STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**FINAL DETERMINATION AFTER HEARING** **Adjud. Case #:** [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O' Brien, Esq.

[redacted]
By: Margaret J. Fowler, Esq.
450 Plaza Drive
Vestal, New York 13850

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the substantiated report dated [redacted] dated [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
April 3, 2015

David Molik
Administrative Hearings Unit

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

[redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street
Room 115
Syracuse, New York 13202
On: [redacted]

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Parties: Justice Center for the Protection of People with Special Needs
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report [redacted] of neglect by the Subject of two Service Recipients, "Service Recipient A" and "Service Recipient B[1]." (Testimony of Justice Center investigator)

2. The initial report to the VPCR made on [redacted], alleged that one Service Recipient told another [redacted] staff member that the Subject had allowed himself and another Service Recipient to fight with one another. (Justice Center Exhibit 5)

3. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

4. On [redacted], the Justice Center substantiated the report for neglect[2] under the theory that the Subject failed to properly supervise two Service Recipients. The Justice Center concluded that:

It was alleged that on [redacted], at the [redacted] …

[1] The investigator testified that he had incorrectly identified the two Service Recipients in his written report. (See Justice Center Exhibit 5) The investigator correctly identified the Service Recipients in his hearing testimony.
[2] There was no evidence in the record that, and the Justice Center did not conclude that the Subject allowed two Service Recipients to fight as had been initially reported to the VPCR.

> while acting as a Custodian (YDA 3), you committed neglect when you left service recipients unattended and unsupervised, which provided the service recipients with an opportunity to "play fight."
>
> This offense has been substantiated as Category 3 neglect pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

5. An Administrative Review was conducted and, as a result, the substantiated report was retained.

6. At the time of the alleged neglect, the Subject was employed by the New York State Office of Children and Family Services (NYS OCFS), at the [redacted]. The Service Recipients were young persons who were adjudicated juvenile delinquents, placed in the custody of OCFS and residing at the [redacted]. The [redacted] is, and was at the time of the report, a limited secure residential facility which houses adjudicated male youths. The Subject was employed in the capacity of a Youth Division Aid (YDA-3), and was employed by *a facility or provider agency* that is subject to the jurisdiction of the Justice Center.

7. On or about [redacted], at approximately 8:00 p.m., the Subject and one other staff member were supervising nine Service Recipients on the unit. This was a holiday weekend [redacted] and, therefore, staffing levels on the unit were below normal levels. Service Recipient A asked the Subject to unlock his bedroom so that he could change his clothes for gym or recreation. The Subject did so and Service Recipient A entered his bedroom. [redacted] procedure generally requires that Service Recipients, who are in their room, are to be locked into their room. (Testimony of Subject)

8. The Subject set Service Recipient A's bedroom door to lock upon closing. (Justice Center Exhibit 8: Video of unit [redacted]) As the Subject was closing the bedroom door, the Subject's attention became distracted by an issue developing on the other side of the unit

between two other Service Recipients. The Subject failed to close the door completely and made his way to the other side of the unit. Because the door did not latch, the bedroom door remained unsecured and Service Recipient B was able to, and did, enter Service Recipient A's bedroom.

9. Once in the bedroom, Service Recipient B engaged in horseplay with Service Recipient A, for approximately 45 seconds, until such time as the Subject returned to the bedroom and ended the horseplay. (Justice Center Exhibit 8: Video of unit [redacted]) There were no injuries as a result of this horseplay.

10. The event occurred in a secure unit. All doors in and out of that unit are locked. The unit is a large room, no more than 35 feet in length, which contains institutional living room type of furniture. On the outside perimeter of the unit there exists several dorm type of bedrooms. Each bedroom has a door which enters/exits onto the unit. (Justice Center Exhibit 8: Video of unit [redacted])

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the Category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been

made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse and/or neglect occurred, …" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the Category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or

manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject(s) committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in Category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to Category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged

in Category two conduct. Reports that result in a Category two finding not elevated to a Category one finding shall be sealed after five years.

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a Category three finding shall be sealed after five years.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the Category of abuse and/or neglect set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of evidence that the Subject committed the neglect alleged in the substantiated report.

In support of the substantiated findings, the Justice Center presented Justice Center Exhibits 1-8. The Subject testified on his own behalf.

The facts of this case are, by and large, not in dispute. The Justice Center relies heavily upon NY OCFS PPM 3247.03: (Supervision of Youth) and the Justice Center investigator's interpretation of this OCFS policy to support its case.

The Justice Center investigator testified and concluded that, when the Subject inadvertently failed to close the bedroom door of Service Recipient A, the Subject effectively

violated the aforementioned supervision policy of OCFS. The Justice Center investigator took the position that NY OCFS PPM 3247.03: (Supervision of Youth) p 4. (Sub section B. General principles of Supervision of Youth), which requires staff to "supervise youth at all times," means literally that staff at OCFS facilitates shall have eyes on Service Recipients at all times. However, such an interpretation contradicts language in the same sub section of the policy which states that staff shall "maintain a vantage point that allows for maximum youth visibility." Additionally, the same sub section of the policy contemplates "special situations" where youth may "require heightened supervision" (NY OCFS PPM 3247.03: Supervision of Youth, p 4. Sub section B. General principles of Supervision of Youth) Neither Service Recipient A nor B was subject to "one-to-one" supervision or "heightened supervision." Additionally, the unit where this event occurred is a secure unit and only staff members have the keys needed to enter and exit the unit. Clearly, "one-to-one" supervision is not the expected level of routine supervision of Service Recipients in OCFS facilities.

With regard to the issue of securing the bedroom door, there were no written OCFS operating guidelines or procedures in the record. The Subject did acknowledge in his testimony that when Service Recipients are in their respective bedrooms, [redacted] practice or policy generally requires that the bedroom doors are to be locked.

During the course of the investigation the Justice Center investigator stated that he also viewed a second video in which two other Service Recipients (not the Service Recipients in this case), were in a unit [redacted] bedroom horse playing, while Subject [redacted] supervised them by standing at the open door. The Justice Center investigator testified that he did not pursue that event because the Subject was supervising the Service Recipients during their horseplay.

The fact that the Subject failed to secure the door is not the pivotal issue in this case. The significant legal issue in this case is whether the lack of direct supervision for 45 seconds was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipients A and/or B. While some omissions and behaviors can give rise to a presumption that the action or inaction is likely to result in physical injury or serious or protracted impairment of Service Recipients, the facts and circumstances of this case do not give rise to such a presumption.

The undisputed evidence in the record was that neither Service Recipient A nor B was injured as a result of this horseplay. None of the Service Recipients on this unit were designated as needing one-to-one supervision. (Cross-examination testimony of Subject) There was no evidence in the record that either Service Recipient A or B had any dislike for one another, or were likely to harm one another. Nor was there any evidence that either Service Recipient was likely to sexually offend, or that the two Service Recipients were sexually involved.

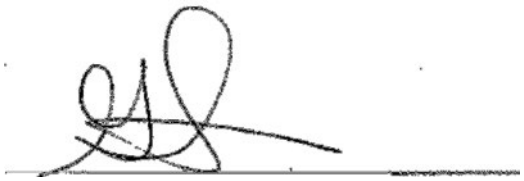
After considering all of the evidence, and the lack of evidence cited above, the Justice Center did not establish by a preponderance of the evidence when the Subject failed to secure the bedroom door of Service Recipient A, which allowed Service Recipient A and Service Recipient B to "engage in horseplay" for 45 seconds, that the Subject's inaction or lack of attention ***was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition*** of Service Recipients A and/or B.

DECISION: The request of [redacted] that the substantiated report [redacted] dated [redacted] be amended and sealed is granted.

The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Bureau.

DATED: January 29, 2015
Schenectady, New York



Gerard D. Serlin, ALJ