THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF CHILDREN AND FAMILIES
600 WASHINGTON STREET, 6TH FLOOR
BOSTON, MASSACHUSETTS 02111

Linda Spears
Commissioner

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IN THE MATTER OF

LG #2017 0417

FAIR HEARING DECISION

Appellant, LG ("LG" or "Appellant") appeals the Department of Children and Families' ("DCF" or "Department") decision to revoke her foster care license and remove children from her foster home pursuant to 110 CMR 7.113B and 110 CMR 7.116(2).

Procedural History

In 2013 the Appellant was approved by the Department of Children and Families (hereinafter "DCF" or "The Department") to provide kinship foster care for her granddaughter, A. In 2014, the Appellant completed additional training and was approved by the Department to provide unrestricted foster care. Between 2013 and 2017, the Appellant fostered seven (7) children and completed annual licensing evaluations without issue. During a licensing reassessment conducted between March and April 2017, the Department learned that in September 2016, the Appellant's son, GP, overdosed during a visit to the Appellant's home and that the Appellant did not disclose the incident to the Department at the time. Based on this information a report was filed with the Department's Special Investigation Unit (SIU) and on March 30, 2017 the Department's Worcester East Area Office, which managed the Appellant's foster home, notified the Appellant of the decision to revoke her foster care license, remove foster children A and K from her home, and of her right to appeal the Department's decision.

The Appellant made a timely request for a Fair Hearing under 110 CMR 10.06. Pursuant to 110 CMR 7.116 (2)(c), the Department's decision to remove the children from the Appellant's foster home was stayed pending a hearing and issuance of the Fair Hearing decision. After the Appellant's request for a hearing, K was reunited with her family. The matter went forward regarding the Department's decision to revoke the Appellant's foster care license and remove A from the Appellant's foster home. The hearing was held at Worcester East Area Office on May 16, 2017. In attendance was Maura Bradford,

Administrative Hearing Officer; RZ, DCF Area Program Manager; MS, DCF Family Resource Worker; DS, Children's Friend Adoption Social Worker; LG, Appellant.

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 digitally recorded and transferred to one (1) Compact Disc. The witnesses were sworn in to testify under oath.

The following evidence was entered into the record:

For the Department:

Exhibit A1: 51A Report, dated March 20, 2017
Exhibit A2: 51B Report, completed, April 10, 2017 by KC
Exhibit A3: Family Resource Annual Reassessment completed, April 16, 2017
Exhibit A4: Removal Letter, dated March 30, 2017
Exhibit A5: License Revocation Letter, dated March 30, 2017
Exhibit A6: Incident Report of [redacted] Police Department, dated September 23, 2016
Exhibit A7: DCF Foster Parent Agreement signed by the Appellant, May 10, 2017

For the Appellant:

The Appellant did not submit documentary evidence

Issue to be Decided

The issue to be decided is whether, based on the information available at the time of and/or subsequent to the Family Resource Annual Reassessment completed by the Department of Children and Families, the Department's decision to revoke the Appellant's foster care license and remove a foster child from the Appellant's foster home was reasonable and made in conformity with the Department's policies and/or regulations and resulted in substantial prejudice to the Appellant. 110 CMR 10.05; 110 CMR 10.06(4)

Findings of Fact

1. The Appellant was an unrestricted foster care provider for the Department. A was placed in the Appellant's care. At the time of the challenged decision, A was five (5) years old and had lived with the Appellant for two (2) years. (Exhibit A3; Testimony of MS)

2. A has developmental delays, including expressive language delays. A was visible in the community; she attended half-day preschool and daycare until 4PM each day and received separate speech and language therapy services. No concerns

were expressed for A's care prior to the challenged decision(s). (Testimony of MS and DS)

3. The Appellant had no adverse history with the Department. The Department and contracted providers visited the Appellant's home at least monthly to monitor children placed in her care. In 2013 and 2015, the Department received reports pursuant to M.G.L. c. 119 §51A; the reports were investigated and unsupported. The Appellant was viewed as a responsive, responsible foster care provider. (Exhibit A3, p. 4; Testimony of MS and DS)

4. The Appellant was the legal guardian for her two granddaughters, G and A, who resided in the home. The Appellant's sons, GP and WP, both have substance abuse histories, involvement with the Department and history of involvement with the criminal justice system. The Appellant's first foster placement was WP's daughter, who was later reunified with WP. After she fostered WP's daughter, the Appellant completed foster parent training and obtained her unrestricted foster care license. The Appellant successfully fostered several children thereafter. (Exhibits A2 and A3; Testimony of MS)

5. The Appellant acknowledged her sons' substance abuse issues. The Appellant loved her sons and provided support where she was able. GP was often homeless and the Appellant occasionally fed GP and washed his clothes if he visited the home. GP was not a frequent visitor to the home. (110 CMR 7.105(14); Testimony of Appellant)

6. On September 23, 2016, GP was released from jail. Upon his release, GP obtained heroin. GP went to the Appellant's house without notice and asked to use her 2nd floor bathroom. When GP arrived at the home he had not yet used the heroin and the Appellant believed he was "clean". GP was in the bathroom for an unusually long period. The Appellant and GP's teenage son, L, went upstairs to check on him. They heard unusual noises coming from the bathroom. When GP did not respond, they broke the door open and found GP unresponsive on the floor. The Appellant called 911. The police and ambulance arrived simultaneously and administered Narcan to revive GP. GP walked out of the home with assistance of the first responders. (Testimony of MS and Appellant; Exhibit A2 and A6)

7. When GP arrived at the home, G and A were in their room upstairs. When the ambulance arrived, A and another foster child, X, were on the first floor watching television. The Appellant told the children that GP was "sick" which was why the ambulance came to the house. (Exhibit A2; Testimony of MS and Appellant)

8. The Appellant was upset about what happened and worried about its repercussions upon her foster care license. The responding police officers told the Appellant it was unlikely to affect her foster care provider status and not to worry. The police did not file a report pursuant to M.G.L. c. 119 §51A. The Appellant did not contact the Department about the incident. (Exhibit A2; Testimony of

Appellant and MS)

9. At the time of GP's overdose, the Appellant's DCF Family Resource Worker (FRW), SB, was in and out of the office due to a family illness. It is unclear whether the Appellant knew who to contact in SB's absence. A home visit was not conducted or was not documented by SB for September. SB retired prior to the conclusion of the annual license reassessment and the Appellant's home was assigned to FRW MS. (Exhibit A2, pp. 7, 8; Fair Hearing Record)

10. Between March and April 2017, the Department conducted the Appellant's annual licensing reassessment. As part of routine procedure, FRW SB contacted the [redacted] Police Department and learned about the police and ambulance response to the Appellant's home for GP's overdose.[1] When SB asked the Appellant about what happened, the Appellant explained what happened in a fully forthcoming manner. It is undisputed that the Appellant did not immediately inform the Department about GP's brief visit to her home and his overdose. (Exhibit A2, p. 10; Exhibit A3; Testimony of MS and Appellant)

11. On March 20, 2017, Department Family Resource Worker SB filed a report pursuant to M.G.L c. 119 §51A[2] which alleged neglect of the children residing in or placed in the Appellant's home, including A. The Department screened-in the report and the Department's Special Investigation Unit (SIU) conducted a response. (Exhibits A1 and A2)

12. The SIU Investigator interviewed the children. The children corroborated the Appellant's statements regarding where they were in the house and what they knew about what happened to GP. The children were not upset by what occurred and felt safe in the Appellant's home. (Exhibit A3; Testimony of Appellant and MS)

13. GP told the SIU Response Worker he was "not involved with [the Appellant's] life given his own issues." After his overdose, GP entered a recovery program in Boston and the Appellant told him he could not visit her home. (Exhibit A2, p. 9; Testimony of Appellant)

14. On March 30, 2017, the Department informed the Appellant of the decision to revoke her foster care license and remove A from her home and of her right to appeal the decision on the basis that the Appellant failed to immediately inform the Department of the incident with GP. As reason for the removal, the Department cited 110 CMR 7.105 (14), which stipulated that a foster parent may not have a household member, frequent visitor or alternative caretaker who could pose a threat of abuse or neglect or compromise the provision of adequate foster care. (Exhibits A4 and A5; Testimony of MS and RZ)

[1] Referring to the Worcester Police Report, FRW MS testified that the police did not complete a lengthy narrative.
[2] The Department submitted unredacted copies of the SIU investigation in which SB was identified as the reporter.

15. In reaching the decision to revoke the license and remove A from the Appellant's foster home, the Department considered that the Appellant violated a fundamental trust and failed to comply with her Foster Parent agreement because she failed to immediately inform the Department about GP's overdose. The Department testified that had they known about the incident at the time, the Department could have intervened to ensure the children were not traumatized and to permit the Appellant to maintain contact with her son and support him in a way that would not put the children at risk. (Exhibit A7; Testimony of RZ)

16. The Department submitted a copy of the Department's Foster Parent Agreement, which this Hearing Officer reviewed. The agreement addresses a Foster Parent's obligation to "immediately report to the Family Resource Unit any change in circumstance, such as: addition of a new household member…death, serious illness, etc. of a household member…and any other change that affects the ability of a foster/pre-adoptive family to meet its required responsibilities…". The agreement did not specify the Department's expectations for a foster parent regarding a visiting family member who becomes ill. (Exhibit A7, p. 4, Item #18)

17. In reaching the challenged decisions, the Department asserted that with GP's known history of chronic relapse, the Appellant should have suspected or anticipated he would use substances when released from jail. I find such an expectation to not be reasonable, particularly where GP arrived to the home and did not appear under the influence of substances. (Testimony of MS and RZ)

18. On April 5, 2017, the Department's Special Investigation Unit (SIU) determined that allegations of neglect of the children by the Appellant were not supported. The SIU determined that GP was not a caregiver for the children. The SIU considered that the children had no knowledge of [GP's overdose] and there was no evidence of impact upon the children or indication they were at risk during the incident. (Exhibit A2, p. 10; see 110 CMR 7.105(14))

19. During the time A was in the Appellant's care, DCF engaged in concurrent case management with [redacted]. Although concerned the Appellant failed to disclose GP's overdose, the [redacted] Adoption Worker did not observe any overt changes in A's behavior that suggested the incident negatively affected A. (Exhibit A2, p. 8; Testimony of DS)

20. Pursuant to 110 CMR 7.116 (2)(c), when the Appellant filed a request for a Fair Hearing, the Department's decision to revoke the Appellant's foster care license/close the Appellant's foster home was stayed pending a hearing and issuance of the Fair Hearing decision.

21. During the hearing, the Department testified that the Appellant's other son, WP, the father of the Appellant's original kinship foster child, had relapsed and his daughter was removed from his care. The Department wished to place WP's daughter with the Appellant; however, given the challenged decision, questioned

whether the Department could do so. The question was not a proper subject of the instant hearing and was not addressed further, except to advise the Department to follow Department protocol as it regarded that placement (see 110 CMR 10.06). I inferred that despite the challenged decision, the Department considered the Appellant a safe and adequate placement.

22. After a review of all the evidence and for the following reasons, I find the Department did not demonstrate a reasonable clinical basis for the decision to revoke the Appellant's foster care license and remove A from her home:

    a) Although the Appellant did not notify the Department of an incident in her home, the Department did not demonstrate that the Appellant failed to ensure that A experienced a safe, supportive, nurturing and stable family environment while in the Appellant's care, which the Department cited as the sole basis for the decision to revoke the Appellant's license and remove A from her home (110 CMR 7.105[14]);
    b) The Department determined there was no threat of abuse or neglect and unsupported the related allegations of neglect (see 110 CMR 7.116(3) et seq.);
    c) The Appellant's failure to notify the Department of the incident in her home was, in and of itself, not sufficient to revoke the Appellant's foster care license and remove A from the Appellant's foster home. (see 110 CMR 7.113; 110 CMR 7.116[2])

Analysis

The issue to be decided is whether, based on the information available at the time of and/or subsequent to the Family Resource Annual Reassessment completed by the Department of Children and Families, the Department's decision to revoke the Appellant's foster care license and remove A from the Appellant's foster home was reasonable and made in conformity with the Department's policies and/or regulations and resulted in substantial prejudice to the Appellant. 110 CMR 10.05; 110 CMR 10.06(4)

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, or (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, or (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

The Department determined the Appellant failed to comply with Department regulations and applicable policies when she failed to inform the Department that her adult son GP overdosed during a brief visit to the Appellant's home. The Department determined it necessary to remove A, a foster child in the Appellant's care and as reason for the removal, the Department cited 110 CMR 7.105 (14), which stipulated that a foster parent may not have a household member, frequent visitor or alternative caretaker who could pose a threat of abuse or neglect or compromise the provision of adequate foster care.

The Appellant argued that the Department's decision failed to take into consideration her long-standing and successful provision of foster care and lack of harm to the children in her care, including A. The Appellant argued that when asked about the incident that occurred in her home, she was forthcoming and felt that the Department's decision was not reasonable.

First, the Appellant acknowledged and recognized that her sons have substance abuse issues but that they are her sons nonetheless and she found it difficult to turn them away. The evidence supported that GP was not utilized as a caregiver and was not a frequent visitor to the home. This Hearing Officer considered the Department's testimony at the hearing, including that if the Department had known that GP overdosed at the home, the Department could have intervened and worked with the Appellant to allow her to have contact with GP without placing the children at risk. This Hearing Officer notes that under 110 CMR 7.113(1)(c)2 and absent concerns for the immediate safety and well-being of foster children in the Appellant's home, the Department may allow the Appellant to retain her license under new terms and conditions, set forth in writing, which could include provisions to address GP's visits to the home going forward.

This Hearing Officer did not easily dismiss the Appellant's failure to contact the Department when the incident occurred. This Hearing Officer considered the Appellant's testimony that she was worried and upset about the status of her license at the time. It is more likely than not that the Appellant understands her agreement with the Department and that the agreement was dependent upon clear, open and honest communication and cannot effectively exist without such communication.

This Hearing Officer was obliged to consider the entire administrative record. In the instant case, the precipitant to the Department's decision was the Appellant's failure to notify the Department that her adult son GP overdosed in her bathroom shortly after arriving at her home. Prior to the incident, the Appellant was a foster parent in good standing and had not regularly seen GP, who was incarcerated, for some months. When the overdose incident was discovered during a routine reassessment some six (6) months after the incident, the Appellant did not withhold any information from the Department. The evidence suggested that at the time of the overdose incident, the Appellant's Family Resource Worker was out of the office and that the Department might not have conducted

a regular monthly visit with the Appellant. During an investigation of the incident, the Department determined that GP was not a caregiver, that he was an infrequent visitor to the home; and, most importantly, that the incident had not caused any harm or risk of harm to the children in the home at the time, including A. With respect to the totality of the evidence and for the reasons enumerated in the above Findings of Fact, this Hearing Officer finds the Department's decision was not made with a reasonable clinical basis. 110 CMR 10.23; M.G.L. c. 30A, § 1(6)

Conclusion and Order

Appellant has shown by a preponderance of the evidence that the Department's decision to revoke her foster care license and remove A from her foster home was not made with a reasonable clinical basis, therefore the Department's decision is **REVERSED**.

Maura E. Bradford

Maura E. Bradford
Administrative Hearing Officer

Date: 1/5/18

Darlene M. Tonucci

Darlene M. Tonucci, Esq.
Supervisor, Fair Hearing Unit

Date: _____

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Linda S. Spears
Commissioner