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: Robert DeCataldo, Esq.

[redacted]
By: Nicole Murphy, Esq.
Fine, Olin and 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 [redacted] that the substantiated report dated [redacted] of abuse (deliberate inappropriate use of restraints) by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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: January 31, 2017
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

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building
163 West 125th 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
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] for abuse (deliberate inappropriate use of restraints). The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a report of substantiated finding dated [redacted] of abuse (deliberate inappropriate use of restraints) by the Subject of a Service Recipient.

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

Allegation 2[1]

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you grabbed a service recipient by the neck during a restraint.
>
> This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) 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 a short-term treatment care facility for youths that is operated by the New York State Office of Mental Health

[1] Allegation 1 was unsubstantiated.

(OMH), which is an agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse, the facility utilized a program entitled: Preventing and Managing Crisis Situations (PMCS) to manage service recipients' aggressive behaviors. Under PMCS, facility staff were never permitted to put their hands on service recipients' necks as a form of manual restraint. (Hearing testimony of Risk Manager [redacted] and Justice Center Exhibit 29)

6. At the time of the alleged abuse, the Service Recipient was a thirteen year old male whose diagnoses included psychotic disorder, mood disorder, attention deficit hyperactivity disorder, and oppositional defiant disorder. The Service Recipient had a history of multiple psychiatric hospitalizations due to his aggressive and assaultive behaviors. (Justice Center Exhibit 22)

7. At the time of the alleged abuse, the Subject had been employed as a facility Mental Health Therapy Aide (MHTA) for approximately three years. Her regular shift was from [redacted], but on [redacted], she volunteered to work an overtime shift from 7:00 a.m. until 3:30 p.m., during which time she was assigned to the Service Recipient's unit. The Subject had received PMCS training at the onset of her employment and she completed refresher PMCS training on [redacted]. (Hearing testimony of Risk Manager [redacted] and Justice Center Exhibit 27) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

8. After lunch was finished on [redacted], the Subject, the Service Recipient, two or three other service recipients, the facility RN, and MHTA 1, began the process of exiting the dining room. While still in the dining room, the Service Recipient put his hands on the facility RN's shoulders from behind and tried to dance with her. Both the facility RN and the Subject

verbally redirected the Service Recipient, reminding him to respect appropriate boundaries, and he removed his hands. At that point, the group exited the dining room and formed a line in the hallway, with the Subject at the end of the line and the Service Recipient in front of her. (Hearing testimony of the Subject)

9. As the group walked down the hallway, the Service Recipient expressed anger at the Subject, some exchange of comments occurred between them, and the Service Recipient stopped walking, turned around and swung at the Subject's face with his right hand. (Hearing testimony of the Subject and Justice Center Exhibit 13)

10. At that point, the facility RN sprang forward and attempted to restrain the Service Recipient by grabbing his right arm. The Subject took the Service Recipient's left arm and grabbed his neck from behind. The Service Recipient resisted and wriggled out of the Subject's hold on his neck. At the same time, MHTA 1, who observed the Service Recipient punch the Subject, handed the clipboard that he had been carrying to one service recipient and the food tray that he had also been carrying to another service recipient. MHTA 1 immediately approached the Service Recipient as the Subject and the facility RN were attempting an authorized two-person removal restraint. MHTA 1 then took the position of the facility RN next to the Service Recipient and held his right arm while the Subject gripped his left arm. (Justice Center Exhibits 8, 17 and 10)

11. The Subject and MHTA 1 then escorted the Service Recipient back to the unit using the authorized two-person removal. When they approached the unit, RN 1 opened the unit door for them to enter. (Justice Center Exhibit 12)

12. Thereafter, staff were required to execute another restraint on the Service Recipient. (Justice Center Exhibits 9, 10, 11, 12 and 13)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the acts giving rise to the substantiated reports.
- 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 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 (deliberate inappropriate use of restraints) 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 the following:

> (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.

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 (deliberate inappropriate use of restraints) alleged in the substantiated report that are the subject of the proceeding and that such act or acts constitute the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse and/or neglect in a report, 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 (deliberate inappropriate use of restraints) cited in the substantiated report constitutes the category of abuse as set forth in the substantiated report.

If the Justice Center did not prove the abuse 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 act described as Allegation 2 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-3 and 5-29) The investigation underlying the substantiated report was conducted by then facility Risk Manager [redacted], who testified on behalf of the Justice Center.

The Subject testified at the hearing in her own behalf and provided one document as evidence. (Subject Exhibit A)

Due to a technical failure, an audio recording of the hearing was not obtained. Counsel for

the Justice Center and for the Subject were advised of this issue and were offered the opportunity to participate in a Reconstruction Hearing. The parties, through their respective attorneys, indicated their preference to waive their rights to a Reconstruction Hearing and chose to proceed upon a written Stipulation memorializing the key points of testimony of the witnesses. The Stipulation of Hearing Evidence was based upon the notes of the Administrative Law Judge made during the witness' hearing testimony, and the parties, through their attorneys, reviewed and executed the said Stipulation.

The issues in this case are whether the Subject grabbed the Service Recipient's neck and, if so, whether that act constituted a deliberate inappropriate use of restraints as defined in SSL § 488(1)(d).

The Subject's answer to the allegation was a steadfast denial that she had grabbed the Service Recipient's neck. The Subject testified that after lunch on [redacted], she was in the dining room with other staff and service recipients and that, as they were preparing to leave, the Service Recipient, who was standing behind the facility RN, put his hands on the facility RN's shoulders. The Subject testified that both she and the facility RN told the Service Recipient to stop, which he did. The Subject testified that when the group exited the dining room, she was the last one out of the dining room, with the Service Recipient directly in front of her, and that while they were in the hallway on the way back to the unit, the Service Recipient said, "you can't tell me what to do" and that when the Subject responded, the Service Recipient stopped walking, turned around and swung at the Subject's face. The Subject testified that she deflected the punch, which just grazed her face, by moving her head. The Subject testified that MHTA 1 immediately grabbed the Service Recipient's right arm, that the Subject grabbed his left arm, that they escorted the Service Recipient back to the unit, and that when they arrived at the unit, the facility RN opened

the door for them.

The Subject testified that, after the Service Recipient attempted to punch her in the face, the Service Recipient did not turn around with his back to her, that the facility RN did not get involved in the struggle, that she (the Subject) observed MHTA 1 give the clipboard and the tray to the two service recipients before coming to her aid, and that she was certain that it had been the facility RN who had opened the unit door to which she and MHTA 1 had escorted the Service Recipient.

Counsel for the Subject pointed to the fact that, of the four witnesses who were present at the relevant time, other than the Subject, two of them had provided signed statements that did not include an allegation that the Subject had grabbed the Service Recipient's neck.

MHTA 1's statement dated [redacted] (Justice Center Exhibit 13) indicates, in relevant part, that when he observed the Service Recipient stop walking, turn around and punch the Subject, he handed one service recipient the clipboard that he was carrying and another service recipient the food tray that he was also carrying and that he then approached and took the Service Recipient's arm from the facility RN. It further indicates that he saw the Subject grab the Service Recipient's arm when the facility RN had his other arm. The statement contains no indication that MHTA 1 observed the Subject touch the Service Recipient's neck. When cross-examined by the Subject's counsel regarding MHTA 1's perspective and position at the point in time when the Subject was alleged to have grabbed the Service Recipient's neck, facility Risk Manager [redacted] testified that she had not pursued that line of questioning when she interviewed MHTA 1. Because MHTA 1's statement indicates that MHTA 1 was initially distracted from the altercation at the point in time when the Subject was alleged to have grabbed the Service Recipient's neck, by handing his clipboard and food tray to the service recipients, his statement cannot be credited as

evidence exonerating the Subject from the allegation.

Service recipient 1 also provided a signed statement, dated [redacted] (Justice Center Exhibit 14) which similarly contains no indication that he observed the Subject touch the Service Recipient's neck. However, the veracity of this evidence is dubious, as it indicates that the Subject had been alone with the group of service recipients at the time of the incident, which was untrue, that MHTA 1 just happened to be walking by, which was untrue, and, further, that service recipient 1 could not remember any other staff being present and could not identify the nurse involved.

The Justice Center relied on the signed statements of the Service Recipient (Justice Center Exhibits 8 and 17), as well as the signed statements of the facility RN (Justice Center Exhibits 10 and 15) in support of the substantiation.

The Service Recipient's statement dated [redacted] (Justice Center Exhibit 8) indicates, in relevant part, that on the preceding day, a staff who he was not able to identify by name, had intentionally used her nails on his neck because he was "acting up." The Service Recipient's statement dated [redacted] (Justice Center Exhibit 17) provides a more detailed account of his version of events. It states in relevant part that, after the Service Recipient stopped touching the facility RN, he turned around, punched the Subject in the face and turned back around again. It states that, at that point, the Subject then grabbed his arm and his neck, as a result of which the Service Recipient sustained a scratch on his neck, and after the Service Recipient wriggled out of the hold, MHTA 1 took him by one arm and the Subject took him by the other and escorted him to the unit. It further states that the facility RN never touched him.

A physical examination of the Service Recipient's neck revealed a red mark in the area where he alleged that he had been grabbed and scratched as a result. (Justice Center Exhibits 18 and 20) A photograph of the scratch was taken. (Justice Center Exhibit 25) Due to the Service

Recipient's "dysregulated [sic]" emotional state, it was concluded by facility Risk Manager [redacted] that it was unclear as to when or how the scratch had occurred. While the fact that a scratch was found on the Service Recipient's neck in the area where he alleged that he had been injured was not, in and of itself, proof of the allegation, it is noteworthy evidence nonetheless.

The facility RN's statement dated [redacted] (Justice Center Exhibit 10) indicates, in relevant part, that prior to the punch, she witnessed a verbal exchange between the Service Recipient and the Subject, during which "they were both getting loud & in each other's faces." It states that then the Service Recipient punched the Subject in the face, that the facility RN was approximately an arm's length away from them, that she attempted to restrain the Service Recipient, that there was a struggle between the Subject and the Service Recipient, and that she knew "that [the Subject] grabbed him by the neck from behind." The facility RN's statement dated [redacted] (Justice Center Exhibit 15) indicates, in relevant part, that the facility RN observed the Subject behind the Service Recipient "on his left side and she had her right hand on his neck when he was not facing her" and that she was "grabbing onto his neck with a firm grasp."

There were some conflicts in the evidence that brought into question the veracity of the Subject's testimony. The Subject's testimony that the facility RN did not get physically involved in the struggle that ensued after the Service Recipient punched the Subject conflicts directly with MHTA 1's statement that he had taken the Service Recipient's arm from the facility RN and the facility RN's statement that she had become physically involved in the struggle when she attempted to restrain the Service Recipient. Also, RN 1's signed statement (Justice Center Exhibit 12) indicates, in relevant part, that she was the one who opened the door to the unit at the time that the Subject and MHTA 1 had escorted the Service Recipient there after the incident, which was disputed by the Subject, who testified that it was the facility RN who had opened the unit door.

More important to the issue of credibility than the Subject's inconsistent rendering of the details of the incident, is the fundamental question of motivation. When weighing the evidence as to whether the Subject grabbed the Service Recipient's neck, a basic consideration is that, while there was no discernable reason for the Service Recipient and, more notably, the facility RN to have concocted a false allegation against the Subject, the Subject had the very tangible motivation of preserving her reputation and employment status to prevaricate and deny the truth of the allegation.

After considering and evaluating all of the evidence, including the hearing testimony of the Subject, all of the written statements and the fact of a scratch on the Service Recipient's neck , it is determined that the Subject's hearing testimony denying that she grabbed the Service Recipient's neck is not credited evidence.

The Justice Center has established by a preponderance of the evidence that the Subject grabbed the Service Recipient's neck from behind and that this action was a manual measure to immobilize or limit the ability of the Service Recipient to freely move his body.

Facility Risk Manager [redacted] testified that under the PMCS policy, staff are never permitted to put their hands on service recipients' necks. The Subject's training history dated [redacted] (Justice Center Exhibit 27) indicates that the Subject received PMCS training on [redacted] and, in any event, there was no argument that such an act, under any circumstances, would be a permitted or an appropriate restraint. Accordingly, it is found that the Subject's act of grabbing the Service Recipient's neck was not a sanctioned restraint, and was not a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to anyone else. The Subject had the option of retreating in the face of the Service Recipient's aggression.

Based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject's conduct constituted abuse (deliberate inappropriate use of restraints) as defined by SSL § 488(1)(d). The report will remain substantiated.

The next issue to be determined is whether the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) 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. Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] of abuse (deliberate inappropriate use of restraints) by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: January 4, 2017
Plainview, New York