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: Julie O'Brien, Esq.

[redacted]

[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 reports, dated [redacted], [redacted], received and dated [redacted], are 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(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

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** **Adjud. Case #:** [redacted]

Before: Diane Herrmann
Administrative Law Judge

Held at: Administrative Hearings Unit
Justice Center for the Protection of People with Special Needs
401 State St., Schenectady, NY
On: [redacted]

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

[redacted]

[redacted]

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 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 [redacted], [redacted], received and dated [redacted], of abuse by [redacted] (Subject) against a service recipient (SR). 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 [redacted]:

Offense 1

> It was alleged that on [redacted], at [redacted], located at [redacted], while acting as a custodian (Detention Counselor), you committed an act of physical abuse when he grabbed, pushed and punched a (S)ervice (R)ecipient.

Offense 2:

> It was alleged that on [redacted], at [redacted], located at [redacted], while acting as a custodian (Detention Counselor), you committed an act of abuse (deliberate inappropriate use of restraints) when you used excessive force and an inappropriate restraint technique on a (S)ervice (R)ecipient in that you grabbed, pushed and punched him, leaned on him while in a prone position and failed to employ appropriate de-escalation techniques.

[redacted]

3. The Justice Center substantiated the actions in Offenses 1 and Offense 2 as Category 3 acts pursuant to Social Service Law.

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

5. At the time of the alleged abuse, the Subject was employed as a detention counselor at [redacted], a facility run by [redacted], which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

6. On [redacted] the subject was working the 3pm-11:30pm shift and was running the evening meeting in the TV room.

7. SR [redacted] was interrupting the meeting and making inappropriate comments.

8. The Subject asked SR [redacted] to leave the room and go upstairs to his bedroom and he refused.

9. The Subject escorted SR [redacted] into the hallway.

10. SR [redacted] hit the Subject and he was put in a two person restraint by the Subject and employee [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 or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

[redacted]

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. 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.

[redacted]

(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 and/or neglect alleged in the

[redacted]

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 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

[redacted]

(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 cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report.

If the Justice Center did not prove the abuse 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 abused SR [redacted] by hitting him and using a deliberate and inappropriate restraint and those acts of abuse led to injury.

[redacted]

The Justice Center called one witness, the investigator. The investigator interviewed five residents of [redacted] and the four employees who were on duty.

The investigator testified that the Subject was in the TV room with four residents running a group meeting. SR [redacted] told the investigator he was asked to leave the group and he refused because he was not the only resident who was giving the Subject a hard time. He said that the Subject pushed him out of the room and then punched his throat. He told the investigator he punched the Subject back and was then was put in a restraint by the Subject and employee [redacted]. The investigator testified that she observed two oval shaped bruises and a scratch on SR [redacted] arm.

The investigator testified that SR [redacted] told her that the Subject was with the residents in the TV room and SR [redacted] became disrespectful. The Subject asked SR [redacted] to leave and he refused. The investigator testified that SR [redacted] told her the Subject grabbed SR [redacted] and pushed him out of the room. SR [redacted] then said the Subject punched SR [redacted] in the neck and he punched him back. SR [redacted] said SR [redacted] was then restrained by the Subject and employee [redacted]

SR [redacted] told the investigator that the Subject removed the SR from the room, threw him into a wall and lost his footing. He said the Subject and SR [redacted] both fell and then SR [redacted] was put in a restraint.

SR [redacted] said that the Subject removed SR [redacted] from the room and then there was a physical altercation. SR [redacted]. told the investigator that the Subject backhanded SR [redacted] to the throat.

The investigator interviewed the Supervisor and he stated that he didn't witness the whole event but he saw SR [redacted] punch the Subject and the Subject and Employee [redacted]

[redacted]

restrain SR [redacted] The Supervisor stated that the Subject applied too much pressure during the restraint.

The investigator testified that the Subjects actions were against the Therapeutic Crisis Intervention, TCI, training. The investigator testified that the Subject should have used a de-escalation technique. The Subject should not have grabbed the youth; he should have asked another staff member to take over when he got into a verbal altercation with SR [redacted]

The investigator testified that the restraint was inappropriate because too much force was used. The investigator based her conclusion on the TCI manual and the Supervisors comments that the Subject used too much force.

The Subject testified in his own defense. The Subject testified that after dinner the residents were with him TV room and he was running the evening meeting. The Subject testified that he was the only staff person in the room and that there were 10 residents, not 4. The Subject said that SR [redacted] was very disruptive and he asked him to leave the room. The Subject was afraid that SR [redacted] would rile up the other residents and things could get out of hand. SR [redacted] refused and continued to make disruptive comments.

The Subject said that he guided SR [redacted] out of the room. He said SR [redacted] was swearing at him and then took a swing at him. The Subject said he grabbed SR [redacted] arms and he and Employee [redacted] did a two person restraint.

Subject [redacted] testified that he did not use excessive force and he never hit SR [redacted]. The Subject admitted into evidence notes from the log book dated [redacted] that indicates SR [redacted] had been disruptive and disrespectful on numerous occasions. Included is a note written on [redacted] that states that SR [redacted] threatened to punch a staff member in the face.

[redacted]

The Subject testified that he was the only staff member in the room with ten residents. The Subject said that there should have been another staff member with him but there wasn't. The Subject said there was no other staff member to take over the meeting, he was alone.

Employee [redacted] testified for the Subject. He stated that he had just started his shift and he was not in the TV room when the incident began. Employee [redacted] said that when the Subject escorted SR [redacted] out of the room he kept his eyes on the TV room to make sure the rest of the residents stayed in the room. Employee [redacted] said the restraint was done properly and that the Supervisor was not close to the restraint but 10-15 feet away.

The last witness for the Subject was Employee [redacted]. Employee [redacted] testified as a character witness. [redacted] stated that the Subject was well-liked by the residents. [redacted] testified that there was a wipe board in the residence on which residents can write the names of staff that have helped them. [redacted] stated that the Subjects name was consistently written on the board. He said that the Subject took the kids fishing and made connections with the residents.

In order to substantiate the case the Justice Center needs to prove by a preponderance of the evidence that Subject committed an act of abuse by hitting and using an inappropriate restraint against SR [redacted] The testimony provided by the JC was inconsistent and contradictory. The witness's statements varied and the details were not consistent. The comments the SR's made to the investigator are suspicious because of a conversation that an employee heard immediately after the event.

Offense One

The Justice Center failed to prove by a preponderance of the evidence that the Subject hit SR [redacted]

SR [redacted] said that the Subject hit him with a closed fist and SR [redacted] was the only one who saw it. SR [redacted] said that he saw the Subject hit SR [redacted] but also said an unnamed staff member was present. The records are clear that there was not another employee present. SR [redacted] also said he saw the incident but later in his statement he stated that he stayed on the couch with SR [redacted] SR [redacted] also said that the SR did not say anything when the Subject hit him. SR [redacted] stated that the SR [redacted] cursed at the Subject and when he was hit. SR [redacted] said that SR [redacted] was doing nothing wrong and the Subject started to bother him. He also said that the SR [redacted] hit his head on the door. The Supervisors initial statement indicates that he spoke to SR [redacted] right after the incident. There is nothing in the statement indicating that SR [redacted] told him the Subject hit him.

The Subject submitted log book entries for the date [redacted]. An employee wrote that when he entered a common area and heard the residents encouraging each other to lie about the incident of [redacted], so that the Subject would get in trouble. This notation was made contemporaneously to the events and before the Justice Center contacted the facility and began the investigation. This raises questions about the veracity of the statements made to the investigator.

Hearsay evidence is admissible at administrative hearings. In this case the hearsay evidence was not consistent and cannot be given enough weight to substantiate the charge of abuse.

Offense Two

The Justice Center has failed to prove the Subject violated TCI protocols and used an inappropriate restraint. The Subject was alone with SR [redacted] when the incident started.

[redacted]

There was not another staff member who could step in and take over. The Subject made several verbal requests and did not engage in physical contact.

The Justice Center based its conclusions that too much force was used on the statement made by the Supervisor. Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances Gray v. Adduci, 73 N.Y.2d 741 (1988), 300 Gramatan Avenue Associates v. State Division of Human Rights, 45 N.Y.2d 176 (1978), Eagle v. Patterson, 57 N.Y.2d 831 (1982), People ex rel Vega v. Smith, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross-examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it depending upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

Employee [redacted] testified that the Supervisor was not close to the restraint and could not have seen how much force was used. The statement is also suspect because the Supervisor did not stop the restraint or step in and take over. It defies common sense that a supervisor would watch an improper restraint and do nothing.

The Justice Center has failed to prove by a preponderance of the evidence that the Subject used an inappropriate restraint on SR [redacted]

[redacted]

DECISION: The request of [redacted] that the substantiated reports, dated [redacted], [redacted], received and dated [redacted], are 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 Diane Herrmann, Administrative Hearings Bureau.

DATED: September 15, 2014
Schenectady, New York

Diane Herrmann, ALJ