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 AND ORDER AFTER HEARING

Adjudication Case #: [redacted]

Held at: New York State Office Building
333 East Washington St.
Syracuse, NY
On: [redacted]

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

[redacted]
By: Terrance McGuinness, Esq.
Levene Gouldin & Thompson, LLP of counsel,
CSEA Inc.
450 Plaza Dr.
Vestal NY, 13850

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject), for physical abuse, deliberate inappropriate use of restraints and neglect against a Service Recipient. The Subject invoked an internal administrative review which was denied. An administrative hearing was then held, on [redacted], in accordance with the requirements of Social Services Law § 494 and Part 700 of 14 NYCRR.

PROCEDURAL HISTORY

The VPCR contains a substantiated report, [redacted], of physical abuse, deliberate inappropriate use of restraints and neglect by the Subject against the Service Recipient**.** The report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center). The substantiated report as against the Subject, dated [redacted], concluded that:

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian (DDSCTA), you committed acts of abuse and/or neglect when you repeatedly agitated a service recipient by requesting that he do chores not assigned to him, used an inappropriate restraint when the service recipient became upset, struck the service recipient in the nose during the restraint and failed to remove yourself when the service recipient became upset.
>
> These allegations have been SUBSTANTIATED as Category 3 physical abuse, deliberate inappropriate use of a restraint and neglect, pursuant to Social Services Law § 493. The allegations have been UNSUBSTANTIATED as rising to the level of psychological abuse. The report of this unsubstantiated finding will now be sealed pursuant to Social Services Law §§493 (3)(d) and 496 (1). *Justice Center Exhibit 1.*

An Administrative Review was conducted at the request of the Subject to amend the report and the Justice Center Administrative Appeals Unit denied the request. On [redacted], a Hearing (the Hearing) was held.

The Administrative Law Judge issued a Recommended Decision after Hearing (Recommended Decision). That Recommended Decision is rejected by the Executive Director pursuant to 14 NYCRR 700.13 and the following constitutes the Final Determination of the Executive Director under 14 NYCRR 700.13.

FACTS

At the time of the alleged abuse and neglect, the Subject was employed at the [redacted] (the Facility), which is operated by the New York State Office for People With Developmental Disabilities (OPWDD), and is a facility or provider agency subject to the jurisdiction of the Justice Center. On [redacted] the Subject was working the day shift and was the assigned one to one aide for the Service Recipient. The Subject had been taunting the Service Recipient about doing his chores, and chores that were not his that morning and saying to the Service Recipient words to the effect of "you will do ten chores if I tell you to".

While the Service Recipient was in the laundry room, performing his assigned chore, the Subject was raising his voice directing comments to the Service Recipient about finishing his chore and telling him he would do ten chores if he told him to. The Service Recipient became agitated and started to hit the dryer. The Subject then entered the laundry room and told the Service Recipient to stop hitting the dryer and touched the Service Recipient on one of his shoulders in an attempt to get him to stop hitting the dryer. The Subject and the Service Recipient became involved in a physical altercation, which resulted in the Service Recipient sustaining a bloody nose. As a result of the altercation, the Subject lost an earring, sustained scratches and had the Service Recipient's blood on his shirt and right arm. Staff Member [redacted] entered the laundry room, touched the Service Recipient on his left wrist prompting him to stop, which he complied with, while saying "I'm bleeding". [redacted]

provided the Service Recipient with paper towels for his bloody nose and the altercation ended.

The New York State Police were called and Trooper [redacted] responded to the scene and concluded that the Subject had not committed a crime.

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 physical abuse, deliberate inappropriate use of restraints and neglect.
- Pursuant to Social Services Law § 493(4), the category level that the physical abuse, deliberate inappropriate use of restraints and neglect constitutes.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in facilities and provider agencies. Social Services Law § 492(3) (c) and 493(1) and (3). Pursuant to Social Services Law § 493(3), the Justice Center determined that the initial report of physical abuse, deliberate inappropriate use of restraints and 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 the evidence that the alleged act or acts of abuse or neglect occurred …" (14 NYCRR 700.3(f))

Pursuant to Social Services Law §§ 494(1)(a)(b) and (2) and 14 NYCRR 700.13 this Final Determination of the Executive Director 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 constitutes physical abuse, deliberate inappropriate use of restraints and

neglect; and pursuant to Social Services Law § 493(4), the category level that the physical abuse constitutes.

Physical abuse of a service recipient is defined by Social Services Law § 488 (1)(a) as:

> (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.

Deliberate inappropriate use of restraints is defined by Social Services Law § 488 (1)(d) as:

> (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.

Neglect is defined by Social Services Law § 488 (1)(h) as:

> (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 committed the act or acts of physical abuse, deliberate inappropriate use of restraints and neglect alleged in the substantiated report and that such act or acts constitute the category level of physical abuse, deliberate inappropriate use of restraints and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

As is relevant to this proceeding, substantiated reports of abuse or neglect shall be categorized pursuant to Social Services Law § 493(4) (a-c). The Subject has been substantiated for a Category 3 level offense, which is abuse and/or neglect committed by a custodian, not otherwise described in categories one and two. Social Services Law § 493 states in pertinent part:

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;
>
> (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.

If the Justice Center proves the alleged physical abuse, deliberate inappropriate use of restraints and neglect, the report will not be amended and sealed. Pursuant to Social Services Law § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of physical abuse, deliberate inappropriate use of restraints and neglect cited in the substantiated report constitutes Category 3 level offenses, as set forth in the substantiated report.

If the Justice Center did not prove the physical abuse, deliberate inappropriate use of restraints and neglect abuse by a preponderance of evidence, the substantiated report must be amended and sealed.

THE HEARING

The Justice Center called one witness, [redacted], the Justice Center investigator who conducted the investigation into the subject incident, and offered thirteen exhibits which were admitted into evidence. *Justice Center Exhibit 13* is a CD which contains recorded statements of the Subject, the Service Recipient and another resident (Resident A) of the Facility obtained during the course of the investigation. The Subject testified and

offered six exhibits which were admitted into evidence (*Subject Exhibit F* is identical to J*ustice Center Exhibit 13)*. [redacted] also testified on the Subject's behalf.

The Service Recipient, at the time of the incident, was a thirty-nine year old man, with a history of traumatic brain injury, self- injurious and assaultive behavior. *Justice Center Exhibits 9 and 10.*

[redacted] testified regarding the Service Recipient's Comprehensive Functional Assessment (*Justice Center Exhibit 9)* and Behavioral Support Program (*Justice Center Exhibit 10)*, noting that the Service Recipient lacked control over behaviors, exhibited inappropriate social behaviors and had assaultive behaviors. He testified that he interviewed the Service Recipient on [redacted], two days following the incident. The Service Recipient stated that he was being told to do chores, by the Subject, which were not his chores and that, while he was fine with his chore, which was house laundry, he did not want to do other chores. He became angry and began to hit the dryer. He was then hit in the nose by the Subject, while in the laundry room. [redacted] testified that when the Service Recipient began to hit the dryer, the Subject was in the doorway to the laundry room. The Subject then fully entered the laundry room, the door closed behind him and he hit the Service recipient in the nose during the physical altercation. At the time of the incident there was no one else in the vicinity of the laundry room. [redacted] was the closest to the laundry room, however he was in the hallway seated at a desk, which he marked on *Subject Exhibit A.* [redacted] also spoke to New York State Trooper [redacted], who responded to the scene. Trooper [redacted] indicated that the Subject and the Service Recipient were in an altercation, hitting each other, so that no crime was committed; that both men were right handed, the Service Recipient had a brace on his left leg at the time and had decreased mobility and that the blood on the Subject's arm came from the Service Recipient's

nose. Trooper [redacted] also came to the conclusion that the Subject was trying to protect himself so that no crime was committed. *Subject Exhibit E.*

[redacted] testified that the Subject had the Service Recipient's blood on his right forearm/elbow area and on his shirt. He also testified that the Subject was struck on the left side of his head and lost an earring, but that the Subject was not bleeding following the incident.

According to [redacted] the Service Recipient did not have any history of bloody noses. *Justice Center Exhibits 9 and 10.*

[redacted] testified that the Subject told him that he did not know how the Service Recipient sustained a bloody nose and denied striking the Service Recipient's nose in any way.

[redacted] testified that it was inappropriate for the Subject to enter the laundry room when the Service Recipient was punching the dryer as the Subject was the target of the Service Recipient's aggression. [redacted] also testified that although it would have been appropriate to restrain the Service Recipient if the Subject was hit by him, he should have used de-escalation techniques first and that since the Subject was the target of the Service Recipeint's frustration, the Subject should have removed himself from the situation. Finally, [redacted] opined that the Subjects version of events was not persuasive, in part because, since both men were right handed, it would only make sense that if the Service Recipient was punching the Subject as described by the Subject, the Subject would have put up his left arm to block the punch, not his right.

On cross-examination [redacted] stated that the Service Recipient was unclear as to some of the specifics of the incident and it was appropriate to ask him leading questions and to ask him for descriptions of individuals for identification purposes given the Service Recipient's behaviors.

Resident A gave a recorded statement to [redacted] on [redacted], on week following the incident. Resident A was in the dining room at the time of the incident and was not able to see in the laundry room, but could hear what was occurring in the laundry room. Resident A stated that earlier in the morning of [redacted] the Service Recipient was upset because the Subject was asking him to do chores and the Subject was angry with the Service Recipient. While in the laundry room, Resident A heard the Subject yelling at the Service Recipient in a deep voice and the Subject sounded "really angry". *Justice Center Exhibit 13.*

The Service Recipient gave a recorded statement to [redacted] on [redacted], two days following the incident. He stated that he was punched in the nose by the Subject who was his one to one staff at the time of the incident. Prior to the incident the Subject was directing him to perform a chore involving the tables, which was not the Service Recipient's chore that day, and the Service Recipient replied that he would not do that chore, but would only do his assigned chore. The Subject then said words to the effect of "if I tell you to do ten chores, you will do ten chores" to which the Service Recipient again replied he would only do his chore. The Service Recipient then went into the laundry room, took towels out of a dryer and folded them. Essentially, the Service Recipient said that in the laundry room, the Subject was asking him why he was assaultive to other specified service recipient's and the Service Recipient stated that the individuals were his friends and he was punched in the nose by the Subject, specifically, the Subject was standing up and came down with his weight and said "wham". He denied that he was angry in the laundry room, that he punched a dryer and that he punched the Subject. *Justice Center Exhibit 13.*

[redacted] testified at the Hearing, in relevant part, as follows:

Prior to the incident the Service Recipient was fine. The incident occurred in the laundry room and at the time of the incident he was in the hallway between the storage room and the laundry room. From his vantage point he could see the laundry room and the dining area, where Resident A was yelling and he could also see the door of his one to one service recipient who he was responsible for. While he was able to see the laundry room, he was also monitoring what was occurring in the dining room and the door of his one to one service recipient. The door to the laundry room was propped opened by the Subject. The Service Recipient was to the Subject's left, taking towels out of the dyer, and did not appear agitated and the Subject was not speaking to the Service Recipient. The Subject stopped and said words to the effect of "I am not doing this anymore", to which the Subject responded "there are only two or three left, finish up." According to [redacted] the Subject's voice was not raised. The Service Recipient then punched the dryer at least two times, the Subject prompted him to stop and entered the laundry room while the door to the laundry room closed. [redacted] then looked towards the dining area and looked at the door to his one to one service recipient, then looked and through the window of the laundry room, saw that the Service Recipient had the Subject bent backwards up against a table, next to the dryer and was punching the Subject in the side of the head, while the Subject's right arm was in front of his face. [redacted] went into the laundry room, put his hand on the Service Recipient's arm and said "stop", at which point the Service Recipient did stop, backed up and said that he was bleeding. [redacted] observed blood from the Service Recipient's nose and saw blood on the Subject's right arm and shirt. He provided paper towels to the Service Recipient. Neither the Subject or [redacted] pushed the blue dot (a device used to summon help in emergent situations), but other staff did respond to the laundry room. [redacted] provided a supporting deposition to Trooper [redacted]. *Subject Exhibit C.*

The Subject testified at the Hearing, in relevant part, as follows:

On the date of the incident he was assigned as the one to one staff for the Service Recipient. At the time of the incident the Service Recipient was in the laundry room performing his assigned chore. The Subject was just inside the door to the laundry room, with his foot propping open the door so it would not close. No one else was in the laundry room at the time. [redacted] was standing in the hallway between the laundry room and the storage room and the Subject and [redacted] were conversing, although they were both also monitoring a situation in the dining room involving Resident A. The Service Recipient was not agitated prior to the time of the incident. While the Service Recipient was doing the laundry, the Subject said words to the effect of "lets finish up the chore" and the Service Recipient replied that he "did not want to do this anymore". The Subject prompted the Service Recipient to complete the chore and the Service Recipient said "no" and began punching a dryer. He asked the Service Recipient to stop punching the dryer, and fully entered the laundry room, which allowed the door to shut, and touched the Service Recipient on the back of his shoulder, at which point the Service Recipient spun around and pushed the Subject up against a table, while attempting to punch the Subject, while his back was up against the table and he was still standing. The Subject had his right arm in front of his face, while his left arm was deflecting punches. He did not engage his blue dot and he does not remember which arm the Service Recipient was punching with, although he was hit on his left ear and lost an earring. [redacted] entered the laundry room, asked the Service recipient to stop, which he did while stating that he was bleeding. The Subject had the Service Recipient's blood on his right forearm and on his shirt in the upper chest area. The Service Recipient sustained a bloody nose. The Subject denied punching the Service Recipient in the nose, denied hitting the Service Recipient in the nose with his right forearm and denied directing

the Service Recipient to do another chore. He testified that if the Service Recipient is engaged in self-injurious behavior, he cannot be left alone. He further testified that the Service Recipient has a history of nose bleeding, that he gets them "all the time" and that they are spontaneous. He could not however explain why this history of nose bleeding is not documented anywhere in *Justice Center Exhibits 9 and 10,* or elsewhere. Finally, the Subject gave a supporting deposition to Trooper [redacted], in which he states he did not "know how [the Service Recipient] received the bloody nose." *Subject Exhibit D.*

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a) and neglect, as defined in Social Services Law § 488(1)(h) against the Service Recipient and that the physical abuse and neglect are properly categorized as Category 3 offenses under Social Services Law § 493(4)(c). The Justice Center has failed to establish by a preponderance of evidence that the Subject committed deliberate inappropriate use of restraints, as defined in Social Services Law § 488(1)(d) against the Service Recipient.

Physical Abuse

The Subject and the Service Recipient were the only individuals in the laundry room at the time of the incident. The Service Recipient, although somewhat inconsistent and unclear in aspects of the incident, was clear as to the core allegations of physical abuse in the report, specifically, that the Subject struck the Service Recipient in the nose. The Service Recipient did in fact sustain a bloody nose, and it has been established that the Service Recipient's blood was on the right dominant arm of the Subject and on the Subject's shirt.

Moreover, Resident A stated that earlier in the morning of [redacted] the Service Recipient was upset because the Subject was asking him to do chores and the Subject was angry with the Service Recipient. Resident A heard the Subject yelling at the Service Recipient in a deep voice and the Subject sounded "really angry" while in the laundry room. *Justice Center Exhibit 13.* Additionally, according to the Service Recipient, prior to the incident the Subject was directing him to perform a chore involving the tables, which was not the Service Recipient's chore that day, and the Service Recipient replied that he would not do that chore, but would only do his assigned chore. The Subject then said words to the effect of "if I tell you to do ten chores, you will do ten chores" to which the Service Recipient again replied he would only do his chore. The Service Recipient said that in the laundry room, the Subject was asking him why he was assaultive to other specified service recipient's and the Service Recipient stated that the individuals were his friends and he was punched in the nose by the Subject, specifically, the Subject was standing up and came down with his weight and said "wham". *Justice Center Exhibit 13.*

These statements of the Subject constitute reliable evidence. They are consistent with the Service Recipient's statement that the Subject struck him in the nose, with the uncontroverted facts that the Service Recipient sustained a bloody nose, while alone in a room with the Subject and that the Service Recipient's blood was on the Subject's right arm and shirt, and they also demonstrate in a reliable fashion, the conduct, and the mind-set of the Subject both prior to and during the incident.

Additionally, while there was some dispute during the Hearing as to the locations of both the Subject and [redacted], just prior to the incident, it was uncontroverted that at the time the Subject entered the laundry room and the door closed, [redacted] then looked towards the dining

area and looked at the door to his one to one service recipient, before claiming he looked through the window of the laundry room and saw that the Service Recipient had the Subject bent backwards up against a table, next to the dryer. *Hearing Testimony of* [redacted] Even according to the Subject, just prior to the incident [redacted] was standing in the hallway between the laundry room and the storage room and the Subject and [redacted] were conversing, although they were both also monitoring a situation in the dining room involving Resident A. *Hearing Testimony of Subject.* Accordingly, [redacted] was clearly distracted during a critical point in time and not in a position to see the operative facts of what happened in its entirety once the Subject entered the laundry room and the door closed. It is also relevant that neither the Subject or [redacted] pushed the blue dot (a device used to summon help in emergent situations), but other staff did respond to the laundry room. *Hearing Testimony of* [redacted] *and the Subject.*

Finally, during the Subject's recorded statement to [redacted], he repeatedly disavowed any knowledge of how the Service Recipient sustained a bloody nose, even stating words to the effect of he "did not do anything to the [Service Recipient's] nose" while denying that he caused it. *Justice Center Exhibit 13.* However, in attempting to explain how the Service Recipient sustained the bloody nose the Subject testified that the Service Recipient has a history of nose bleeding, that he gets them "all the time" and that they are spontaneous. He could not however explain why this history of nose bleeding is not documented anywhere in *Justice Center Exhibits 9 and 10,* or elsewhere. *Justice Center Exhibit 9*, although apparently updated [redacted], documents in an exhaustive fashion the Service Recipient's medical history well prior to the incident and there is no mention of nose bleeds. This is also the case with *Justice Center Exhibit 10.* In addition there was no proof offered in any form, during the Hearing that the

Service Recipient had bloody noses "all the time" and that they were spontaneous. It is simply not plausible that such a history would not be documented in some form or that someone else at the Facility would have knowledge of a chronic pattern of spontaneous bleeding. All of these statements and evidence cast considerable doubt on the reliability of the Subject's account of the incident and impeach his credibility relative to his denial of the core allegations of physical abuse in the report, specifically, that the Subject struck the Service Recipient in the nose.

These statements, coupled with the Service Recipient's clear statement as to the core allegations of physical abuse in the report, specifically, that the Subject struck the Service Recipient in the nose and other evidence adduced at the Hearing, including that the Service Recipient did in fact sustain a bloody nose, and that the Service Recipient's blood was on the right arm of the Subject and on the Subject's shirt, among other proof, establish by a preponderance of the evidence, the Subject's alleged physical abuse contained in the substantiated report. *Justice Center Exhibit 1.*

Finally, physical abuse, in relevant part, is defined by Social Services Law § 488(1)(a) as "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".

Here, it is clear from the record that the Subject intentionally or recklessly caused, by physical contact physical injury to the Service Recipient and caused the likelihood of physical

injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Clearly, the Subject struck the Service Recipient in the nose, and the Service Recipient did in fact sustain a bloody nose. Moreover, this conduct on the part of the Subject, given the Service Recipient's history of physically aggressive behavior caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. *Justice Center Exhibits 9 and 10.*

Although Social Services Law § 488(1)(a) also contains the clause "[p]hysical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person", the Subject did not urge this theory of the case and the Subject always denied striking the Service Recipient in the nose and repeatedly disavowed any knowledge of how the Service Recipient sustained a bloody nose, even stating words to the effect of he "did not do anything to the [Service Recipient's] nose". *Hearing Testimony of the Subject and Justice Center Exhibit 13.* Clearly, one cannot disclaim knowledge of an act and deny the act, and at the same time claim the act was necessary to protect the safety of a person.

Not only has the Justice Center established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a), against the Service Recipient, but it has also established that the physical abuse is properly categorized as a Category 3 offense under Social Services law § 493(4)(c).

Neglect

The Subject has been shown by a preponderance of the evidence to have committed neglect against the Service Recipient for agitating him by requesting he perform chores which were not his. The Service Recipient stated that prior to the incident the Subject was directing him to perform a chore involving the tables, which was not the Service Recipient's chore that day,

and the Service Recipient replied that he would not do that chore, but would only do his assigned chore. The Subject then said words to the effect of "if I tell you to do ten chores, you will do ten chores" to which the Service Recipient again replied he would only do his chore. *Justice Center Exhibit 13*. Moreover Resident A stated that earlier in the morning of [redacted] the Service Recipient was upset because the Subject was asking him to do chores and the Subject was angry with the Service Recipient. Resident A heard the Subject yelling at the Service Recipient in a deep voice and the Subject sounded "really angry", while in the laundry room. *Justice Center Exhibit 13.* These statements attributed to the Subject in conjunction with the conditions under which they were made underscore their reliability. They also demonstrate in a reliable fashion, the conduct, and the mind-set of the Subject both prior to and during the incident.

These statements of the Subject also support and are consistent with [redacted] opinion that the Subject was the target of the Service Recipient's frustration on the day of the incident. While the Subject denied this occurred, his statements above and the Service Recipient's conduct during the incident all contradict his denial. Both the Subject and [redacted] testified that during the incident in the laundry room, [redacted] was immediately able to get the Service Recipient to disengage from the physical altercation, with minimal effort. This supports the Service Recipient's and Resident A's account of the day, specifically that the Subject was agitating the Service Recipient by requesting that he perform chores which were not his. Clearly, directing language to the effect of "if I tell you to do ten chores, you will do ten chores" at the Service Recipient and directing anger at the Service Recipient by yelling at the Service Recipient in a deep voice which evidenced being "really angry" breached his duty as a custodian to the Service Recipient.

Neglect is defined in Social Services Law § 488(1)(h), in relevant part as, " 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". Clearly, acting in this manner towards, any service recipient, breaches a custodian's duty, but directing this language, given the Service Recipient's behaviors and challenges identified in *Justice Center Exhibits 9 and 10*, was clearly, at the very least, likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, and may have actually precipitated the entire chain of events that day which resulted in the Service Recipient sustaining a bloody nose.

Accordingly, the Justice Center has established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h) against the Service Recipient. Finally, given the above, not only has the Justice Center established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h), against the Service Recipient, but it has also established that the neglect is properly categorized as a Category 3 offense under Social Services law § 493(4)(c).

Deliberate Inappropriate Use of Restraints

The Justice Center has failed to establish by a preponderance of evidence that the Subject committed deliberate inappropriate use of restraints, as defined in Social Services Law § 488(1)(d) against the Service Recipient.

The Justice Center's theory relative to the allegation of deliberate inappropriate use of restraints, appears to be that prior to the physical altercation in the laundry room the Subject did not follow SCIP-R protocols and that when the Service Recipient became agitated the Subject should have used de-escalation techniques, remove himself and get another staff member to take

over or engage his blue dot. On the present record, as set forth above, there is simply insufficient proof to conclude that the Subject committed deliberate inappropriate use of restraints, as defined in Social Services Law § 488(1)(d) against the Service Recipient.

The Administrative Law Judge in the Recommended Decision, recommended that this case be unsubstantiated as to the allegations of physical abuse, deliberate inappropriate use of restraints and neglect, essentially based on two grounds: 1) The Justice Center did not established by a preponderance of evidence that the Subject committed physical abuse, deliberate inappropriate use of restraints and neglect, against the Service Recipient and 2) that the recorded statements were hearsay. As this Final Determination and Order after Hearing, also concludes that the allegation of deliberate inappropriate use of restraints was not established by a preponderance of the evidence, only the allegations of physical abuse and neglect will be discussed.

The portion of the Recommended Decision based on the failure of the Justice Center to establish the physical abuse and neglect by a preponderance of the evidence was largely based on the fact that the Service Recipient's recorded statement, alone, was not enough to substantiate the allegations. This was based on the hearsay nature of the recorded statement and that the Service recipient was asked leading questions and was inaccurate as to some details.

While it is true that the Service Recipient was somewhat inconsistent and unclear in aspects of the incident, he was clear as to the core allegations of physical abuse in the report, specifically, that the Subject struck the Service Recipient in the nose. Additionally, as set forth above, other reliable proof established that the Service Recipient did in fact sustain a bloody nose, and that the Service Recipient's blood was on the right arm of the Subject and on the Subject's shirt.

Additionally, the Recommended Decision, found the Subject's version of events to be plausible, and specifically rejected the Justice Center's impeachment of the Subject's claim that the Service Recipient had a history of bloody noses, some of which were spontaneous, specifically stating, "[t]he CFA admitted into evidence is dated [redacted], five months after the incident. Medical conditions change so the fact that it is not written on a CFA completed after the incident is not sufficient proof to cast doubts on the Subject's credibility".

However, as set forth above the Subject could not explain why this history of nose bleeding is not documented anywhere in *Justice Center Exhibits 9 and 10,* or elsewhere. *Justice Center Exhibit 9*, although apparently updated in [redacted], documents in an exhaustive fashion the Service Recipient's medical history well prior to the incident and there is no mention of nose bleeds. This is also the case with *Justice Center Exhibit 10.* In addition there was no proof offered in any form, during the Hearing that the Service Recipient had bloody noses "all the time" and that they were spontaneous. It is simply not plausible that such a history would not be documented in some form or that someone else at the Facility would have knowledge of a chronic pattern of spontaneous bleeding, and the Subject's credibility was in fact impeached by this complete lack of support for his explanation of the bloody nose. Additionally, as set forth above, there was ample proof to establish, by a preponderance of the evidence, the neglect allegations in the substantiated report.

Finally, hearsay is admissible in administrative proceedings and hearsay evidence can form the basis of an administrative determination. *Gray v. Adduci*, 73 N.Y.2d 741 (1988). Here, for the reasons set forth above, the evidence offered by the Justice Center and admitted into evidence, were sufficiently relevant and probative to establish, by a preponderance of the

evidence, that the Subject committed physical abuse and neglect and that such physical abuse and neglect are properly set at Category 3.

Accordingly, based on the foregoing it is hereby:

ORDERED: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is granted in part and denied in part. The Subject has been shown by a preponderance of the evidence to have committed physical abuse and neglect.

The substantiated report for physical abuse and neglect are properly categorized as Category 3 physical abuse and neglect.

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).

The request of [redacted] that the substantiated report dated [redacted] be amended and sealed with respect to the report related to deliberate inappropriate use of restraints is granted. The Subject has not been shown by a preponderance of the evidence to have committed deliberate inappropriate use of restraints.

This decision is ordered by Davin Robinson, Chief of Staff, who has been designated by the Executive Director to make such decisions.

DATED: September 16, 2015
Delmar, New York

_____
Davin Robinson
Chief of Staff

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: Diane Herrmann
Administrative Law Judge

Held at: New York State Office Building
333 East Washington St.
Syracuse, NY
On: [redacted]

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

[redacted]
By: Terrance McGuiness, Esq.
Levene Gouldin & Thompson, LLP of counsel,
CSEA Inc.
450 Plaza Dr.
Vestal NY, 13850

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, [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] the Subject committed acts of abuse and/or neglect when he repeatedly agitated a service recipient by requesting that he do chores not assigned to him, used an inappropriate restraint when the service recipient became upset, struck the service recipient in the nose during the restraint and failed to remove himself when the service recipient became upset.

3. The Justice Center substantiated the actions as a Category 3 offense 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 DSCDA at [redacted]

[redacted] a facility run by OPWDD, which is an Agency or Provider that is subject to the jurisdiction of the Justice Center.

6. On [redacted] the Subject was working the day shift and was assigned to be the one/one aide for service recipient [redacted] (SR [redacted])

7. SR [redacted] was in the laundry room doing his assigned chore when he became agitated and hit the dryer several times.

8. The Subject entered the laundry room to find out what was wrong and told SR [redacted] he should just finish his chore because he only had a few more towels to fold.

9. SR [redacted] hit the Subject and the Subject raised his arms to protect his face. SR [redacted] continued to hit the Subject.

10. Employee [redacted] entered the laundry room and used a touch control and SR [redacted] stopped hitting the Subject.

11. As a result of the altercation the Subject lost an earring and had cuts and scratches on his neck and SR [redacted] had a bloody nose.

12. The New York State police were called and Trooper [redacted] investigated. Trooper [redacted] concluded the Subject had not committed a crime.

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 or neglect in residential care facilities. SSL § 492(3) (c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

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 level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

(a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability

who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

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

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

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

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading

a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

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

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the

category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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

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

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

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws,

regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

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

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

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

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

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

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

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

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

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

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

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

If the Justice Center proves the alleged abuse, 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 fair preponderance of evidence that the Subject abused and or neglected SR [redacted] by requesting that he do chores that he wasn't assigned, used an inappropriate restraint and hit the SR and those acts of abuse led to injury.

The Justice Center called one witness, the investigator. The investigator testified that SR [redacted] told him the Subject was bothering him and asking him to do chores that weren't his. The investigator testified that SR [redacted] told him that when he was in the laundry room the Subject punched him in the nose and that he hit him back. The investigator testified that there were no witnesses to what initially happened in the laundry room but he found SR [redacted] credible.

An interview was also conducted with SR [redacted]; he stated that the Subject was harassing SR [redacted] all day. He also said that he was in the dining room and he could hear

yelling from the laundry room. The investigator testified that SR [redacted] was very high functioning and hesitant to speak to him. The investigator testified that he found him credible because he had nothing to gain or lose by speaking to him.

On cross examination the investigator admitted that the first question he asked SR [redacted] was whether he was punched in the nose. The investigator stated that because of SR [redacted] impaired cognitive ability it was proper to use leading questions. The investigator admitted that SR [redacted] had the date, time and location of the incident incorrect. SR [redacted] was not able to identify who hit him but answered questions about the body type of the person and then a staff member sitting in on the interview started naming employees. SR [redacted] said that the second name, the Subject, was the person who hit him.

Employee [redacted] testified for the Subject. Employee [redacted] was working the same shift as the Subject and was very familiar with SR [redacted] Employee [redacted] said that SR [redacted] was explosive and had assaulted both employees and fellow service recipients. Employee [redacted] said that SR [redacted] responded to different de-escalation techniques depending on his level of agitation. On the day in question he was in the hallway with the Subject when they both heard SR [redacted] hitting the dryer. Employee [redacted] testified that the Subject went into the laundry room and he stayed in the hallway. There was a window in the doorway and after a few minutes he looked into the laundry room and saw the Subject bent over the dryer and SR [redacted] hitting him. He entered the laundry room and touched SR [redacted] on the arm and said he needed to stop and he would give him paper towels for his bloody nose. SR [redacted] stopped and he led him out of the room to get medical attention for his bloody nose.

The Subject testified in his own defense. The Subject testified that he was outside the laundry room watching SR [redacted] do his chores. He testified that he entered the laundry room

when SR [redacted] began punching the dryer. He testified that he told him he was almost done with his chores and he only had a few more towels to fold. He said SR [redacted] began hitting him and he ended up bent over the dryer as he continued to hit him. The Subject testified that he put his arms up to protect his face and did not hit the SR or throw an elbow. The Subject was adamant that he was in a defensive posture the entire time.

The Subject testified that employee [redacted] entered the laundry room and used touch control and SR [redacted] stopped hitting him. The Subject testified that as a result of being hit he lost an earring and that he had scratches and bruising around his ear.

The substantiated charge against the subject consisted of three parts; the Subject agitated SR [redacted] by requesting he do chores not assigned to him, used an inappropriate restraint when the SR became upset, and struck the SR in the nose. The Justice Center failed to substantiate any of these allegations.

The only testimony regarding the Subject asking SR [redacted] to do chores that were not assigned to him came from SR [redacted] SR [redacted] said that the Subject was bothering him to do chores that weren't his assigned chores. SR [redacted] said this happened in the laundry room and it was clear from the testimony that laundry was SR [redacted] assigned chore. SR [redacted] made a comment that the Subject had agitated the SR earlier in the day but he did not say he heard the Subject ask SR [redacted] to do chores he was not assigned.

The investigator said the inappropriate restraint charge resulted from the Subject's actions when SR [redacted] became agitated. The investigator testified that you can have an inappropriate restraint without a restraint when you don't follow SCIP protocols. The investigator testified that SR [redacted] was agitated and the Subject should have: either used de-escalation techniques or remove himself and get another staff member to take over. The Subject

testified that when he went in the laundry room he was not aware that SR [redacted] was angry at him until he was bent over the dryer and getting hit. The Subject did not have an opportunity to remove himself before he got hit, or to use any de-escalation techniques. In addition the Subject was the one/one aide assigned to SR [redacted] When the SR [redacted] hit the dryer it was the Subject's responsibility to enter the laundry room and check on him.

The only individual who said the Subject hit SR [redacted] was the SR [redacted] 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.

SR [redacted] statement alone is not enough to substantiate the allegations. The interview with SR [redacted] is questionable because the investigator began by asking a leading question. SR [redacted] had every single detail incorrect and needed to be provided the name of the person who is alleged to have hit him.

All that is clear is that there was an altercation in the laundry room; a witness saw SR [redacted] hit the Subject and both parties suffered minor injuries. SR [redacted] was agitated and

has a history of attacking staff and fellow SR's. The Subjects explanation of the events was plausible, a witness saw SR [redacted] hitting him and he suffered injuries consistent with his version of the incident.

The Justice Center argued that the Subject was not credible because he was evasive when questioned and at the hearing he testified that he was standing in the hallway outside the laundry room. The Justice Center requested an adjournment to bring in an employee in to testify that the Subject was sitting in the hallway and that request was denied. The proposed witness did not witness the events in the laundry room but stated the Subject was sitting in the hallway. The witness's written statement was admitted into evidence. Whether the Subject was standing or sitting in the hallway was a minor point. The incident happened almost a year ago, whether the Subject was incorrect when he said he was standing was not enough to cast doubt on his entire testimony. The Subject was not asked in his initial interrogation whether he was sitting or standing, further proof that it was a minor point that would not undermine his credibility.

The Justice Center also questioned the Subjects veracity because he testified SR [redacted] had a history of bloody noses and this was not listed on the Comprehensive Functionality Assessment. The CFA admitted into evidence is dated [redacted], five months after the incident. Medical conditions change so the fact that it is not written on a CFA completed after the incident is not sufficient proof to cast doubts on the Subject's credibility.

Accordingly, it is determined that the Agency has not met its burden of proving by a preponderance of the evidence that the Subject committed abuse alleged. The substantiated report will be amended or sealed.

DECISION: The request of that the substantiated report [redacted]

[redacted], are amended and sealed is granted.

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

DATED:

Schenectady, New York

Diane Herrmann, ALJ