DISABILITY LAW CENTER INVESTIGATION REPORT

EVERGREEN CENTER, MILFORD, MASSACHUSETTS

I. INTRODUCTION

The Disability Law Center (DLC) is a private, non-profit organization that is mandated by Congress and designated to provide "protection and advocacy" services to individuals with developmental disabilities, pursuant to the Protection and Advocacy for Persons with Developmental Disabilities Act, 42 U.S.C. §§1501 et seq., (PAIDD). As part of this mandate, DLC is authorized to investigate incidents of alleged abuse and neglect of people with disabilities within the Commonwealth of Massachusetts.

On November 5, 2015, DLC received a complaint to the system regarding the treatment of a residential student, "PK,[1]" at the Evergreen Center in Milford, Massachusetts. PK was a residential student at EC from May 2014 until November 1, 2015. The central focus of the complaint concerned an injury that occurred sometime during the evening of October 31, 2015 and was discovered on November 1, 2015, but additional concerns were raised about injuries to PK in the time period prior to the October 31st incident. Evergreen Center ("EC") describes itself as providing special education services to students between the ages of 6 and 22 who need a residential program and have a variety of disabilities, including autism, severe intellectual impairments, developmental disabilities, physical disabilities or are "dually diagnosed."

In response to this complaint to the system, DLC invoked its statutory authority as the Protection and Advocacy (P&A) system of Massachusetts to conduct an investigation. The Law Center began its investigation on December 1, 2015 by notifying the school and seeking PK's records. EC has fully cooperated with DLC's investigation by providing DLC with records of PK in a timely fashion, as well as arranging for DLC to interview relevant EC staff. Medical records concerning PK's injuries were obtained from medical facilities as well. DLC also obtained and reviewed records from relevant state agencies. DLC conducted on-site interviews of EC staff members on February 19, 2016 and March 3, 2016. On March 14, 2016 DLC staff conducted a site visit to the residence where the injury to PK occurred.

[1] PK is a pseudonym created by DLC to protect the identity of the student.

During DLC's interview of the school's COO, he described some corrective measures that had recently been put into place to address concerns resulting from the injuries to PK. Since these changes are relatively new, DLC has not been able to evaluate the effectiveness of the school's remedial actions. That issue and the question of what further corrective action may be needed are discussed at the end of this report.

II. LEGAL AUTHORITY

DLC, as the designated Protection and Advocacy System for Massachusetts, is authorized under the PAIDD statute "to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported . . . or if there is probable cause to believe that the incidents occurred."

42 USC § 15043(a)(2)(b). As noted above, this investigation was commenced based upon a "complaint to the system."

The PAIDD regulations define "abuse" as:

> [A]ny act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

45 C.F.R. § 1386.19.

The PAIDD regulations define "neglect" as:

> [A] negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with developmental disabilities or which placed an individual with developmental disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff.

45 C.F.R. § 1386.19.

III. RELEVANT FACTS

A. Injuries from October 31, 2015

The first issue concerns PK's facial and head injuries that were discovered on November 1, 2015. On October 31, 2015, EC Staff A was assigned to PK and reports no incidents or difficulties throughout the day. Then, at about 4:00 p.m., Staff B was assigned as PK's 1:1 aide for the remainder of the evening until Staff B left the residence shortly after 11:00 p.m. No incidents were reported until dinner time, when PK was upset and having difficulties. As a result, the shift supervisor asked Staff B to take PK to his room to calm him down. There were no reports of sounds or commotion while PK and Staff B were gone. Other staff report that Staff B and PK returned and no one noticed anything wrong with PK, nor did other staff notice any redness or injuries on his face. PK was reportedly calmer and proceeded to eat without incident.

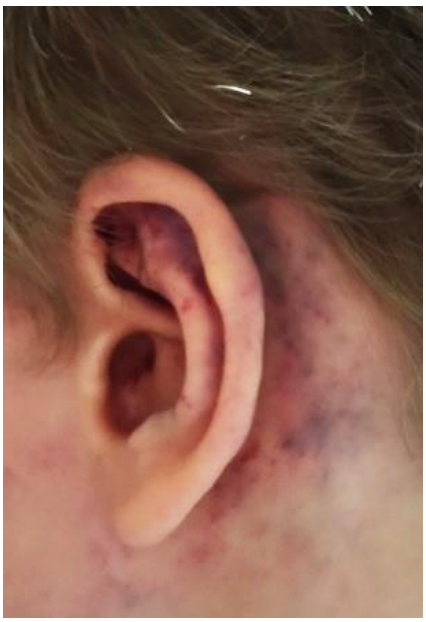
Around 9:00 p.m., the shift supervisor asked Staff B to get PK ready for bed. PK and Staff B were reportedly gone for 10 minutes. As Staff B and PK returned, staff reported hearing noises from PK as he was approaching. Staff reported to DLC that these noises sounded like the vocalizations PK makes when he is upset. When PK and Staff B emerged into the common area, PK was carrying his pajamas. Staff were unable to say for sure if PK was just in his underwear or if he still had his clothing on. No staff reported that they saw PK in a pull up[2]. The house manager then asked Staff B what happened, and Staff B reportedly responded that PK was being difficult and would not get dressed in his pajamas. The house manager then helped PK get into his pajamas and stayed with PK in the dining area until he calmed down. It took about 30 minutes for PK to calm down. The house manager reports he did not see any redness or injuries on PK's face during this time.

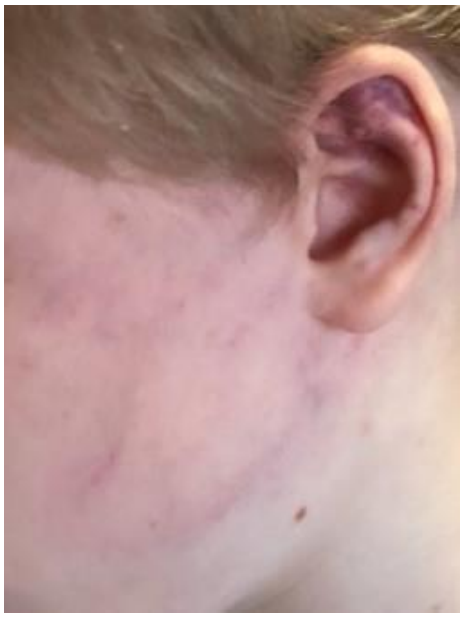
There were no reported incidents the rest of the evening. Staff B put PK to bed shortly before ending his shift at 11:00p.m. This was the third time Staff B was alone with PK during the evening on October 31, 2015. Overnight staff report that PK fell asleep and did not wake up until morning. The overnight staff report that they conducted bed checks multiple times throughout the evening and did not notice anything wrong with PK.

[2] Staff B told EC management during its internal investigation interview that he was trying to put a pull up on PK while they were away from the group. According to several other EC staff, PK does not wear pull-ups.

PK's injuries were discovered by Staff C on the morning of November 1, 2015 when he attempted to help PK shower around 8:30a.m. Once in the bathroom, Staff C noticed the bruising on PK's face. Staff C then called in other staff to view PK's injuries and reviewed the house logs to see if there was any information from the overnight shift or evening shift on October 31, 2015. Not finding any documentation that would explain the bruises, Staff C called staff who had worked the evening of October 31, 2015. Staff C did not get any additional information from them, so Staff C called an EC senior staff member and arranged for PK to go see nursing staff due to bruising of unknown origin.

It was at the point when Staff C was leaving the house to bring PK to the nurse that PK's parents arrived for their weekly visit. As a result, PK's parents followed Staff C to the nurse's office. Once at the nurse's office, the nurse conducted a skin check and examined PK. The nurse noted blue/purplish bruising on the back of PK's ear, broken blood vessels under his eye, and other bruises on one of PK's arm and on his lower back. There was so much blood in PK's ear that the nurse could not view the eardrum. PK's mother took pictures of the injuries, and the nurse took five pictures as well, with both sets of photos similarly reflecting the injuries. The nurse then sent her pictures to a member of the EC senior staff member. These pictures, which were taken by the mother while in the nurse's office, show what looked like a handprint outline on the left side of PK's face and clear bruising behind his left ear. (See below.)





The nurse told DLC she was "not concerned" about possible abuse at this point. The nurse wanted PK's primary care physician to examine him, however the primary care physician advised that PK needed to go to the emergency room instead.

Staff C transported PK to the local emergency room at Milford Hospital while the family followed in their own vehicle. At the hospital were PK, both of his parents, his sister, and Staff C. A member of the Evergreen management staff arrived subsequently and joined the family in the waiting area. The EC senior staff member remained at the hospital during PK's examination. Doctors at the hospital diagnosed PK with a ruptured left eardrum, bruising to both ear and eye areas with the left being worse than the right, multiple bruises to upper arms "concerning for fingers," as well as multiple bruises in various stages on his shoulder, hips and thighs. Further, they found dried fecal matter caked on his buttocks that was not easily removed. Doctors were also concerned about a possible skull fracture. The parents reported to the emergency room doctor that PK stated "I feel safe now" to them in the exam room. Doctors concluded that his injuries were the result of "blunt trauma" by an unknown object and assailant and that PK needed to be transported to UMass Medical Center for trauma services. As a result, PK was transported to UMass via ambulance.

Once at UMass, PK was evaluated by doctors and members of the child protective team who took pictures of the injuries. The doctors found that he had many bruises over various parts of his body that were in different stages of healing including "bruising over anterior upper arms bilaterally, appear to be finger shaped." The doctor identified 18 different bruises during PK's skin check at the hospital including on his left cheek, left ear, left forehead, right forehead, left arm, right arm, right leg, left leg, and buttocks. The doctor concluded that the bruising on the left cheek appeared in "the pattern of a slap mark." In conclusion, the doctor found that "in my medical opinion, bruising to the ears are highly specific for inflicted injuries as ears are generally protected from injury during routine play and activities. In addition, there are other concerning bruises and a ruptured ear drum. This case represents child physical abuse."

Further, PK received a nutritional assessment while at UMass due to concerns that he "appears very thin/underweight." This assessment found "suspected inadequate energy intake" since he lost 13.4% of his body weight in less than four months. EC reports they had attempted to address this issue by tracking PK's food intake and taking him to see a nutritionist. Despite

these efforts, PK's weight continued to be an issue as was noted in the UMass medical records. PK remained in the hospital from November 1, 2015 until November 7, 2015, during which time he experienced a tonic-clonic seizure. (Notably, PK had never experienced this type of seizure until after the injuries on October 31, 2015.)

EC conducted staff interviews for its own internal investigation on Monday, November 2, 2015. The internal report found that Staff B failed to report a restraint of PK the night of October 31, 2015, failed to properly document PK's behaviors during the pajama incident, and that there were inconsistencies between the statements of Staff B and all other staff interviewed. During EC's interview with Staff B, he reports that PK grabbed his hand, attempted to scratch and bite him, then was hitting himself in the ears.[3] Staff B reported to EC he had trouble putting a pull-up on PK. However, PK did not wear pull-ups[4], nor did he have a history of the self-injurious behavior Staff B described. EC then put Staff B on administrative leave and subsequently discharged Staff B on November 4, 2015. Following their own investigation, EC filed a 51A report with DCF. EC did not recommend any other remedial action at that time.

The parent of PK contacted the police on November 2, 2015. EC had not previously contacted the police. The police conducted a visit to PK's residence on November 3, 2105, however, the police detective informed the Department of Early Education and Care ("EEC") that "the room had already been cleaned and many surface areas contained only bleach residue."

During interviews with staff, DLC learned that Staff B had recently been demoted. Staff informed DLC that Staff B was vocal about his discontent with the demotion. In addition, Staff B had been vocal about having to come in on October 31st to work on the weekend when he was previously not scheduled.

B. Other bruises that were not appropriately considered or analyzed

In the weeks leading up to the October 31, 2015 injuries, PK's skin checks note the bruising that was found on his arm and buttocks when he was at the hospital. Of particular concern is that the bruising on PK's arm seems to be in the shape of a hand grab with four round bruises on one

[3] DLC was able to speak with Staff B who confirmed the information he previously provided to EEC and EC.
[4] When DLC spoke with Staff B, Staff B explained that staff frequently put pull-ups on residents at night so that they do not wet the bed, and that Staff B had confirmed their use with other experienced staff regarding PK.

side and one round bruise on the other. Staff did not document the cause of these bruises on the skin checks, nor where they able to provide DLC with an explanation during interviews.

PK's file was missing four days of skin checks on October 21, 2015, October 23, 2015, October 24, 2015 and October 29, 2015. In the two weeks prior to PK's hospitalization on November 1, 2015, many days noted the presences of bruises. Specifically, on October 20, 2015, the skin checked noted brown bruises on PK's right arm. Then, on October 27, 2015, the skin check notes a new, green bruise on PK's left buttocks. On October 30, 2015, the skin check notes new green bruises on PK's right upper arm, a brown bruise on his right buttocks and multiple brown bruises on his right arm. There were no explanations provided in the records for these injuries. The injuries were not reported to any higher level staff, nor were staff able to provide DLC with any explanations during interviews.

In reviewing all of student PK's records from Evergreen, DLC noticed times where there were clusters of bruising noted, yet no explanation. Evergreen has explained to DLC that due to students' severe and often self-injurious behavior, they can bruise themselves or their classmates. While that may be true generally, there was no documentation of a self-injurious incident to explain PK's bruising, or that another student harmed him either intentionally or unintentionally.

IV. FINDINGS

1. **Subjecting PK to a substantial blunt force to the head and face, sufficient to cause a large bruise to the face and result in serious physical injuries, as documented in medical records, including a punctured ear drum, constitutes "abuse" within the definition of the PAIDD regulations: "any act . . . which caused . . . injury, [including] striking…" 45 C.F.R. § 1386.19.[5]**

[5] After EC's internal investigation, the school terminated one staff member based in part on the impression that "something about his version of the story did not smell right" and that his description of the events of that evening was inconsistent with the statements of the other relevant staff members. Notwithstanding that termination and the focus on that particular staff member, certain questions remain about the responses of the other staff members: 1) Is it plausible that PK's vocalizations, having been subjected to such a violent striking, were not loud enough or strong enough to draw the attention of other staff members present in the house that evening? Viewing the layout of the residence where PK was hurt confirmed that there was a fair distance between PK's bedroom and the living room. If in fact staff did not hear such a violent hitting while working in the same house, then DLC would recommend that EC create a system to train and encourage staff to maintain an awareness of other staff working the same shift. (2) Similarly, is it plausible that, when PK was subjected to such a violent striking with physical harm to his face, there were not any visible manifestation of the assault sufficient to draw the attention and notice of other staff members

2. Response to the discovered injuries to PK:

a. Immediate aftermath: The injury to PK which presumably occurred on Saturday, October 31st, was discovered by the school on Sunday, November 1st. As attested to by EC management, that very same day the hospital found that the injury was caused by "blunt force trauma." The school did not report the incident to DCF until Monday afternoon after completion of its internal investigation, nor did it report the abuse to the Police Department. Although EC maintains that they did not have a basis for a DCF complaint until they had done their internal investigation, in fact, senior school staff knew as early as Sunday that medical personnel at Milford Hospital had found that the substantial physical injury had resulted from blunt force trauma to PK. EC policy states that it will first conduct its own investigation and then determine whether it is necessary to file a 51A report. Chapter 119, Section 51A states that

> A mandated reporter, who in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from [abuse]…shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department.

DLC finds that there was reasonable cause to believe a child was suffering from abuse or neglect on Sunday, November 1, 2015. While one could debate whether there was reasonable cause when the nurse viewed PK's injuries and observed the substantial bruising, large amounts of blood in PK's ear, and slap mark on his face, inarguably there was reasonable cause when the doctor at Milford hospital found that PK's injuries were from blunt force trauma. Notably the physician's statement was in addition to other information this senior staff member had, including the pictures of PK's injuries, viewing them himself, and the fact that the origin of the injuries were unknown. Since the statute is clear that an oral report must be made immediately once reasonable cause is found, DLC finds that EC's policy, as well as their actions in this instance, do not meet the requirements of Section 51A. From a practical standpoint, the circumstances in this case illustrate why the school's interpretation of their obligation fails. These students have difficult behaviors and may give themselves or their classmates injuries, but

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who interacted with PK while he was in the common area prior to being taken to bed around 11pm? Many staff members acknowledged how extremely fair PK's skin is. PK remained in the living room area with other staff members for well over an hour before going to bed. Although the appearance and discernibility of head and facial injuries can evolve over time, it is a fair question to pose whether the marks on his face were visible and seen by other staff members if the injuries happened during the pajama incident.

many of them cannot communicate which makes them more vulnerable. Further, most of the students who attend Evergreen are residential students whose parents do not have the ability to see them every day and ensure their well-being.

We understand that EEC approved the current policy, but DLC does not feel it abides by Chapter 119, Section 51A which requires a school to call DCF immediately once there is reasonable cause, while only allowing 48 hours for the school to file their written report. Further, EEC found that EC was out of compliance by waiting to call DCF. Even if EC were correct in its delayed report to DCF on Monday, that fails to explain the failure in notifying the local police department. By the time the Police were notified of the incident, direct evidence from the incident was no longer available since the area had been cleaned with bleach. If the police had been notified earlier, evidentiary materials, such as PK's sheets, pillowcase and clothing, could have been obtained and analyzed. Instead, by the time the police visited the school, there were no such articles to be retrieved or analyzed, and they were left with just bleach residue. **The failure to notify DCF and the local police department, while arguably after the immediate threat to PK since he never returned to the school, would constitute "neglect" since the delay in notifying the authorities contributes to a "failure to provide a safe environment"[6] to other students at the school's residences.**

b. Long term response: In its initial write up of its "Administrative Review Summary," under the heading of "Recommendation to Prevent Similar Incidents," EC's states, "Not applicable due to termination of employee." This is too narrow of a view of what EC would need to do to minimize the possibility of such an incident re-occurring. In the aftermath of such a violent incident, even if one were to assume that the only culpable individual was the worker who was terminated, it would be incumbent on the school to review thoroughly its entire HR policies and procedures to analyze whether omissions, however inadvertent, occurred. In addition, EC should examine its full complement of supervision and training policies and protocols. Notably EC states that it has now taken steps to improve its hiring, training and supervision practices. See Remedial Steps taken in section V below.

[6] 45 C.F.R. § 1386.19.

3. **The failure of the school to identify, track, analyze and respond to the series of bruises that PK had leading up to the October 31st incident is neglect under the PAIDD regulations.** As noted above, the regulatory definition of "neglect" includes, ". . . a negligent act or omission by an individual responsible for providing treatment . . . which caused or may have caused injury . . . or placed an individual with developmental disabilities at risk of injury." EC's own internal policy requires that skin checks be conducted daily. The documents from EC do not reflect a consistent pattern of daily skin checks.[7] A review of the skin checks that did occur evidenced a pattern of bruises sustained by PK in the two weeks leading up to the October 31st incident, but that pattern of bruises was not flagged, analyzed or interpreted. There is a designated section on the skin check form to discuss possible causes of injuries and to state whether the nurse was notified. It was not until the November 1, 2015 skin check that these two sections were filled out. These sections were not completed on any of the skin check forms noting bruises in the two weeks leading up to October 31, 2015. Nor was the pattern of bruises brought to the attention of higher level staff to ascertain whether they might be evidence of excessive force or mistreatment of PK. This failure to take appropriate analytic or responsive steps either caused or may have caused injury or put PK at risk of injury. At this point, one cannot definitively state whether the harm on October 31st might have been avoided if the earlier pattern of bruising had been flagged and brought to the attention of senior staff, but the failure to do so put PK at higher risk of abuse. This failure to identify, analyze and bring attention to the pattern of bruises constitutes neglect under the PAIDD regulations.

V. REMEDIAL ACTIONS

The school was asked what actions have been taken or will be taken to address concerns stemming from the October 31, 2015 incident. The following summarizes the main points of EC's response:

A. Changes/improvements that have occurred as a response to the incident with PK

[7] For example, in the two weeks leading up to PK's injuries, there were four days that did not have skin checks. It is unclear whether the skin checks failed to occur or whether the documents were misplaced or lost.

1. An additional training was created on the topic of variables that contribute to the symptoms of the students and how to appropriately respond to problem symptoms.

2. Modifications were made to several job descriptions (Residential Supervisor, Residential Supervisor/Instructor Double, & Lead Instructor) that now specify a six-month probationary period for staff members that do not meet the preferred experience standards. The probationary period comes with an increased frequency of supervision (i.e., once every two weeks, as opposed to the usual once every other month; now, once every month)

3. The supervision schedule of all staff out of their probationary period was increased from once every two months to once every month.

4. Evergreen's abuse policy for children under the age of 18 added clarifications regarding contacting the police in cases involving suspected felonies.

B. Changes/improvements that have happened and will continue to occur as a response to the PK incident

5. The additional training that was created on the topic of variables that contribute to the symptoms of the students and how to appropriately respond to problem symptoms has also been delivered to staff that have completed their probationary period and will be delivered in follow-up meetings until all staff have been trained.

6. Evergreen administration has conducted a review of its policies relative to the supervision of staff and reporting suspected cases of abuse and neglect. As a result of this review, Evergreen administration made the changes noted above.

C. Future changes/improvements that EC will be doing as a response

7. Staffing schedules have been altered to increase the level of participation in team meetings.

8. For staff that are involuntarily re-assigned to a lesser position vis-a-vis Corrective Action Plan (CAP), an attestation statement will be added to the CAP that indicates "I am ready

to accept my new assignment and report to my assignment with a professional attitude. I will speak with my supervisor if I can no longer meet this expectation." At the time that the staff member signs the attestation, his or her supervisor will discuss it with the staff member to make sure they understand their commitment.

Additional Remedial Actions Needed:

While the remedial actions already taken by the school are appropriate, a number of additional remedial steps are needed:

1. **EC's policies and practices concerning the reporting of possible abuse to DCF must be modified**. As soon as the school has reasonable cause to believe abuse or neglect has occurred, it must call DCF pursuant to Section 51A as soon as possible. In this instance it would entail reporting to DCF at the latest as soon as the medical personnel at the hospital found that there been blunt force trauma applied to PK on Sunday, or even upon seeing the outline of a handprint on his face when he was examined by the nurse, rather than calling Monday afternoon after EC had completed its own investigation.

2. **EC's policies and practices concerning the reporting of possible abuse to the local police department must be modified.** As soon as the school has reasonable cause to believe abuse or neglect has occurred, it must call the police. In this instance it would entail reporting to the police department as soon as the medical hospital found that there been blunt force trauma applied to PK on Sunday, and would have avoided the loss of potentially important evidence from the incident.

3. **EC's policies and practices concerning the conducting and documenting of skin checks must be strengthened.** Those policies and practices must ensure that when unexplained bruises are found, they are consistently and thoroughly evaluated. Staff should fill out the section on the skin checks of how the student possibly incurred the injury, even if they are stating that the cause is unknown. Finally the policies and practices must ensure that any patterns of unexplained bruises are

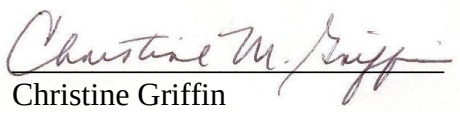
reported up the chain of command so appropriate prophylactic measures may be taken.

4. **EC must modify its training curriculum such that staff members are encouraged to share any concerns they may have about other staff and their treatment of the residents.** In this instance there had been some concerns expressed about the staff member who was later terminated, and the clear message from the Administration must be to underscore the point that when staff have questions or concerns about how a staff member is treating a resident, or a staff member is unhappy with his/her position, the Administration urges and welcomes staff to share such concerns so the problem can be addressed.

5. **EC needs to modify its policies and practices so that it would be more clearly attuned to the potential problem of staff members who are unhappy with their current position, whether by demotion or otherwise.**

VI. CONCLUSION

DLC seeks that Evergreen Center adopt these additional remedial measures to reduce or eliminate the risk of abuse or neglect of residents with developmental disabilities. DLC seeks that Evergreen Center provide DLC with a written update as to the implementation of the above recommendations within 90 days.



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