THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF CHILDREN AND FAMILIES
CENTRAL ADMINISTRATIVE OFFICE
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IN THE MATTER OF	)	
	)	
Ms. K.B.	)	**FAIR HEARING DECISION**
	)	
FH # 2017-0237	)	
	)	

The Appellant (Ms. K.B.) in this Fair Hearing was the overnight staff at the [redacted] where the reported child was residing. The Appellant appealed the Department of Children and Families' (hereinafter "DCF" or "the Department") decision to support the allegations of neglect pursuant to M.G.L. c. 119, §§51A and B.

Procedural History

On January 9, 2017, the Department received a 51A alleging the sexual abuse of child A by a staff member at the residential program where she resided. Subsequently three more 51A reports were filed regarding this program and incorporated, as permitted by Department policy, into the pending response. The second report dated January 13, 2017, alleged the sexual exploitation of the child by a staff member at the program. The final two reports dated January 19 & 23, 2017, were irrelevant to this hearing as they did not pertain to this appeal. On February 7, 2017, the Department made the decision, after conducting the response and as permitted by Department policy, to add and support an allegation of neglect of the child by the Appellant. The Department notified the Appellant of its decision and her right to appeal.[1]

The Appellant made a timely request for a Fair Hearing under 110 CMR 10.06. The Hearing was held on May 12, 2017, at the DCF Central Office in Boston, MA. All witnesses were sworn in to testify under oath. The record remained open until May 26, 2017, to allow Appellant's Counsel to submit a written memorandum.

[1] The first two reports relate to the reported child and the reason the Appellant was determined to be neglectful. The two other reports involve the program and a separate child but were irrelevant to this hearing. The allegation of sexual abuse of the child by a different staff was supported but was not the subject of this appeal.

The following persons appeared at the Fair Hearing:

Ms. Lisa Henshall	Fair Hearing Officer
Ms. K.B.	Appellant
Atty. J.S.	Appellant's Counsel
Mr. T.H.	Special Investigation Unit (SIU) Response Worker

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

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

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

For the Department:

Exhibit 1	Child Abuse/Neglect Report dated 1/9/17
Exhibit 2	Child Abuse/Neglect Report dated 1/13/17
Exhibit 3	Child Abuse/Neglect Report dated 1/19/17
Exhibit 4	Child Abuse/Neglect Report dated 1/23/17
Exhibit 5	Child Abuse/Neglect Investigation dated 2/07/17
Exhibit 6	Statements from Staff 2 pgs.
Exhibit 7	Overnight flow chart
Exhibit 8	Medication Sheet 2 pgs.
Exhibit 9	EEC compliance issues
Exhibit 10	Team sign in sheets for the SAIN
Exhibit 11	EEC Completed Investigation

Appellant:

None

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

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 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, 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 or human trafficking. 110 CMR 10.05 DCF Protective Intake Policy #86-015, rev. 2/28/16

Findings of Fact

1. The subject child of the Fair Hearing was A, who was seventeen (17) years old at the time of the reported incident. The child was a resident at the [redacted]. (Exhibits 1-5; Testimony of the SIU Response Worker)

2. The Appellant was employed by the [redacted] to be an overnight residential case worker. Therefore, she was a caregiver pursuant to Departmental regulation. 110 CMR 2.00; DCF Protective Intake Policy #86-015, rev. 2/28/16 (Exhibits 1-5; Testimony of the SIU Response Worker; Testimony of the Appellant)

3. The Department received a 51A report on January 9, 2017, alleging the sexual abuse of child A by another staff at the residential program. A second report dated January 13, 2017, alleged the sexual exploitation of the child by a staff at the program. The reports were screened in, pursuant to M.G.L. c. 119, §51B, and assigned for a response. There were two subsequent reports filed (January 19 & 23, 2017) and incorporated into the pending response as permitted by Department policy but were not the subject of this Hearing. As a result of the information obtained during the response the Department made the decision, as permitted by Department policy, to add and support an allegation of neglect of the child by the Appellant. (Exhibits 1, 2, & 5; Testimony of the SIU Response Worker)

4. The Appellant was one of three overnight staff members at the program on the night in question. The Appellant began working at this program in October 2016. The Appellant participated in training for this position in August 2016. (Exhibit 5; Testimony of the Appellant)

5. The Appellant and Staff TM were the awake staff while Staff MM was the sleeping overnight staff. It was undisputed that an overnight awake staff (residential counselor) was to conduct bed checks every 15 minutes to ensure residents were accounted for; there may have been some discrepancies on how the staff would split these up but this was the expectation. In addition, there was a call in number to leave a recording to document observations or concerns and a paper log. Staff MM was medication certified administrator but there was no formal job description for this position. (Testimony of the Appellant; Exhibit 11; Exhibit 5; Testimony of the SIU Response Worker)

6. On the night in question, two residents told the Appellant and Staff TM, that they were concerned that A and staff MM were in the "sensory" room together with the door locked. (Testimony of the SIU Response Worker; Exhibit 5; Testimony of the Appellant) The expectation was that when staff is speaking to a resident the door to the room remains open. (Testimony of the Appellant)

7. It was undisputed that three of the six children in the program were awake for the majority of the night and not listening to staff, and were not in their rooms.(Fair Hearing record)

8. The expectation was that when staff was speaking with a resident, the room door remained open. (Testimony of the Appellant)

9. Staff (TM) proceeded to follow up with the residents' concerns and found the child (A) in the room with Staff MM; that was the extent. There was no follow up and no evidence that he discussed the details with the Appellant. (Testimony of the SIU Response Worker; Exhibit 5)

10. With respect to the 15 minute room checks, the Appellant indicated that she and Staff TM split the night so he was responsible for the first half and she the second half. The Appellant indicated that while the Staff MM and A were together, it was Staff TM's responsibility to conduct the checks. There was no evidence to support the claim that the responsibility for the room checks belonged solely to staff TM. (Exhibit C; Testimony of the Appellant; Exhibit 11; Testimony of the SIU Response Worker)

11. The overnight flow chart, used by the Appellant and Staff TM to document the fifteen minute room checks and the recorded telephone line, was "lost." A subsequently submitted sheet that was submitted was inconsistent with what residents and staff had originally reported; the document appeared altered. (Exhibit 7) For that reason, I gave no weight to that evidence.

12. It was undisputed that the Appellant was aware that A had been alone with Staff MM, which was considered "inappropriate" for any staff regardless of the amount of time. The Appellant did not address her concerns as she had not known what to do and after conferring with Staff TM it was determined they would let the administrative staff know later that morning. (Exhibit 5, pgs. 8 & 14; Testimony of the Appellant)

13. It remained unclear exactly what time the Appellant "alerted" the administrative staff about this incident but it was sometime after 7:00am. The child was accounted for and in her bedroom as of approximately 3:30am. (Testimony of the SIU Response Worker; Exhibit 5; Testimony of the Appellant)

14. There was no immediate supervisor working the overnight shift but there was an on call administrator. It is unclear what the program protocol was, if any, for this situation. (Testimony of the SIU Response Worker; Testimony of the Appellant)

15. There was no evidence that the Appellant was aware that there were concerns that A and staff MM were engaged in sexual behaviors or inappropriate sexual contact. Regardless, the Appellant was concerned about something as she contacted the on-call supervisor the next morning as she "wanted to make sure the kids were safe, if there was a situation." (Fair Hearing Record; Exhibit 5, p. 8; Testimony of the Appellant)

16. The EEC determined that the program had not provided adequate orientation training as evidenced by the fact that the Appellant and staff TM did not notify on call staff after learning of this incident. (Exhibit 9)

17. The documentation to record the fifteen minute checks and did not match the information provided by residents and staff regarding their whereabouts that evening. It was unclear what was going on in the program as three of the children were up after midnight and not in their bed.

(Exhibit 11; Exhibit C; Testimony of the SIU Response Worker) I find that the bed checks were not being done as required by the program.

18. At the end of its investigation, the Department supported the aforementioned report for neglect of the child by the Appellant. The Department based this determination on the Appellant's actions and her failure to provide minimally adequate supervision. The Department concluded this constituted neglect as defined by its regulations and policy. The required bed checks were not done and the resident had been in the sensory room with Staff MM 2-3 times over the course of the night, for extend periods of time. The Appellant was notified that that there was something going on in the sensory room (after 1am) between Staff MM and the child; there was no follow up by the Appellant until after 7am the following morning. 110 CMR 2.00; DCF Protective Intake Policy #86-015, rev. 2/28/16 (Exhibit 5; Testimony of the SIU Response Worker)

19. Based on the credible evidence, I find that the Department did have reasonable cause to believe that child A was <u>neglected</u> per the Department's definition. The Appellant failed to provide the child with minimally adequate supervision and the Appellant's actions/inactions posed a substantial risk to the child's safety and well-being. 110 CMR 2.00; DCF Protective Intake Policy #86-015, rev. 2/28/16

    a. The Appellant was assigned as overnight staff along with Staff TM and responsible for the minor residents of this program;
    b. The child was in the sensory room with staff MM, unaccounted for from 2-3am.
    c. The Appellant was expected to do 15 minute room checks to account for all residents but did not. It was reasonable for the Department to determine that the checks were not done, based on the child being with Staff MM on a different floor for about an hour and more than once that night;
    d. Other residents of the program were interviewed and confirmed that the child was downstairs with staff MM ;
    e. There was no evidence to indicate that these required checks had been done and that she had fulfilled her work requirement;
    f. The Appellant failed to provide minimally adequate supervision by not doing the required checks;
    g. The Appellant was aware that something "concerning" may have gone on in the "sensory" room between child A and Staff MM and although there was no evidence that she knew specifically what was going on; she had enough concerns that she contacted her on-call administrator hours later as she "wanted to make sure kids were safe, if there was a situation."
    h. The Appellant's inactions posed a substantial risk to the child's safety and well-being. The Appellant along with Staff TM were to conduct room checks every 15 minutes, per program policy; as such, it was reasonable to infer that the residents of this program required an ongoing level of supervision. The failure to comply with these checks placed this child at substantial risk. (Exhibit 5, p. 8; Testimony of the SIU Response Worker; Fair Hearing Record; See Analysis)

<u>Applicable Standards</u>

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. 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 caregiver; 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 the 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 § 51A. Id. At 63. This same reasonable cause standard of proof applies to decisions to support allegations under §51B." Id. At 64; G.L. c.119, s 51B

A "caregiver" means a child's (a) parent, (b) stepparent, (c) guardian, (d) any household member entrusted with the responsibility for a child's health or welfare, and (e) any other person entrusted with the responsibility for a child's health or welfare whether in the child's home, a relative's home, a school setting, a day care setting (including baby-sitting), a foster home, a group care facility, or any other comparable setting. As such, "caregiver" includes (but is not limited to) school teachers, baby-sitters, school bus drivers, camp counselors, etc. The "caregiver" definition is meant to be construed broadly and inclusively to encompass any person who is, at the time in question, entrusted with a degree of responsibility for the child. This specifically includes a caregiver who is himself/herself a child (i.e. baby-sitter). 110 CMR 2.00; Protective Intake Policy #86-015 Rev. 2/28/16

"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. 110 CMR 10.23

Analysis

On the basis of the factual findings and standards set forth above and for the reasons set forth below, I affirm the Department's neglect support decision.

The Appellant, one of two overnight residential case workers at the program at the time in question and where the child resided, was a "caregiver," pursuant to Departmental regulation. 110 CMR 2.00; Protective Intake Policy #86-015 Rev. 2/28/16

The Appellant, as argued by Counsel, contested the Department's decision to support the allegation of neglect on behalf of A. The Appellant argued that the supported decision of neglect in this case should be reversed. The Appellant felt that while she was aware that there had been a "situation" between child A and Staff MM during the overnight, she was unaware of the details and therefore did not call her on call supervisor until after 7am. In addition, the Appellant felt she was not neglectful as she and Staff TM had agreed to split the overnight checks. Therefore during the time the child was unaccounted for it the room checks would not her responsibility. Staff TM would have been responsible for the first half and she the second half of the night. The record remained open to allow Counsel to submit a closing argument, however this was never received.

The Appellant's argument was not persuasive, however, recognizing that there were also programmatic issues that were out of her control and which needed to be addressed.

While the Appellant did contact her on call supervisor, it was hours after the "situation" concluded. The Appellant did what she thought she should do prior to ending her shift and indicated that she did not know the details of the "situation" that occurred between the child and Staff MM; however, she acknowledged something had transpired and that she ultimately called her supervisor as she worried for the safety of the children.

There was no evidence to support the Appellant's ascertain that the 15 minute bed checks, at the time the child was unaccounted for, were not her responsibility. The Appellant acknowledged that this task was one of two primary job functions and based on the evidence presented it was not done as expected. It was undisputed that child was out of her room at various (2-3) times during this shift and was unaccounted for when she was located in a room with a male staff (MM). The Appellant failed to provide this child with minimally adequate supervision. As supervisors were not present at the time of the reported incident they were unaware of any concerns until they were contacted by the Appellant more than four hours later. Lindsay v. Department of Social Servs., 439 Mass. 789 (2003)

Based on a review of the evidence, presented in its totality, the Department had reasonable cause to believe that the Appellant's actions constituted neglect as defined by the Department's regulation and that the Appellant's inactions posed a substantial risk to the child's safety and well-being. 110 2.00; CMR Protective Intake Policy #86-015 Rev. 2/28/16 p. 28 (See Findings)Therefore, its decision to support the allegation of neglect was made in compliance with its policy.

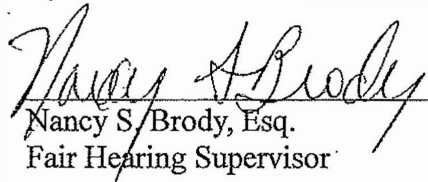
Conclusion and Order

The Department's decision to support the 51A report for neglect of A by the Appellant 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 Suffolk County, or in the county in which she 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.

Lisa Anne Henshall
Fair Hearing Officer

10-17-17
Date



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