**THE COMMONWEALTH OF MASSACHUSETTS**
**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**
**DEPARTMENT OF CHILDREN AND FAMILIES**
**CENTRAL ADMINISTRATIVE OFFICE**
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**Linda S. Spears**
**Commissioner**

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| IN THE MATTER OF | |
|---|---|
| SM | 2017-0128 |

## FAIR HEARING DECISION

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

### Procedural History

On June 25, 2015, the Department received a 51A report alleging neglect of A by the staff at the [redacted] facility in [redacted] The Department screened-in the report for a non-emergency investigation. On July 16, 2015, the Department made the decision that SM had neglected A. The Department did not notify SM of its decision and his right to appeal until January 12, 2017. On February 1, 2017, SM requested a fair hearing to appeal the Department's decision

A hearing was held at the DCF Central Office on April 7, 2017. SM was present and testified at the hearing. SM was represented by an attorney. No one appeared to represent the Department.

The Department submitted the following exhibits after the hearing. [1]

Exhibit A: 51A report
Exhibit B: 51B report
Exhibit C: E-mail with attached Critical Incident Report dated June 30, 2015.
Exhibit D: [redacted] Internal Investigation Report Form (much of which is unreadable due to the poor quality of the copy and it does not appear to be collated in the proper order, a readable and properly ordered copy is also submitted as Exhibit J).
Exhibit E: Letter from the Department investigator requesting a police report.
Exhibit F: [redacted] Employee Performance Review Notes for Shadow Shift #1, including policy regarding storage and use of cleaning supplies.
Exhibit G: [redacted] Fire Department Incident Detail.
Exhibit H: [redacted] Police Department Incident Report.
Exhibit I: [redacted] Employee Performance Review Notes for Shadow Shifts #1 through 5 and Orientation Supervision #1 through 12.
Exhibit J: Cover letter and [redacted] Internal Investigation Report Form consisting of 5 unnumbered pages followed by 15 numbered pages.

The hearing was digitally recorded and transferred to compact disc.

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 investigation, 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. 110 CMR 10.05

[1] SM had been provided with the Department's exhibits prior to the hearing.

## Findings of Fact

The following findings are made based upon review and weighing of the evidence contained in the hearing record.

1. The [redacted] facility (hereinafter "the program") in [redacted] consists of three houses located on the same street and/or in neighboring lots. It is a residential short term placement for adolescent boys in the custody of the Department. (Testimony of SM).

2. The program is an open door community residence. Residents are referred to the program by the Department with the goal of family reunification and/or community reintegration. Residents attend community schools and participate in community activities. Residents are not regularly searched upon returning from unsupervised activities in the community. (Exhibit I, p. 17).

3. The house in question has a capacity of 9 residents supervised by 3 staff members. (Exhibit B, p. 10).

4. New staff training/orientation involves at least 5 shifts of "shadowing" experienced staff members with specific policies/procedures reviewed during each shift and at least 12 supervision orientation sessions during which various policies/procedures are addressed. (Exhibit I).

5. The program has a written policy regarding cleaning supplies. The written policy states that all cleaning supplies are to be kept in a locked cabinet at all times. Staff members handle the cleaning products and spray down surfaces to be cleaned by residents. Residents are not to have physical contact with the chemicals. Residents should not be using any of the chemicals without staff supervision. Chemicals need to be properly secured after use. (Exhibit B, pp. 10-11;Exhibit F; Exhibit I, pp. 1-2, 27; Exhibit J, p. 6).

6. Despite the written policy, the actual practice in the program was to allow the residents to handle the cleaning products. Many staff members routinely allowed the residents to enter the supply cabinet and take the supplies they need for their assigned chore. Some staff got the cleaning products from the cabinet, but then gave them to residents. In either case, the residents would use the cleaning products themselves and then return them to the cabinet. (Exhibit B, pp. 11, 12, 13, 18, 20, 21; Exhibit J, pp. 3, 4, 5, 7, 8, 9, 10, 11, 12, 13; Testimony of SM).

7. SM earned his Bachelor of Science degree in criminal justice and, after graduation, SM began working as a residential caseworker at the program in 2014, at the age of 22 or 23. (Testimony of SM).

8. SM and other staff members, including supervisors, were specifically told during their initial training that staff assign chores to residents and then give them the cleaning products they need. Staff collect the supplies afterward. Staff would only deviate from this procedure if a resident presented as a safety risk or started joking about spraying staff in the face. (Exhibit B, pp. 11, 12, 13, 18, 20, 21; Exhibit J, pp. 3, 4, 5, 7, 8, 9, 10, 11, 12, 13; Testimony of SM).

9. A (age 14) was placed at the program on May 27, 2015, after his school filed a Child Requiring Assistance (CRA) petition due to his behavior. A's legal guardian could not manage him and the court placed A in the Department's custody and ordered his placement out of the home. (Exhibit C, p. 6).

10. On or before June 24, 2015, A began secretly acquiring items in the house (household chemicals, aluminum foil and various containers) without staff knowledge so that he could make "bottle bombs." (Exhibit C, pp. 3, 10).

11. At approximately noon on June 24, 2015, the shift supervisor and assistant program director found cleaning supplies under the sink in the downstairs bathroom and a soap dispenser containing a liquid that did not appear to be soap outside of the first floor bathroom. A few hours later, the supervisor observed A in the downstairs bathroom acting suspicious. After A left, the supervisor checked the bathroom and found toilet bowl cleaner and Comet under the sink. A was observed to be acting suspicious by other staff that afternoon and one staff member heard him say, "Why didn't it go off?" Although the staff involved removed the items from the bathroom, none of that information was passed on to the staff members coming in to work the evening shift. (Exhibit B, p. 11; Exhibit J, unnumbered page 3).

12. On June 24, 2015, SM arrived for his shift by 6:00pm. The residents completed their chores and then A asked SM if he could clean the downstairs toilet. SM agreed to allow him to clean the toilet and he gave A toilet bowl cleaner. SM initially stood in the bathroom doorway supervising A until another resident entered the staff office and refused to leave. SM left A in the bathroom and went to the office to deal with the other resident. A was left alone for approximately 10 minutes. After SM left, A assembled at least one bottle bomb and placed it in the oven in the kitchen. The bottle "exploded" making a loud popping sound and the area began filling with smoke. (Exhibit B, pp. 11-14, 18, 20-21; Exhibit J, pp. 3-4, 13).

13. A staff member called 911. Local police, state police and the bomb squad responded. The building was evacuated. A ran away from the program. Other bottle bombs were located and detonated. Police pursued and eventually located

A and he was arrested and charged with possession of incendiary devices. (Exhibit B, pp. 2, 3; 17, 19).

14. On June 25, 2015, the Department received a 51A report alleging neglect of A by program staff. The Department screened-in the report for an investigation. (Exhibit A).

15. The Department investigator attended interviews of staff members, including SM, and four residents including A. She also reviewed several documents including the program's internal investigation, police and fire incident reports and program policies/procedures. She obtained information consistent with the above findings. (Exhibit B, C, G, H, I, J).

16. All of the residents reported that the usual practice at the program before the above incident had been that the staff would open the supply closet and either allow them to get the cleaning products they needed or staff would give them the products. (Exhibit B, pp. 12-14, 18).

17. The majority of staff members reported that the written policy was not followed and that the actual practice was that residents handled the cleaning products themselves. (Exhibit B, pp. 10-11).

18. On July 8, 2015, the [redacted] completed an internal investigation. The investigation led to several significant conclusions. Staff members were not following the written policy regarding cleaning supplies. A had successfully been able to obtain cleaning supplies at least twice during the day shift prior to SM's arrival. This was not communicated to SM or the other evening shift staff members. This was determined to be a significant contributing factor to the incident and it was recommended that the program institute a formal "shift change" meeting to ensure information is shared with in-coming shifts. Staff members were not aware that the common household products could be combined to make an explosive device. It was noted that other procedures in place resulted in residents routinely being able to distract staff and steal prohibited items from locked closets/cabinets. The official procedure for "chore time" needed to change (i.e., the order of chores being completed, the number of clients completing chores at once, etc) to improve the staff's ability to properly monitor residents and support each other if a resident is being non-compliant during chore times. (Exhibit J, unnumbered pages 3-4).

19. On July 16, 2015, the Department made the decision that the allegation of neglect of A by SM was supported. The Department determined that SM failed to provide A with minimally adequate supervision, more specifically, he allowed him to handle cleaning products unsupervised in violation of the program's policy. (Exhibit 23-24).

20. SM testified at the hearing. He testified that the written policy regarding handling of cleaning supplies was not used in practice at the program. During his orientation training he was told that the supplies were kept in a locked cabinet, but residents were given the cleaning supplies they needed for their assigned chores and then returned to the cabinet. He was not aware of anyone at the program following the written policy and he was not aware that products had been found unsecured or that A was acting suspiciously earlier on the day of the incident. (Testimony of SM). I find SM's testimony to be credible.

21. SM also testified that A was only left alone in the bathroom with the cleaning product(s) for 20 seconds while he dealt with the situation with the other resident in the staff office. (Testimony of SM). This is inconsistent with the statement he gave immediately following the incident as documented in the [redacted] Internal Investigation. At that time, he stated that A was left unsupervised for 10 minutes. Given the discrepancies in SM's statements, I do not credit his testimony on this point and find his earlier estimate of the time elapsed was likely more accurate.

## Analysis

In order to "support" a report of abuse or neglect, the Department must have reasonable cause to believe that an incident of abuse or neglect by a caretaker occurred.

"'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).

"[A] presentation of facts which create a suspicion of child abuse is sufficient to trigger the requirements of s. 51A." Care and Protection of Robert, 408 Mass. 52, 63 (1990) 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 "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. Id. at 64

As a staff member on duty at the time in question, SM was a caretaker for A under Department regulations at the time in question. 110 CMR 2.00.

"Neglect means failure by a caretaker, 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; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition." 110 CMR §2.00.

The Department made the decision that SM failed to provide minimally adequate supervision of A by allowing him to handle cleaning products unsupervised in violation of the program's policy.

SM argues that, despite the written policy, he was trained to allow residents to handle cleaning products. He acknowledged giving A a cleaning product on the day in question. He did initially supervise A while he was cleaning. He only left because he was called to the staff office to assist with another resident. He was not aware of what had occurred earlier in the day or that the chemicals and other items in the house could be combined to create an explosive.

The evidence shows that the program serves adolescent boys in the Department's custody; therefore, the decision that it is an appropriate placement for any particular adolescent is made by the Department. It is designed to be a short term placement to assess an adolescent's needs and quickly return them home or to a community setting. It is not a locked facility or designed to deal with criminal or significant behavioral issues. It is an "open door" community residence where residents attend school and other activities in the community without supervision. The nature of the program is an important point in evaluating what should be considered a reasonable expectation for minimally adequate supervision.

Since the residents would typically have unimpeded access to any household item one may find in the community, it is not particularly clear from the evidence why the written policy regarding handling of household cleaners was so restrictive. There is nothing in the policy that outlines the potential risks of allowing residents to handle cleaning supplies and none of the staff were aware that they could be combined to create an explosive.

In any case, there is no dispute that most, if not all, of the direct care staff routinely allowed residents to handle the cleaning products themselves unless there was some obvious risk. This is the practice that was taught to SM during his training period despite what the written policy stated and this is what he observed other staff members doing during his year of employment prior to the incident in question.

Several other staff members, including supervisory staff that working an earlier shift, were aware that A was acting suspiciously and that he had been acquiring cleaning supplies. This knowledge was not passed on to any of the evening shift staff to alert them that they should maintain a heightened vigilance in monitoring him and, in particular, his use of cleaning products.

It is notable that SM had no prior experience working in such a program. He began working at the program upon his graduation from college and, therefore, the extent of his knowledge of potential risks was limited to what he experienced in the year since he was hired and there is no evidence that a similar incident had ever occurred during that time.

I find that SM was reasonable to rely on the "hands on" training he received while at the program.

Given the population that the program was designed to serve, the Department's decision to place A in a placement knowing that he would have access to any material available in the community, SM's reasonable reliance on the Department's judgment that the level of supervision offered by the program was sufficient for A, the practical training SM received, his understandably limited experience with any potential risks and the lack of communication among staff members, I find that SM reasonably assumed that A could be left alone for a brief period of time while handling a cleaning product.

Considering all of the evidence, I find that there is no reasonable cause to believe that SM failed to provide A with minimally adequate supervision given what he knew or should have known under the circumstances and, therefore, he did not neglect A under Department regulations.

## Conclusion and Order

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

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

8-15-17
Date

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

Date

Linda S. Spears, Commissioner