claimed four rules were violated by the Appellant. The Department's findings that these rules were violated are set out in more

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[230] WAC 388-02-0225(1).
[231] WAC 388-76-10995(2)(a).
[232] WAC 388-76-10940 Remedies—Generally. The department may take one or more of the following actions in any case which the department finds that an adult family home failed or refused to comply with the applicable requirements of chapters 70.128, 70.129, or 74.34 RCW or this chapter:
. . .
(4) Order stop placement; and/or (5) Suspension or revocation of a license.

detail in the Statement of Deficiencies in Ex. Dept. 7. They are discussed in order below.

24. The first rule that the Department claimed was violated was WAC 388-76-10020 **License—Ability to provide care and services**. That rule provides, in relevant part:

> The provider must have the:
>
> (1) Understanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of vulnerable adults;. . .

The Department believes that the Appellant does not have the understanding or the ability to meet the needs of her residents. The Appellants do not mention this rule in their response. The Department argues that she has an unwillingness or inability to learn, and she has demonstrated a lack of understanding of how to protect five residents from verbal and sexual abuse. This placed all residents at risk of emotional and physical harm and a diminished quality of life. The Department argues that [APPELLANT 1] demonstrated her lack of understanding when she failed to understand the need to report sexual abuse to the Department, and also did not protect her residents from verbal abuse. The Appellant violated WAC 388-76-10020. This failure placed residents at risk of continued abuse. The provider's inability to appropriately deal with these incidents of sexual and mental abuse demonstrate that she does not possess the understanding to operate an adult family home.

25. The second rule that the Department claimed was violated was WAC 388-76-10620(2)(a), (c) **Resident rights – Quality of Life – General**. That rule provides, in relevant part:

> (2) Within reasonable home rules designed to protect the rights and quality of life of residents, the home must ensure the resident's right to:
>
> (a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and negotiated care plan;
> . . .
> (c) Make choices about aspects of his or her life in the home that are significant to the resident;

The Department argues that the Appellant failed to allow three residents to make choices about food and drink. The Appellants do not mention this rule in their response. Failure to allow three residents to have some control over food choices placed them at risk for diminished quality of life. The residents complained about access to food and food choices. These complaints were consistent. Other witnesses corroborated the residents' complaints. There was no evidence provided that these limitations were officially sanctioned or necessary and the resident's care plans do not justify them. The Appellant violated WAC 388-76-10620(2)(a), and (c).

26. The third rule that the Department claimed was violated was WAC 388-76-10670(1), (2), (3), and (4). **Prevention of abuse.** That rule provides, in relevant part:

> The adult family home must:
>
> (1) Meet the requirements of chapter 74.34 RCW;
>
> (2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;
>
> (3) Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion; and
>
> (4) Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring.

The Department argues that the licensee failed to ensure residents in the adult family home were free from abuse. The Appellants do not mention this rule in their response. Failure to ensure residents were not ridiculed and yelled at resulted in emotional distress for three residents. [NAME 4], [NAME 6], and [NAME 2] all reported verbal confrontations or belittling behavior by either [APPELLANT 2] or [APPELLANT 3]. As the adult family home provider, [APPELLANT 1] had a responsibility to protect her residents and prevent these types of interactions between residents and staff. Her failure to do so is a violation of the minimum licensing requirements. The Appellant violated WAC 388-76-10670(1), (2), (3) and (4).

27. The fourth rule that the Department claimed the provider violated was WAC 388-76-10673(2)(a), (b) **Abuse and neglect reporting – Mandated reporting to department – Required**. That rule provides in relevant part:

> (2) Reports must be made to:
>
> (a) The centralized toll free telephone number provided by the department; and
> (b) The appropriate law enforcement agencies, as required under chapter 74.34 RCW.

The licensee failed to report an allegation of sexual abuse between one resident and a Household Member (HM). This rule requires providers to report suspected abuse, neglect, or exploitation to the toll free number provided by the Department. The Appellants do not mention this rule in their response. [APPELLANT 1] failed in meeting this requirement because she did not report sexual abuse to the appropriate authorities when she became aware of the report that it occurred. Furthermore, even after a mental health provider and Department staff told her to report the suspicion of abuse, and a police officer had been to her house investigating sexual assault, she still did not

report the reports of abuse. Even after the Department field manager asked her to call in a complaint, she did not report the abuse in a timely manner. At the time of the adult family home complaint investigation, [APPELLANT 1] admitted that she did not report the sexual contact revealed between [NAME 2] and [NAME 1] as soon as she knew about it. Instead, she reported that she enrolled [NAME 2] in counseling. Both of her staff also were aware of the incident and did not report it, even though they knew that there had been a sexual incident on the day it occurred, and also knew that the resident was attending counseling because of it. The Appellant violated WAC 388-76-10673 (2)(a) and (b).

28. Given the seriousness of the risk of harm as well as the actual harm to residents, the remedies imposed on [ADULT FAMILY HOME 1] by the Department were appropriate.

29. **Conclusions of Law: Neglect.** In addition to its authority to impose remedies on an adult family home licensee, the Department is authorized to investigate allegations of abandonment, abuse, neglect, exploitation, or financial exploitation of a resident of an adult family home. WAC 388-76-11000. Based on such investigations, the Department may issue preliminary findings against individuals. WAC 388-76-1105. The Resident Protection Program found that the three Appellants neglected residents of the adult family home, and that [APPELLANT 3] verbally abused residents of the adult family home.

30. Chapter 74.34 of the Revised Code of Washington (RCW) is titled "Abuse of Vulnerable Adults." The statute establishes a system for reporting instances of neglect of a vulnerable adult and 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 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."[233]

31. The statute defines "vulnerable adult" to include a person sixty (60) years of age or older who has the functional, mental, or physical inability to care for himself or herself; a person found incapacitated under chapter 11.88 RCW; a person who has a developmental disability as defined under RCW 71A.10.020; a person admitted to any facility; a person receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or a person receiving services from an individual provider. The evidence in the hearing record supports the finding that [NAME 2], [NAME 6], [NAME 4], [NAME 3], and [NAME 5] are vulnerable adults under the statutory definition. They are entitled to the protections provided under the statute. [NAME 1] is also a vulnerable adult under the statute because he is a person who has a developmental disability who is receiving services from an individual provider.

32. A final finding of either neglect or abuse will be reported to any federal or state registry or list of individuals found to have abandoned, abused neglected, exploited, or financially exploited a vulnerable adult.[234] A finding of either neglect or

[233] RCW 74.34.020(9).
[234] WAC 388-76-11035(5).

abuse prohibits an individual from being employed in a capacity that would allow him or her to have unsupervised access to vulnerable adults.[235]

33. Any individual who has access to a long-term care facility is eligible for a finding of abuse, neglect, exploitation, or financial exploitation to be made against them, regardless of whether the individual is a licensed provider.[236] In an adult family home, this includes the ability to make findings against a provider, an employee of the adult family home, an entity representative, anyone affiliated with a provider, and a caregiver.[237] The findings of neglect made in this proceeding are made against the Appellants in their role as persons with access to vulnerable adults.

34. The Department's Initial Abuse Finding Notice,[238] mailed to the Appellant, cites to both subparagraphs (a) and (b) of the definition of "neglect" as a basis for the finding of neglect. A "duty of care" must exist between the alleged perpetrator and the vulnerable adult if a finding of neglect is to be substantiated. The corresponding relevant regulation defines a "Person or entity with a duty of care" to include an entity providing the basic necessities of life to a vulnerable adult where: (a) the person is employed by, or on behalf of, the vulnerable adult; or (b) The person voluntarily agrees to provide, and had been providing, the basic necessities of life to the vulnerable adult on a continuing basis.[239] The evidence in the hearing record supports the unchallenged finding that the Appellants has been providing, the basic necessities of life to the vulnerable adults on a continuing basis. The Appellants were persons with a duty of care towards the vulnerable adults.

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[235] RCW 74.39A.051(8).
[236] WAC 388-76-11000 – 11040.
[237] WAC 388-76-11000.
[238] Exhibit 19.
[239] WAC 388-71-0105 "Person or entity with a duty of care."

35. The Department argues that the Appellant neglected the residents of the adult family home by failing to report sexual contact to the proper authorities, and by failing to take any steps to protect the other residents of the home from [NAME 2] and [NAME 1]. The Appellants were told that there was "humping" between [NAME 1] and [NAME 2]. Webster's Third New International Dictionary's only definition that would include interaction between two persons defines "hump" as: "5. To copulate with, usually considered vulgar." [240] "Copulate" means: "2: to unite in sexual intercourse." [241] In their earlier statements to the counselors, law enforcement, and the Department investigators the Appellants did not mention [NAME 1] as an Elvis impersonator or a dance called "the hump." After the Appellants changed their stories, and had to make up a new version that explained away some of the statements that had been made, they started to talk about a dance. The so-called dance does not explain the contact between the two men, and the reports regarding it are not credible. Failing to report sexual behaviors means that those behaviors cannot be properly handled and investigated. Failing to take any measures to protect the other residents in the adult family home from sexual abuse is an act or omission that demonstrates a serious disregard of such magnitude as to constitute a clear and present danger to a vulnerable adult's health, welfare, or safety. The Findings of Fact above support the legal conclusion that each Appellant's conduct was negligent.

36. The term "abuse" is defined in RCW 73.34.020(2) as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult." Abuse includes sexual abuse, mentall abuse, physical abuse, and

[240] Webster's Third New International Dictionary 1102 (2002).
[241] Id. 503.

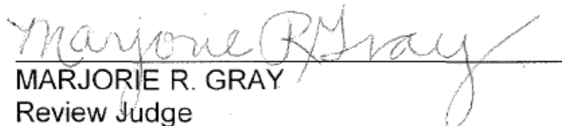
exploitation of a vulnerable adult.[242] "Mental abuse" is "a willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriate isolating of a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." [243] Residents consistently reported that [APPELLANT 3] yelled at them. Yelling is by definition mental abuse. [APPELLANT 3] also belittled a resident by saying that she was going to treat him like a baby if he did not change his behavior. The Findings of Fact above support the legal conclusion that [APPELLANT 3] mentally abused residents of the adult family home.

37. Instructions for filing a petition for reconsideration to the Board of Appeals or a petition for review in superior court are contained in the attached document.

IV. DECISION AND ORDER

The Initial Decision is **reversed**. The Department's decisions are **affirmed.**

Mailed on March 30, 2012.



MARJORIE R. GRAY
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: [APPELLANT 1], Appellant
[APPELLANT 2], Appellant
[APPELLANT 3], Appellant
Gary Preble, Appellants' Representative
Angela Coats-McCarthy, AAG, Dept.'s Rep., MS: 40124
Joanna Giles, AAG, Dept.'s Representative

[242] RCW 74.34.020(2); see also WAC 388-76-10000.
[243] WAC 388-76-10000.

Suzanne Plaja, Program Administrator, MS: 45600
Bett Schlemmer, Program Administrator, MS: 45600
Bill Gales, Administrative Law Judge, Seattle OAH