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** **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: Juliane O'Brien, Esq.

[redacted]
By: Margaret J. Fowler, Esq.
Levene, Gouldin & Thompson, LLP
P.O. Box F-1706
Binghamton, New York 13902

[redacted]

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

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

The substantiated report 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 David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: June 15, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Office Building
333 East Washington Street
Syracuse, New York 13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for 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 "substantiated" report dated [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to intervene when you observed another staff member performing an inappropriate restraint on a service recipient.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, [redacted], located at [redacted], is a medium security residential facility for male children ages thirteen to eighteen years old who have been adjudicated as juvenile delinquents by a Family

Court Judge. The [redacted] is operated by the New York State Office of Children and Family Services (OCFS), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted])

5. At the time of the alleged neglect, the Subject had been employed by the OCFS since [redacted]. The Subject worked as a Youth Division Aide 3 (YDA3). (Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was a sixteen year old resident of the [redacted]. The Service Recipient stood approximately five feet six inches tall and weighed approximately 140 pounds. (Hearing testimony of Justice Center Investigator [redacted]

7. On [redacted], the Subject worked a double shift at the [redacted]: the first shift from 6:00 a.m. to 2:00 p.m. in Unit [redacted], and the second shift from 2:00 p.m. to 11:00 p.m. in Unit [redacted]. The Service Recipient was a resident of Unit [redacted]. (Hearing testimonies of Justice Center Investigator [redacted] and the Subject)

8. On [redacted] at approximately 3:53 p.m., the Subject was assisting other [redacted] staff who were conducting searches of the service recipients' bedrooms in Unit [redacted]. At the time, all service recipients in Unit [redacted] were remanded to their respective bedrooms with their bedroom doors closed and locked. The service recipients were instructed by [redacted] staff to remain in their bedrooms while the searches were being conducted. The Subject was working with Staff A, who approached the Service Recipient's bedroom door in response to the Service Recipient banging on and kicking at the door. Staff A directed the Service Recipient to stop banging on and kicking at the bedroom door. When the Service Recipient continued his behavior, Staff A used his radio to call a "Code Yellow" and requested the assistance of the

response team. (Justice Center Exhibit 7; Justice Center Exhibit 12: Video, Subject Exhibit A page 6, and Hearing testimony of the Subject)

9. After making the "Code Yellow" call, Staff A unlocked the Service Recipient's door and entered into the doorway. Almost immediately after Staff A entered the doorway, the Service Recipient started punching and kicking him and attempted to push past him. Staff A's attempt to restrain the Service Recipient, in response to the Service Recipient's behavior, resulted in Staff A and the Service Recipient going into the Service Recipient's bedroom and falling onto the Service Recipient's bed. When they fell onto the Service Recipient's bed, Staff A's body landed on top of the Service Recipient's body and remained that way until the response team arrived. (Justice Center Exhibit 7, Justice Center Exhibit 12: video, Subject Exhibit A page 6 and Hearing testimony of the Subject)

10. Almost immediately after Staff A and the Service Recipient entered the Service Recipient's bedroom, the Subject and Staff B entered the bedroom. While Staff A was on top of the Service Recipient, the Service Recipient punched, kicked and generally struggled with Staff A. Neither the Subject nor Staff B made any attempt physically to stop Staff A's conduct, remove Staff A from the Service Recipient or otherwise physically intervene. (Justice Center Exhibit 7, Justice Center Exhibit 12: video, Subject Exhibit A pages 6 to 10, and Hearing testimony of the Subject)

11. Approximately eleven seconds after Staff A and the Service Recipient entered the Service Recipient's bedroom, response team members Staff C and Staff D arrived and entered the bedroom. Staff C relieved Staff A by placing the Service Recipient in a single person standing restraint. Approximately six seconds after Staff C entered the bedroom, Staff B exited the bedroom. Approximately thirty-three seconds after entering the bedroom, Staff C exited the

bedroom with the Service Recipient in a single person standing restraint. (Justice Center Exhibit 7, Justice Center Exhibit 12: video, Subject Exhibit A pages 6 to 10, and Hearing testimony of the Subject)

12. Staff A stood approximately six feet three inches tall and weighed approximately 220 pounds. The restraint technique used by Staff A, from the time he fell onto the bed with the Service Recipient until the time he was relieved by Staff C, was not a technique that was taught or approved by the OCFS. (Justice Center Exhibits 8 and 9, and Hearing testimony of Justice Center Investigator [redacted])

13. The OCFS policy requires that when a Staff observes "staff-on-youth abuse or any other harmful practice," they are to immediately intervene to stop such behavior. (Justice Center Exhibit 8)

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 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))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1) (h), to include:

> "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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (3), which is defined as follows:

> 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.

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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-11) The Justice Center also presented a CD/DVD which contains audio recordings of the Justice Center Investigator's witness interviews and interrogations. The CD/DVD also contains a visual only video of the incident. (Justice Center Exhibit 12) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented two exhibits. (Subject Exhibits A and B)

The Justice Center proved by a preponderance of the evidence that the Subject had a duty to immediately take steps to stop Staff A from continuing to perform a non-approved restraint on the Service Recipient, that she failed to intervene and that her failure to intervene was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

A majority of the facts are not in dispute. Significantly, credible evidence in the record sufficiently establishes that the conduct of Staff A amounted to a restraint technique that was

neither taught nor approved by the OCFS. Restraint is defined in Social Services law as "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. (SSL § 488(1)(d)) The record reflects that Staff A used his body to limit the Service Recipient's ability to freely move his body, and therefore, Staff A's conduct constitutes a restraint. The OCFS policy does not allow the use of a restraint in a service recipient's bedroom or on furniture. The OCFS policy also does not allow a restraint in which staff places his or her body on top of a service recipient's body. (Justice Center Exhibit 9) Nonetheless, Staff A attempted or performed a restraint on the Service Recipient which took place in the Service Recipient's bedroom and on the Service Recipient's bed. Furthermore, while performing the restraint, Staff A's body remained on top of the Service Recipient's body.

The only material fact that was disputed by the Subject was the Subject's conduct inside the Service Recipient's bedroom while Staff A was restraining or attempting to restrain the Service Recipient. Unfortunately, the Justice Center's video recording of the incident provides little help discerning what occurred inside the Service Recipient's bedroom as the video was recorded from the perspective of the hallway and encompasses only occurrences in the hallway outside the bedroom door. Nonetheless, sufficient other evidence exists in the record to come to a finding concerning the Subject's conduct.

The Subject stated in her Justice Center interrogation that she tried to pick Staff A off the Service Recipient (Justice Center Exhibit 12: Subject Interrogation). However, in the hearing she testified that all she did was put her hand on Staff A's back to let him know she was there if he needed her help. (Hearing testimony of the Subject) This contradiction was not explained by the Subject in her testimony or by any other evidence in the record. Therefore, the Subject's

recorded audio statement, in which she claimed to have physically intervened, is not credited evidence.

There is no other evidence in the record that supports the contention that the Subject physically intervened in Staff A's restraint or attempted restraint of the Service Recipient. Consequently, it is determined that the Subject was present while Staff A was restraining or attempting to restrain the Service Recipient, that she witnessed Staff A performing a restraint technique on the Service Recipient that was neither taught nor approved by the OCFS, and that she failed to take any steps to immediately stop the improper restraint.

To prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached the Subject's custodian's duty to the Service Recipient and resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Credible evidence in the record establishes that the Subject had a duty to immediately intervene when she observed Staff A performing an unapproved restraint technique on the Service Recipient and she breached that duty by failing to intervene. Furthermore, the evidence establishes that, due to the nature of the restraint technique used by Staff A and the relative size difference between Staff A and the Service Recipient, Staff A's use of the unapproved restraint technique was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

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 neglect alleged. The substantiated report will not be amended or sealed.

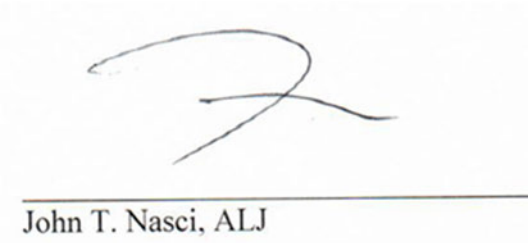
Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

DECISION: The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 3 act.

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: June 14, 2016
Schenectady, New York



John T. Nasci, ALJ