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
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Todd Sardella, Esq.

[redacted]

[redacted]

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

ORDERED: The request of [redacted] that the allegations "substantiated" on [redacted], [redacted], dated and received on [redacted] be amended and sealed is granted in part and denied in part, it is denied as to Offenses 1 and 3. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The request of [redacted] that the allegations "substantiated" on [redacted], [redacted], dated and received on [redacted] be amended and sealed is granted as to Offense 2. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated allegations are properly categorized as Category 2 acts.

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

[redacted]

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

DATED: Schenectady, New York
December 31, 2015

David Molik
Administrative Hearings Unit

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

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

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
333 East Washington Street, Room 522
Syracuse, New York 13202
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
Appearance Waived

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

[redacted]

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or neglect. The Subject requested that the 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 which resulted in three substantiated allegations (Offenses 1-3), "substantiated" on [redacted], dated and received on [redacted] of abuse and/or neglect by the Subject of a Service Recipient.

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

Offense 1

It was alleged that on [redacted], and thereafter, at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you failed to report a reportable incident upon discovery, after it was reported to you by another staff member that a particular service recipient had accused another service recipient of unwanted sexual conduct, and that four additional service recipients had made similar complaints of sexual misconduct by this same service recipient and another service recipient.

This allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493.

Offense 2

It was alleged that on [redacted], and thereafter, at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable

[redacted]

incidents) when, upon receiving the report of the sexual conduct described in Offense 1, you took actions, in contravention of governing state agency regulations, policy or procures, that impeded the reporting and investigation of the incident by failing to report it to the Justice Center and instead conducting what purported to be your own "investigation" of the incident, and then making false statements to Justice Center investigators during their investigation of the report.

This allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493.

Offense 3

It was alleged that on [redacted], and thereafter, at the [redacted], located at [redacted] while acting as a custodian, you committed neglect when you failed to take any protective measures after receiving a report of a reportable incident alleging sexual misconduct by two service recipients towards five other service recipients.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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

4. The facility, [redacted], located at [redacted], is a voluntary in-patient substance abuse treatment facility, and is operated by the Office of Alcoholism and Substance Abuse Services, OASAS, which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. The facility serves persons with substance abuse issues.

5. At the time of the alleged abuse and/or neglect, the Subject was employed at the [redacted]. The Subject had for several years served in the capacity of facility director. The Subject was a mandated reporter of abuse and/or neglect.

6. At the time of the alleged abuse and/or neglect, the five Service Recipients were adult male residents of the [redacted] facility. The Service Recipients had been patients/residents at the facility for varying lengths of time.

7. OASAS facility directors were directed to participate in the webinar on reporting to the VPCR, which was held on [redacted] During the webinar OASAS counsel provided a "report everything" directive and OASAS counsel took the position during training that "everything should be reported to the VPCR, including events such as Emergency Room visits and voluntary discharges." (Justice Center Exhibit 8 and hearing testimony of OASAS [redacted]) During the webinar training session the term "reasonable cause" was not defined and no reference to the Justice Center website definition of "reasonable cause" was provided to participants in the training. (Hearing testimony of OASAS [redacted])

8. On [redacted], sometime after 6:00 p.m. and before 7:30 p.m., the two alleged perpetrators, Service Recipients, arrived at the [redacted]. [redacted] staff member [redacted] processed the new patients when they arrived after hours. [redacted] has no private rooms and there was concern about whether the two alleged perpetrators, who were transgender, should room separate from one another, or should be assigned to a room together.

9. During the processing, staff [redacted] sorted through the luggage of the new patients and it became obvious that they were together, as each had items of paraphernalia and clothing belonging to the other, in their respective suitcases. Staff [redacted] thought that the two should not share a room and ultimately, after consultation with a supervisor, the decision was made to assign one of them to a room with a different roommate, and the other one to a bed in the medical wing, because a second room was unavailable. (Hearing testimony of OASAS employee [redacted]) Sometime after admission, on the evening of [redacted], the two new patients sexually harassed, sexually solicited, and engaged in sexual touching of other Service Recipients at [redacted]. (Justice Center Exhibits 3-7)

10. Sometime before staff [redacted] shift ended at 11 p.m., on the evening of [redacted], Service Recipient 1 approached staff [redacted] and alleged that he had been "touched" or "harassed" by one of the two transgender residents. At about the same time, or shortly thereafter, four more Service Recipients approached staff [redacted] and complained of sexually harassing behavior toward them by the transgender residents. The alleged behavior included sexual propositioning and watching some of the Service Recipients use the bathroom. Service Recipient 1 ultimately alleged that one of the perpetrators had touched his genitals over his clothing. (Justice Center Exhibit 3)

11. Staff [redacted] took the five Service Recipients to a conference room at the opposite end of the facility and asked them to create a written record to document what they had experienced. Each Service Recipient wrote a statement and, while doing so, there was no discussion of the incidents among the group. This process took approximately 15-20 minutes. (Justice Center Exhibits 3-7 and hearing testimony of OASAS employee [redacted])

12. At 11:15 p.m. on [redacted], staff [redacted], sent a "read receipt" email explaining this situation to the Subject. Staff [redacted] placed the written statements in the Subject's internal facility mailbox. (Justice Center Exhibit 12) The Subject read the email at approximately 8 a.m. on the morning of [redacted] and the Subject's secretary retrieved the statements from the internal facility mailbox as well. (Hearing testimony of OASAS employee [redacted].)

13. On the morning of [redacted], Service Recipient 1 approached [redacted] clinical supervisor, [redacted]. Service Recipient 1 stated that he had received no update on his complaint and wanted a meeting with the Subject. [redacted] facilitated a morning meeting between the Subject and Service Recipient 1. [redacted] was present at the

meeting. During the meeting, Service Recipient 1 provided details of the allegations. The Subject stated that they (the Subject and), would view the video and get back to the Service Recipient that same day. (Recorded audio interview with ALJ Exhibit 1)

14. The Subject and met again with Service Recipient 1 during the afternoon of . During this meeting, the Subject and told Service Recipient 1 that they had viewed the video, and that the video was not consistent with Service Recipient 1's allegation, primarily because of their interpretation of Service Recipient 1's body language. (Recorded audio interview with ALJ Exhibit 1)

15. Service Recipient 1 self-discharged from the facility on (Justice Center Exhibit 10: clinical discharge, hearing testimony of Justice Center Investigator , and hearing testimony of the Subject)

16. Previous to these allegations, there had been unfounded complaints of a similar nature lodged against transgender persons. Finding placement for an emergency discharge for Service Recipients from this OASAS facility was often impossible on short notice. While homeless shelters were sometimes a safe option, they were not always available. This facility has one common area, and there is no place to make an intra-facility transfer, such as another cottage or building. (Hearing testimony of OASAS employee) OASAS has no policy or procedure which prescribes the appropriate actions to be taken in instances where sexual harassment or abuse is alleged as between Service Recipients, and in particular no prescribed plan of action for separating the victim and alleged perpetrator. (Hearing testimony of OASAS)

[redacted]

ISSUES

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

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3) (c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse 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…" (Title 14 NYCRR 700.3(f))

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

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

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

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

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

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

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

the ability of a person receiving services to freely move his or her arms, legs or body.

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

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

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

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical

[redacted]

> 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.

As pertinent to this case, a reportable incident also includes conduct defined as a "significant incident," which includes, under SSL § 488((1)(i), "an incident, other than an incident of abuse or neglect, that because of the severity or the sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but not be limited to: (1) conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; . . . ."

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:
>
> (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.

[redacted]

> (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 established by a preponderance of evidence that the Subject committed prohibited acts, described as "Offenses 1 and 3" in the substantiated report, but did not establish by a preponderance of the evidence the prohibited act, described as "Offense 2." Addressing the sole question of whether the substantiated allegations constitute abuse or neglect, it is concluded that the substantiated allegations committed by the Subject constitute abuse, specifically obstruction of reports of reportable incidents, and neglect. The Category of the affirmed substantiated allegations that such acts constitute is Category 2.

In support of its substantiated allegations, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. The Justice Center also called two additional witnesses, OASAS [redacted] and OASAS

employee [redacted]

The Justice Center submitted 19 exhibits into the record. The Subject submitted two exhibits on his own behalf and the Administrative Law Judge presiding over the hearing admitted four audio recorded interviews as ALJ Exhibit 1. The Subject testified on his own behalf and provided no witnesses.

The Justice Center proved by a preponderance of the evidence, as alleged in Offense 1, that the Subject failed to report a reportable incident upon discovery, after it was reported to him by another staff member that Service Recipient 1 had accused another Service Recipient of unwanted sexual conduct, and that four additional Service Recipients had made similar complaints of sexual misconduct against the same Service Recipient and another Service Recipient.

The Justice Center further proved by a preponderance of the evidence, as alleged in Offense 3, that the Subject committed neglect, when he failed to take any protective measures after receiving a report of a reportable incident alleging sexual misconduct by two Service Recipients against five other Service Recipients. The Subject's "lack of attention" breached his duty and this was "likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition" of the five Service Recipients.

Offense 1

Where a custodian is alleged to have committed obstruction of reports of reportable incidents, based on a failure to report a reportable incident upon discovery, under SSL§ 488 (1)(f), the evidence must establish by a preponderance of evidence that:

1. The Subject is a custodian, and that;
2. The Subject failed to report a reportable incident upon discovery.

[redacted]

The uncontradicted evidence in the record establishes that the Subject is a custodian, and as a result, necessarily a mandated reporter[1] at the [redacted] facility. A mandated reporter is required to report allegations of reportable incidents to the VPCR immediately upon discovery. Where, as here, the mandated reporter does not actually witness a suspected reportable incident, discovery occurs when another person, including the vulnerable person, comes before the mandated reporter, in his or her professional or official capacity, and provides the mandated reporter with reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident. (SSL § 491(1) (b))

In this case, the Subject argued that, based upon the definition of "reasonable cause" utilized on the Justice Center's website, he did not have reason to believe that he should act upon the five Service Recipients' allegations.[2]

The Justice Center defines reasonable cause on its website:[3]

> "Reasonable cause" means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury. (See Subject Exhibit A)

"Reasonable Cause to Suspect" is not a statutorily defined term. However, it generally means a rational or sensible suspicion that a reportable incident has occurred and, conclusive evidence that an incident occurred is not required. The reasonable suspicion may be based on

[1] "Custodian," pursuant to SSL § 488 (2) "Custodian" means a director, operator, employee or volunteer of a facility or provider agency; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a facility or provider agency pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency.

[2] The Subject requested that a hard copy of the Justice Center website document referenced in foot note 4 be admitted in to evidence and same was admitted as Subject's Exhibit A.

[3] See: New York State Justice Center for the Protection of People with Special Needs, N.Y.S. Protection of People with Special Needs Act Notice To Mandated Reporters Justice Center Guidance – June 11, 2013, http://www.justicecenter.ny.gov/sites/default/files/documents/Notice_to_Mandated_Reporters_06-11-2013.pdf

the mandated reporter's observations, training and experience, and, may also be based upon a mandated reporter's disbelief of an explanation provided for an injury. Although not dispositive, the definition of "reasonable cause" contained in Criminal Procedure Law § 70.10(2), may be instructive. Under that provision, "Reasonable cause to believe that a person has committed an offense" exists when evidence or information which appears reliable discloses facts or circumstances which are collectively of such weight and persuasiveness as to convince a person of ordinary intelligence, judgment and experience that it is reasonably likely that such offense was committed and that such person committed it. Except as otherwise provided in this chapter, such apparently reliable evidence may include or consist of hearsay." NY CLS CPL § 70.10(2)

If a mandated reporter learns about an incident because a Service Recipient reports it to him or her, the mandated reporter must make some assessment of whether there is "reasonable cause" to suspect that the Service Recipient has been subjected to a reportable incident. In making such an assessment, the mandated reporter should rely on his or her "observations, training and experience" and, on some level, will have to assess the reliability of the Service Recipient's report.

Some limited inquiry may be required to make this assessment. However, what the mandated reporter may not do is conduct an investigation and decide that he or she does not believe that there is a "preponderance of the evidence" to support an allegation of abuse and/or neglect and that, therefore, the incident does not need to be reported to the VPCR. In this case, that is exactly what the Subject did.

The Subject concluded, after interviewing Service Recipient 1, that his verbal allegation was inconsistent with his written statement. (Justice Center Exhibit 3) The Subject testified that during the interview, Service Recipient 1 stated that, "... he had been approached in an

[redacted]

inappropriate sexual manner." The Subject then asked Service Recipient 1 to elaborate, and he said simply that he, "... came at me in a sexual manner..." and never during the interview did Service Recipient 1 state that his private parts had been grabbed through the clothing. This was, in the Subject's opinion, inconsistent with the written statement provided by Service Recipient 1. (Hearing testimony of Justice Center Investigator [redacted] and hearing testimony of Subject)

The Subject testified that much of the video, which he had initially viewed, had been overwritten by the time the Justice Center Investigator commenced his investigation, or at least when the Justice Center Investigator first appeared at the [redacted] facility on [redacted], approximately 7 weeks after the [redacted] call to the VPCR.[4] The Subject told the Justice Center Investigator, and also testified that, the overwritten video illustrated that Service Recipient 1 waited 15 minutes before going to the nurse's station, while he had stated that he had gone directly to the nurse's station in his written statement. (See Justice Center Exhibit 3)

Based upon the interview with Service Recipient 1, a review of surveillance video, his own analysis of Service Recipient 1's body language, and the history of false homophobic allegations, the Subject concluded that there was not "reasonable cause" to report these allegations to the Justice Center.

At the time when the Subject was presented with the written allegations of the five Service Recipients, together with the email from staff [redacted], the Subject had "reasonable cause" to make a report. The written statements made clear factual allegations of reportable incidents as defined in SSL § 488(1)(i)(1), and Service Recipient 1 clearly alleged a violation of Penal Law § 130.55. OASAS policy required that the police are notified of any allegation of sexual touching. (Hearing testimony of OASAS [redacted]) Instead of reporting the allegations, the Subject made credibility determinations and assessed body

[4] The [redacted] date was established by the Justice Center Investigator in his testimony.

language, making his own de-facto determination that there was not a preponderance of the evidence to support the allegations.

The Justice Center proved by a preponderance of the evidence that the Subject failed to report a reportable incident upon discovery, after it was reported to him by another staff member. Specifically, he failed to report that Service Recipient 1 had accused another Service Recipient of unwanted sexual conduct, and that four additional Service Recipients had made similar complaints of sexual misconduct against the same Service Recipient and another Service Recipient.

Offense 2

The Justice Center also alleged that the Subject made false statements to the Justice Center Investigator during his investigation of the report.[5] The Justice Center took the position that the Subject claimed to have done an investigation and concluded that the allegations were not credible, when in fact the investigation consisted only of a review of three relevant seconds of a surveillance video which was in total, about six minutes in length. The implication was that the Subject told the Investigator that he had conducted an investigation and review based on more video evidence than which he had actually examined, and therefore, the Subject lied to the Investigator.

Where such conduct is committed by a custodian, the evidence must establish:

1. a custodian engaged in conduct that impeded the discovery or the reporting or the investigation of the treatment of a Service Recipient

2. by doing one of the following:

- falsifying records related to the safety, treatment, or supervision of a Service Recipient; or

[5] The Justice Center attorney did not seek to have the audio interview recording of the Subject and the Investigator moved into evidence. However, the ALJ presiding over the hearing moved same into evidence as ALJ Exhibit # 1.

[redacted]

- actively persuading a mandated reporter from making a report of a reportable incident to the VPCR with the intent to suppress the reporting or the investigation of that incident; or

- intentionally making a false statement during an investigation into a reportable incident; or

- intentionally withholding material information during an investigation into a reportable incident.

On cross-examination the Investigator testified that when he interrogated the Subject, the Subject told him that he had viewed other perspectives of video surveillance, which had been "overwritten" by the time the Justice Center investigation commenced, approximately seven weeks after the call to the VPCR. However, the Justice Center Investigator also testified that another facility employee, [redacted], who was also involved in the investigation, did not mention during a recorded[6] interview ever having viewed unpreserved or lost video. The Subject testified at the hearing, and maintained during the investigation, that he and [redacted] viewed other video perspectives related to the allegations, which were overwritten and not available at the time of the Justice Center investigation.

[redacted] was interviewed by Investigator [redacted], for the first time on [redacted]. [redacted] was employed as an Addiction Counselor 3 and was also a clinical supervisor at the [redacted] facility. [redacted] was employed at the facility for 18 years. [redacted] was approached by Service Recipient 1 on the morning of [redacted], at which time the Service Recipient asked [redacted] for a meeting with the Subject on the issue of his complaint of [redacted].

[redacted] facilitated this meeting and was present. During this morning meeting Service Recipient 1 provided details of the allegations. [redacted] and the Subject stated

[6] This recorded audio interview is also captured on ALJ Exhibit 1.

[redacted]

that they would view facility surveillance video and get back to the Service Recipient that same day. The Subject and [redacted] viewed some facility surveillance video, but it was unclear from the interview whether the reviewed video was limited to the video perspective admitted into evidence at the hearing, or whether [redacted] and the Subject also viewed other video lost, or overwritten by the time the Justice Center investigation began. (Recorded audio interview with [redacted] ALJ Exhibit 1)

On [redacted], [redacted] was interviewed a second time by Investigator [redacted] During the second interview [redacted] was shown the video[7] which was ultimately admitted into evidence at the hearing. (ALJ Exhibit 1 and hearing testimony of [redacted]) During the interview [redacted] acknowledged that she had watched this video with the Subject. However, it is unclear from the recorded interview whether the video which was reviewed by [redacted] and the Subject was limited to the video perspective admitted into evidence at the hearing, or whether [redacted] also claimed that she and the Subject viewed other video lost, or overwritten, by the time the Justice Center investigation began. (Recorded audio interview with [redacted] ALJ Exhibit 1)

The Justice Center did not establish by a preponderance of the evidence that the Subject committed abuse by making false statements to the Justice Center investigator during the investigation of the report, as alleged in "Offense 2." There is no evidence in the record that the only video used by the Subject is the video which was admitted as an exhibit. Therefore, there is no basis to establish that the subject lied.

Offense 3

[7] See Justice Center Exhibit 17

[redacted]

The Subject argued that he had no options for protecting the Service Recipients from the alleged perpetrators. The uncontroverted evidence in the record was that OASAS has no policy or procedure which addresses the appropriate actions to be taken in instances where sexual harassment or abuse is alleged as between Service Recipients. In particular, there exists no prescribed plan of action for separating the potential victim and perpetrator. (Hearing testimony of OASAS [redacted])

Finding placement for an emergency discharge from this OASAS facility is difficult, and while the best option might be a homeless shelter, these shelters are not always available. The [redacted] facility has one common area, and there is no "safe" location in which to make an intra-facility transfer. (Hearing testimony of OASAS employee [redacted])

The [redacted] of OASAS testified that discharging a perpetrator to "the street" was not a safe discharge and stated that, "I don't know that we [OASAS] would be willing to put them [referring in general to alleged perpetrators] on the street," but that OASAS would work diligently to find them a placement, but also admitted that other placements are not always available. (Hearing testimony of OASAS [redacted])

The Subject relied upon the aforementioned testimony in the record to support his argument that he did all that he could do. This is not a case where the Subject risked running afoul of OASAS policy, or the Justice Center, if he had sought alternative placements either for the Service Recipients or the perpetrators. The fact is, the Subject did nothing and did not seek consultation with or direction from a supervisor until four days after he became aware of the issue. The Subject did not even notify the police, despite the fact that Service Recipient 1 clearly alleged a violation of Penal Law § 130.55.[8] OASAS policy requires that the police are notified

[8] There was some evidence in the record that the Subject offered to contact the police on behalf of Service Recipient 1, and that he declined. (Recorded audio interview with [redacted]: ALJ Exhibit 1)

[redacted]

of any allegation of sexual touching. (Hearing testimony of OASAS [redacted])

The Subject also argued, in lay person's terms, that there was not a preponderance of evidence in the record that the alleged conduct actually occurred in the first instance, and therefore, the Justice Center has not proved that he failed to protect the Service Recipients from such conduct.

[redacted], an Investigator with the Justice Center, acknowledged during his testimony that the Justice Center did not begin its investigation of this complaint until approximately seven weeks after the call was placed to the VPCR. The Investigator testified that Service Recipient 1 had self-discharged by the time the call to the VPCR was made and, therefore, there was no immediate risk.[9]

The Investigator testified that he was unable to locate and unable to interview any of the Service Recipients, or the two alleged perpetrators. Service Recipients 2-5 were believed to have taken a bus to the Albany area after discharge. The Subject provided a possible location for Service Recipient 1 but the Investigator was unable to find Service Recipient 1 at this location. The Investigator testified that he made efforts to locate Service Recipient 1 while the investigation remained open but was unable to do so. Notwithstanding, the Subject presented proof that while the investigation was open, Service Recipient 1 was arrested by [redacted] Police on [redacted]. (Subject Exhibit B, Justice Center Exhibit 1, hearing testimony of [redacted])

After considering all of the evidence, including the handwritten statements of Service Recipients 1-5, as well as surveillance video from [redacted], (see Justice Centers Exhibits 3-7 and

[9] The record was unclear as to when Service Recipients 2-5 were discharged, but none were residents at [redacted] when the Justice Center commenced the investigation.

[redacted]

Justice Center Exhibit 17), the Justice Center has established by a preponderance of the evidence, the events alleged by the five Service Recipients.

The Subject failed to present any convincing rebuttal evidence on those allegations and the fact that similar unfounded allegations, likely motivated by homophobia, have been made in the past at [redacted], is grossly unpersuasive. The surveillance video does corroborate the allegations, in particular those allegations made by Service Recipient 1. Additionally, the statements of Service Recipients 2-5, while alleging similar behavior, are distinct from one another. Staff [redacted] testified that he was present when the written statements where created and he ensured that there was no collaboration among the Service Recipients. Accordingly, the statements of Service Recipients 1-5 are credited evidence.

The Justice Center further proved by a preponderance of the evidence that the Subject committed neglect when he failed to take any protective measures after receiving a report of a reportable incident alleging sexual misconduct by two Service Recipients against five other Service Recipients. The Subject's lack of attention breached his duty and this was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the five Service Recipients.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse and/or neglect alleged. The substantiated allegations will not be amended or sealed, except as to "Offense 2" which is unsubstantiated.

Although the allegations will remain substantiated, the next question to be decided is whether the substantiated allegations constitutes the category level of abuse and/or neglect as set

[redacted]

forth in the substantiated allegations**.** After considering the entire record, it is determined that the substantiated allegations are properly categorized as Category 2 acts.

Category 2 conduct under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. A report that results in substantiated allegations of a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: The request of [redacted] that the allegations "substantiated" on [redacted], [redacted], dated and received on [redacted] be amended and sealed is granted in part and denied in part, it is denied as to Offenses 1 and 3. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

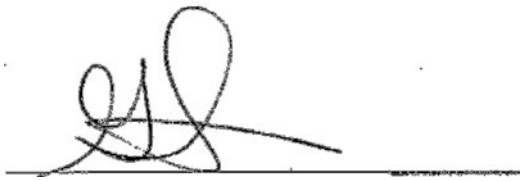
The request of [redacted] that the allegations "substantiated" on [redacted], [redacted], dated and received on [redacted] be amended and sealed is granted as to Offense 2. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated allegations are properly categorized as Category 2 acts.

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

[redacted]

DATED: June 5, 2015
Schenectady, New York



Gerard D. Serlin, ALJ