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DEPARTMENT OF CHILDREN AND FAMILIES
CENTRAL ADMINISTRATIVE OFFICE
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Commissioner

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IN THE MATTER OF

SC #2017-0085

FAIR HEARING DECISION

SC appeals the Department of Children and Families' (hereinafter "DCF" or "the Department") decision to support allegations of neglect pursuant to G.L. c. 119, §§51A and B.

Procedural History

On November 21, 2016, the Department received a 51A report alleging neglect of Ar and Ai by their daycare provider, SC. The Department screened-in the report for a response and, on December 20, 2016, the Department made the decision that the allegations of neglect of Ar and Ai by SC were supported. The Department notified SC of its decision and her right to appeal.

SC made a timely request for a Fair Hearing to appeal the Department's decision. A hearing was held at the DCF Central Office on April 7, 2017. The Department response worker and SC testified at the hearing. SC was represented by an attorney.

The hearing was digitally recorded and transferred to compact disc.

The hearing record was held open for two weeks to allow the Department to submit the Department of Early Education and Care (DEEC) investigation. The hearing officer requested that the Department response worker review the Department's records, if any, involving Ar and Ai's mother to submit a statement (without disclosing any confidential information) regarding mother's history of credibility or lack thereof in general terms and/or related specifically to the allegations in this case. The hearing record was closed on April 21, 2017.

The Department submitted the following exhibits at and after the hearing.

Exhibit A: 51A report
Exhibit B: 51B report
Exhibit C: Department's notice of decision.
Exhibit D: [redacted] Transportation Policy
Exhibit E: Handwritten note from Ar and Ai's mother dated October 11, 2106.
Exhibit F: DEEC Small Group and Large Group Transportation Plan and Authorization.
Exhibit G: [redacted] Official Transportation Notification.
Exhibit H: [redacted] attendance forms
Exhibit I: EEC Investigation report dated January 30, 2017.

SC submitted the following exhibits at the hearing.

Exhibit 1: Enrollment Packet for Ar.
Exhibit 2: Four letters of reference for SC.
Exhibit 3: Photograph

The Hearing Officer attests to having no prior involvement, personal interest or bias in this matter.

Issue to be Decided

The issue presented in this Fair Hearing is whether, based upon the evidence and the hearing record as a whole, and on the information available at the time of and subsequent to the response, the Department's decision or procedural action, in supporting the 51A report violated applicable statutory or regulatory requirements, or the Department's policies or procedures, and resulted in substantial prejudice to the Appellant; if there is no applicable statute, policy, regulation or procedure, whether the Department failed to act with a reasonable basis or in a reasonable manner which resulted in substantial prejudice to the Appellant; for a decision to support a report of abuse or neglect, giving due weight to the clinical judgments of the Department social workers, whether there was reasonable cause to believe that a child had been abused or neglected; and the actions or inactions by the parent(s)/caregiver(s) place the child(ren) in danger or pose substantial risk to the child(ren)'s safety or well-being; or the person was responsible for the child(ren) being a victim of sexual exploitation or human trafficking. 110 CMR 10.05; DCF Protective Intake Policy #86-015, rev. 2/28/16

Findings of Fact

1. SC has been providing daycare for children in her home since approximately 2002. She was licensed by DEEC to care for up to 10 children. Prior to the allegations that

are the subject of this appeal, DEEC had never received any complaints about SC's care of children in her home. In 2016, SC was a daycare provider through [redacted] (Testimony of SC; Exhibit I, p. 1; Exhibit A, pp. 1, 4).

2. As of September 2016, SC had 5 children attending the daycare, siblings ages 2 and 5, 3 year old twins and another 2 year old. Four of the children had been attending SC's daycare for 2 years and one had attended for 5 months. None of the parents had any concerns about SC's care of their children and they all reported that the children were well cared for and they enjoyed attending the daycare. (Exhibit B, p. 4).

3. RB is the mother of Ar (age 2) and Ai (age 9). Ar has significant developmental delays. At some point he began receiving early intervention services 3 times weekly. He received speech, occupational and play therapy. (Exhibit A, p. 1; Exhibit B, p. 7).

4. At the end of the summer 2016, RB told Ar's early intervention worker that she was having financial difficulties and she was going to return to work. (Exhibit B, p. 7).

5. RB obtained a daycare voucher for the children so that she could return to work. She enrolled Ar and Ai in SC's daycare. They began attending on September 14, 2016. (Testimony of SC; Exhibit 1; Exhibit B, pp. 3, 5).

6. As Ar and Ai's daycare provider, she was their caregiver under Department regulations at the time in question. 110 CMR 2.00; DCF Protective Intake Policy #86-015, rev. 2/28/16

7. On September 17, 2016, RB informed SC that she quit her job, however, the children continued to attend SC's daycare. (Exhibit B, p. 3; Exhibit H).

8. Ar attended all day. He usually arrived between 7:30am and 8:00am. Ai attended the daycare after school. She took the school bus to a stop near SC's home and walked unsupervised to SC's home with RB's permission. The bus was scheduled to arrive at the bus stop at 3:28pm, however the time varied depending on traffic. The time she arrived at SC's home varied considerably and could be anytime between 3:30pm and 4:20pm. There were times she did not attend at all and mother would arrive with her when she came to pick up Ar. At times, she arrived late because she stopped at a friend's house nearby on her way to SC's home. Whenever she was late, she always gave SC an excuse for why she was late. RB arrived at SC's home anytime between 3:30pm and 5:00pm. She often would come early to pick up Ai and then return later for Ar. (Testimony of SC; Exhibit 1; Exhibit B, pp. 3, 5, 7; Exhibit F; Exhibit G; Exhibit H).

9. RB apparently had some discussion with SC about having the early intervention workers coming to her home to provide services to Ar. SC attempted to set some parameters to limit the disruption to her and the children's routine and she expressed concern about the number of people involved and having 3 different therapists coming to the home at the same time. She did not refuse to allow the early

intervention workers to come to her home. It was unclear whether RB misunderstood SC. RB told the early intervention staff that SC refused to allow them to come into her home to work with Ar and she maintained that she was unable to make any alternative arrangements. She indicated that she was still working and that she could not find another daycare in the area that could accommodate her work schedule and Ai's transportation needs. As a result, early intervention services to Ar were terminated. (Exhibit B, pp. 5, 8; Exhibit I, p. 3; Testimony of SC).

10. Ar has food allergies. He was known to be allergic to eggs, peaches and pears. RB listed Ar's food allergies in his daycare enrollment form and she sent an Epipen to daycare with him and she showed SC how to use it. (Exhibit 1; Exhibit B, pp. 6, 8).

11. There was no evidence that SC ever fed Ar any of the foods to which he was allergic or that he ever had an allergic reaction to any food SC served him. (Exhibit B; Testimony of SC).

12. Ar has asthma and he was prescribed an albuterol inhaler as needed. RB also indicated this on his enrollment form and she sent his inhaler to daycare with him. She did not show SC how to administer the inhaler to Ar. (Exhibit 1; Exhibit B, pp. 6, 8; Exhibit I, p. 4).

13. One day in November 2016, SC noticed that Ar was running around and he seemed to be having difficulty breathing. She tried to give him an albuterol treatment, but he would not sit still and allow her to do so. SC called mother to ask her for clarification on how to administer the medication. Mother told her she would come to her home to do it. In the meantime, SC was able to get Ar to stop running around and his breathing improved. Mother arrived about 5 minutes later and administered the treatment. (Exhibit B, pp. 6, 8; Exhibit I, p. 4; Testimony of SC).

14. On October 4, 2016, Ai went to a friend's house after being dropped off at the bus stop. RB arrived at SC's home at about 5:00pm to pick up both children and found that Ai was not there. RB called 911. Ai arrived a few minutes later and RB cancelled the police response. SC notified [redacted] and DEEC of the incident. (Exhibit A, pp. 3, 4; Exhibit B, pp. 3, 5).

15. Neither [redacted] nor DEEC filed a 51A report based upon the above incident. (Exhibit A, p. 4).

16. On October 11, 2016, a supervisor with [redacted] met with SC to review the transportation policy. The policy regarding school age children was not particularly clear. Paragraph one seemed to be referring to pre-school children transported from home directly to the daycare center by van. The daycare provider was required to call the parent and/or van driver if a child did not arrive when expected. Paragraph two addressed school age children walking to school from the daycare or to the daycare from school. That section only required that the child's parent give permission for the child to walk unsupervised. It did not address the

situation that occurred in this case where a school age child walked to or from a bus stop and failed to arrive by a certain time. (Exhibit B, p. 3; Exhibit D)

17. In any case, the [redacted] supervisor asked SC to develop a concrete plan with RB regarding when to expect Ai and what time she will contact mother if Ai does not arrive by that time. It was unclear whether mother or SC documented such a plan, however, the daycare attendance records indicate that Ai did not arrive late after school again. Mother did provide SC with written notice on that date that Ai would begin attending the daycare before school in addition to after school. (Exhibit B, p. 3; Exhibit E).

18. Ai attended daycare before and after school everyday that week. From that point on her attendance was sporadic. She did not attend the daycare at all the week of October 17th. The next week she went to SC's home after school, but mother picked her up almost immediately after she arrived. She only attended two mornings and one afternoon the week after that. She attended only after school during the week of November 14, 2016. (Exhibit E; Exhibit H).

19. On November 18, 2016, mother went to pick up Ar and Ai at about 4:45pm. When she arrived she noticed Ar's diaper was saggy and had an odor. SC offered to change it before mother left. Mother declined and she left with the children. She arrived at her home with the children at about 5:00pm. When she changed Ar's diaper, she found it was soiled with feces that appeared old and hard. (Exhibit B, p. 6).

20. On November 21, 2017, RB called [redacted] and she filed a 51A report alleging neglect of Ar and Ai by SC. She reported that she believed that SC kept Ar in his high chair all day and he came home with a soiled diaper the previous Friday and CS failed to call her when Ai did not go to the daycare after school one day a month earlier. The Department screened-in the report for an investigation. (Exhibit A).

21. The Department response worker spoke with SC and her [redacted] worker. SC denied leaving Ar in a high chair all day or failing to change his diaper on a regular basis. She acknowledged the incident when Ai did not come to daycare after school and she (CS) did not call RB. SC and her [redacted] worker reported that CS was asked to write a concrete plan with mother. SC did not provide a copy of such a plan. She did provide attendance records and other documentation showing information consistent with the above findings. (Exhibit B, pp. 2-4; Exhibits D, E, F and G).

22. The response worker spoke with the parents of other children attending the daycare. None of the parents expressed any concerns. (Exhibit B, p. 4).

23. The response worker spoke with RB. In addition to the concerns she mentioned in the 51A report, she also complained that SC refused to allow early intervention workers into her home to work with Ar, she fed Ar "[redacted]" food which

could be harmful due to his allergies and SC cared for her elderly parents in the morning until they leave for adult daycare. She also reported the occasion on which SC called her about Ar's albuterol treatment. She said that SC was either unwilling or unable to give him the treatment SC called her requesting that she come to the home to give him the treatment. It took her over an hour to get there and Ar was wheezing when she arrived. (Exhibit B, p. 6).

24. The response worker contacted Ar's former early intervention worker who confirmed that mother said SC would not allow the early intervention workers into her home and mother could not make other arrangements because of her employment so the service was terminated. (Exhibit B, p. 7).

25. The response worker spoke with a therapeutic mentor who worked with Ai. She reported that she was present when RB came home with Ar on November 18, 2016, and she observed his diaper to be soaked and falling apart. She felt that the diaper had not been changed in hours, if at all that day. (Exhibit B, p. 7).

26. The response worker contacted SC by phone to discuss the additional concerns raised by RB. She acknowledged that she was aware of Ar's food allergies as noted by RB on the enrollment form. She reported she feeds the children breakfast lunch and dinner as well as snacks. She provided examples of the foods she served. She denied feeding Ar food he is allergic to or that he ever had any issues with the food. She acknowledged that she had trouble giving Ar a breathing treatment and she called RB. The response worker apparently did not inform SC that RB said it took her over an hour to get there, therefore, she did not address that issue. She denied that she refused to allow the early intervention workers into her home although she did say it would be a disruption to her program and she suggested to RB that she make alternative arrangements. She acknowledged that she took care of her elderly parents, but they are in a program from 7:00am until 4:00pm and their presence does not effect her care of the daycare children. (Exhibit B, p. 7-8).

27. On December 20, 2016, the Department made the decision that the allegations of neglect of Ar and Ai by SC were supported. The Department determined that she failed to provide adequate care for Ar by feeding him [redacted] food which RB was not familiar with despite his allergies, not allowing early intervention workers into her home, failing to administer Ar's breathing treatment and sending him home on November 18, 2016, with a soiled diaper. The Department found that she failed to provide minimally adequate care for Ai by failing to notify mother when Ai did not go to the daycare after school on October 4, 2016. (Exhibit B, pp. 8-10).

28. SC testified at the hearing. Her testimony was consistent with the above findings. In addition, SC testified that PB never complained to her about the food she was serving the children. PB also never notified her when Ai was going to be absent making it difficult for her to know if and when to expect her. Regarding Ar's albuterol treatment, she said that when she called PB, she (PB) said she could be there in a few minutes to give Ar the treatment and she arrived about 5 minutes later. She was not over an hour away as she reported. Regarding the early intervention

services, she denied that she refused to allow them to come to her home to work with Ar. She stated that she has had early intervention services provided to children in her home in the past. She submitted a photograph showing two early intervention workers who were providing services to the twins (also pictured in the photograph) in her home. (Testimony of SC; Exhibit 3). I find SC's testimony credible.

29. SC submitted several character references from parents who have had children in her care. They all spoke extremely highly of her and expressed their desire to have their children continue to attend her daycare. One parent noted that her son had a "breathing incident" while in SC's care. Not only did SC obtain medical attention for him, she stayed by his side at the hospital. (Exhibit 2).

30. I find that PB's credibility is highly questionable for a number of reasons. Her integrity and motivation for discrediting SC is suspect. She obtained a daycare voucher in order to allow her to work. She apparently obtained employment to qualify for a voucher, but quit her job within a few days of securing daycare slots for the children. She told Ar's early intervention workers that she could not make any alternative arrangement for services because of her employment and she failed to make any alternative arrangement for Ar's early intervention services despite her apparent ability to be available for the service to be provided at her home. Although she claimed to be concerned about SC's failure to notify her when Ai did not arrive after school one day, the following week she expanded Ai's use of the program to include the before school program. Despite her alleged concerns about the care provided by SC, she continued to send the children to her daycare even though she was not working and clearly had a choice not to do so.

31. I do find that the Department's decision to support the allegation of neglect was made in compliance with its policies and regulations. DCF Protective Intake Policy #86-015, rev. 2/28/16 For the reasons explained in the following analysis, there was not evidence that the Appellant failed to ,provide minimally adequate care for the children and that her actions or inactions placed them in danger or posed substantial risk to the child(ren)'s safety or well-being.[1]

Analysis

A "support" finding means there is reasonable cause to believe that a child(ren) was abused and/or neglected and the actions or inactions by the parent(s)/caregiver(s) place the child(ren) in danger or pose substantial risk to the child(ren)'s safety or well-being; or the person was responsible for the child(ren) being a victim of sexual exploitation or human trafficking. DCF Protective Intake Policy #86-015 Rev. 2/28/16.

[1] Such evidence, that the child was in danger or the Appellant's actions posed a substantial risk to the child's safety or well-being would be necessary for the Department to "support" the allegations, as opposed to the Department making a finding of "concern" which would also require that the child was neglected, but that there is a lower level of risk to the child, i.e. the actions or inactions by the Appellant create the potential for abuse or neglect, but there is no immediate danger to the child's safety or well-being. (See DCF Protective Intake Policy #86-015, Rev. 2/28/16, p. 28, 29)

"'Reasonable cause to believe' means a collection of facts, knowledge or observations which tend to support or are consistent with the allegations, and when viewed in light of the surrounding circumstances and credibility of persons providing information, would lead one to conclude that a child has been abused or neglected." 110 C.M.R. 4.32(2).

"Neglect" is defined as failure by a caregiver, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; malnutrition; or failure to thrive. Neglect cannot result solely from inadequate economic resources or be due solely to the existence of a handicapping condition. DCF Protective Intake Policy #86-015, rev. 2/28/16; 110 CMR 2.00

As Ar and Ai's daycare provider, she was their caregiver under Department regulations at the time in question. 110 CMR 2.00; DCF Protective Intake Policy #86-015, rev. 2/28/16

The Department determined that SC neglected Ai by failing to notify PB on one occasion when she did not go directly to the daycare after school and PB arrived before she did.

SC argued that she did not call mother to notify her that Ai was late because it was not unusual for her to arrive late or not at all.

The evidence showed that Ai's arrival time had been erratic throughout the time she attended the daycare and SC never knew for certain when to expect her or whether she was coming at all. Although the bus was scheduled to arrive at the bus stop at 3:28pm, it could easily be delayed by traffic. Whenever Ai was later than usual, she always had an excuse for the delay. There were times when Ai would stop to see friends on the way to the daycare. At times, PB would pick her up after school and Ai would be with PB when she would arrive later to pick up Ar. PB never notified SC when Ai was not going to be attending the daycare.

Considering all of the evidence, I find that SC's failure to contact mother on the day in question was reasonable given the circumstances which were in part due to PB's actions. It is also notable that when [redacted] and DEEC were notified, neither agency filed a report of neglect by SC. Even PB, who clearly was aware of the process for filing a 51A report, did not file a report on that occasion and not only did she continue to have Ai attend the daycare, she began sending Ai in the mornings before school as well as after school. The evidence also showed that Ai was clearly familiar with the neighborhood where some of her friends lived. I do not believe that she was placed at risk by SC's failure to contact mother. It is also noted that the "Transportation Policy" was not particularly clear about a daycare provider's responsibility when a school age child was coming to the daycare from a school bus stop.

The Department determined that SC neglected Ar by feeding him [redacted] food despite his allergies.

SC argued that she posted a menu and, although at times she may change or deviate from the menu, she never fed Ar any of the foods to which he was allergic and he never had any allergic reaction to any of the food she served.

I do not believe that SC failed to provide adequate food for Ar. The enrollment form completed by PB included a section for her to list his allergies which she did and there was no evidence that SC ever served him those foods.

The Department determined that SC neglected Ar by refusing to allow the early intervention workers to provide services to Ar in her home.

SC denied that she refused to allow early intervention workers to come to her home. She contends that she has had early intervention services provided to other children in her home.

The evidence showed that PB told early intervention workers that SC refused to allow the service at the daycare and she could not be available for them to provide services in her home due to her work schedule. Based upon what PB told them, early intervention services were terminated. Clearly PB was not being honest about the situation. As noted above, PB quit her job a few days after the children began attending daycare, therefore, she could have made herself available so that the services could be provided in her home regardless of whether SC would allow the service at daycare or not. There was no evidence that the early intervention staff ever spoke directly to SC. Based upon SC's credible testimony, I believe that she would have allowed the service to be provided as long as it did not interfere with the daily routine. In any case, even if SC had refused to allow the service in her home, it is PB's responsibility to ensure that Ar receives necessary services and SC has no obligation to allow any particular service provider into her home.

The Department determined that SC neglected Ar by failing to administer the breathing treatment and, instead she called PB and waited over an hour for her to arrive to administer the treatment.

SC argued that Ar was not having an asthma attack, but he did seem to be having some trouble breathing. She attempted to give him a treatment, but he would not sit still and allow her to do so. She contacted PB for clarification on how to administer the treatment. PB told her that she would be there in a few minutes. PB arrived 5 minutes later. In the meantime, she was able to settle Ar down and he seemed fine. PB did give him a treatment and she showed SC how to get Ar to accept the treatment.

Considering SC's credible testimony, her history of seeking medical attention when necessary and PB's questionable reliability, I credit SC's version of events. There was also no evidence that Ar required any further treatment or that he was at risk of harm due to the 5 minute delay. SC acted reasonably in attempting to administer the treatment and then contacting PB when she was unsuccessful. Again, it is notable that PB did not make any report of medical neglect at that time.

Finally, the Department determined that SC neglected Ar because he had a soiled diaper when PB came to pick him up on November 18, 2016.

SC argued that she and her assistant check the children in diapers every 15-30 minutes and they change their diapers as necessary. She denied there was an excessive amount of time since she last changed his diaper.

The evidence showed that PB mentioned Ar needed to be changed when she arrived to pick him up. SC offered to change him, but PB declined the offer and left with him in a dirty diaper. When she arrived home and changed him, there was a provider at the home who confirmed his diaper was heavily soiled. Although she offered her opinion that the diaper had not been changed in hours if at all, her opinion was not supported by any evidence and I find that unlikely given SC's reputation for providing excellent care for infants and toddlers. As any parent is aware, a child's diaper can become heavily soiled despite frequent diaper changes. In any case, there is no evidence that Ar had any negative effect such as redness or a rash and therefore, I find it unlikely that he sat in a soiled diaper for any significant length of time. I do not believe that the length of time since his last diaper changed placed him at risk of harm.

Conclusion and Order

The Department's decision to support allegations of neglect of Ar and Ai by SC was made without a reasonable basis and therefore, the Department's decision is REVERSED.

Anne Dale Nialetz (ADN)
Anne Dale Nialetz,
Administrative Hearing Officer

7-19-17
Date

Nancy S. Brody
Nancy S. Brody. Esq.
Supervisor, Fair Hearing Unit

Date

Linda S. Spears
Commissioner