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: Thomas Parisi, Esq.

[redacted]
By: Anthony Chilliest, Esq.
103 East 125th Street, Suite 1102
New York, New York 10035

[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 report "substantiated" on [redacted], [redacted] dated and received on [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: May 19, 2015
Schenectady, New York

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

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building
163 W 125th Street
New York, New York 10027
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
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[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 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 report "substantiated" on [redacted], [redacted] dated and received on [redacted] of abuse and/or neglect by the Subject of Service Recipients.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian (Workplace Violence Coordinator [redacted]), you committed an act of abuse (obstruction of reports of reportable incidents) when you became aware of and failed to report allegations of abuse and/or neglect against service recipients.
>
> This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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

4. The facility, the [redacted], located at [redacted], is a group home for adults with

[redacted]

developmental disabilities and is operated by the New York State Office of People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse, the Subject, [redacted], had been employed at the facility as a [redacted] (a staff trainer) since 2005 and also as a Workplace Violence Coordinator (an administrative liaison between the facility Director's Office and the Workplace Violence Committee) since 2008. (Testimony of [redacted]; Subject)

6. On [redacted], Facility Staff Member 1 alleged that Facility Staff Member 2 pushed a Service Recipient and directed derogatory and threatening language towards Facility Staff Member 1 in the presence of three Service Recipients, including the Service Recipient who was allegedly pushed. (Justice Center Exhibit 5)

7. On that date, Facility Staff Member 1 complained to her supervisor, [redacted], who contacted DDPS4 Program Specialist, [redacted] for guidance as to the complaint. Based on [redacted] instructions, [redacted] advised Facility Staff Member 1 of her right to fill out and submit a Workplace Violence Incident Reporting Form (the Form), which she did that day. (Justice Center Exhibits 12 and 15)

8. The processing of a Workplace Violence Incident Reporting Form is governed by the [redacted] *Workplace Violence Prevention & Response Policy & Program*. It delineates that, once the form is completed by an employee, it is reviewed and completed, in the designated area, by the employee's supervisor. The form then goes to the Treatment Team Leader of the unit, who completes the designated area and then forwards it to the Safety Department. Once the Safety Department makes sure that the form is completed properly, it date stamps receipt of the form and forwards a completed copy back to the employee and to the

[redacted]

Director's office. The Director reviews the form and completes a page 4 Addendum. The Director then sends the completed form to the Workplace Violence Administrator or one of the Co-chairs of the Workplace Violence/Health and Safety Committee. The form is thereafter brought to a committee meeting, and the committee reviews the entire matter including the course of action taken, and provides its comments, which are recorded in the designated area. (Subject Exhibit 5)

9. The processing of the Workplace Violence Incident Reporting Form dated [redacted], initially followed the protocol as outlined in the [redacted] *Workplace Violence Prevention & Response Policy & Program*. After receiving the form from Facility Staff Member 1, [redacted] completed and signed the portion of the form designated for the Residential Unit Supervisor or Discipline Coordinator. (Justice Center Exhibit 6)

10. Treatment Team Leader, [redacted], completed and signed the portion of the Workplace Violence Incident Reporting Form designated for the Treatment Team Leader/Department Head. (Justice Center Exhibit 6)

11. Thereafter, the form was submitted to the facility Health and Safety Workplace Violence Office, which date stamped it on [redacted], and docketed it as Case # 13-0070-2. Despite the fact that [redacted] title was Workplace Violence Coordinator, her position was administrative and completely separate from and unrelated to, the similarly named, Health and Safety Workplace Violence Office, which had an entirely different function (security) and was in a separate building on the facility grounds. The form was also submitted to the Office of the Director of the [redacted], where it was date stamped on [redacted], as well. (Justice Center Exhibit 5)

12. On [redacted], facility Deputy Director, [redacted] reviewed Facility

[redacted]

Staff Member 1's Workplace Violence Incident Reporting Form dated [redacted]. [redacted] realized that, despite the allegations of physical abuse of a Service Recipient and verbal abuse in the presence of three Service Recipients, a mandatory OPWDD 147 Reporting Form for Reportable Incidences and Notable Occurrences (Form 147) had not been generated and that no report had been made to the Justice Center regarding the allegations. (Justice Center Exhibit 4)

13. [redacted] immediately completed a Form 147 and made appropriate notifications, including a report to the Justice Center regarding the allegations of abuse against the Service Recipients at the facility on [redacted], and abuse by the staff members who had failed to report it. (Justice Center Exhibit 11)

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 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 or neglect occurred…" (Title 14 NYCRR 700.3(f))

[redacted]

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.

[redacted]

(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 substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as 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:

[redacted]

(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

[redacted]

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.

[redacted]

(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 as 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 a prohibited act, described as "Offense 1" in the substantiated report. Specifically, the evidence did not establish that [redacted] had, during the material time, known of the allegations of abuse of Service Recipients contained in the Workplace Violence Incident Reporting Form dated [redacted], and therefore, [redacted] cannot be found to have committed an act of abuse for failing to report a reportable incident.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-16) The investigation underlying the substantiated report was conducted by OPWDD Internal Investigator, [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

[redacted] testified on her own behalf and provided four documents as evidence.

[redacted]

(Subject Exhibits 1 and 3-5)

The Justice Center's theory was, essentially, that as the Workplace Violence Coordinator, [redacted], a mandated reporter, knew, or should have known, of the allegations of abuse of Service Recipients contained in the Workplace Violence Incident Reporting Form dated [redacted], and, as such, she failed to report a reportable incident to the Justice Center.

[redacted] testified that she had never been in possession of the Workplace Violence Incident Reporting Form dated [redacted], and that it was not until sometime after [redacted] discovered the Form, in her own office on [redacted], that [redacted] had become aware of its contents. (Testimony of [redacted]; Subject)

[redacted] uncontradicted testimony was that, despite the fact that her title was Workplace Violence Coordinator, her position was administrative and completely separate from and unrelated to, the similarly named, Health and Safety Workplace Violence Office, which had an entirely different function (security) and was in a separate building on the facility grounds. (Testimony of [redacted]; Subject)

The Investigative Report states that:

> "Evidence indicates that the office of Health and Safety Workplace Violence, which coordinator [redacted] is in charge of, did receive the report in question on [redacted], as per their stamp on the such said (sic) report..." (Justice Center Exhibit 4)

However, it was clear from all of the evidence in the hearing record, that this statement is inaccurate. [redacted] was not "in charge of" the Safety office. The Justice Center relied on the fact that the Form was stamped and docketed by the Safety office, however, [redacted] did not work in the Safety office.

[redacted] testified further that, despite her job title, it was not her role to deal with the substance of Workplace Violence Incident Reporting Forms. She only received the Forms after

[redacted]

the facility Director had reviewed them, completed the fourth page Addendum and then forwarded them to [redacted], whose duty it was to present the Forms to the Workplace Violence Committee meeting for its review. (Testimony of [redacted]; Subject)

The steps outlined in the [redacted] *Workplace Violence Prevention & Response Policy & Program*, a facility document that was unknown to [redacted], corroborated [redacted] clear explanation of the steps that are followed when an employee submits a Workplace Violence Incident Reporting Form. (Testimony of [redacted]; Subject and Subject Exhibit 5)

The procedure is that, after the aggrieved employee completes the Form, (Justice Center Exhibit 5), it is brought to the employee's supervisor. After the supervisor reviews the form and completes the designated section, (Justice Center Exhibit 6), it is brought to his or her supervisor or the TTL. After that person completes the designated section on the form, (Justice Center Exhibit 6), it is sent to the Safety Office. After the Safety Office date stamps and dockets the form, (Justice Center Exhibit 5), it is sent to the Administrative Director's office. After the Director's office date stamps the form, (Justice Center Exhibit 5), the Director or Deputy Director reviews the form and completes a fourth page Addendum. After the Director or Deputy Director completes the Addendum, the whole form is sent to the Workplace Violence Coordinator [redacted], who stores the form along with any other pending Workplace Violence Incident Reporting Forms until the next Workplace Violence Committee meeting for its review. After the Workplace Violence Coordinator reads each form out loud at the Committee meeting, the Committee adds its comments to that part of the fourth page Addendum designated for that purpose. The Workplace Violence Coordinator is not required to review the contents of the forms prior to the Committee meeting and [redacted] did not do so in this case. (Testimony of [redacted]; Subject and Subject Exhibit 5)

[redacted]

A review of the Workplace Violence Incident Reporting Form discloses that there is no area on the face of it for the Workplace Violence Coordinator to sign the form. There is no evidence in the hearing record that the Workplace Violence Coordinator is to stamp the form either. It is noteworthy, then, that each person whose hands the forms pass through are required to either sign them or stamp them, but no such requirement exists for [redacted] role as the Workplace Violence Coordinator.

[redacted] uncontradicted testimony was that she did not think that the Workplace Violence Incident Reporting Form dated [redacted], was ever brought to the Workplace Violence Committee for its review. The Work Place Violence Prevention Meeting Minutes dated [redacted], disclose that on that date, which was the first meeting after [redacted] found the Form dated [redacted], 18 Workplace Violence Incident Reporting Forms were reviewed by the Committee, but not the form generated by Facility Staff Member 1 on [redacted]. (Subject Exhibit 3)

The fourth page Addendum to the Form, that the Director was supposed to complete before sending the whole form to [redacted] and the Committee, was never tendered as evidence and, apparently, was an omission that was never corrected, a fact that corroborates [redacted] testimony.

[redacted] admitted in her testimony that there are some occasions when she would become aware of the existence of Workplace Violence Incident Reporting Forms, before they would come to her through the Director's office. [redacted] testified that if an employee inquired of her as to the status of a form that the employee had submitted, [redacted] would approach the facility Health and Safety Workplace Violence Office about it. However, [redacted] testified that no such inquiry was made by Facility Staff Member 1 regarding the

[redacted]

Workplace Violence Incident Reporting Form dated [redacted]. (Testimony of [redacted]; Subject)

The Justice Center's strongest evidence was that in the [redacted], interrogation of Developmental Assistant II, [redacted], he said that he gave Workplace Violence Incident Reporting Forms to [redacted], after he signed them. When asked about workplace violence protocols, [redacted] responded,

> "... When a staff fills out a workplace form... I will record it, review it, write onto it, sign my name off to it, and then turn it over to, to safety and also to personnel -- not personnel, to the workplace violence - - [redacted]." (Justice Center Exhibits 12 and 15)

[redacted] was unable to name [redacted] position and referred to her as the "head person." When prompted to remember this specific incident, [redacted] told the investigator that he went to [redacted] to discuss whether there was anything he "...should do as prevention... in a case such as this?" He said,

> "... she says, you know " Other than what you did by, you know, separating them and bringing the paperwork over here, that's it unless she... wants to proceed and go to call the police," and everything like that." (Justice Center Exhibits 12 and 15)

The investigator pointed out to [redacted] that, although he had written on the form that a Form 147 had been completed regarding the allegations of abuse of Service Recipients, there was no record of a Form 147 having been generated. He was then asked again about whether a Form 147 was filled out and [redacted] answered, "... There probably was one generated. If I wrote it here, more than likely, yes, that's the reason why I wrote it, was—was it was generated." (Justice Center Exhibits 12 and 15)

[redacted] reiterated numerous times throughout his interrogation that a Form 147 had been generated. In fact, this was untrue. There was no record of the mandatory Form 147

[redacted]

having been generated by any of the mandated reporters who had reviewed and signed the Workplace Violence Incident Reporting Form dated [redacted]. It was not until [redacted], that [redacted] completed a Form 147, some two months after the incident.

[redacted] statements incriminating [redacted] are not credited evidence. [redacted] proved himself to be unreliable by stating falsely that the Form 147 had been generated when it had not. This was a pivotal issue in his interrogation and he did not provide an accurate account. [redacted] had a strong motivation to fabricate during his interrogation to avoid culpability in order to preserve his employment and it is impossible to untangle the truth from that which he fabricated.

[redacted] hearing testimony was credible and consistent with her interrogation statements and the facility protocol as set out in the [redacted] *Workplace Violence Prevention & Response Policy & Program.*

On the question of whether [redacted], who was being interrogated as a "targeted" person, gave the Workplace Violence Incident Reporting Form dated [redacted], to [redacted], who provided hearing testimony that he did not, it is found that [redacted] did not give the form to [redacted]. His version is not only in conflict with [redacted] sworn testimony, but it is inconsistent with the facility protocol for handling these matters.

The Justice Center relied on some answers given by [redacted] in her interrogation on [redacted] to establish that [redacted] had been aware that the form dated [redacted], contained allegations constituting a reportable incident.

After she explained to [redacted], the correct protocol for the handling of Workplace Violence Incident Reporting Forms, [redacted] was asked, "... do you remember, by any chance, seeing this form before? Does it sound familiar? Does it look familiar?" [redacted] replied to

[redacted]

this with a hesitant, "Somewhat, yes." She was asked, "From whatever you can recall, what, information do you remember? Anything at all?" [redacted] responded that she had asked the Treatment Team Leader if, "... the other forms were completed about this case?" [redacted] then reiterated to [redacted] that a Workplace Violence Incident Reporting Form only went to her once it was fully completed by all designated parties and that she would not accept a form that did not have the fourth page Addendum attached and completed. (Justice Center Exhibits 13 and 15)

The Investigative Report indicates that on [redacted](sic), [redacted] approached [redacted], when she was at the facility, and [redacted] told her that she had been unable to locate a copy of the Workplace Violence Incident Reporting Form dated [redacted], or any committee meeting notes regarding the Form. The Investigative Report states that "She stated that although she remembers talking about it at some point, she does not have any actual document."

[redacted] consistently admitted that she had been aware of the existence of the Workplace Violence Incident Reporting Form, dated [redacted], prior to [redacted]. This admission, however, proves only that [redacted] knew of the form's existence, but does not establish that [redacted] had read the form or was aware that it contained allegations constituting a reportable incident.

The Justice Center relied on that part of the Form OPWDD 147 that was generated by Deputy Director, [redacted] on [redacted], that indicates, "... Also a charge of neglect should be investigated for non reporting regarding... WPV [redacted] who reviewed *or may have* reviewed complaint." (Justice Center Exhibits 13 and 15)

Although the suggestion that [redacted] should have been investigated was a legitimate

basis for looking into her conduct, the statement that "... she reviewed *or may have* reviewed..." the form establishes nothing and, therefore, is not persuasive evidence.

At the hearing, [redacted] testified regarding the contents of a letter that she authored and provided to Justice Center counsel, [redacted], dated [redacted]. The letter indicates that on [redacted], [redacted] spoke by telephone to [redacted] at the facility Safety office and to [redacted] Staff Development Specialist supervisor [redacted]. The letter further indicates that on [redacted], [redacted] spoke to administrative secretary [redacted], who had worked for [redacted] before she left the facility. (Justice Center Exhibit 17)

[redacted] and [redacted] all independently confirmed [redacted] testimony that [redacted] would receive Workplace Violence Incident Reporting Forms after they had gone from the Safety office to Administration and Administration had stamped it. [redacted] and [redacted] further indicated that [redacted] would occasionally inquire of the Safety office about Workplace Violence Incident Reporting Forms, which was also evidence consistent with [redacted] testimony. (Justice Center Exhibit 17)

In the final analysis, based on all of the evidence, it is concluded that the Justice Center has not met its burden of proving by a preponderance of the evidence that [redacted] committed the abuse alleged in the substantiated report. It was not established that [redacted] had, during the material time, become aware of the allegations of abuse and/or neglect of Service Recipients contained in the Workplace Violence Incident Reporting Form dated [redacted], and therefore, [redacted] cannot be found to have committed an act of abuse for failing to report a reportable incident. Accordingly, the substantiated allegation of abuse is hereby reversed.

[redacted]

DECISION: The request of [redacted] that the report "substantiated" on [redacted], [redacted] dated and received on [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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: April 15, 2015
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge