EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF CHILDREN & FAMILIES
CENTRAL ADMINISTRATIVE OFFICE
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BOSTON, MASSACHUSETTS 02111

LINDA S. SPEARS,
COMMISSIONER

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IN THE MATTER OF

O. R.

FH # 2017 0243

HEARING DECISION

Procedural Information

The Appellant in this Fair Hearing is Mr. OR, Jr. ("the Appellant"). The Appellant appeals the Department of Children and Families' ("the Department" or "DCF") decision to support a report of neglect pursuant to Mass. Gen. L., c. 119, sec. 51A. Notice of the Department's decision was sent to the Appellant on February 2, 2017, and the Appellant filed a timely appeal with the Fair Hearing Office on February 27, 2017.

The Fair Hearing was held on June 15, 2017, at the DCF Springfield Area Office. The following persons appeared at the Fair Hearing:

Linda A. Horvath, Esquire	Administrative Hearing Officer
OR, Jr.	Appellant
AS	Union Representative, UAW Local 2322
HP	Union Representative, UAW Local 2322
OR, Sr.	Appellant's Father/Witness
SC	DCF Special Investigator

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.

The Fair Hearing was recorded pursuant to DCF regulation. 110 CMR 10.26.

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

For the Department:

Exhibit 1: 1/10/17 51A Report
Exhibit 2: 2/7/17 51B Report
Exhibit 3: Copy of Photograph of Child
Exhibit 4: 1/9/17 [redacted]
Exhibit 5: 1/6/17 Injury Report Form, Daycare, Ms. RC
Exhibit 6: 1/6/17 [redacted]e One Incident Report, Ms. CG (Foster Parent)

For the Appellant:

Exhibit A: 3/22/17 Correspondence of LM
Exhibit B: Petition in Support of Appellant

Statement of the Issue

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 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 of human trafficking." Protective Intake Policy #86-015, rev. 2/28/16; 110 CMR 10.05.

Findings of Fact

1. The subject child of this Fair Hearing is the then one-year-old (1), female foster child, "G" ("the child"). (Exhibit 1, pp.1 and 2.) In January, 2017, G was in the custody of DCF and was attending the [redacted] childcare program ("the Program"). She was transported to and from the Program via a van/bus (hereinafter "van") provided by the Program. (Exhibit 1, pp.1.)

2. At the time of the 51A filing referenced below, the Appellant was employed as a van driver for the Program. (Exhibit 1, pp.1 and 2.) The Appellant has been employed by the Program for almost six years. (Testimony of Appellant.) He has a good record without any reported incidents and without a DCF record. (Exhibit 2, pp.3 and 4; Testimony of Appellant.)

3. On Tuesday, January 10, 2017, the Department received a report pursuant to M.G.L. c. 119, s. 51A, alleging the neglect of the child by the Appellant for not appropriately securing the car seat, in which the child was traveling, to the van seat while on route from the Program to her foster home. While the Appellant was driving, the child's safety seat fell off the van seat causing injury to the child. (Exhibit 1, p.2; Exhibit 2, p.3.)

4. The Department screened-in the 51A report as a non-emergency response. (Exhibit 1, p.3.)

5. On Friday, January 6, 2017,[1] at 10:20 AM, while at daycare, the child sustained a bump to the right side of her forehead and a small scratch on her nose when she was trying to stand on a child-sized chair, lost her balance, and fell onto the carpet. (Exhibit 5.) The seat of the chair was only a few inches off the ground. (Exhibit 2, p.2; Testimony of SC.) The daycare provider described the child's injury as a "pea sized red mark on her upper right eyebrow"; the child did not cry. The red mark faded within an hour. (Exhibit 2, pp.2 and 3.)

6. The DCF Special Investigator viewed and verified the height of the chair and that it was located in a carpeted area. (Exhibit 2, p.3; Testimony of SC.)

7. When the child arrived home from daycare on the Program's van, the foster mother saw a "large bump and bruise" on the child's forehead. (Exhibit 2, pp.1 and 2.) The foster mother thereafter telephoned the daycare provider who notified her of the child falling off the chair.[2] (Exhibit 5; Exhibit 6.) The injury was significant and worsened over the weekend. (Testimony of SC; See, Photograph at Exhibit 3.)

8. Unbeknownst to the foster mother, on Friday, January 6, 2017, while being transported home from daycare by the Appellant, the child, while still in her car seat, fell off the van seat to the van floor. (Exhibit 2, p.2.) The Appellant did not inform the child's foster parent or any staff at the Program (supervisor or dispatcher) of the incident and did not fill out an incident report. (Exhibit 2, pp.2, 3 and 4; Testimony of Appellant.)

9. On Monday, January 9, 2017, the child went to daycare. When the daycare provider saw the large bump and bruise on the child, she immediately called the foster mother to inform her that it was too large a bruise for that injury to have occurred when the child fell off a small chair. (Exhibit 2, p.2) It "wasn't the same mark that she had at daycare. It was a much larger injury and in a different place." (Id.)

10. The child was taken to her pediatrician's office for evaluation on January 9th however, the only information that could be relayed to the pediatrician at the examination was that the child fell off a toddler chair. (Exhibit 1, p.2; Exhibit 4; Testimony of SC.)

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[1] The Daycare's Injury Report Form erroneously indicates the date of incident was in 2016. (Exhibit 5.)
[2] The daycare provider also emailed an incident report to the foster mother two days later, on Sunday, January 8, 2017. (Exhibit 1, p.2; See, Exhibit 5.)

11. The child's neurological exam was normal. (Exhibit 4.) The pediatrician opined, "The bruise on the forehead will change but will last for weeks before finally disappearing." (Id.) On January 19, 2017, thirteen (13) days after the incident, the child still had a "light bruise and small lump" on her forehead. (Exhibit 2, p.3.)

12. The proper car seat installation for the Program's drivers is the following:[3] The driver first checks to make sure the seat is up to date, puts it on the van seat, straps all belts through the seat and listens to make sure to hear the seat belt click. Then the driver pulls on the seat belt to ensure it is locked. Lastly, the driver puts his or her "hand/knee" with weight on the seat to ensure that it is stable. (Exhibit 2, p.3.) The Appellant recited the correct installation procedure during his DCF interview. (Id. at p.4.)

13. The Appellant was scheduled to attend a mandatory "car seat installation training" on March 16, 2016, however the Appellant did not attend. (Exhibit 2, p.3.) His training consisted of working with another driver who showed him how to install car seats when he first began his employment six years earlier. (Id. at p.4; Testimony of Appellant.)

14. Also on January 9th after seeing the bruise, the daycare provider spoke to the Program who thereafter viewed its video of the child's van ride home on January 6th. The DCF Special Investigator also viewed the video during the course of the investigation, and it was viewed and commented on at the fair hearing.[4] The video consists of two parts. For some of the video, the view of the Appellant's actions is blocked by the Appellant himself due to the position and angle of the camera. (Exhibit 2, p.3; Testimony of Appellant; Testimony of Ms. SC.)

    a) The child sat in the same location on the van each day. On January 6, 2017, the Appellant obtained a car seat from another van for the child that was different than her usual seat. The child had a bigger ("full") jacket on and she fit into the subject car seat better as it was "deeper." (Testimony of Appellant.)
    b) The Appellant had never before used the subject car seat and was not aware when/if the car seat had ever before been checked for safety. (Testimony of Appellant.)
    c) The Appellant was aware that the van's seatbelt buckle was "cracked" but it still buckled. He had previously reported it to his supervisor who told him to use it as long as it buckled. (Testimony of Appellant.)
    d) The Appellant put the car seat onto the van seat and buckled it in using the van's seat belt; he then tightened it. The Appellant then used the belts that come

[3] The DCF Special Investigator obtained this information from Mr. LM, a dispatcher and substitute driver for the Program. (Exhibit 2, p.3.)

[4] The Program could not copy the video onto a CD for the DCF Investigator due to technical difficulties, and DCF was also not able to copy the video onto a CD for evidence at the hearing. (Testimony of Ms. SC.) All parties, including the undersigned hearing officer, were able to view the video at the hearing. Details of the video are recited into the hearing record.

attached to the car seat, wrapped them around the car seat and strapped them in place; this cannot be seen in the video due to the camera angle. The Appellant then pulled on the straps two times to tighten the car seat to the van seat; this pulling motion by the Appellant can be seen in the video. (Testimony of Appellant.)

e) The Appellant claimed to then use his hand to then put weight on the seat to make sure it was safely secured to the van seat before putting the child in it; this is not seen in the video and is contested by DCF. He admittedly did not use his knee to put weight on the seat as he was trained that using his knee was not mandatory. (Testimony of Appellant; See, Finding #12.)

f) After the seat installation, the seat was facing straight forward. The Appellant then moved past it and bumped the car seat with his leg, which clearly moved the seat toward the right in the video. The seat was "wobbly" and not secured to the van seat. (Testimony of SC; Exhibit 2, p.4.)

g) It is uncontested that the Appellant then strapped the child in the car seat's 5-point harness. The Appellant claimed to have then checked the seat again to make sure it was secure; this also cannot be seen in the video. (Testimony of Appellant.)

h) There is no evidence that the Appellant noticed any preexisting marks or bruises on the child's face when he first strapped the child into the car seat. (See, hearing record.)

i) As the Appellant was driving, he took a left-hand turn and through his rearview mirror noticed the entire car seat, with the baby still strapped in it, fell off the van seat to the left in the video toward the van door. (Testimony of Appellant.) There is no evidence or allegation that the Appellant was speeding during the incident. (Testimony of Ms. SC.)

j) Although the Appellant informed the DCF Special Investigator that the child was not crying after she fell (Exhibit 2, p.4), the child can clearly be heard crying loudly in the video and the Appellant was "verbally consoling" the child when he was pulling over.[5] (Id.; See, hearing record.)

k) The Appellant immediately pulled the van over to tend to the child. (Testimony of Appellant.) From the video, it is impossible to see the child's face after the fall. (See, hearing record.) The Appellant first saw that the child was face down in the car seat but was still secure within the seat. (Id.) The Appellant denied he saw any marks or bruises on the child. (Exhibit 2, p.4.)

l) Although the Appellant denied the child's face hit the ground due to the protection of the sides of the car seat (Testimony of Appellant), he cannot know this for sure as the Appellant was driving the van when the seat containing the child hit the ground. The video angle also does not show the child as she hit the van floor.

m) The Appellant noticed that the van's seatbelt located underneath the car seat had unclicked, and that the straps attached from the car seat to the van seat also came undone. The Appellant then used the same van seatbelt to buckle in the car seat but positioned it differently (wrapped it around the front of the car seat), in order to continue traveling on his route. (Testimony of Appellant.)

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[5] The Appellant acknowledged at the fair hearing that the child was crying when she fell. (Testimony of Appellant.)

15. Per Program policy, immediately after checking the child after the fall, the Appellant should have remained stopped in the vehicle and telephoned the Program's Director, KG, whose number he had, in order to report the incident. If the Appellant was unable to locate the Director's number, he was required to telephone the Program's night dispatcher, who would have given him the number. (Exhibit 2, p.3.)

16. At the very least, the Appellant was aware that policy dictates that if there is an accident, he is to call his supervisor, and if there is a "crash" he is also to call 911. (Testimony of Appellant.) The Appellant did not remain on the scene where he pulled the van over and call 911 because he claimed he "did not see anything wrong with [the child's] face." (Id.) He did not telephone his supervisor (who leaves at 3:30 PM) because he/she was gone for the day. (Id.) The Appellant acknowledged that he was trained to "call in and report to [the] dispatcher immediately" (Exhibit 2, p.4), but he did not do this either. (Testimony of Appellant.)

17. Although during his DCF interview the Appellant reported that his dispatcher was still at the program at the time of the incident (Exhibit 2, p.4), his testimony was inconsistent stating that he did not call the regular dispatcher because he knew he/she had left for the day. He also acknowledged that he did not telephone the back-up/night dispatcher. (Testimony of Appellant.)

18. The child fell off the van seat at 3:52 PM (time obtained from the video). (Testimony of Ms. AS.) The Appellant dropped the child off at her foster home at approximately 4:15—4:20 PM. He did not inform the foster mother of the child's fall in the van. (Testimony of Appellant.)

19. The Appellant was instructed by his supervisor, and it is contained in the [redacted] training manual (Testimony of Ms. AS), that he is not to speak to parents/guardians directly but to inform his supervisor of any incidents and his supervisor would thereafter speak with the caregivers. (Testimony of Appellant.) The Appellant's testimony that there was no superior at the Program to call after hours on that date (Id.) is not credible.

20. When the Appellant arrived at work on Monday, January 9th, the supervisor was already aware that something had occurred on the van the previous Friday. (Testimony of Appellant.)

21. As a result of the incident, the Appellant was suspended. (Exhibit 2, p.3.) Many staff and clients of the Program support the Appellant and want him reinstated as a van driver. (Exhibit B.)

22. After the Appellant's suspension, the substitute driver for the Appellant's route attempted to strap in the subject car seat the child was placed in on the day of the incident. The driver noticed two times that the seat would not secure tightly and leaned to the side. He did not use it and brought it to the Supervisor's attention who disposed of it that day. (Exhibit 2, p.3; Exhibit A.)

23. On February 1, 2017, the Department supported the aforementioned report in accordance with M.G.L. c. 119, s. 51B for neglect on behalf of the subject child by the Appellant due to the Appellant not ensuring that the child's car seat was safely secured to the van seat, thereby causing the child, while strapped in the car seat, to fall over onto the van floor while the van was in motion, and sustain a "significant bruise" on her head. (Exhibit 2, p.5.)

24. The Department also supported the aforementioned report in accordance with M.G.L. c. 119, s. 51B for neglect on behalf of the subject child by the Appellant due to the Appellant's failure to provide minimally adequate medical care when he failed to report to the foster mother, his supervisor, dispatcher, or back-up dispatcher that the child had fallen while in her car seat onto the van floor. "Because foster parent was not aware of the significance of the fall, she was not looking for signs of concussion nor did she bring the child to the Doctor immediately to ensure there was no significant head injury." The foster mother was only aware of the earlier fall of that morning from a small toddler chair. (Exhibit 2, p.5.)

25. The Department closed its case following the support decision as no services were required. (Exhibit 2, p.5.)

Applicable Standards

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 of human trafficking." Protective Intake Policy #86-015, rev. 2/28/16.

"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.

"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. Protective Intake Policy #86-015, rev. 2/28/16.

To prevail, an Appellant must show based upon all of the evidence presented at the hearing, by a preponderance of the evidence 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 that 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 of human trafficking." Protective Intake Policy #86-015, rev. 2/28/16. 110 CMR 10.23.

Analysis

The Appellant is deemed a "caregiver" pursuant to Protective Intake Policy #86-015, with respect to the subject child.

Though not done deliberately, the Appellant failed through negligence to provide the child with minimally adequate "other essential care" in the form of safety, when he failed to sufficiently secure the car seat to the van seat, which allowed the child to fall across the van onto the floor while the van was in motion. Admittedly, the Appellant had never used the subject car seat and was not aware if it had ever been checked for safety. Also, the Appellant was aware that the buckle of the van's seatbelt was cracked, though it still buckled and was instructed by his supervisor to continue using it. What can be seen from video evidence is that the Appellant pulled on the seat straps two times to tighten it. Though the Appellant claimed to have used his hand, not his knee (an acceptable form of checking the seat according to the Program) to put weight on the seat to make sure it was safely secured, this is not detected in the video. Also not detected in the video is the Appellant checking the seat for safety again after putting the child into it. Shown clearly in the video is that prior to the Appellant strapping the child into the 5-point harness, the seat moved to the right and was clearly not secure. Noteworthy, is that a substitute van driver who tried to secure the subject car seat two times noticed that it did not secure tightly and leaned to the side; the seat was thereafter disposed of.

The Appellant's inaction of not making sure the child's car seat securely fastened to the van seat placed the child in danger and posed a substantial risk to the child's safety, as it allowed for the child (still strapped in the seat) to fall while the van was in motion. While the Appellant argued that there is no definitive evidence the child sustained the large bump and bruise on her forehead as a result of the fall in the van, the evidence suggests otherwise. The child's fall at the daycare occurred at 10:20AM, and consisted of a pea-sized mark/bump on the right side of her forehead; the redness of that mark faded within an hour. There is no evidence the Appellant noticed a mark/bruise on the child when he first placed the child in her seat on the van. However, thereafter when the child was returned to her foster home, the foster mother described the child's bruise as a "large bump and bruise" and immediately telephoned the daycare provider. There is no evidence that the child sustained an injury while at the foster home that weekend. The injury seen by the daycare provider on Monday, January 9th was not consistent with the child falling off a toddler chair only a few inches off the ground and was in a different location than the injury sustained at the daycare. Noteworthy is that the Appellant's avoidance in reporting the incident to *any* Program staff member or to the foster parent on the date of the incident does not bode well for his credibility in his denial that the child sustained the injury from the fall in the van.

The Appellant failed to provide the child with minimally adequate medical care, when he failed to inform any party whatsoever (foster mother, Program staff member) of the child's fall in the van. The video depicts a very significant fall. The Appellant had no way of knowing how injured the child actually was, and his lack of reporting the incident could have led to more significant medical issues for the child. The Department's argument is a valid one—if the child had sustained a concussion or internal bleeding, there would have been no way of knowing as the only incident the foster mother was aware of that evening was the child's small fall from a toddler chair onto a carpet. The Appellant's inaction of not reporting the incident posed a substantial danger to the child's physical well-being.

Based upon the totality of evidence, for reasons cited above and in the detailed Findings of Fact, I find the Department's concerns to be valid and to rise to the level of "reasonable cause to believe" that neglect did occur in this case.

Conclusion

The Department's decision to support the 51A report of January 10, 2017, for neglect by the Appellant on behalf of the subject child is **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 the Appellant lives within thirty (30) days of the receipt of this decision. (See, M.G.L. c. 30A, s. 14.) In the event of an appeal, the Hearing Officer reserves the right to supplement the Findings of Fact.

Linda A. Horvath
Linda A. Horvath, Esquire
Administrative Hearing Officer

Date: 9-26-17

Cristina Tedstone
Director, Fair Hearing Unit