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

In the Matter of the Appeal of

FINAL DETERMINATION AFTER HEARING

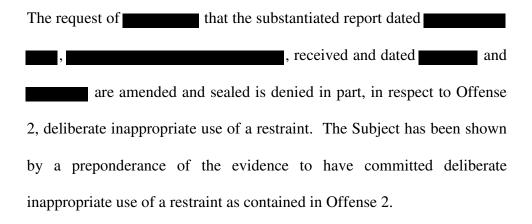
Adjudication Case #:

Pursuant to § 494 of the Social Services Law

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: Willow Baer, Esq.

By: Eric Wilke, Esq. CSEA, Inc. 143 Washington Ave. Capital Station Box 7125 Albany, NY 12224 The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.



The substantiated report is amended to a Category 3 act.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c). 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 14, 2015

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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	RECOMMENDED DECISION AFTER HEARING
	Pursuant to § 494 of the Social Services I	Law Adjudication Case #:
Before:		Herrmann istrative Law Judge
Held at:	Admin 401 Sta	ustice Center istrative Hearings Unit ate St. ectady, NY 12305
Parties:		Center for the Protection of People with l Needs Willow Baer, Esq. 161 Delaware Avenue Delmar, New York 12054-1310
	By:	Eric Wilke, Esq. CSEA, Inc. 143 Washington Ave. Capital Station Box 7125 Albany, NY 12224

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating ______ (the Subject) for abuse and/or neglect. The Subject requested that the Justice Center, Administrative Appeals Unit (AAU) amend the report to reflect that the Subject is not a subject of the substantiated report. The AAU 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 dated

, received and dated and and of abuse by

(Subject) against a service recipient. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

2. The initial report alleges, in pertinent part, that on

Offense 1

The offense has been SUBSTANTIATED as Category 2 physical abuse pursuant to Social Service Law § 493.

Offense 2:

It was alleged that on	, at the				, locate	ed at
		, you	committed	abuse	when	you

deliberately used an inappropriate restraint on a service recipient, in that you inappropriately initiated such restraint, and then used excessive and inappropriate force during the restraint when you placed your arm around the service recipient's neck and pulled him to the floor.

The offense has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of a restraint) pursuant to Social Service Law § 493.

3. An Administrative Review was conducted and as a result the substantiated report

was retained.

4. At the time of the alleged abuse, the Subject was employed as a YDA IV at

provider agency that is subject to the jurisdiction of the Justice Center.

5. Service recipient SR was a resident at

6. On the Subject was working in a classroom and SR

was a student in the class.

7. The Subject approached SR **Example 1** to find out why he was not completing the class assignment.

8. The Subject talked to SR and asked him to leave the classroom.

9. SR sector refused and the Subject attempted a standing escort to lead him out of the classroom.

10. SR resisted and held onto the desk and after a brief struggle SR and the Subject ended up on the floor. The Subject performed a single person restraint until staff members relieved him.

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 or neglect.

• Pursuant to Social Services Law § 493(4), the category level of abuse 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 and/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 or neglect; and pursuant to Social Services Law § 493(4), the Category of abuse or neglect that such act or acts constitute.

The abuse and 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.

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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.
- "Neglect," which shall mean any action, inaction or lack of attention that (h) 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 and/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/or neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/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 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, 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

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 established by a preponderance of evidence that the Subject committed the act of abuse in offense two, deliberate inappropriate use of restraint, but it was not properly categorized as a category two level of abuse and will be lowered to a category three level of abuse.

The Justice Center presented two witnesses and admitted into evidence the statements of staff members who were present during the restraint, a video of the incident, and various documents including the OCFS manual on restraints. The Subject testified on his own behalf, and called two witnesses.

The first witness for the Justice Center was the case investigator, **Sector** investigator summarized her investigation and introduced the video of the incident. Investigator testified that according to her investigation and a review of OCFS policies, the restraint of SR **Sector** was not permissible. The investigator testified that a single person restraint was not justified because it was not in response to an emergency situation because no one was in imminent danger. The investigator testified that SR **Sector** told her that the Subject asked him to leave the classroom and he refused. She said the SR **Sector** denied throwing a punch and said that he held onto the desk because he did not want to leave. She testified that SR **Sector** did not answer her when she asked if he got hurt or was in pain. The second witness was **Sector**, a trainer for OCFS. He testified that employees are taught to exhaust all nonphysical options before restraining a youth. **Sector** testified that the Subject should have called for help and he did not use an approved restraint or technique.

The Subject called two witnesses, who was the Assistant Director of at the time of the incident and the subject. Neither witness was in the classroom but each testified that the Subject had a good rapport with the residents.

The Subject testified in his own defense. The Subject testified that SR was recently transferred from the mental health unit and was aggressive and difficult to manage. The Subject testified that SR was had assaulted both staff and residents.

The Subject testified that the night before the incident he had received a text message from a supervisor giving him a heads up that the Subject said he wanted to punch someone. During the morning meeting SR **said** said he wanted to go back to the mental health unit. Once in the classroom the other students refused to sit next to the SR and in the video there is a whole row of empty seats next to him.

At the beginning of the class the Subject said he escorted SR **manual** out of the classroom to calm down. He testified that SR **manual** told him he felt like punching someone and then went back into the classroom. The Subject kept a close eye on him and noticed he was not completing class work.

The Subject was concerned so he went over to his desk to check on him. The Subject said SR **sector** his hands were clenched and he was mumbling. He spoke to him briefly and was trying to get him to leave the classroom. The Subject said he attempted a standing escort and he thought SR **sector** would cooperate. Instead, he ended up struggling with SR **sector** and they both ended up on the floor. The Subject denied using a chokehold and said that he was trying to put his hand around his chest and it ended up near his neck.

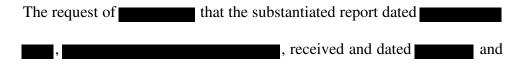
The actions the Subject took were against OCFS policy because it was not an emergency situation that justified a solo restraint/escort. There was no indication that SR

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an immediate threat and the Subject should have called for assistance or cleared the classroom. Accordingly, it is determined that the Agency has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse alleged in offense two, deliberate inappropriate use of restraint. Offense one states that the Subject committed an act of physical abuse when he grabbed a SR around the neck in a chokehold and pulled him to the floor. Based on the testimony and video it is not clear that the Subject used a chokehold or pulled the SR to the floor. The Justice Center has failed to substantiate offense one.

The Justice Center improperly categorized the level of abuse as a category two. To substantiate a category two level abuse the conduct by the Subject must have seriously endangered the health, safety or welfare of SR **SR** SR **SR** was not injured and did not complain of any medical problems as a result of the restraint. There were no documents that detail any injuries or health complaints. The JC has not met its burden to show that it was a category two level of abuse. The substantiated abuse will be lowered to a category three level.

DECISION: The request of that the substantiated report dated **manual**, received and dated **manual** and **manual** are amended and sealed is granted in part, with respect to Offense 1, physical abuse. The Subject has not been shown by a preponderance of the evidence to have committed physical abuse as contained in Offense 1.



are amended and sealed is denied in part, in respect to Offense 2, deliberate inappropriate use of a restraint. The Subject has been shown by a preponderance of the evidence to have committed deliberate inappropriate use of a restraint as contained in Offense 2.

The substantiated report is amended to a Category 3 act.

This decision is recommended by Diane Herrmann, Administrative Hearings Unit.

DATED: September 15, 2014. Schenectady, New York

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Diane Herrmann, ALJ