STATE OF MINNESOTA
IN COURT OF APPEALS
A08-1960

Alicia John,
Respondent,

vs.

Cal Ludeman, Commissioner of Human Services,
Appellant.

Filed August 25, 2009
Affirmed
Peterson, Judge

Ramsey County District Court
File No. 62-CV-08-1973

Peter B. Knapp, Michele Anderson-Horecka (certified student attorney), William Mitchell Law Clinic, 875 Summit Avenue, St. Paul, MN 55105 (for respondent)

Lori Swanson, Attorney General, Cara M. Hawkinson, Assistant Attorney General, 900 Bremer Tower, 445 Minnesota Street, St. Paul, MN 55101-2134 9 (for appellant)

Considered and decided by Peterson, Presiding Judge; Ross, Judge; and Connolly, Judge.

U N P U B L I S H E D O P I N I O N

PETERSON, Judge

This appeal is from a district court order that reversed an order by appellant Commissioner of Human Services that disqualified respondent from providing direct-

contact services to persons served by licensed facilities. We affirm the district court's reversal of the commissioner's order.

FACTS

Respondent Alicia John was employed by Midwest Special Services (Midwest) from May 2005 through the summer of 2006. Midwest is a day training-and-habilitation program that provides employment opportunities for persons with disabilities. Respondent was employed as a program assistant, and her duties included assisting disabled individuals with tasks such as eating. One of the individuals that respondent worked with was D.B., who was a quadriplegic with limited fine motor skills. D.B. had a Risk Management Plan (RMP) that stated that he "may have occasional choking episodes." The RMP stated: "[D.B.] is served bite sized foods. Staff feed [D.B.] at a pace that is conducive to [D.B.] thoroughly chewing each bite." One of respondent's job duties was to "[i]mplement Individualized Program Plan and Risk Management Plans . . . as directed by the Program Instructor."

On May 18, 2006, respondent was working in the north program room at Midwest with another staff member, Stacy Quaale. Usually, another program assistant, Joseph Witha, also worked in the room, but he was on vacation. Respondent prepared lunch for D.B., which included a roast-beef sandwich on a long bun. Respondent cut the sandwich in half. There was conflicting testimony regarding whether respondent then served the food to D.B. or gave it to Quaale, who served it to D.B. After D.B. was served, Quaale left the room. D.B. then began choking and coughing. Respondent checked on him, and D.B. said that he was okay. He began coughing and choking again. Respondent left the

room to contact another employee who unsuccessfully administered the Heimlich maneuver. Someone called 911, but by the time paramedics arrived, D.B.'s heart had stopped. Because D.B. had a do-not-resuscitate order on file, no one attempted to resuscitate him. According to the autopsy report, D.B. died from asphyxiation by choking. Pending an investigation, respondent was removed from direct contact with consumers.

The Department of Human Services (DHS) began an investigation, and a memorandum detailing the investigation results concluded that because respondent's failure to follow the RMP resulted in death, respondent committed serious maltreatment. DHS disqualified respondent from a position allowing direct contact with persons receiving services from facilities licensed by DHS. Respondent requested reconsideration, and DHS affirmed the disqualification.

Respondent filed a request challenging the disqualification, and an evidentiary hearing was held. At the hearing, the investigator who conducted the DHS investigation and the investigator who conducted Midwest's internal investigation both testified regarding the findings of their investigations. Witha and Quaale, respondent's coworkers in the north program room, also testified at the hearing. Witha testified that he did not see respondent cut D.B.'s food into bite-size pieces all the time. He testified that he was "aware that [D.B.'s RMP] said that his food needed to be cut up into bite size pieces." He testified that he did not learn this specifically by reading the RMP, but because he heard it from other staff members and it was "common knowledge." Quaale testified that

she cut D.B.'s food into bite-size pieces, although she could not recall specifically where she learned that she should do this.

Jamie Assel, the program instructor, testified regarding training procedures and procedures for feeding D.B. Assel stated that when respondent was hired, respondent would have gone through the case files for all of the people she would be working with in the north room and the case files included the RMPs. Assel also testified that "[w]e needed to cut up [D.B.'s food] in bite size pieces" and that the staff were trained to do this. She testified that the RMP is available at all times to program assistants and they are encouraged to review them if any changes are made. According to Assel, as part of respondent's training, she read RMPs for two hours. She also testified that there was no procedure for determining whether staff members were familiar with the RMPs.

Respondent testified that she read the RMPs as part of her initial training but had not read them since. However, she stated that most of her training came from watching others. She said that if she forgot how to do something, she would ask questions and it varied whether or not her questions were answered. She also testified that Quaale had shown her to cut D.B.'s sandwiches in half or in fourths, and that on the day D.B. died, she had cut his sandwich in half because that was what she understood she was supposed to do.

After the hearing, the human-services judge (HSJ) recommended affirming the disqualification. The commissioner adopted this recommendation. Respondent appealed to district court, and the district court reversed the decision. The district court's decision was based on its conclusion that the HSJ had not considered mitigating factors as

required by statute. The district court concluded that respondent's responsibility was mitigated due to lack of sufficient training, failure to provide adequate supervision of staff, and the fact that respondent was left alone to care for consumers during lunch. This appeal followed.

D E C I S I O N

"Review of the commissioner's orders relating to maltreatment determinations is governed by Minn. Stat. § 256.045. . . ." *Zahler v. Minn. Dep't of Human Servs.*, 624 N.W.2d 297, 300 (Minn. App. 2001), *review denied* (Minn. June 19, 2001). Under that statute, a party who is aggrieved by an order of the commissioner may appeal the order to the district court. Minn. Stat. § 256.045, subd. 7 (2008). The district court "shall take no new or additional evidence unless it determines that such evidence is necessary for a more equitable disposition of the appeal." *Id.*, subd. 8 (2008). "Any party aggrieved by the order of the district court may appeal the order as in other civil cases." *Id.*, subd. 9 (2008). "[W]hen judicial review is authorized under Minn. Stat. § 256.045, the district court is engaged in appellate review. . . ." *Zahler*, 624 N.W.2d at 301. "Accordingly, this court reviews the commissioner's order independently, giving no deference to the district court's review." *Id.* This court

> [m]ay affirm the decision of the agency or remand the case for further proceedings; or it may reverse or modify the decision if the substantial rights of the petitioners may have been prejudiced because the administrative finding, inferences, conclusion, or decisions are:
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> (a) in violation of constitutional provisions; or
>
> (b) in excess of the statutory authority or jurisdiction of the agency; or
>
> (c) made upon unlawful procedure; or

> (d) affected by other error of law; or
> (e) unsupported by substantial evidence in view of the entire record as submitted; or
> (f) arbitrary or capricious.

Minn. Stat. § 14.69 (2008). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Zahler*, 624 N.W.2d at 301 (quotation omitted). "[D]ecisions of administrative agencies enjoy a presumption of correctness, and deference should be shown by courts to the agencies' expertise." *In re Appeal of O'Boyle*, 655 N.W.2d 331, 334 (Minn. App. 2002) (quotation omitted).

An individual is disqualified from direct contact with persons receiving services from a facility licensed by the DHS if less than seven years have passed since a determination or disposition of the individual's "substantiated serious or recurring maltreatment of . . . a vulnerable adult." Minn. Stat. § 245C.15, subd. 4(b)(2) (2008); *see* Minn. Stat. § 245C.14, subd. 1 (2008) (disqualification from direct contact). "Serious maltreatment" is defined as "sexual abuse, maltreatment resulting in death, maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury." Minn. Stat. § 245C.02, subd. 18 (2008). "Maltreatment" includes neglect, Minn. Stat. § 626.5572, subd. 15 (2008), which is defined as follows:

> (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
> (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

> (2) which is not the result of an accident or therapeutic conduct.
>
> (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minn. Stat. § 626.5572, subd. 17 (2008).

The commissioner argues that the district court erred because the HSJ's determination of disqualification is supported by substantial evidence. There is no dispute that D.B. was a vulnerable adult, and the parties do not dispute that some form of serious maltreatment occurred. But an individual is disqualified for serious maltreatment for which "(i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment." Minn. Stat. § 245C.15, subd. 4(b)(2). When determining whether a person was responsible for maltreatment, DHS is required to consider mitigating factors as follows:

> (c) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:
> . . .
>
> (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a

> consideration of the scope of the individual employee's authority[.]

Minn. Stat. § 626.557, subd. 9c (2008).[1]

With regard to the comparative responsibility of Midwest and the other caregivers, the HSJ concluded:

> [Respondent] argues that the culpability of others should be considered in that others also did not cut the food into bite sized pieces. [Respondent] suggests that the actions of others as part of an unavailing legal argument that there are other blameworthy individuals. I reject this argument as the actions of others may have relevance in a case involving the facility as a whole but not as it relates to an individual's actions.

This statement that the "actions of others" did not have relevance in this case demonstrates that the HSJ ignored the statutory requirement that the agency "shall consider . . . the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee." Minn. Stat. § 626.557, subd. 9c(2). The actions of other potentially "blameworthy individuals" are factors that the HSJ is required by statute to consider in reaching its decision. *See* Minn. Stat. § 645.44, subd. 16 (2008) ("'Shall' is mandatory.")

The HSJ refused to consider evidence in the record that potentially mitigated respondent's responsibility. There is evidence that Midwest did not provide adequate training with respect to preparing food for and feeding D.B. As part of her training, respondent was given two hours to read through RMPs for about 16 consumers. Both

[1] There are two other factors to consider, but respondent does not dispute that they were adequately considered.

Quaale and Witha testified that, although they knew D.B.'s food was to be cut into bite-size pieces, they did not learn this by reading D.B.'s RMP. Midwest's internal investigator testified that, at the time of the incident, Quaale and Witha reported that they were not aware that D.B.'s food needed to be cut into bite-size pieces. Witha testified that he knew that respondent sometimes did not cut D.B.'s food into bite-size pieces; it appears, however, that respondent was never told that she was incorrectly cutting D.B.'s food, and she believed that she was correctly cutting it. Also, Assel had told the staff that D.B. had a goal of eating more independently and that it was not necessary to feed him finger-type foods, which suggests that staff were given instructions that were inconsistent with the RMP. Furthermore, although respondent did not review the RMPs after her initial training, the HSJ acknowledged "that [respondent] was not alone in this practice and that there did not appear to be any clear means of insuring that [the RMPs] were reviewed on an annual basis unless there were changes."

Respondent and Quaale offered conflicting testimony regarding who served the food to D.B., and the agency investigator acknowledged that the investigation did not reach a conclusion on this issue. In addition to the requirement of cutting up D.B.'s food, the RMP stated, "Staff feed [D.B.] at a pace that is conducive to [D.B.] thoroughly chewing each bite." The HSJ refused to consider evidence that D.B. was improperly fed or improperly supervised while eating and instead relied on respondent's role in preparing the food. But Quaale left respondent alone with eleven consumers in the room just after D.B. was fed, which meant that the room fell below the required supervision ratio of one staff member to ten consumers. Whether Midwest or another caregiver bore

responsibility for improperly feeding D.B. or supervising D.B. while he ate was a relevant consideration that potentially mitigated respondent's responsibility.

The evidence supports the HSJ's finding that there was "a profound breakdown in communication" and that "each of the parties had a responsibility to implement [D.B.'s RMP] and cut his food into bite-sized pieces." But by concluding that evidence of others' potential responsibility was not relevant "as it relates to an individual's actions," the HSJ explicitly refused to consider mitigating factors that the statute required her to consider.

The Administrative Procedures Act allows a court to remand to the agency for further proceedings or to reverse the agency's determination. Minn. Stat. § 14.69. This court has remanded "for further evidentiary proceedings" when the agency "failed to make essential findings and to draw essential conclusions." *O'Boyle*, 655 N.W.2d at 335. But in this case, the hearing created a sufficient record and the HSJ made the necessary findings. The error was in the HSJ's failure to consider mitigating factors as required by statute, which is an error of law. Therefore, no further evidentiary proceedings are necessary and the district court properly reversed the commissioner's decision to disqualify respondent.

Affirmed.