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:

West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, New York 14224
On: [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Parties:

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

[redacted]
By: Jason P. Jaros, Esq.
8207 Main Street
Williamsville, New York 14221

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject), for abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving 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 abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident**.** 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 [redacted], located at [redacted], while acting as a custodian (Social Worker Supervisor), you committed an act of abuse (failure to report a reportable incident) when you failed to report a service recipient's allegation that he was strangled by another staff member during a restraint.
>
> This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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.

FINDINGS OF FACT

At the time of the alleged abuse, the Subject, a custodian, was employed by the [redacted] (the Facility), a facility licensed by the Office of Children and Family Services (OCFS). The Service Recipient resided at the [redacted] and was a young person who was charged with a crime and was awaiting prosecution as a juvenile delinquent. The Subject worked as a Supervisor Social Worker and was employed by a facility or provider agency that is subject to the jurisdiction of the Justice Center. The Subject was a mandated reporter.

On [redacted], while performing a restraint on the Service Recipient, staff member [redacted] was bitten on his arm by the Service Recipient. (*Hearing Testimony of Justice Center Investigator* [redacted]) [redacted] then attempted to employ a maneuver, to release the bite, described in the facility restraint training (*Subject Exhibit A*, page 27), which consisted of [redacted] pushing his arm further into the mouth of the Service Recipient, at which time the Service Recipient released the bite. There was physical contact between [redacted], another staff member [redacted] and the Service Recipient, prior to, during and after the bite release. (*Hearing Testimony of Justice Center Investigator* [redacted], *Hearing Testimony of* [redacted] *and Justice Center Exhibit 7).*

This maneuver was successful and the Service Recipient was restrained and briefly placed in hand cuffs. (*Hearing Testimony of Justice Center Investigator* [redacted]*).*

At some point during the physical altercation the Service Recipient said words to the effect of [redacted] choked me. (*Hearing Testimony of Justice Center Investigator* [redacted]*).*

On the day of the incident the Subject was working, out of the Facility, and received telephone calls from both [redacted] and an intake worker, indicating that [redacted] was going to the hospital as a result of a restraint involving the Service Recipient. The Subject then went to the Facility, to speak to the Service Recipient about the incident and to check on his condition. The Subject asked the Service Recipient if he had bitten [redacted] and he replied something to the effect of "well he was choking me."

The Subject then asked the Service Recipient the same question in several different forms, for example, she then asked him something to the effect of "you mean he put his hands around your neck?", and "let me see your neck" and "are you injured?."

The Subject observed no marks on the Service Recipient's neck. The Subject decided, based on all the interviews the Subject conducted and reports of the incident, that what had occurred between the Service Recipient and [redacted] was a properly executed bite release maneuver. The Subject was familiar with the bite release technique, but had never performed the technique other than in training. When the Service Recipient told the Subject that [redacted] choked him, the Subject wanted to do an evaluation to determine what happened. The Subject is not an investigator and the Subject's job responsibilities did not include investigating allegations of abuse and neglect. (*Hearing Testimony of the Subject)*.

The Subject is a custodian and mandated reporter. Social Services Law §§ 488(2) and (5) respectively. The Subject did not report the incident to the Justice Center.

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 allegation constitutes abuse (obstruction of reports of reportable incidents).

- Pursuant to Social Services Law § 493(4), the category level that the abuse (obstruction of reports of reportable incidents) 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 abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient 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 allegation constitutes abuse (obstruction of reports of reportable incidents); and pursuant to Social Services Law § 493(4), the category level that the abuse (obstruction of reports of reportable incidents) 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.

Obstruction of reports of reportable incidents is defined by Social Services Law § 488 (1)(f) as:

> (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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act of abuse (obstruction of reports of reportable

incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient alleged in the substantiated report and that such act or acts constitute the category level 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 abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient 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 abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient cited in the substantiated report constitutes a Category 3 act, as set forth in the substantiated report.

If the Justice Center did not prove the abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient by a preponderance of evidence, the substantiated report must be amended and sealed.

THE HEARING

The Justice Center called as witnesses [redacted], the Justice Center investigator who conducted the investigation into the subject incident, [redacted] a Justice Center Supervising Investigator and offered eleven exhibits which were admitted into evidence. *Justice Center Exhibit 7* is a CD which contains a recorded statement of Staff [redacted] obtained during the course of the investigation. The Subject testified, called [redacted] to testify on the Subject's behalf and offered three exhibits which were admitted into evidence. Additionally, *Subject Exhibit C* is a recorded statement of [redacted] obtained during the course of the investigation.

[redacted] testified, in relevant part, that the Service Recipient claimed that he was choked by [redacted], and that choking was not an approved technique at the Facility. In particular, [redacted] testified that the Service Recipient stated, during the incident itself, that he was being choked and also told the Subject that he was choked by [redacted], approximately an hour after the incident.

The Subject was not at the Facility at the time of the incident, but was informed that there was an altercation between the Service Recipient and [redacted]. The Subject then returned to the Facility and spoke to the Service recipient, within an hour of the incident, and he told the Subject that [redacted] had choked him. The Subject told [redacted] that she did not report the incident to the VPCR because she did not believe that [redacted] choked the Service Recipient during the restraint and that she did not have "reasonable cause" to report the incident. (*Hearing Testimony of Justice Center Investigator* [redacted]*).*

[redacted] told [redacted] that on the date of the incident he was working and heard the Service Recipient tell the Subject that he was choked by [redacted]. [redacted] assumed the report had been called into the VPCR, but when [redacted] learned that it was not, [redacted] reported the incident to the VPCR in [redacted]. (*Hearing Testimony of Justice Center Investigator* [redacted]*).*

[redacted] was interviewed by [redacted] and told him in relevant part that: there was a struggle in the Service Recipients cell which resulted in [redacted] and staff member [redacted] restraining the Service Recipient; during the restraint the Service Recipient bit [redacted] on the arm while [redacted] was jamming his arm in the Service Recipients mouth; the Service Recipient said that [redacted] was choking him and [redacted] repositioned his arm. [redacted] did not recall the Service Recipient, during the restraint, stating that he was being choked; [redacted] also testified that his investigatory recommendations were that [redacted] should be unsubstantiated for physical abuse

and that the Subject should be substantiated for failure to report. (*Hearing Testimony of Justice Center Investigator* [redacted]*).*

[redacted], who at the time of his testimony, was a Justice Center Supervising Investigator [redacted], testified that as of [redacted], mandated reporters should have had some training in reporting and other matters relating to the Justice Center. For instance, he identified *Justice Center Exhibit 4*, which is a Justice Center guidance document on reporting obligations, dated [redacted]. [redacted] testified that he had seen something similar to *Subject Exhibit B*, entitled "DRAFT – Quick reference Guide for Reporting to the Justice Center", but that he did not believe it was a Justice Center document. (*Hearing Testimony of* [redacted]*).*

[redacted] testified in relevant part as follows: on the date of the incident the Service Recipient was causing a disturbance, hitting walls, swearing at [redacted] among other things; [redacted] believed based on the Service Recipients conduct that it was necessary to restrain him; while attempting to cuff the Service Recipient during the restraint, [redacted], who was assisted by [redacted], put his right forearm on the Service Recipients chest to prevent him from getting up, and the Service Recipient bit and locked down on [redacted] forearm; [redacted] then pushed his arm into the Service Recipient's mouth and attempted to grab his nose, but failed; The Service Recipient let go of the bite and [redacted] immobilized the Service Recipient's head by placing his arm below the Service Recipient's ear so he could not bite; when asked if this was an approved technique, [redacted] replied that he did not know; during this physical altercation the Service Recipient said "you are choking me."

[redacted] testified that the bite release technique he utilized was an authorized technique that he was trained on in accordance with *Subject Exhibit A*, however this was the first time he had used the technique outside of training. Following the restraint/physical altercation with the

Service Recipient, he reported it to the Subject, the same day, telling her there was a restraint, the individuals involved in the restraint and that he was bitten by the Service Recipient, and he believes he told her the service Recipient said that he was choked during the restraint; [redacted] also went to the hospital to be checked out and filled out a "Critical Incident Report" *Justice Center Exhibit 6*, in accordance with facility policy, which indicated that the Service Recipient stated during the physical altercation that he was choked. (*Hearing Testimony of* [redacted]*).*

The Subject testified at the Hearing, in relevant part, as follows: In [redacted] the Subject's immediate supervisor sent the Subject an e-mail which attached *Justice Center Exhibit 4* and *Subject Exhibit B*. Prior to the subject incident on [redacted], there was no official training on the Justice Center, but she was told to understand Justice Center Exhibit 4 and *Subject Exhibit B (Subject Exhibit B)* is not a document generated or provided by the Justice Center).

On the day of the incident the Subject was working, out of the Facility, and received telephone calls from both [redacted] and an intake worker, indicating that [redacted] was going to the hospital as a result of a restraint involving the Service Recipient. The Subject then went to the Facility, to speak to the Service Recipient about the incident and to check on his condition. The Service Recipient was handcuffed, appeared angry and stated that he had been fighting with [redacted]. The Subject asked the Service Recipient if he had bitten [redacted] and he replied something to the effect of "well he was choking me." The Subject then further pressed the Service Recipient's version of events by asking him the same question in several different forms, for example, she then asked him something to the effect of "you mean he put his hands around your neck?", and "let me see your neck" and "are you injured?." The Subject testified that she observed no marks on the Service Recipient's neck and that he was not otherwise injured. The

Subject then decided, based on all the interviews she conducted that what had occurred between the Service Recipient and [redacted] was a properly executed bite release maneuver. She further testified that she was familiar with the bite release technique, but that she had never performed the technique other than in training. The Subject did discuss the incident with [redacted] that day but could not remember exactly what he said. She also reviewed reports made concerning the incident.

The Subject testified that she did not report the incident to the Justice Center essentially because, based on her interviews and evaluation of the incident, she did not have "reasonable cause", because there was no injury to the Service Recipient and because *Subject Exhibit B*, indicated that if there was a restraint with no injury, the incident was not reportable. She further testified that it was her understanding that her obligation to report, based on reasonable cause, existed only if an allegation of abuse seemed legitimate. On cross-examination she testified that the OCFS staff apologized for incorrectly training staff on Justice Center Reporting requirements, in part based on *Subject Exhibit B.* When the Service Recipient told her that [redacted] choked him, she testified that she wanted to do an evaluation to determine what happened, although she admitted that she is not an investigator and her job responsibilities did not include investigation allegations of abuse and neglect. *(Hearing Testimony of the Subject)*.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient.

Social Services Law § 491provides in pertinent part:

> Duty to report incidents. 1. (a) Mandated reporters shall report allegations of reportable incidents to the vulnerable persons'

> central register as established by section four hundred ninety-two of this article and in accordance with the requirements set forth therein. (b) Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery. For purposes of this article, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another person, including the vulnerable person, comes before the mandated reporter in the mandated reporter's 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.

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 Social Services Law § 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.

The uncontroverted evidence in the record establishes that the Subject was at the time of the incident, a custodian, and as a result, necessarily a mandated reporter. 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. Social Services Law § 491(1)(b).

Social Services Law § 488(1)(a-i) defines “reportable incidents” ranging from various types of abuse and neglect to “significant incidents” which are incidents other than incidents of abuse or neglect. Among the types of reportable incidents contained in Social Services Law § 488(1) are physical abuse, which explicitly includes choking (Social Services Law § 488(1)(a)) and deliberate inappropriate use of restraints. Social Services Law § 488(1)(d).

The threshold for reporting under Social Services Law § 491 is significantly less than substantiating a report of abuse or neglect. The threshold for reporting, in the instant matter, was triggered when another person, including the vulnerable person, came before the Subject, in her professional or official capacity, and provided the Subject with reasonable cause to suspect that the Service Recipient had been subjected to a reportable incident. Social Services Law § 491(1)(b).

As set forth above, even before the Subject returned to the Facility, she received telephone calls from both [redacted] and an intake worker, indicating that [redacted] was going to the hospital as a result of a restraint involving the Service Recipient. Even at this point in time she had knowledge that there had been a physical altercation between [redacted] and the Service Recipient and that [redacted] was on his way to the hospital. Shortly thereafter the Subject returned to the Facility and learned directly from the Service Recipient, [redacted] and a Facility report (*Justice Center Exhibit 6)* that the Service Recipient claimed he was choked by [redacted] during the restraint, and in fact had so stated during the restraint.

At this point in time the Subject's obligation to report the incident was triggered. She knew that there was physical contact between the Service Recipient and [redacted] which placed [redacted] arms/hands in the area of the Service Recipient's neck and that both during and after the physical contact the Service Recipient claimed that he had been choked by [redacted]. In other words, it was the above information which clearly gave the Subject reasonable cause to **suspect** that the Service Recipient had been subjected to a **reportable incident**. (emphasis added) Social Services Law § 491(1)(b). The reportable incident the Subject had reasonable cause to suspect the Service Recipient had been subjected to could have been physical abuse, which explicitly

includes choking, deliberate inappropriate use of restraints, a significant incident, among others. Social Services Law §§ 488(1)(a), 488(1)(d) and 488(1)(i).

Rather than report the incident, the Subject conducted an investigation and determined that the matter was unsubstantiated. The Subject, in other words, set out to investigate the incident, evaluate the evidence, the witnesses and make an investigative determination as to whether the allegation of choking should be substantiated or unsubstantiated. This is plainly not the role of the mandated reporter and if it were, the entire critical process of investigation and review to determine whether a report should be substantiated or unsubstantiated would be contravened which would indeed be a dangerous dynamic, as a subject's colleagues would become the arbiters of substantiated and unsubstantiated allegations of abuse and neglect, rather than independent, objective trained professional investigators and other professionals.

The Subjects investigation, according to her, involved: asking the Service Recipient if he had bitten [redacted] and he replied something to the effect of "well he was choking me." The Subject then further pressed the Service Recipient's version of events by asking him the same question in several different forms, for example, she then asked him something to the effect of "you mean he put his hands around your neck?", and "let me see your neck" and "are you injured?." She observed no marks on the Service Recipient's neck and that he was not otherwise injured. She then decided, based on all the interviews she conducted and reports she reviewed , including *Justice Center Exhibit 6* that what had occurred between the Service Recipient and [redacted] was a properly executed bite release maneuver, even though she had never performed this technique other than in training. *(Hearing Testimony of the Subject)*.

The Subject argued that she did not report the incident to the Justice Center essentially because, based on her interviews and evaluation of the incident, she did not have "reasonable

cause", because there was no injury to the Service Recipient, because *Subject Exhibit B*, indicated that if there was a restraint with no injury, the incident was not reportable and because of Justice Center guidance on "reasonable cause" contained in *Justice Center Exhibit 4*.

These arguments are all misplaced.

First, as set forth above, the Subject had reasonable cause to **suspect** that the Service Recipient had been subjected to a **reportable incident**. (emphasis added) Social Services Law § 491(1)(b). The reportable incident the Subject had reasonable cause to suspect the Service Recipient had been subjected to could have been physical abuse, which explicitly includes choking, deliberate inappropriate use of restraints, a significant incident, among others. Social Services Law §§ 488(1)(a), 488(1)(d) and 488(1)(i). Further the definition of "reasonable cause" contained in *Justice Center Exhibit 4*, indicates that based on observation, training and experience, the reporter has a **suspicion** that a vulnerable person has been subjected to abuse, neglect or a significant incident. This is a far cry from the Subjects understanding that her obligation to report based on reasonable cause only existed if an allegation seemed legitimate.

Second, the lack of any discernable injury is of no moment as most of the types of reportable incidents contained in Social Services Law § 488(1) do not require any actual injury even for substantiation, including physical abuse, deliberate inappropriate use of restraints, neglect or significant incidents.

Finally, the Subject's reliance on *Subject Exhibit B* is also misplaced. Her belief that she did not have to report a restraint with no injury based on *Subject Exhibit B*, is incorrect under the Social Services Law as set forth above, but is also inconsistent with *Subject Exhibit B*, which is not a Justice Center document and states that a "[r]estraint with no injury or allegation of abuse" does not require reporting the Justice Center. Not only is this guidance incorrect on the injury

component, but in the instant case, there was an allegation of abuse (choking), so that even under the mandate of *Subject Exhibit B* the Subject had an obligation to report.

In other words, none of the Subjects arguments afford her a safe harbor for not reporting the subject incident at all, let alone immediately upon discovery.

Accordingly, based on the above the Justice Center has established by a preponderance of evidence that the Subject committed abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient.

Not only has the Justice Center established by a preponderance of evidence that the Subject committed abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident, as defined in Social Services Law § 488(1)(f), but it has also established that the abuse is properly categorized as a Category 3 offense under Social Services law § 493(4)(c).

The Administrative Law Judge in the Recommended Decision, recommended that this case be unsubstantiated as to the allegation of abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident involving a Service Recipient, because, the Administrative Law Judge found that the Justice Center failed to established by a preponderance of evidence that the Subject had reasonable cause to suspect that the Service Recipient had been subjected to a reportable incident, essentially based on the arguments advanced by the Subject at the Hearing as set forth above.

For the same reasons the Subject's arguments, as to her basis for not reporting the subject incident, are rejected as set for above, so too is the rational for recommending this matter be unsubstantiated in the Recommended Decision rejected as well.

Accordingly, based on the foregoing it is hereby:

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident.

The substantiated report for abuse (obstruction of reports of reportable incidents), based on the Subject's alleged failure to report a reportable incident is properly categorized as a Category 3 act.

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

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

DATED: March 9, 2016
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

Adjud. Case #: [redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, New York 14224
On: [redacted]

Vulnerable Persons' Central Register
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Parties: Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq

[redacted]

By: Jason P. Jaros, Esq.
8207 Main Street
Williamsville, New York 14221

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 the subject of a 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 "substantiated" report dated [redacted], dated [redacted] of abuse and/or neglect by the Subject of a Service Recipient.

2. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

3. On [redacted] the Justice Center substantiated the report for abuse and/or neglect under the theory that the Subject had ***reasonable cause*** to report a reportable incident to the VPCR and failed to do so. The Justice Center concluded that:

> It was alleged that on [redacted], at [redacted], located at [redacted], while acting as a custodian (Social Worker Supervisor), you committed an act of abuse (failure to report a reportable incident) when you failed to report a [S]ervice [R]ecipient's allegation that he was strangled by another staff member during a restraint.
>
> This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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

5. At the time of the alleged abuse and/or neglect, the Subject was employed by the [redacted], a facility licensed by the Office of Children and Family Services. The Service Recipient resided at the [redacted] and was a young person who was charged with a crime and was awaiting prosecution as a juvenile delinquent. The Subject worked as a Supervisor Social Worker and was employed by a facility or provider agency that is subject to the jurisdiction of the Justice Center. The Subject was a mandated reporter of abuse and /or neglect.

6. On [redacted], while performing a restraint on the Service Recipient, staff member [redacted] was bitten by the Service Recipient. The Service Recipient "locked down" his bite onto [redacted] arm. (Testimony of Justice Center Investigator: [redacted]) [redacted] employed a maneuver prescribed by the relevant facility restraint training. (Subject Exhibit A, page 27) The prescribed maneuver performed consisted of the staff member pushing his arm further into the mouth of the Service Recipient and then pinching off the Service Recipient's nostrils in an effort to force the Service Recipient to release his bite hold on the staff's arm. This maneuver was successful and the Service Recipient was restrained and briefly placed in hand cuffs. (Testimony of Justice Center Investigator: [redacted])

7. At some point thereafter, the Service Recipient said: "I want the cuffs off; [redacted] choked me." (Testimony of Justice Center Investigator: [redacted]) The Subject who was the facility supervisor, went to the Service Recipient's room within an hour to check on him. The Subject saw no marks or injuries and interviewed the Service Recipient. The Service Recipient described the maneuver which the staff member had performed on him. The maneuver as described by the Service Recipient was not a choke, but was the prescribed technique for releasing a biting Service Recipient, who had locked down on a staff member's arm.

8. On or about [redacted], the Subject received a "flow chart" from the New York State Office of Children and Family Services (Subject Exhibit B), which indicated among other things, that only restraints which were performed intentionally incorrectly, needed to be reported to the VPCR. Additionally, in the months leading up to this incident the Subject had been provided with Justice Center web site definition of reasonable cause. (Hearing testimony of Subject) The Subject relied upon the Justice Center definition of reasonable cause and the flow chart provided by OCFS in concluding that that the allegation of choking need not be reported to the VPCR.

9. On or about [redacted], [redacted] at the [redacted] reported to the VPCR that the Service Recipient had disclosed that he was "strangled" or "choked." (Hearing testimony of Justice Center investigator: [redacted])

10. The Justice Center investigated the report and concluded that the Service Recipient was neither choked nor strangled and, that the maneuver performed was a prescribed method for defeating a bite. The Justice Center did not substantiate the report as to staff member [redacted]. (Hearing testimony of Justice Center investigator: [redacted])

11. When interviewed by the investigator from the Justice Center the Subject was asked why she did not call the VPCR to report the choking allegation and the Subject stated that she did not believe that she had reasonable cause to suspect that a reportable incident had occurred. (Hearing testimony of Justice Center investigator: [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 or neglect.

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

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and/or neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse and/or neglect occurred, …" (Title 14 NYCRR 700.3(f))

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

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

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

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

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

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

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the

withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

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

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

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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

4. Substantiated reports of abuse and/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 and or/neglect cited in the substantiated report constitutes the Category of abuse and/ or neglect set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that [redacted] was a mandated reporter who had reasonable cause to suspect that the Service Recipient had been subjected to a reportable incident and then failed to immediately report this suspicion to the Vulnerable Persons' Central Register.

In support of the substantiated findings, the Justice Center presented Justice Center Exhibits 1-11. Two witnesses testified on behalf of the Justice Center. On behalf of the Subject, [redacted], the staff member who performed the maneuver at issue testified. The Subject testified and presented 2 Exhibits.

The facts of this case were largely uncontroverted and the parties appear to be in agreement as to all material facts. The Justice Center alleged that the Service Recipient reported to the Subject that he was choked by a staff member. The Justice Center argued that this disclosure triggered the statutory obligation of the Subject to report the allegation to the VPCR.

The first issue to be addressed is whether an allegation of "choking" is a reportable incident. The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488: "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

> "Physical abuse," … 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: … choking …

Clearly, the allegation of choking is a reportable incident. However, the Subject argued that the obligation to report such an allegation is only triggered when the mandated reporter has

reasonable cause to believe that such reportable incident has occurred. The obligations of a mandated reporter are set forth in Social Services Law § 491:

> Duty to report incidents. 1. (a) Mandated reporters shall report allegations of reportable incidents to the vulnerable persons' central register as established by section four hundred ninety-two of this article and in accordance with the requirements set forth therein.
>
> (b) Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery. For purposes of this article, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another person, including the vulnerable person, comes before the mandated reporter in the mandated reporter's 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 …

Before the obligation to call the VPCR is triggered, the mandated reporter must have ***reasonable cause*** to suspect that the vulnerable person has been subjected to a reportable incident. However, reasonable cause is not defined in the relevant Justice Center legislation. Nor is reasonable cause defined in any rule or regulation promulgated by the Justice Center.

It is a well settled proposition of New York law that an agency's interpretation of the statutes and regulations it is responsible for administering is entitled to great deference. Kurland v. New York City Campaign Fin. Bd., 23 Misc. 3d 567, 873 N.Y.S.2d 440, 2009 NY Slip Op 29027 [N.Y. Sup Ct, New York County 2009] citing *Seittelman v Sabol*, 91 NY2d 618, 625, [1998]; Matter of Partnership 92 LP & Bldg. Mgt. Co., Inc. v State of N.Y. Div. of Hous. & Community Renewal, 46 AD3d 425, 429, [1st Dept 2007]; New York City Campaign Fin. Bd. v Ortiz, 38 AD3d 75, 80-81, [1st Dept 2006]

The Justice Center defines reasonable cause on its' web site:[1]

[1] 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

> ***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.

The Subject testified, and that there was no dispute in the record, upon learning of the allegation the Subject went to the Service Recipient, made certain that any medical care needed was provided, and then asked the Service Recipient to describe exactly what happened. The Service Recipient acknowledged all of his behaviors leading up to the restraint and openly admitted that he bit and "locked onto" to the arm of staff [redacted]. The Service Recipient then described the technique which [redacted] used to release the bite. While the Service Recipient characterized the technique as a "choke," the technique described by the Service Recipient was clearly a bite release technique which is taught and sanctioned for use in the facility. (Testimony of Subject & Hearing testimony of Justice Center investigator: [redacted])

While the Justice Center argued that the Subject should not have engaged in any investigation and should have instead, immediately, called the VPCR, the statute at issue includes the phrase reasonable cause. The Subject testified that she relied upon the Justice Center's own definition of reasonable cause in deciding not to report to the VPCR. While reasonable cause could be defined in a manner which creates a "strict liability"[2] obligation to

[2] An example of a strict liability definition of reasonable cause in the realm of abuse and /or neglect reporting can be found in Social Services Law §413. While still in effect, this statute no longer sets the standard for reporting suspected abuse or neglect of a child in a facility such as the one at issue in this case. However, up until June 30, 2013 Social Services Law §413 did set the standard for triggering a report of abuse and/or what was then referred to as maltreatment, in the [redacted]. Social Services Law §413 states in pertinent part that:

> The following persons and officials are required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child …

report; as currently defined there is no strict liability obligation to report and instead the definition employed by the Justice Center is far closer to a reasonable person standard, than to a *strict liability* standard.[3] Additionally, but not dispositive is the fact that the flow chart provided by OCFS to the [redacted] is ambiguous at best and misleading at worst with regard to describing the circumstances which trigger a VPCR report. (See Subject Exhibit B)

After considering all of the evidence, based upon her observations, training and experience as a supervisor, and specifically her knowledge of the restraint techniques taught and utilized at the [redacted], the Subject did not have reasonable cause to suspect that staff [redacted] had choked the Service Recipient.

The Justice Center has not established by a preponderance of the evidence that [redacted] was a mandated reporter who had reasonable cause to suspect that the Service Recipient had been subjected to a reportable incident and then failed to immediately report this suspicion to the Vulnerable Persons' Central Register.

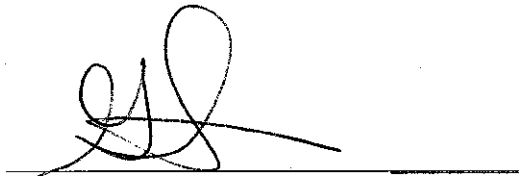
DECISION: The request of [redacted] that the substantiated report [redacted], dated [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

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[3] Although not pivotal to the outcome of the case, supervising Justice Center investigator [redacted] testified at the hearing that he attended a Justice Center "meet and greet" held with area *Custodians* regarding the Justice Center in [redacted]. The Subject was present at this training and the Subject or someone in the audience asked about interpreting the "***reasonable cause***" standard. In response to the inquiry, Justice Center Assistant Chief of Investigation for [redacted], [redacted] advised the audience he didn't want to get into that discussion, but that he did say that this meant: "what a reasonable person would do under the circumstances."

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

DATED: February 24, 2015
West Seneca, New York



Gerard D. Serlin, ALJ