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

LINDA S. SPEARS,
COMMISSIONER

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IN THE MATTER OF	)	
	)	**HEARING DECISION**
I. P.	)	
	)	
FH # 2017 1196	)	

Procedural Information

The Appellant in this Fair Hearing is Ms. IP ("the Appellant"). The Appellant appealed 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 September 5, 2017, and the Appellant filed a timely appeal with the Fair Hearing Office on September 22, 2017.

The Fair Hearing was held on November 11, 2017, at the DCF VanWart Area Office. The following persons appeared at the Fair Hearing:

Linda A. Horvath, Esquire	Administrative Hearing Officer
IP	Appellant
BJ	DCF Special Investigations Supervisor
AP	Appellant's Mother
SC	Fair Hearing Supervisor/Observer

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:	8/14/17 51A Report
Exhibit 2:	9/8/17 51B Report
Exhibit 3:	9/5/17 Support Letter

For the Appellant:

Exhibit A:	5/25/17 [redacted] Card w/attached [redacted] Training Documentation
Exhibit B:	5/24/17 [redacted] Job Offer
Exhibit C:	7/28/17 [redacted] Termination Letter
Exhibit D:	8/25/17 [redacted] Termination Letter

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 male child "J" ("the child"), who was seventeen (17) years old at the time of the 51A filing referenced below. (Exhibit 1, p.1.)

2. In August of 2017, the child was in the temporary custody of DCF through a Care and Protection Petition. (Exhibit 2, p.2.) The child began residing in a [redacted] placement in [redacted] MA ("the program") on May 11, 2017. (Exhibit 1, p. 2; Exhibit 2, p.1—2.)

3. The child had a history of being neglected and abused. The child has a low IQ and low functioning level; he had behavioral issues due to defiance and emotional dysregulation. He has been bullied and assaulted by peers at the program. There was

a language/cultural barrier between the child and his peers/program staff as he is originally from [redacted] and was still learning English. (Exhibit 1, p.4; Exhibit 2, p.2.)

4. The Appellant was first employed by [redacted] on or about May 24, 2017, at another [redacted] location as an instructional assistant. (Exhibit B.) When the position of instructional assistant was eliminated two months later (Exhibit B), [redacted] offered the Appellant the position of resident counselor at the [redacted] location where the child lived. The Appellant had been working at that position for three (3) weeks at the time of the subject 51A filing referenced below. (Testimony of Appellant.)

5. On August 14, 2017, the Department received a report pursuant to M.G.L. c. 119, s. 51A, alleging neglect of the child by the Appellant and five other staff members[1] due to lack of supervision. The child left the residence on Saturday, August 12, 2017, between 8PM and 9:00PM and made his way to [redacted], MA (2-1/2 hours away) his hometown. None of the staff members knew the child had left. He was returned to the program the next day at 2PM. (Exhibit 1, pp.3 and 4; Exhibit 2, p.3.) This was not the first time the child had gone AWOL from the program. (Exhibit 2, p.5.)

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

7. The subject 51A was the first filed against the Appellant. (Exhibit 2, p.2.)

8. The events of Saturday, August 12, 2017, occurred as follows:

   a) The Appellant was working the second shift at the program along with second shift lead supervisor, ND ("supervisor"), and others. (Exhibit 2, p.5.)
   b) On the night in question, a group of four residents (not including the subject child) came back from community time at approximately 8PM. Thereafter, things were "hectic" getting all the residents to take showers and eat. At one point, the child left his room on the second floor to get water; that was the last the supervisor saw of the child. (Id. at p.2.) The supervisor thereafter prepared medications for the residents in the med office, which was the supervisor's duty at that time. (Id.)
   c) At approximately 8PM, the Appellant was at her designated position on the second floor near the subject child's room; she was the only second floor staff on that shift when there should have been two staff; the program was out-of-ratio at that time. (Exhibit 2, p.6; Testimony of Appellant.) The child had gone to the bathroom and she informed him he needed to ask permission next time. The Appellant "...did not see him go back into his room at that point...[S]he checked his room somewhere between 8PM and 9PM and he wasn't in the room...[T]he bed was unmade and the door was open and the lights were off." She assumed he

[1] Two were second shift staff, including the Appellant; the other three were overnight staff. (Exhibit 2.) It was determined that the overnight shift staff followed proper protocol. Only the Appellant was supported for neglect following the DCF response. (Id. at pp.7 and 8.)

had gone downstairs, but she did not look for him, and she did not inform the supervisor that the child was not in his room. (Exhibit 2, pp.6 and 8.)

d) Thereafter, before 9PM, the Appellant went downstairs to use the bathroom. She informed the supervisor who then went upstairs to cover for her along with another male staff member, "D". She noticed the basement door was open and yelled down to see if anyone was downstairs; no one responded however then the child came up the stairs. The Appellant did not know where the child went thereafter but assumed he had gone back upstairs. The Appellant used the bathroom and then she went back upstairs. Before she clocked out at 10PM, the Appellant did the head count on her designated side of the second floor, however she did not notice that J was not there. (Id. at p.6; Testimony of Appellant.)

e) The program is equipped with a "Detex" electronic monitoring system for the staff wherein they carry an electronic wand when doing their room checks. They wave the wand at the electronic units in the residents' bedrooms, which records that a room check has been done. (Exhibit 2, pp.3—4.)

f) The Detex check was not done at the usual time of 9PM. The Detex check "slipped the mind" of the supervisor because it was so busy (Id. at p.5) and he was "doing meds," which was his duty at that time. (Id. at pp.4, 5 and 6.) The Appellant did not perform the Detex check and she could not verify why it was not done. (Id. at p.6.)

g) Per program surveillance, the child left the program at 9:12PM. (Exhibit 1; Exhibit 2, p.8.)

h) The second shift staff members did not notice that the child was missing before going off shift at 10PM. Second shift staff informed overnight staff (10PM to 8AM) that there was nothing remarkable to report and all the residents were accounted for. (Exhibit 2, pp.4—5; 6.)

i) Later that evening, after getting off shift, the Appellant was in the community with friends when she saw the child standing outside a local Applebee's restaurant at approximately 11PM, talking with a middle-aged man and a woman. The Appellant did not approach the child to ask why he was there and did not call the program, but rather just assumed he was there with program staff members; being new to the program, she does not know all of the staff. "...[I]n hindsight she should've said something." (Exhibit 2, p.6.)

j) The overnight shift staff (10PM to 8AM) discovered the child was missing at approximately 2AM on Sunday, August 13th; he had put pillows in his bed covered by his comforter to appear as if he was there. (Exhibit 2, pp.4, 5 and 6.) Overnight staff followed proper protocol after learning the child had gone AWOL. (Id. at pp.7 and 8.)

k) The child was able to travel to the eastern part of the state where he had once lived reportedly by a "friend" who is an Uber driver. (Exhibit 2, p.4.)

9. The following findings are derived from the child's interview with the DCF Special Investigator: On August 12th, he left the program because four other residents were "trying to jump him." The Appellant and N were the staff on duty at the time. They are usually good about checking on him and they had done so at various times during their shift that day. At 8PM, the child was upstairs in his room; sometime thereafter,

he made sure the Appellant and N were not around, and walked downstairs and left without anyone seeing him. (Exhibit 2, p.4.)

10. Per the Appellant and supervisor, there were no indicators or red flags that the child was going AWOL on that night. (Exhibit 2, pp. 5 and 6.)

11. On September 5, 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 lack of supervision. (Exhibit 2, pp.7—9.) Although the Appellant was a newer staff member to the program on subject date, "...there were several points in time where she could have addressed certain situations and prevented [the child] from going AWOL." (Id. at p.9.)

12. The Department closed its case following the support decision as no services were required. (Exhibit 2, pp.7 and 9.)

13. Following her DCF interview (Testimony of Appellant), the program officially terminated the Appellant from her employment on August 25, 2017, citing the Appellant's violation of mandated reporting laws (by not reporting child was in the community/Applebee's on August 12, 2017) as well as program standards and policy. (Exhibit D.)

14. The Appellant completed a CPI (restraint-training) course on May 25, 2017. (Exhibit A, p.1.) The Appellant denied she received ANY other trainings denoted by her employer including "Mandated Reporting" training. (See, Exhibit A, p.2.) She cited as argument for such, the white out marks on the page, lack of her initials agreeing that she participated in the various trainings, as well as the discrepancy in the completion date for CPI training of August 9, 2017, as compared to May 25th on her CPI "Blue Card." (Testimony of Appellant; Exhibit A, pp.1—2.)

15. Based upon a review of the evidence presented in its entirety, I find that the Department had reasonable cause to believe that the Appellant was unable to take those actions necessary to provide J with minimally adequate supervision, and the inaction by the Appellant posed a substantial risk to the child's safety and well-being. (DCF Protective Intake Policy #86-015, rev. 2/28/16; See, Analysis.)

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 or human trafficking.

DCF 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.

"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. *Protective Intake Policy No. 86-015* (rev. 02/28/2016)

To prevail at a Fair Hearing, an Appellant must show based upon all evidence presented at the hearing, by a preponderance of the evidence that the Department's decision or procedural action 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. If there is no applicable policy, regulation or procedure, the Appellant must show by a preponderance of the evidence that the Department acted without a reasonable basis or in an unreasonable manner, which resulted in substantial prejudice to the Appellant. If the challenged decision is a supported report of abuse or neglect, the

Appellant must show 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.

Analysis

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

As the program staff member in charge of supervision of the residents on the second floor on the date in question, the Appellant had ample opportunities to check on the whereabouts of J, as was her duty, but did not do so. After seeing the child use the bathroom without permission, the Appellant acknowledged she did not see the child go back into his bedroom, and she did not check whether he did or not. The Appellant also acknowledged that she performed a room check sometime after 8PM and the child was not there but saw that his bed was unmade, the door was open and the lights were off. She assumed that he had gone downstairs, however she did not verify his whereabouts again at that time. Thereafter, before 9PM while on the first floor, when the Appellant viewed the child coming up from the basement, she assumed, but again did not verify, that the child immediately returned to the second floor where the supervisor and staff "D" were covering for her at the time. At 9PM, the Appellant did not perform a Detex check on the second floor, and prior to leaving shift at 10PM, the Appellant did not perform a final check on the second floor residents. Lastly, when the Appellant saw the child out in the community very late that evening, the Appellant did not verify who was supervising the child.

The child going AWOL on the night in question and/or his opportunity to travel as far as he did was preventable. The Appellant did not perform room checks/head counts properly throughout the evening, and did not check on the safety and well-being of the child when she saw him in the community late at night after getting off shift. As a result of her inaction, the intellectually and behaviorally challenged child was able to travel 2-1/2 hours away via an unknown "friend." As such, the Appellant failed to provide the child with minimally adequate supervision, and this lack of supervision posed a substantial risk to the child's safety and well-being.

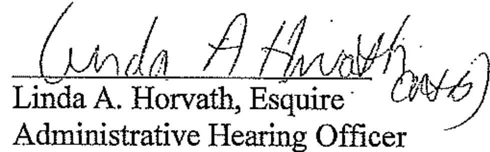
The Appellant's arguments that she was not trained properly for the position, and that the program document regarding when/if the Appellant completed certain trainings was altered to the program's benefit, is not persuasive given the facts of this matter. Her position mandated, if nothing else, that she was to know the whereabouts of (to supervise) the residents of the second floor of which the child was one.

In light of the totality of evidence in this case, as discussed above and in the detailed Findings of Fact, the Department had sufficient evidence to support the allegation of neglect of the child in this matter.

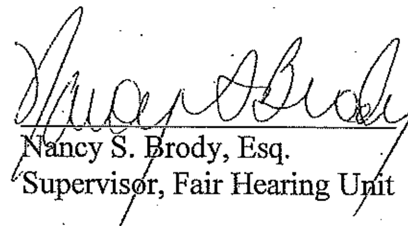
Conclusion

The Department's decision to support the 51A report of August 14, 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, she 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, Esquire
Administrative Hearing Officer



Date: 1-22-18

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