#### DISABILITY LAW CENTER INVESTIGATION REPORT

# Meadowridge Academy, Swansea, Massachusetts April 11, 2018

#### I. Introduction

The Disability Law Center ("DLC") is a private, non-profit organization mandated by Congress and designated by the Governor of Massachusetts as the protection and advocacy ("P&A") system of Massachusetts. The federal P&A statutes specifically authorize P&A agencies, such as DLC, to investigate incidents of abuse or neglect of individuals with disabilities when the agency receives a complaint or determines that there is probable cause – that is, reasonable grounds to believe that individuals have been, or may be subject to abuse or neglect.<sup>1</sup>

Between November and December 2016, DLC received two complaints to the P&A system<sup>2</sup> regarding treatment of children with disabilities enrolled in Meadowridge Academy ("Meadowridge) in Swansea, Massachusetts. DLC requested and reviewed students' records (with parental consent). DLC also requested and received records from multiple state oversight agencies and the local police department, which substantiated abuse and neglect. On April 14, 2017, DLC determined there was probable cause that students with disabilities have been, or may be, subject to abuse and neglect at Meadowridge.<sup>3</sup> As a result of both the complaints and the probable cause finding, DLC exercised its P&A authority to fully investigate abuse and neglect at Meadowridge.<sup>4</sup> In September 2017, DLC notified Meadowridge of its intent to investigate. After a comprehensive investigation, DLC found students with disabilities at Meadowridge were subjected to abuse, neglect and improper practices during the 2014-2015 and 2015-2016 school years.

Meadowridge is to be commended on the openness and cooperation they showed DLC in conducting its investigation. More importantly, the school is to be commended for its substantial efforts to address the past problems at the school. Meadowridge has implemented extensive corrective action measures to prevent further harm to students with disabilities. Meadowridge also provided additional therapy and services to victims of abuse and neglect. DLC is not seeking additional remedial action.

#### II. Background

Meadowridge is a private, co-ed residential school, approved by the Massachusetts Department of Elementary and Secondary Education (Chapter 766 School). Meadowridge is a part of the Justice Resource Institute ("JRI") network. The residential school has capacity for 36 students with disabilities, ages 12 to 22. Meadowridge serves as an acute, comprehensive treatment placement for students with significant mental health issues, behavioral difficulties and complex trauma histories. Many students at Meadowridge are in state custody and funding for the school is often a cost-share between the state custody agency and the local education agency.

The majority of students are from Massachusetts, but about a quarter of the students are from other states in the Northeast.

As part of the preliminary investigation, DLC reviewed extensive records for January 2014 to January 2017 from the Massachusetts Department of Elementary and Secondary Education ("DESE"), the Department of Early Education and Care ("EEC"), Department of Children and Families ("DCF"), Disabled Persons Protection Commission ("DPPC"), as well as the Swansea Police Department ("SPD"). Police records reported 142 police incidents at Meadowridge in this three year time span. Many of these involved runaway students or alleged assaults between students or between students and staff, raising concern about the ability of Meadowridge to maintain a safe environment. More troubling, the EEC and DCF records revealed findings of serious sexual misconduct between staff and students.

DLC also conducted a site visit at Meadowridge on September 27, 2017. This included an interview with Meadowridge's Program Director Meredith Rapoza ("Director Rapoza") and JRI Senior Vice President Kari Beserra in the presence of counsel for the school. During the visit, DLC conducted an extensive tour of the building, including classrooms, exclusionary time-out rooms, communal areas and dormitories. After the visit, DLC requested and received extensive records from Meadowridge, specifically: student demographics; restraint data; clinical program model information; runaway data; boundary policies and training; credentials for education staff; vetting new employee procedures; staff retention policies; secure and open campus policies; information on the camera and wand monitoring system; and internal investigation procedures.

DLC staff returned to Meadowridge on January 18, 2018, conducted a follow-up interview with Director Rapoza in the presence of school counsel. DLC also requested additional information, which Meadowridge provided.

## III. 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). Similarly, DLC is equivalently authorized under the PAIMI statute for individuals with mental illness. 42 U.S.C. § 10805(a)(1)(A). As noted above, this investigation was commenced based upon multiple complaints to the system and a probable cause finding. Although a complaint to the system and a finding of probable cause constitute independent alternative bases for commencement of an investigation, in order to seek and secure various records in the P&A investigation, DLC made a finding of probable cause. P&A systems are the "final arbitrators" of a probable cause determination and P&A access cannot be denied because the subject of the investigation disagrees with the finding.

The PAIDD and PAIMI regulations define the terms "neglect" and "abuse" in almost the identical language. The PAIDD regulations define "abuse" as:

any 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 but is not limited to 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. § 1326.19. (The equivalent definition of "abuse" in the PAIMI regulations is found at 42 C.F.R. § 51.2).

The PAIDD regulations define "neglect" as:

a negligent act or omission by an individual responsible for providing services, supports or other assistance which caused or may have caused injury or death to an individual with a developmental disability(ies) or which placed an individual with developmental disability(ies) 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; or provide a safe environment which also includes failure to maintain adequate numbers of trained staff or failure to take appropriate steps to prevent self—abuse, harassment, or assault by a peer.

45 C.F.R. § 1326.19. (The equivalent definition of "neglect" under PAIMI is found at 42 C.F.R. § 51.2).

# **IV.** Factual Findings

# A. Abuse Findings

1. During the 2014-2015 school year, a Meadowridge residential supervisor engaged in sexual misconduct, a practice which is likely to cause both immediate and long-term psychological harm, which constituted abuse.

In June 2015, the male Assistant Residential Director and a 17-year old female student engaged in sexual intercourse and used marijuana and alcohol provided by the Assistant Residential Director. The Assistant Residential Director and the female student had exchanged phone numbers, texted privately and he had picked her up and dropped her off at her family member's home during a weekend visit. The student also alleged the two had previously gone off campus together in his vehicle as well as engaged in kissing on campus. Two residential counselors (supervised by the Assistant Residential Director) reported noticing frequent checkins and the Assistant Residential Director and the student leaving or returning to the campus in his vehicle alone. Neither counselor reported the boundary violations.

In July 2015, the student reported her relationship to a Meadowridge staff member. Meadowridge conducted an internal investigation, filed a complaint with the Department of Children and Families ("DCF"); and reported the matter to the Swansea Police Department ("SPD"). DCF substantiated the allegations and Meadowridge's internal investigation substantiated boundary policy violations. The Assistant Residential Director resigned in July 2015 during the investigation process. The outcome of the police investigation is unknown.

2. From 2014-2016, several Meadowridge staff members engaged in sexually inappropriate behavior, a practice which is likely to cause both immediate and long-term psychological harm, which constituted abuse.

The Department of Early Education and Care ("EEC") substantiated several boundary violations and other sexually inappropriate behavior from January 2014 to October 2016:

- In January 2014, a student was awake late at night accompanied by a residential counselor. The student was placing Legos in sexual positions and attempting to bait the residential counselor into doing the same and speak about the sexual positions. The residential counselor did not attempt to stop the student. The EEC investigation found the staff used "poor judgment" in allowing the student to continue with the sexualized play.
- In September 2015, during unstructured residential time, a group of students were playing music and dancing in the residential lounge. A female student was shaking her hips (twerking) in front of and in very close proximity to a residential male staff member. The EEC investigation found fault in the residential counselor's failure to interrupt or attempt to stop the act.
- In November 2015, the Early Education Care found boundary violations between the then Clinical Director and a student. The Clinical Director resigned during the investigation. The EEC faulted Meadowridge for failing to file a complaint with DCF (51A).
- In October 2016, two students alleged that a residential counselor FaceTimed with her boyfriend during work hours, made sexual comments and her boyfriend exposed his genitals over the FaceTime. One student alleged the residential counselor had also shared nude photos of herself with him. She also allowed students to access Facebook on her cell during outings. Meadowridge terminated her employment after an internal investigation.

DLC finds that Meadowridge staff engaged in professional boundary violations and sexually inappropriate behavior, which is likely to cause immediate and long-term psychological harm to students with disabilities.

#### B. Neglect

1. From 2014-2016, Meadowridge neglected students with disabilities by failing to provide a safe environment.

The Swansea Police Department records revealed 142 police incidents from 2014-2016. Many of the police incidents include an extremely high number of runaways as well as frequent assaults between peers and to a lesser extent assaults by students on staff. One of the student's files reviewed revealed 7 instances of peer assault in a single year. Many of the police reports contain concerns about Meadowridge's actions (e.g. inappropriately waiting to call SPD, despite seriousness of incident; and, frequent number of 911 hang up calls).

The most intense police incident occurred in August 2014. A student in crisis was being unwillingly escorted to the hospital. Several students attempted to interfere with the ambulance leaving and in the process several students eloped from campus. Meadowridge staff and SPD were not able to regain order and two other police departments were called. SPD records revealed concern about Meadowridge staff's ability to maintain order and safely keep students inside the school building.<sup>8</sup>

In many of the records obtained by DLC, Meadowridge administration faulted high residential staff turnover as a major reason for repeated instances of runaways, assaults and staff misconduct. Meadowridge reported to DLC that residential staff generally stayed less than one year. This results in Meadowridge continually having new and untrained staff.

DLC finds between 2014 and 2016, Meadowridge neglected students by failing to provide a safe environment to students. Specifically, Meadowridge failed to retain an adequate number of trained staff (i.e. extremely high staff turnover impacting quality of service). Additionally, Meadowridge failed to establish and maintain an adequate level of supervision and undertake effective steps to reduce or eliminate risks from students running away from the school's campus (e.g. almost 100 runaways in a 3 year period). This results in an unsafe environment for students and exposes students to actual or potential harm. Moreover, Meadowridge failed to take appropriate steps to prevent peer assault, despite repeated student-on-student assaults which required police intervention over a 3 year period. Most seriously, Meadowridge failed ot keep students safe from predatory sexual misconduct, as evidenced by a supervisor engaging in sexual intercourse with a student and a residential counselor sharing sexually explicit language and images with students.

DLC investigated Meadowridge's hiring policies, educator licensing protocols and restraint practices (including data) and found all of the policies and practices to be legally compliant.<sup>9</sup>

# V. Meadowridge's Remedial Action

In order to address the range of concerns identified above, Meadowridge, prior to our investigation, developed robust corrective actions, which has substantially addressed the abuse and neglect concerns identified above.

#### A. Additional Services for Victims of Abuse and Neglect

Meadowridge indicated that it assessed and provided additional clinical hours, therapy hours and monitoring for students who were victims of sexual misconduct and boundary violations. Meadowridge provided these services proactively and informally at the time of each incident. However, Meadowridge has agreed to amend their internal investigation form to include a section about additional services for potential victims of abuse and neglect in the future. This form will formalize the process and ensure any misconduct in the future is addressed with the victim.

## **B.** Leadership and Staff Changes

Meadowridge has gone through leadership and staff changes. All of the staff involved in any incidents of misconduct were either terminated or resigned voluntarily during the investigation. Meadowridge continues to investigate and terminate employees who violate boundary and other Meadowridge policies. Meadowridge Director, Meredith Rapoza, began her position in June 2014. She noted she has slowly transitioned the program from a general clinical model designed for students with mental illness and conduct disorders, to a trauma-informed care model, which better suits the current population. She noted the cultural and clinical model shift has taken time and she has implemented many policies (outlined below) to see the transformation fully develop. Meadowridge provided us with recent data on restraints, staff retention, runaways and allegations of abuse in order to substantiate its progress.

#### C. New Staff Retention Policies

Meadowridge identified that one of the largest barriers to curbing the number of runaways, boundary violations and assaults has been staff retention, especially with residential staff. Residential staff retention is a common problem across the industry as it is a low-paying job requiring little experience. Meadowridge noted most residential staff leave after one year, which is commonplace in the industry. In order to help retain staff (and build on training, instead of constantly training new staff), Meadowridge implemented the following:

- Weekly leadership development meeting for administrators to assist them in developing their "in the moment" leadership skills when problems arise;
- Each senior administrator has documented supervision goals focused on restraint/incident reduction;
- Residential Counselors have bi-weekly goal-oriented developmental supervision to help develop skills and track progress;
- Meadowridge has introduced birthday celebrations, career anniversary celebrations and team building activities (e.g. staff softball, mystery dinner, bowling, holiday party) to improve morale;
- Meadowridge has implemented monthly staff surveys to increase staff member's voices in decision-making; and,
- Residential staff increased starting pay (up to \$16/hour) and introduction of sign-on bonuses paid out at 6 and 12 months of successful employment.

Meadowridge reported that residential staff turnover has been reduced from 45% in 2015 to 41% in 2017. Meadowridge reported it will continue to evaluate and improve retention policies in order to continue to reduce staff turnover.

# D. Improved Staff Training & Clinical Approach

Meadowridge also identified gaps in staff training that potentially contributed to higher instances of runaways, police involvement and boundary violations. Meadowridge has shifted its training models from philosophical training (lecture style) to a more practical application model. Meadowridge has incorporated a full-day shadow training into their residential staff orientation Additionally, Meadowridge revised the boundary training to include real-life examples of boundary issues. New staff members have the opportunity to discuss real-life boundary quandaries and learn appropriate responses. Additionally, Meadowridge has updated boundary training to include how to identify warning signs of boundary violations in both students and employees, so staff are better able to report an issue if one arises.

In order to ensure training is reviewed regularly with staff, Meadowridge began frequently incorporating boundary discussions into staff meeting reviews, Administrative Team leadership meetings and individual staff supervisions.

Meadowridge also identified gaps in residential staff's understanding of how students who have experienced trauma can be prone to boundary issues. Thus, in 2017, Meadowridge also modified the clinical student risk assessment intake form to include a rating scale for "level of risk to others" based on history of traumatic experiences, history of boundary allegations and frequency of each. This helps both clinical and residential staff to be more in tune with students prone to attempting to engage staff inappropriately and address it proactively.

In conjunction with this risk assessment effort, Meadowridge also introduced weekly clinical case discussions in full staff meetings (residential staff present) to assist all staff in understanding student histories and how they affect student behavior/presentation (focus on the "why," not the "what") and how to effectively respond to identified behavior/presentation. Meadowridge reports this has greatly increased residential staff's effectiveness in de-escalation and avoiding boundary issues.

Finally, in response to a number of boundary issues during unstructured recreational time, Meadowridge has changed its recreational activities policy. Previously, the time was generally unstructured and students had a variety of activities to choose from (including unstructured dancing). Now, Meadowridge proactively structures recreational time in a proscriptive manner to address the needs of the community. Moreover, Meadowridge reported unstructured dancing is no longer a permitted recreational activity, in order to avoid boundary problems like the incident in September 2015.

## E. Increased Employee Monitoring & Reporting Practices

As a result of the former Residential Supervisor's sexual misconduct, Meadowridge identified a gap in its employee reporting policies. Previously, staff were directed to report

potential employee misconduct to their direct supervisors. In the June 2015 incident, this would have required staff to report the misconduct to the violator – their boss. Meadowridge amended this policy and now any staff member can raise an employee misconduct or boundary violation with their direct supervisor, another supervisor, or the Executive Director directly.

As a result of several substantiated instances of misconduct, Meadowridge also increased student safeguards and employee supervision. The school placed windows in all doors that previously did not have windows to increase visibility in all areas of the school. More recently, in March 2017, Meadowridge installed 58 cameras in all hallways, classrooms and other public areas. The video can be accessed remotely by the administration at any time. Any incident that is brought to the administration's attention is clipped and saved. Meadowridge had previously been retaining videos for only two weeks, but at DLC's request, Meadowridge has agreed to increase their storage protocol to retain the videos for a period of 30 days.

The Executive Director also started regularly conducting unannounced visits to the facility at night to increase overnight staff oversight and compliance. Meadowridge also continues to use a wand system (installed November 2014) at night to track and log room checks performed by staff. The wand is activated by an electronic checkpoint at the entrance of each bedroom. The wand system provides assurance that employees are actually checking rooms on the required schedule. Each morning a supervisor or manager reviews the logs to confirm that checks were conducted as scheduled.

The improved staff training, clinical model shift in combination with increased employee monitoring and reporting practices has decreased runaways dramatically and eliminated staff boundary violations at Meadowridge. From December 2016 until October 2017, Meadowridge had 6 runaways, down from 23 runaways from December 2014 until October 2015. Additionally, in the past year, nine allegations of abuse or neglect have been filed with DCF on behalf of Meadowridge students. Eight of nine allegations have been screened out, or investigated and unsubstantiated (i.e. DCF found no evidence of abuse or neglect). One allegation, involving misconduct between two students is currently under investigation. Ultimately, DLC finds Meadowridge has substantially remedied the abuse and neglect found from 2014-2016. However, to ensure that Meadowridge continues to make progress and improve its programs, DLC will monitor Meadowridge for a year.

#### VI. Monitoring

DLC has requested and Meadowridge has agreed to cooperate and help facilitate DLC's monitoring of this remedial plan for a period of 12 months. After 12 months, DLC will determine whether any further action/monitoring is required. The monitoring will include the following:

#### A. Record Review

On a triennial basis (June 2018, October 2018, February 2019), Meadowridge will provide DLC with the following records:

- 1. All DCF abuse and neglect complaints filed as well as DCF findings (screened-out/substantiated/unsubstantiated)
- **2.** All restraint data;
- **3.** Data on number of runaways;
- **4.** Data on number of police incidents;
- **5.** All student injury-incident reports;
- **6.** Employee retention data;
- **7.** Any other internal record or document reflecting additional corrective action taken involving the violations in this report.

# **B.** On Site Monitoring

Within 30 days of receiving the above triennial reports, DLC will determine whether to conduct an on-site visit. These visits will include staff interviews, building tours, and classroom observations.

<sup>1</sup> See 45 C.F.R. § 1386.19 (defining probable cause under PAIDD as "a reasonable ground for belief that an individual with developmental disability(ies) has been or may be subject to abuse and neglect." See also 42 C.F.R. § 51.2 (defining probable cause under PAIMI in a substantially similar manner). See also 42 U.S.C. § 10801(a)(1)(A); 29 U.S.C. § 794e(f)(2); 42 U.S.C. § 300d-53(k) (defining authority to investigate abuse and neglect when P&A receives reports of incidents of abuse and neglect or determines there is probable cause).

<sup>&</sup>lt;sup>2</sup> See 45 C.F.R. § 1386.19 (defining "complaint" as "includes, but is not limited to, any report or communication, whether formal or informal, written or oral, received by the P&A system, including...electronic communications, telephone calls (including anonymous calls) from any source alleging abuse or neglect of an individual with a developmental disability." See also 42 U.S.C. § 10805(a)(1)(A) (noting P&A authority to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system.").

<sup>&</sup>lt;sup>3</sup> See 45 C.F.R. § 1386.19 (stating the P&A makes a determination of probable cause based on "reasonable inferences" drawn from experience involving similar incidents and problems surrounding abuse and neglect).

<sup>&</sup>lt;sup>4</sup> 42 U.S.C. § 15043(a)(2)(B). 42 U.S.C. § 10805(a)(1)(A); *See also* 29 U.S.C. § 794e(f)(2); 42 U.S.C. § 300d-53(k). <sup>5</sup> DLC has identical authority under the PAIR statue for individuals who do not fall within the PAIDD and PAIMII

<sup>&</sup>lt;sup>5</sup> DLC has identical authority under the PAIR statue for individuals who do not fall within the PAIDD and PAIMII statutes. *See* 29 U.S.C. § 794(e)(f)(2)(stating that P&A's have the same investigation authority for people who meet the definition set forth in 29 U.S.C. § § 794(a)(1)(b) as the P&A has for people with developmental disabilities). <sup>6</sup> *See Connecticut Office of P&A for Persons with Disabilities v. Hartford Bd. of Edu.*, 464 F.3d 229, 242 (2nd Cir. 2006). See 45 C.F.R. § 1386.19; 42 C.F.R. § 51.2 (defining probable cause under PAIDD and PAIMI).

<sup>&</sup>lt;sup>7</sup> Protection and Advocacy for Persons with Disabilities v. Armstrong, 266 F.Supp.2d 303, 320 (D.Conn.2003), quoting Arizona Ctr. for Disability Law v. Allen, 197 F.R.D. 689, 693 (D.Ariz.2000). Gerard Treatment Programs, L.L.C., 152 F.Supp.2d at 1159 (noting that a P & A system determines when probable cause exists, and access cannot be denied because a facility disagrees with the determination).

<sup>&</sup>lt;sup>8</sup> Fall River Herald News, *Swansea police call for mutual aid to help with large disturbance at Meadowridge Academy* (Aug. 6, 2014), available at: <a href="http://www.heraldnews.com/article/20140806/NEWS/140808073">http://www.heraldnews.com/article/20140806/NEWS/140808073</a>.

<sup>&</sup>lt;sup>9</sup> DLC found the Assistant Education Director, who was acting as the Education Director with support from a licensed administrator at another JRI school, only had a teaching license, not an administrative license. However, DLC also found Meadowridge was in the process of applying for a DESE waiver, which was granted during DLC's investigation. Thus, DLC found Meadowridge to be compliant with state licensing policies and practices.