BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of the	)	
	)	
D M	)	OAH No. 15-0928-SAN
	)	Agency No.

DECISION

I. Introduction

D M appeals the decision by the Office of Children's Services (OCS) to substantiate four related allegations of neglect. All four allegations arise out of the same March 2015 incident in which Ms. M left her sixteen-year-old son J to babysit his three younger half-siblings two days after he was taken to the emergency room for an intentional overdose. After an investigation, OCS issued a substantiated finding of neglect as to each of the four children. After a full hearing and upon careful consideration of the record and the law, this decision concludes that OCS did not meet its burden of proving that the substantiations of neglect were appropriate.

II. Material Facts

D M is the mother of J Q and C, E, and L M. J, who was not raised in Anchorage, has had a difficult time adjusting to life in Anchorage, and has also suffered depression relating to the death of his biological father in 2012.[1] In March 2015, J was living with Ms. M, his step-father U M, and his three younger half-siblings. J, who was sixteen, often helped watch ten-year-old C and seven-year-olds E and L while their parents were out of the house.

On Friday, March 13, 2015, J text messaged a friend, saying he had intentionally ingested several medications in an attempt to harm himself.[2] J was brought to the emergency department, where he reported having taken five tablets of Tylenol-3, five tablets of 200 mg ibuprofen, and 3-5 tablets of baclofen.[3]

While at the emergency department, J was evaluated by F G, a licensed clinical social worker.[4] Mr. G's notes repeatedly indicate that J had characterized his action as a suicide

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1 Testimony of Ms. M; R. 21.

2 R. 21.

3 R. 21.

4 R. 21-27. The record does not contain any medical records from this visit; it only contains behavioral health care records. Accordingly, it is unknown whether J required any medical intervention. The behavioral health records indicate that J was referred for a behavioral health evaluation at 3:10 p.m., and cleared by the medical staff by 7:00 p.m. R. 21.

attempt, but also that Mr. G himself did not view it as "a serious attempt."[5] Mr. G did not consider J to be of "high [or] imminent" suicide risk, a category listed as possibly requiring an "observer present."[6] Likewise, under "treatment recommendations," Mr. G did not check the box for "patient observer required."[7]

J was not kept overnight for observation, and was instead sent home with his step-father with instructions for the family to contact his doctor and the behavioral health center early the following week.[8] Mr. G's notes describe a lengthy discussion with Mr. M and J about the decision to send J home rather than keep him for observation.[9] According to Mr. G's notes, "patient and father have agreed that patient is safe to return home."[10] Mr. M informed Mr. G that he would be home with J through Saturday, but would return to work on Sunday. J agreed to text his friends or his step-father if he had any thoughts of suicide.[11] Other than being advised to call "Monday or Tuesday" for a behavioral health appointment, the notes do not reflect that J's family was given any additional precautions or directions about his health or mental state.[12]

The following day, Saturday, March 14, 2015, J was in good spirits and behaving appropriately. He got up in the morning and helped his mother, and later the family went out riding together.[13] To Ms. M, "it just seemed normal, like any other day," and she believed the previous day's issues were resolved.[14]

The next day – Sunday, March 15, 2015 – J was again behaving normally, and did not do or say anything to suggest to Ms. M that he was depressed or upset. At around 5:30 that afternoon, while Mr. M was at work, Ms. M left the house for several hours, leaving J in charge of his younger siblings.[15] J often babysat his younger siblings, and Ms. M had no concerns about

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5 R. 23, 25.
6 R. 25.
7 R. 25.
8 R. 25. There is conflicting evidence about whether Ms. M accompanied J to the Emergency Department at the time of the first incident. Ms. M testified that both she and Mr. M were there, and she described information provided by hospital staff. But the contemporaneously-kept notes of the behavioral evaluation specifically describe Mr. M's arrival to the Emergency Department and subsequent discussions with Mr. G, yet do not describe Ms. M as being present. *See* R. 24-25.
9 R. 24.
10 R. 25.
11 R. 24.
12 Testimony of Ms. M; R. 24-28.
13 Testimony of Ms. M.
14 Testimony of Ms. M.
15 Testimony of Ms. M.

leaving the children with him on that day.[16] Ms. M was at a social event fifteen minutes from home, and, as was her standard practice, she texted J hourly to check in with him, as well as texting him when she was headed home.

After his siblings were asleep, J again ingested an unknown quantity of pills.[17] J then immediately texted Mr. M, and then called 911 at Mr. M's direction.[18] J was taken to the emergency department for a second time, and this time was admitted into inpatient care.[19]

As a result of these events, OCS received a protective services report (PSR) suggesting that the Ms may have engaged in neglect of all four children.[20] OCS assigned Protective Services Specialist I Karly Shoenhair to investigate the PSR.[21] For her investigation, Ms. Shoenhair interviewed the three younger children at their school, and Ms. Shoenhair and Anya Nicolai went to the family home to conduct additional interviews.[22] At the home, Ms. Nicolai interviewed Ms. M, and Ms. Shoenhair interviewed Mr. M and J.[23] Lastly, Ms. Shoenhair also obtained the behavioral health evaluation reports from J's two emergency department visits.[24]

As a result of her investigation, Ms. Shoenhair concluded that the neglect allegations should be substantiated against both parents.[25] She made this determination without knowing how long Ms. M had been away from the home on the evening of March 15, 2015, nor how long she had planned to be away when she left home.[26]

On June 17, 2015, OCS issued a letter substantiating allegations of neglect against both parents as to each of the four children.[27] OCS later rescinded the substantiations against Mr. M

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16 Testimony of Ms. M.

17 R. 28. The OCS Initial Assessment Summary describes the second incident as "J attempt[ing] to overdose on prescription medication by taking a combination of Motrin, Tylenol, and melatonin." R. 4-5. A March 16 behavioral health evaluation offers a third-hand account that J may have taken "approximately 5 Ibuprofen, approximately 5 Tylenol-3 tablets, and 5-8 muscle relaxants." *See* R. 28.

18 R. 28.

19 Testimony of Ms. M, R. 31-33.

20 Ms. Shoenhair testified that the PSR was based only on the second attempt and without information about the first attempt, and that the first attempt was divulged during the investigation. But the PSR itself clearly describes two separate incidents of J "attempt[ing] to overdose." *See* R. 2.

21 Testimony of Ms. Shoenhair; R. 4.

22 Testimony of Ms. Shoenhair; Testimony of Ms. Nicolai; R. 4-7, 11-20.

23 *Id*.

24 Testimony of Ms. Shoenhair; R. 21-34.

25 Testimony of Ms. Shoenhair; R. 4-9.

26 Testimony of Ms. Shoenhair.

27 R. 8.

on the basis that these events occurred while he was at work and had appropriately delegated child care responsibilities to Ms. M.[28]

III. Procedural History

OCS issued its substantiation finding on June 17, 2015. On June 29, 2015, Ms. M submitted a request for a formal hearing. The hearing was held on September 29, 2015. OCS was represented by counsel. Ms. M appeared *pro se*.

On its witness list, OCS identified three witnesses: Ms. Shoenhair, and two mental health providers who had evaluated or treated J during the time period in question. At the hearing, however, OCS did not call either of the treating professionals on its witness list. OCS called only Ms. Shoenhair and Ms. Nicolai, and called no further witnesses. Ms. M then testified on her own behalf, and called no other witnesses.

Following the hearing, the record was held open for either party to submit written closing arguments. OCS submitted its written closing argument on October 9, 2015. The record closed without further submissions from either party.

IV. Discussion

OCS maintains a central registry of all investigation reports. Those reports are confidential, but may be disclosed to other governmental agencies in connection with investigations or judicial proceedings involving child abuse, neglect, or custody.[29] At the conclusion of an investigation, OCS may find that an allegation has been substantiated.[30] The substantiations in this case are based solely on findings of neglect, and, specifically, are based on the finding that Ms. M "failed to provide adequate care and control for the children."[31] When a substantiated finding is appealed, OCS has the burden of proving by a preponderance of the evidence that the finding should be upheld.

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28 Testimony of Ms. Shoenhair.

29 AS 47.17.040(b).

30 *See* CPS Manual, Sec. 2.2.10.1, p. 2.

31 *See* OCS Closing Brief, p. 1. *n.b.* Neglect is variously defined in Chapter 47 of the Alaska Statutes as "the failure by a person responsible for the child's welfare to provide necessary food, care, clothing, shelter, or medical attention for a child" and as "fail[ing] to provide the child with adequate food, shelter, education, medical attention, or other care and control necessary for the child's physical and mental health and development [.]" *Compare* AS 47.27.190(11) *with* AS 47.10.014. Relying on its own policy manual, OCS contends that a neglect finding in the substantiation context is a form of "maltreatment" under AS 47.17.290(3) and (9), which considers, *inter alia*, whether a child's welfare is "harmed or threatened" by the conduct. Because this decision concludes that OCS did not meet its burden of proving a failure to provide adequate care and control, it is not necessary to address whether a substantiation of neglect requires OCS to meet the more stringent requirements of AS 47.27.190(11), or to otherwise address the applicability of OCS's policy manual to these proceedings.

A. Substantiation of Neglect as to J

OCS contends that Ms. M failed to provide J with sufficient care and control when she left him home to supervise his younger siblings while in a fragile emotional state. For the reasons that follow, however, OCS did not meet its burden of showing that Ms. M neglected J by having him babysit his siblings on March 15, 2015.

The essence of OCS's claim is that Ms. M should not have left J home alone "knowing J was suicidal."[32] The fundamental problem with OCS's claim is its reliance on hindsight to prove that what ultimately happened was reasonably foreseeable at the time Ms. M made the decisions now being challenged. J frequently babysat his siblings prior to the weekend in question. OCS cannot contend either that letting a sixteen-year-old stay home alone, or having a sixteen-year-old supervise his younger siblings for a few hours, is an inherently neglectful or otherwise problematic act. Rather, the particular charge of neglect here is based on a determination that Ms. M left J home and in charge of his siblings – with the knowledge "that J was suicidal."[33]

But OCS did not prove that, at the time Ms. M left the house on March 15th, she – or anyone else – actually knew that J was suicidal. It is noteworthy that the hospital social worker, Mr. G, characterized J's March 13, 2015 actions as "not a serious [suicide] attempt."[34] Mr. G also did not believe J to be at high risk for suicide, and did not recommend continuous observation of J.[35] J's parents were not given orders to keep him in their line of sight, nor to stay with him at all times; they were told to take him home, and to call Monday or Tuesday to make an appointment.

Based on these instructions and the hospital's decision not to admit J for observation, Ms. M reasonably believed J was not suicidal. The reasonableness of this belief was amplified by J's behavior over the course of the weekend. J had had a typical weekend, behaving normally and appropriately. Ms. M credibly testified that she did not think J was at risk at the time she left home on Sunday evening.

It is also noteworthy that OCS's own witnesses seemed unsure of the exact nature or scope of the supposedly neglectful act in this case. Ms. Shoenhair testified that it would not have

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32 OCS Pre-Hearing Brief at 3.

33 OCS Pre-Hearing Brief at 3.

34 R. 25

35 R. 25. Mr. G's notes reflect that he was specifically aware that Mr. M would be at work on Sunday. There is no evidence that Mr. G advised that J not be left alone. To the contrary, the notes describe J as agreeing he could text friends or Mr. M if he found himself not doing well. R. 24.

been neglect for Ms. M to leave J inside supervising his siblings while she was outside shoveling the driveway. But Ms. Shoenhair was unable to say whether it would have been neglect for Ms. M to leave J home supervising his siblings in order for her to go to the grocery store. And with specific regard to Ms. M's absence from home on March 15, 2015, Ms. Shoenhair did not know how long Ms. M had actually been gone from the house, or how long she expected to be gone, at the time that J ingested the pills. Yet, Ms. Shoenhair concluded that this absence constituted neglect.

The evidence does not support a finding that being left home to babysit his siblings for the evening constituted a threat to J's welfare.[36] Ms. M did not believe that J's behavioral health concerns required line-of-sight supervision over the weekend. This belief was reasonable given the information she had available to her at the time. In the absence of any evidence that Ms. M knew or should have known of a risk of ongoing suicidal ideation, it is unreasonable to find neglect in these circumstances. The unfortunate fact that J attempted self-harm while his mother was out of the house does not justify a finding of neglect. Therefore, OCS did not meet its burden of showing that its substantiation finding as to J should be upheld.

B. Substantiation of Neglect as to C, E, and L

OCS also substantiated allegations of neglect as to each of the younger children on the basis that Ms. M provided them with inadequate care and control when she left them in J's charge two days after the incident on March 13, 2015. For reasons similar to those discussed above, OCS did not meet its burden of showing that its substantiation finding as to the younger children should be upheld.

OCS's argument focuses chiefly on what it perceives as potential threats to the younger children's welfare. OCS identifies possible negative scenarios that might have occurred if J had actually taken enough medication to incapacitate himself, and if he had not then sought help, and if he had then become unconscious, and if the younger children had then woken up before their parents had returned home, and if they had then either found J incapacitated, or needed some kind of assistance.[37]

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[36] To the extent OCS also argues that Ms. M's actions caused "actual harm" to J, this argument fails as well. *See* OCS's Closing brief, p. 2. It is undisputed that J was "harmed" by ingesting pills. But Ms. M did not *cause* J to attempt self-harm. It is far too great a leap to find that being left unattended for the evening was the cause of J's suicide attempt.

[37] *See* OCS Closing Brief, p. 3.

As established above, however, OCS has not established that Ms. M should have anticipated his March 15, 2015 act of attempted self-harm. Indeed, it does not appear that the behavioral health experts who evaluated J two days earlier anticipated it. Accordingly, in light of the totality of evidence in the record, Ms. M's decision to leave C, E, and L in J's care for a few hours on March 15, 2015 does not constitute neglect.

V. Conclusion

OCS did not establish by a preponderance of evidence that the circumstances of March 15, 2015 amount to neglect by Ms. M. The substantiations of neglect are therefore reversed.

DATED this 21st day of October, 2015.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 24th day of November, 2015.

By: *Signed*
Name: Jared Kosin
Title: Executive Director, ORR, DHSS

[This document has been modified to conform to the technical standards for publication.]