

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**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: Christopher Mirabella, Esq.

[REDACTED]  
[REDACTED]  
[REDACTED]

By: Nicole A. Murphy, Esq.  
Fine, Olin & Anderman, LLP  
39 Broadway, Suite 1910  
New York, New York 10006

██████████

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 ██████████ that the substantiated report dated ██████████  
██████████ ██████████ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and 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:** October 3, 2016  
Schenectady, New York

  
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David Molik  
Administrative Hearings Unit

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Louis P. Renzi  
Administrative Law Judge

Held at:

Adam Clayton Powell State Office Building  
163 West 125<sup>th</sup> Street  
New York, New York 10027  
On: [REDACTED]

Parties:

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  
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## **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse and 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] [REDACTED] [REDACTED] of abuse and 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 abuse (obstruction of reports of reportable incidents) when, after becoming aware that a service recipient was injured and/or assaulted, you failed to report the incident to the Vulnerable Persons' Central Register.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).<sup>1</sup>

### **Allegation 2**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to promptly seek medical attention for an injured service recipient.

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<sup>1</sup> This substantiation should have said abuse. The Subject had notice and defended against abuse (obstruction of reports of reportable incidents).

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, located at [REDACTED] is an [REDACTED] group home for persons with developmental disabilities, operated by the Office for People With Developmental Disabilities (OPWDD), a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and neglect, the Subject was employed by OPWDD for approximately twenty-seven years and had been at the [REDACTED] for four months. The Subject worked as a Developmental Assistant 1 Night Shift Supervisor. (Hearing Testimony of Subject)

6. At the time of the alleged abuse and neglect, the Service Recipient was a sixty- five year old female with a diagnosis of diabetes and profound mental retardation; she had been a resident of the [REDACTED] for many years. (Justice Center Exhibit 14)

7. On [REDACTED], the Subject began her shift as the overnight supervisor at the [REDACTED] at approximately 10:30 p.m. Between 6:10 a.m. and 6:15 a.m. on [REDACTED], the day of the alleged abuse and neglect, the Subject received a call via the intercom from Staff "A" inquiring as to whether the Subject knew anything about the Service Recipient's face. The Subject answered that she did not. Staff "A" advised the Subject that she needed to go upstairs and see the Service Recipient. The Subject responded but before reaching the Service Recipient's room, she received another call from Staff "A" advising the Subject that she would shower the Service Recipient first and then bring her down to the dining area. Between 6:35 a.m. and 6:40 a.m., Staff "A" brought the Service Recipient downstairs where the Subject observed red marks

and two small scratches underneath the Service Recipient's eyes and small marks on the bottom of the Service Recipient's eyelids. (Justice Center Exhibits 17, 21)

8. The Subject began questioning multiple staff members to see if anyone knew what had happened to the Service Recipient's face. Staff "B" stated that he or she believed that another service recipient had scratched the Service Recipient as he had a history of doing so in the past. The Subject did not call a Nurse to check on the Service Recipient. When the Day Shift Supervisor (Staff "C") arrived at approximately 7:30 a.m., the Subject told him about the Service Recipient's face. Staff "C" told the Subject that he would call the nurse. (Hearing Testimony of Subject; Justice Center Exhibit 21)

9. The Service Recipient was not examined by a nurse until approximately 4:45 p.m. on [REDACTED], when RN [REDACTED] observed scratches under both of the Service Recipient's eyes and swelling in the eye areas and instructed the staff to take the Service Recipient to the Emergency Room. (Justice Center Exhibits 18, 21)

10. RN [REDACTED] also telephoned Treatment Team Leader (TTL) [REDACTED] who arrived at the [REDACTED] and found that the incident had not been reported by the Subject or the Day Shift Supervisor. TTL [REDACTED] photographed the Service Recipient and reported the incident to the Justice Center. (Justice Center Exhibits 6, 8, 18, 21)

11. The Subject did not report the incident to the Justice Center. (Hearing testimony of Subject)

### **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))

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

- (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.
- (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.

Social Services Law § 488(1) defines a “reportable incident” in relevant part as conduct which must be reported to the Vulnerable Persons' Central Register by a mandated reporter; such conduct is further described in subsections (a) through (i) thereof, which define abuse, neglect and significant incidents.

Social Services Law § 488(1)(i) defines a “significant incident” in relevant part as:

- (i) “Significant incident” shall mean an incident, other than an incident of abuse or neglect, that because of its 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 shall 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[.]

Social Services Law § 491(1)(a) and (b) require that:

- (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. A report to the register shall include the name, title and contact information of every person known to the mandated reporter to have the same information as the mandated reporter concerning



the reportable incident. Nothing in this subdivision shall be construed to prohibit a mandated reporter from contacting or reporting to law enforcement or emergency services before or after reporting to the vulnerable persons' central register.

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:

- (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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse and 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))

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 acts of abuse and/or neglect cited in the substantiated report constitute the category of abuse and neglect set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or 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 the acts described as "Allegation 1" and "Allegation 2" 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- 20, 22) The Justice Center also presented an audio recording of the interrogation of the Subject. (Justice Center Exhibit 21) The investigation underlying the substantiated report was conducted by Justice Center Investigator

██████████ who was the only witness who testified at the hearing on behalf of the Justice Center.

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The Subject testified in her own behalf and provided no other evidence.

**Allegation 1 - Abuse (Obstruction of Reports of Reportable Incidents)**

In order to sustain an allegation of abuse (obstruction of reports of reportable incidents), the Justice Center must prove that the Subject was a custodian and mandated reporter who failed to report a reportable incident upon discovery. (SSL §§ 488(1)(f), 491(1)(a) and (b))

The record establishes that the Subject was a custodian, and therefore a mandated reporter, who pledged to abide by the Code of Conduct for Custodians of People with Special Needs (Code of Conduct). (Justice Center Exhibits 7, 22) At the time of the alleged abuse, the Subject was working at the facility as a Night Shift Supervisor and was a custodian as that term is defined in Social Services Law § 488(2). The Subject admitted that she did not report the incident. (Hearing Testimony of Subject; Justice Center Exhibit 21) The only issue to be decided here is whether the incident was reportable upon discovery.

The Subject testified that she did not see any signs of abuse, therefore she did not believe the incident was reportable. Her belief was misinformed.

SSL § 488(1) defines a “reportable incident” as abuse, neglect (SSL § 488(1)(a-h)) or a “significant incident” (SSL § 488(1)(i)), which is an incident, other than an incident of abuse or neglect, that because of its 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.

The threshold for reporting an incident to the VPCR under SSL § 491 is significantly less

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<sup>2</sup> The investigation was begun by Investigator ██████████ who subsequently left the Justice Center.

than that for substantiating a report of abuse or neglect. The threshold for reporting is triggered when a mandated reporter witnesses a suspected reportable incident, or when another 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 (Service Recipient) has been subjected to a reportable incident. (SSL § 491(1)(b))

Here, the Subject was presented with information by staff that the Service Recipient was most likely assaulted and scratched by another service recipient who was known to have exhibited such behavior in the past, according to the evidence. This fits one of the definitions of "significant incident"; i.e., it was allegedly deliberate or reckless conduct which, if committed by a staff member against a service recipient would have been abuse, which is clearly reportable under the statute. (SSL § 488(1)(i)(1)) The Subject testified during the hearing that she understood abuse and neglect to be reportable. (Hearing testimony of Subject)

The risk of harm to this Service Recipient, who suffers from diabetes, from a scratch to her skin (which otherwise may have been relatively minor), is significant due to the heightened possibility of infection – which is exactly what happened here. The Subject testified that she was aware of the Service Recipient's diagnosis, and thus she knew or should have known that even a minor injury could become serious if not appropriately treated.

At that point in time the Subject, as a mandated reporter in her official capacity as Night Shift Supervisor, had reasonable cause to suspect that the Service Recipient had been the victim of a reportable incident. She passed the information to the Day Shift Supervisor who was relieving her on duty, but failed to notify the Vulnerable Persons' Central Register (VPCR).

In her defense, the Subject testified that she had not been trained with regard to reporting requirements of the Justice Center as set forth in SSL §§ 488(1) and 491(1). It is concluded that,

since ignorance of the law is not generally a defense to a violation, and there are no apparent exceptions applicable to the instant matter, the Subject was bound by the requirements of SSL §§ 488(1) and 491(1) at the time of this incident, without regard to her training, or lack thereof.

Accordingly, the Justice Center has proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when, after becoming aware that a service recipient was likely assaulted, and had been injured, the Subject failed to report the incident to the VPCR.

### **Allegation 2 - Neglect**

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either 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. (SSL § 488(1)(h))

On the day of the alleged neglect, the Subject was employed by OPWDD as a Night Shift Supervisor and was a custodian as that term is defined in Social Services Law § 488(2). The Subject had been working with vulnerable populations since 1987 and, in addition to her supervisory responsibilities, had also engaged in direct support care for service recipients. (Hearing Testimony of Investigator [REDACTED]; Hearing testimony of Subject) The Subject had a duty to ensure that the Service Recipient received prompt medical care. In relevant part, SSL § 488(1)(h)(ii) defines neglect as a “failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care...” Based upon her many years of experience in the field, the Subject knew or should have known that even minor scratches have the potential to become serious, as happened here. The Subject breached her duty by failing to promptly and effectively

obtain medical attention for the injured Service Recipient.

Between 6:35 a.m. and 6:40 a.m. on the day of the alleged neglect, the Subject observed red marks and two small scratches under the Service Recipient's eyes, and small marks on the bottom of the Service Recipient's eyelids. Instead of calling a nurse, the Subject began an investigation, questioning the staff in an attempt to ascertain what had happened to the Service Recipient's face, and when it had happened. (Justice Center Exhibit 21)

When questioned during her interrogation as to whether she had called anyone after observing the marks and bruises on the Service Recipient's face, the Subject replied: "My mistake. No, I did not." When asked why she had not, the Subject replied: "Again, my mistake, I should have called, but I spoke to [Staff C] and he said that he was going to call the Nurse, but I should have called myself. I should have covered to make sure [the Service Recipient] was taken care of." (Justice Center Exhibit 21) The Subject thus acknowledged her breach of duty to the Service Recipient.

This breach resulted in the serious and protracted impairment of the physical condition of the Service Recipient, as evidenced by the photograph of the Service Recipient's face, taken late in the afternoon. (Justice Center Exhibit 6) The injuries worsened significantly from the time they were first seen by the Subject at approximately 6:40 a.m., thus proving the point. The Subject's failure to act upon initial discovery of the injuries, relying instead upon an incoming supervisor to act, resulted in the worsening of the injuries. (Hearing Testimony of Investigator [REDACTED]; Justice Center Exhibits 6, 8, 15, 18)

It is concluded that a preponderance of the evidence has established that the Subject committed neglect by failing to promptly seek medical attention for 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 abuse and 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 and 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 of abuse and neglect is properly categorized as Category 3 conduct.

**DECISION:**

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 and neglect.

The substantiated report is properly categorized as Category 3 conduct.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

**DATED:** September 14, 2016  
Schenectady, New York

  
Louis P. Renzi, ALJ