THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF SOCIAL SERVICES
CENTRAL ADMINISTRATIVE OFFICE
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Commissioner

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IN THE MATTER OF

KA #2017-0087

FAIR HEARING DECISION

Appellant, KA, appealed the Department of Children and Families' (hereinafter "DCF" or "the Department") decision to support an allegation of neglect pursuant to G.L. c. 119, §§51A and B.

Procedural History

On December 13, 2016, the Department received a 51A report alleging the neglect of child B by a staff member in a residential placement program. The Department received a second 51A report on December 15, 2016, also alleging the neglect of B by program staff. A response was conducted and on January 10, 2017, the Department made the decision to support the allegation of neglect of B by staff member KA.

The Department notified KA of its decision and his right to appeal. KA made a timely request for a Fair Hearing to appeal the Department's decision and a hearing was scheduled. On January 30, 2017, counsel for the Appellant requested discovery in the matter. On March 15, 2017 the Fair Hearing Unit issued an order allowing the request in part. The hearing was held on April 14, 2017 at the DCF Central Office in Boston. The witnesses were sworn in to testify under oath.

The following persons appeared at the Fair Hearing:

Carmen C. Colon	Administrative Hearing Officer
KA	Appellant
GW	Attorney for Appellant
TH	DCF Response Worker

The following evidence was entered into the record for this Fair Hearing:

For the Department

Exhibit A	Intake Report/ 51A, 12/13/16
Exhibit B	Intake Report/ 51A, 12/15/16
Exhibit C	Non-Emergency Response, approved on 1/10/17
Exhibit D	Written notice of supported allegation, 1/9/17
Exhibit E	[redacted] Police Department Arrest Report, 12/13/16
Exhibit F	[redacted] Incident Report, 12/13/17
Exhibit G	[redacted] Team Meeting Sign In, 12/8/16
Exhibit H	[Reported child] Response and Return Plan, 11/10/16
Exhibit I	Treatment Review Document [Reported child], 12/20/16
Exhibit J	Residential Child Comprehensive Assessment, 10/6/16
Exhibit K	[redacted] Team Meeting Sign In, 11/10/16
Exhibit L	Residential Progress Note, 11/10/16
Exhibit M	Residential Collateral Contact, 12/8/16
Exhibit N	Shift Summary Report, 12/12/16
Exhibit O	[redacted] Security Checklist, 12/12/16
Exhibit P	[redacted] Location Check Sheet, 12/12/16

For the Appellant

Exhibit 1	[redacted] Location Check Sheet, 12/12/16
Exhibit 2	Supervisor [redacted] Location Check Sheet, 12/12/16
Exhibit 3	[redacted] Policy Number [redacted], rev. 8/5/14
Exhibit 4	Supervisor Task List, 12/12/16

The Hearing Officer need not strictly follow the rules of evidence…Only evidence which is relevant and material may be admitted and form the basis of the decision. (110 CMR 10.21)

In accordance with 110 CMR 10.03, the Administrative Hearing Officer attests to impartiality in this case, having had no direct or indirect interest, personal involvement or bias in this case.

Issue to be Decided

The issue presented in this 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, the issue is 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, the issues are whether there was reasonable cause to believe that a child had been abused or neglected; and, whether

the actions or inactions by the parent or caregiver placed the child in danger or posed substantial risk to the child's safety or well-being, or the person was responsible for the child being a victim of sexual exploitation or human trafficking. *DCF Protective Intake Policy #86-015* (rev. 2/28/16), 110 CMR 10.05

Findings of Fact

1. The subject child of this response was 17-year-old B, a resident at the [redacted] residential program in [redacted], MA. B was in DCF custody; he was referred to the [redacted] program under a DCF Care and Protection arrangement with DYS services. (Exhibit C, pp. 1-2; Exhibit J)

2. B was placed at the program to practice emotional regulation of his anger and impulsivity, which had contributed to past legal issues, and to learn independent living skills. His hopes on entering the program were to obtain a job, graduate from high school, maintain a relationship with his father, and transition to his own apartment. (Exhibit J)

3. The Appellant was a staff member in the program. His duties included monitoring residents. (Exhibit C, pp. 22, 25)

4. The Appellant was a caregiver to B pursuant to Departmental policy. DCF Protective Intake Policy #86-015 (rev. 2/28/16)

5. B shared a bedroom with 18-year-old resident PB, and another resident named E. Their room was off a common area known as "BC2" that was approximately 10 feet x 15 feet in size. (Exhibit C, pp. 25, 30-31)

6. B struggled with physical and verbal boundaries while at the program (Exhibit C, p. 22).

7. On December 12, 2016, B allegedly sexually assaulted PB, while B and PB were alone in their room together. PB reported the incident to program staff and the police. B was placed under arrest and charged. (Exhibit C, p. 10; Exhibit E)

8. B had broken the bedroom door off its hinges a day or two prior to the alleged assault. The door had been placed outside the bedroom, along the wall of BC2. (Exhibit C, p. 22, 24)

9. PB reported to the police that the assault began around 10pm. He told the DCF Response Worker that he believed it occurred between 10:30 and 11pm, because he knew it was around shift change time. He stated that B made sexual advances on him for around 20 to 25 minutes. He said that B moved the door into place in the doorway before assaulting him. (Exhibit E; Exhibit C, p. 24-25)

10. I find PB to be a credible reporter. While there was some inconsistency in PB's

account of when the assault began, the details he gave of how and when the incident ended and how he reported it were corroborated by multiple staff members who were present at 11pm shift change. There was no evidence that PB had a history of false reporting or that he had motivation to fabricate the incident. (Exhibit C, pp. 23-25; Exhibit E)

11. According to the program's location check sheet, the Appellant was assigned to BC2 from 9-11pm on the evening of the incident. Another staff member was also stationed in BC2 at the same time. (Exhibit 1)

12. DCF Response Worker TH interviewed the other staff member assigned to BC2 during the course of the response, but did not question her regarding her assignment to the BC2 area. TH testified that he was not aware of her assignment to BC2; he questioned her because she was the first person to whom PB disclosed the incident. (Fair Hearing Record)

13. According to the program director, staff members stationed to an area were expected to check on residents every 15 minutes and document their location. (Exhibit C, p. 22)

14. The program's written policy required staff assigned to the location check sheet to "visually place eyes on every client every 15 minutes [...]." (Exhibit 3, p. 2)

15. The Appellant acknowledged being assigned to monitor the common area outside B and PB's room between 9:30 and 11pm on the evening of the reported incident. He stated that he stayed in BC2 the whole time, did all of his 15-minute room checks between 9:30 and 11pm, and did not notice anything suspicious. (Exhibit C, p. 25)

16. The Appellant reported that B and PB's door was off to the side, but that at some point it had been moved into place. He could not recall who moved it or when, but stated that it did not impede his room checks. (Exhibit C, p. 25)

17. Staff member SD reported that he relieved the Appellant of his shift around 10:50-10:55pm. He stated that B and PB's room was the second room he went to check on. He found their room door wedged into place and had difficulty opening it by himself. B helped him by pushing the door from the inside. Supervisor KW reported assisting SD in removing the door from the doorway (Exhibit C, p. 25)

18. The Appellant was written up by the program for not doing his 15 minute checks. (Exhibit C, p. 28)

19. The Department supported the allegation of neglect of B for failure to provide B with minimally adequate supervision. It noted that PB reported that B put their bedroom door in place and sexually assaulted him over a period of 20-25 minutes. It concluded that it was not plausible that the Appellant could have done all of his

15 minute checks on B while the door was wedged into place. The Department relied on documentation from the program and the testimony of the Appellant, resident PB, staff member SD, and resident MTS in making its determination. (Exhibit C, pp. 32-33)

20. I did not find MTS to be a reliable reporter due to the significant inconsistencies in his testimony. Therefore, I did not give any weight to his statements.

21. The Department did not interview B, upon instruction from B's attorney. (Exhibit C, pp. 20-21)

22. At the Fair Hearing, counsel for the Appellant argued that only the staff member assigned to complete the location check sheet was responsible for monitoring residents at 15 minute intervals. Counsel claimed that Exhibit 4 showed that it was staff member M who was assigned the location check sheet from 7-11pm on the night of the incident, not the Appellant, therefore the Appellant was not responsible for monitoring residents during the incident. The Appellant testified that only one person was assigned at a time to complete the check sheet. (Fair Hearing Record)

23. The supervisor task list did not indicate the time period within a shift for when a staff member was responsible for a given task. (Exhibit 4)

24. Counsel also argued that both the location check sheet completed by staff and the location check sheet completed by a supervisor showed PB to be asleep from 10:15-11pm the night of the incident, thereby casting doubt that PB was assaulted during that time frame. Counsel claimed that there was no evidence that the location check sheet was fabricated. (Fair Hearing Record)

25. I find that the Department had reasonable cause to believe that the Appellant did not provide minimally adequate supervision to B, and therefore neglected B under Department regulations, for the following reasons:
    - The Appellant was a caregiver to B;
    - The Appellant acknowledged being responsible for monitoring the BC2 common area outside of B's room and performing room checks at 15 minutes intervals from 9:30 to 11pm;
    - It was not disputed that an incident occurred between B and PB which resulted in B being arrested and charged with sexual assault of PB;
    - PB was credible in his report that B made the alleged sexual advances on him for 20-25 minutes, after 10pm and around 11pm shift change, and that these occurred after B wedged their bedroom door back into place;
    - SD's statement, that when he went to do a room check on B and PB's room shortly after 10:50-55pm he found the door wedged into place and needed assistance in moving it, was corroborated by another staff member and was consistent with PB's account of the incident;
    - Given the above, it was reasonable for the Department to conclude that the

Appellant did not conduct a room check on B and PB during the 20-25min interval in which their door was wedged into place.

26. I further find that the Appellant's actions posed substantial risk to B's safety and well-being. I therefore find that the Department's support decision was in compliance with its policies and regulations. *DCF Protective Intake Policy #86-015* (rev. 2/28/16), 110 CMR 4.32

Applicable Standards and Analysis

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 CMR 4.32 (2). Factors to consider include, but are not limited to, the following: direct disclosure by the child(ren) or caretaker; physical evidence of injury or harm; observable behavioral indicators; corroboration by collaterals (e.g. professionals, credible family members); and the social worker's and supervisor's clinical base of knowledge. 110 CMR 4.32(2)

Reasonable cause implies a relatively low standard of proof which, in the context of 51B, serves a threshold function in determining whether there is a need for further assessment and/or intervention. *Care and Protection of Robert*, 408 Mass. 52, 63-64 (1990). "[A] presentation of facts which create a suspicion of child abuse is sufficient to trigger the requirements of s. 51A. *Id.* at 63. This same reasonable cause standard of proof applies to decisions to support allegations under s. 51B. *Id.* at 64; M.G.L. c. 119, s. 51B.

Caregiver

(1) A child's parent, stepparent or guardian, or any household member entrusted with responsibility for a child's health or welfare; or

(2) Any person entrusted with responsibility for a child's health or welfare, whether in the child's home, relative's home, a school setting, a child care setting (including babysitting), a foster home, a group care facility, or any other comparable setting.

As such, the term "caregiver" includes, but is not limited to school teachers, babysitters, school bus drivers, and camp counselors. *DCF Protective Intake Policy No. 86-015* (rev. 02/28/2016)

Neglect is 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 a failure to thrive. Neglect cannot result solely from inadequate economic resources or be due solely to the existence of a handicapping condition. (*Id.*)
Abuse means the non-accidental commission of any act by a caregiver upon a child under age 18, which causes, or creates a substantial risk of physical or emotional injury, or

constitutes a sexual offense under the law of the Commonwealth or any sexual contact between a caregiver and a child under the care of that individual, or the person was responsible for the child(ren) being a victim of sexual exploitation or human trafficking. (*Id.*)

To Support a finding means:

- There is reasonable cause to believe that 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 . . . (*Id.*)

Danger is a condition in which a caregiver's actions or behaviors have resulted in harm to a child or may result in harm to a child in the immediate future. (*Id.*)

A Fair Hearing shall address (1) whether the Department's or provider's decision was not in conformity with its policies and/or regulations and resulted in substantial prejudice to the aggrieved party;. . . In making a determination on these questions, the Fair Hearing Officer shall not recommend reversal of the clinical decision made by a trained social worker if there is reasonable basis for the questioned decision. 110 CMR 10.05

Department regulation 110 CMR 4.27 governs the investigation of non-emergency reports. Pursuant to 110 CMR 4.27 (2), "[...] Parents and other individuals living in the home are visited a minimum of one time, the initial visit occurs in the home within three working days after the screening decision. Any parent or parent substitute living out of the home, who can be located, is contacted a minimum of one time. The nature of the contact is determined by the investigator and supervisor."

To prevail, an Appellant must show by a preponderance of all of the evidence presented at the hearing, that: (a) the Department's or Provider's decision was not in conformity with the Department's policies and/or regulations and/or statutes and/or case law and resulted in substantial prejudice to the Appellant, (b) the Department's or Provider's procedural actions were not in conformity with the Department's policies and/or regulations, and resulted in substantial prejudice to the aggrieved party, (c) if there is no applicable policy, regulation or procedure, that the Department or Provider acted without a reasonable basis or in an unreasonable manner which resulted in substantial prejudice to the aggrieved party; or (d) if the challenged decision is a supported report of abuse or neglect, that the Department has not demonstrated there is reasonable cause to believe that a child was abused or neglected and the actions or inactions by the parent(s)/caregiver(s) placed the child(ren) in danger or posed 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 10.23; *DCF Protective Intake Policy #86-015* (rev. 2/28/16)

B was a resident who had difficulty with verbal and physical boundaries. He was in the program so that he could improve his emotional regulation and independent living skills. He had goals of obtaining a job, graduating from high school, keeping up family relationships, and transitioning to living on his own.

The Department determined that the Appellant neglected B when he failed to perform 15 minute checks on B during a period when he was assigned to do checks, and during which time B allegedly sexually assaulted his roommate PB. To make its determination, the Department relied on evidence that the door to B's room was wedged shut during the 20-25 minute period of the alleged assault, which would have prevented the Appellant from conducting at least one of his 15 minute checks.

The Appellant denied and disputed the allegations. During the response, the Appellant told the DCF response worker that he completed all the 15 minute room checks for which he was responsible in the BC2 area and that he did not notice anything suspicious. He reported that at some point he noticed that the broken door to B and PB's room had been put back in their doorway, but he claimed that it did not hinder his checks. At the Fair Hearing, counsel for the Appellant argued that the the Appellant was not responsible for conducting room checks during the period of the reported incident, based on a reading of the supervisor task list (Exhibit 4) for that evening, so he could not have neglected him.

The Appellant's assertion at his Fair Hearing that he was not responsible for monitoring B during the time period of the alleged incident significantly contradicted his prior statement to the DCF response worker in which he acknowledged being responsible for monitoring the common area outside B's room from 9:30 to 11pm and completing all his 15 minute room checks. Consequently, his interpretation of assignment of duties on the night of the incident, absent corroboration, was not reliable. In addition, the fact that the Department did not interview the other worker assigned (on paper) to monitor the same common area, did not relieve the Appellant of responsibility to perform his assigned duties.

The Appellant's claim that because the location check sheets show PB asleep from 10:15 to 11pm he could not have been assaulted during that time, was not persuasive. Multiple staff corroborated that PB exited the room at the 11pm shift change. PB was a credible reporter whose description of the incident indicated that he was awake during at the time and that it took place prior to 11pm and after 10pm.

Considering the entirety of the record, the Department had reasonable cause to believe that B was neglected by the Appellant when the Appellant did not provide him with minimally adequate supervision. Reasonable cause implies a relatively low standard of proof which, in the context of 51B, serves a threshold function in determining whether there is a need for further assessment and/or intervention. *Care and Protection of Robert*, 408 Mass. 52, 63-64 (1990). There was no evidence that resident PB and staff member SD, on whom the Department relied to make its determination, were not credible witnesses. The details PB gave regarding the reported incident were corroborated by multiple staff members. Even without MTS's testimony, there was sufficient evidence that the Department had reasonable cause to believe the allegation.
The Appellant posed substantial risk to B's safety and well-being through his actions. B was arrested, charged, and removed from the program following the incident. B had known difficulty with emotional regulation and was referred to the program under a Care

and Protection arrangement due to his needs and past legal issues.

Conclusion and Order

The Department's decision to support the allegation of neglect of B by Appellant was made in conformity with Department regulations and policy and is therefore AFFIRMED.

This is the final administrative decision of the Department. If the Appellant wishes to appeal this decision, he may do so by filing a complaint in the Superior Court for the county in which he lives within thirty (30) days of the receipt of the decision. (See, G.L., c. 30A, §14.) In the event of an appeal, the Hearing Officer reserves the right to supplement the findings.

Carmen C. Colon
Carmen C. Colon
Administrative Hearing Officer

5-17-18
Date

Susan Diamantopoulos
Susan Diamantopoulos
Fair Hearing Supervisor