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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AFTER HEARING

ADJUDICATION CASE
[redacted]

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

[redacted]

By: Lawrence D. Hasseler, Esq.
Conboy, McKay, Bachman & Kendall, LLP
407 Sherman Street
Watertown, New York 13601

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 [redacted], dated [redacted] be amended and sealed is granted in part and denied in part. The Justice Center has established by a preponderance of the evidence the finding of *Deliberate inappropriate use of restraints*. Therefore, the Subject's request to amend and seal is denied as to the finding of *Deliberate inappropriate use of restraints*. However, as to the finding of *Physical abuse, which is also a variant of abuse contemplated under the relevant statute,* the Subject has not been shown by a preponderance of the evidence to have committed *Physical abuse*. Therefore, the Subject's request to amend and seal the report as to *Physical abuse* is granted pursuant to SSL § 494(1) (a) and Title 14 NYCRR § 700.6 (a).

The substantiated report is properly categorized as a level two category.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Person's 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: March 26, 2014
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: Gerard D. Serlin
Administrative Law Judge

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

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

[redacted]

By: Lawrence D. Hasseler, Esq.
Conboy, McKay, Bachman & Kendall, LLP
407 Sherman Street
Watertown, New York 13601

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for abuse. 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.

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 [redacted], received on [redacted] of abuse by the Subject of service recipient [redacted].

2. The initial report alleges, in pertinent part, that:

> … [T]hat on or about [redacted] at approximately 7:00 a.m, Direct Care Provider [redacted] …performed an inappropriate restraint, by grabbing and twisting the wrist of individual [redacted], while pressing [redacted] head to the floor. (Justice Center Exh. 4)

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

4. On or about [redacted], the Justice Center substantiated the report against the Subject for *physical abuse* and *the deliberate inappropriate use of a restraint*. The Justice Center concluded that[1]:

Offense 1

> On or about [redacted], at the [redacted], located at [redacted], while acting as a DSP 1, you committed an act of physical abuse when you grabbed and twisted the

[1] (Justice Center Exh. 1 p.1)

wrist of a person in your care, and this conduct resulted in physical injury to a person receiving services from said facility or provider agency.

This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law § 493.

Offense 2

On or about [redacted], at the [redacted], located at [redacted], while acting as a DSP 1, you engaged in the deliberate inappropriate use of a restraint when you grabbed and twisted the wrist of a person in your care and pressed that person's head to the ground.

This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law 493.

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

6. At the time of the alleged abuse the Subject was employed by the [redacted], and the alleged abused service recipient was a resident of [redacted] (hereinafter "[redacted]") [redacted] located at [redacted]. The Subject was employed as a Direct Support Provider (hereinafter "DSP"). The Subject of the report was employed by an *agency* or *provider* that is subject to the jurisdiction of the Justice Center.

7. [redacted] was employed as a DSP with the [redacted] for approximately five years. [redacted] employment was not continuous and included a period of voluntary separation from employment with [redacted] At the time of the report [redacted] worked as a "non-permanent" [2] at three [redacted] operated by [redacted]

[2] As a non-permanent employee of [redacted] worked various hours at any number of the [redacted] homes operated by the [redacted]

8. [redacted] had been previously employed on a permanent ("non-substitute") basis with the [redacted] During the time period of approximately [redacted] through [redacted], [redacted] was employed on a permanent basis and assigned to an [redacted] located on [redacted] in [redacted][3]. During that time period, service recipient [redacted] was a resident of the [redacted] and [redacted] was involved in, or participated in, one or possibly two physical interventions with [redacted] (Testimony of [redacted]; Appellant)

9. [redacted] worked at three of the [redacted] locations operated by [redacted] in the weeks previous to the incident. [redacted] worked at [redacted] (where the incident at issue occurred) for about eight hours per week during the two to three week period preceding the event. During the same time period, [redacted] worked as many as 40-50 hours per week at two other [redacted] operated by [redacted] (Testimony of [redacted]; Appellant) Just before the [redacted] incident, [redacted] accepted a new position with another employer. (Testimony [redacted]; Appellant)

10. On [redacted], at approximately 5:45 a.m., [redacted] reported for work at [redacted]. [redacted] was scheduled to work from 6:00 a.m. to 9:00 a.m. Also present was DSP [redacted] and DSP Supervisor, [redacted]. At about 6:45 a.m., service recipient [redacted] awoke and entered the kitchen. [redacted] was unhappy and in a "miserable mood." [redacted]. cursed at staff, looked at DSP [redacted] and said "You're an asshole. I'm gonna get rid of you. It's your fault somebody came upstairs to wake me up." (Justice Center Exhs. 10 & 11) [redacted] then ate breakfast.

11. After breakfast, DSP [redacted] asked [redacted] to assist [redacted] with morning hygiene. DSP [redacted] was attending to another resident. Service recipient [redacted] was typically "grumpy" in the morning. (Justice Center Exh. 11) [redacted] is an individual who is mildly

[3] The incident at issue occurred at [redacted] which is located at [redacted] in [redacted].

mentally retarded and also has a mental health diagnosis with symptoms including: paranoia, confusion and hallucinations. (Testimony [redacted]-Residential Coordinator for [redacted] Justice Center) [redacted] *Behavior Support Program* includes, as both short and long term objectives, a tapered reduction in the total number of instances of physical, aggressive and assaultive behavior that [redacted] engages in on a monthly basis. (Justice Center Exh. 15)

13. While [redacted] was assisting another service recipient with hygiene needs, [redacted] attempted to persuade [redacted] to go upstairs for hygiene but [redacted] became uncooperative. [redacted] made a movement toward the front door and possibly grabbed the door handle as if he was going to leave the residence. [redacted] then grabbed the back of [redacted] shirt and pulled him backward. [redacted] fell to the floor and became very angry with [redacted][4].

14. [redacted] then yelled, "I want him out of here" and entered the kitchen-dining room area. [redacted] observed from the bathroom that [redacted] green t-shirt collar was ripped. Supervisor [redacted] was seated at a table in the kitchen. [redacted] then asked [redacted] to sit in a chair and calm down. [redacted] told [redacted] that he would "take care of the situation." [redacted] was sitting in the chair, crying and cursing, at which time [redacted] entered the kitchen and said to [redacted], "[redacted], let's go upstairs and shave."

15. [redacted] lunged from the chair, attacked [redacted] and grabbed him by the shirt, twisting [redacted] shirt at the neckline. [redacted] grabbed [redacted] hand. The two men struggled and fell to the floor. [redacted] repeatedly asked [redacted] to release his shirt. [redacted] may have partially or briefly obstructed [redacted] airway. [redacted] continued to try to pry [redacted] hands

[4] Although the Justice Center did take the position that [redacted] physical intervention at the doorway was both unwarranted and inconsistent with [redacted] *Behavior Support Program*, the mechanics of the intervention used by [redacted] to obtain compliance of [redacted] was not the basis for the ultimate indication in the VPCR. (See Justice Center Exh. 15) The Justice Center's primary contention with regard to this intervention was that it created a situation where [redacted] was greatly agitated and that [redacted] should not have thereafter entered the kitchen where [redacted] sat agitated.

from [redacted] shirt. At that point [redacted] had both of his hands grasping [redacted] shirt. [redacted] also attempted to kick [redacted] in the groin and attempted to punch [redacted]

16. DSP [redacted] entered the room where the altercation was occurring and yelled loudly for [redacted] and [redacted] to separate. [redacted] released but [redacted] continued to pull on [redacted] shirt in the neck area. DSP [redacted] then grabbed [redacted] hand and told him to let go of [redacted] shirt/collar area. [redacted] then released his grip on [redacted] (Justice Center Exhs. 10 & 11)

17. [redacted] turned away from [redacted] and attempted to walk away. As he did so, [redacted] kicked [redacted] in the rear-end. [redacted] then turned around and grabbed [redacted] wrist and extended the wrist. [redacted] simultaneously placed his hand behind [redacted] head. (Justice Center Exhs. 10 & 11; see also Testimony of [redacted], Subject)

18. The mechanics of the physical intervention utilized by [redacted] in response to [redacted] kicking [redacted] in the rear-end, and set forth in paragraph # 17 above, were not an approved Strategy for Crisis Intervention and Prevention (hereinafter "SCIP"). (Justice Center Exh. 22; see also Testimony of [redacted] - Residential Coordinator for [redacted] Justice Center)

19. After the physical intervention [redacted] complained of a wrist injury and was medically evaluated at the [redacted] Urgent Care. An evaluation of the right wrist concluded that there was no break, facture or dislocation. The diagnosis of "wrist strain/sprain" was made. (Justice Center Exhs. 12 & 13)

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 or neglect.

- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that [redacted], the Subject, committed the abuse alleged under SSL § 488(1)(d) Deliberate inappropriate use of restraints. The substantiated report will not be amended or sealed as it pertains to the finding of *deliberate inappropriate use of restraints*. The category level of abuse that such act or acts constitute is a category two offense. However, the Justice Center did not establish by a preponderance of the evidence that the Subject committed the abuse under SSL § 488(1)(a) Physical abuse.

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL §§ 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse presently under review was substantiated. A "substantiated report" is defined as a report made where "… an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

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 level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care 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 committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

   (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

   > (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
   > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;
(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i)

through (x) of this paragraph with the intent to obstruct such investigation; and
(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

(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 cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report. The Justice Center will inform any inquiring licensing or provider agency that the Subject is substantiated in the report. If applicable, its existence is subject to disclosure to licensing and provider agencies making inquiry concerning the Subject pursuant to SSL §§ 495(2) and 424-a.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed. Its existence will not be disclosed to licensing and provider agencies.

In support of its indicated findings, the Justice Center presented the VPCR report, narrative summary conclusion, case notes, documents gathered during the course of investigation and numerous other exhibits. (Justice Center Exhs. 1-22) Although the entirety of the admitted Exhibits was deemed relevant, only the most significant Exhibits are discussed herein.

The Justice Center also presented two witnesses in support of their case. Both witnesses testified credibly in all respects. The Appellant testified on his own behalf, and presented some credited testimony.

At the hearing, [redacted] counsel argued that if the physical conduct [redacted] engaged in was other than as was prescribed in the service recipient's individual treatment plan or behavioral intervention plan, then the conduct constituted an emergency intervention necessary to protect the safety of any person.

The facts leading up to and underlying the physical intervention were largely not in dispute. The point of factual dispute is as follows: the Justice Center argued and presented the hearsay written, and audio recorded statement of co-employee DSP [redacted] to support the conclusion that [redacted] had disengaged from [redacted] when he was kicked in the rear-end by [redacted], at which time [redacted] re-engaged [redacted] by grabbing his wrist and head.

However, [redacted] argued that whatever intervention he used with [redacted] was justified, because [redacted] was choking him [redacted], at that time. [redacted] counsel further argued that [redacted] could not have intentionally used a restraint technique which was deliberately inconsistent with [redacted] individual treatment plan or behavioral intervention plan, because [redacted] was unfamiliar with [redacted] individual treatment plan.

[redacted] Testimony

At the hearing, the sum and substance of [redacted] testimony on the two points of relevant factual contention was as follows:

After the incident at the front door, [redacted] screamed and cursed at [redacted] and then walked down the hallway into a living area and ultimately entered into the open dining room-kitchen area. [redacted] followed [redacted] into the dining room–kitchen area. [redacted] approached [redacted] from behind but did not get too close. [redacted] turned around so as to face [redacted] and said, "How would you like it if I grabbed you by the shirt," at which time [redacted] grabbed [redacted] shirt collar and dug his fingernails into [redacted] chest. At that point, [redacted] had not emerged from the bathroom and [redacted] attempted to initiate a one-person "take down" as no one, not even [redacted] (who was also present in the room), came to [redacted] aid. [redacted] then used his leg or foot to bring [redacted] to his back. [redacted] continued to hold [redacted] shirt as the two men fell to the ground. [redacted] attempted to kick at [redacted] as [redacted] lay on his back and [redacted] moved side-to-side to evade the kicks. [redacted] then shouted for the two men to break it up, or to stop, bu [redacted] still refused to let go of [redacted] [redacted] then grabbed [redacted] wrist and flexed it back to break [redacted] hold on [redacted] shirt. [redacted] disengaged. [redacted] and [redacted] separated.

[redacted] testified unequivocally that he did not disengage from [redacted] and then re-engage [redacted] after being kicked in the rear-end, as was alleged by [redacted] [redacted] testified that [redacted] was simply mistaken about what he saw occur between he and [redacted] [redacted] also denied having pressed on [redacted] head as [redacted] lay supine on the floor.

On the issue of his familiarity with [redacted] individual treatment plan, [redacted] testified that he was previously employed on a permanent ("non-substitute") basis with [redacted] During the

approximate time period of [redacted] through [redacted], [redacted] was employed on a permanent basis and assigned to an [redacted] located on [redacted] in [redacted]. During that time period, service recipient [redacted] was a resident of the [redacted] and [redacted] was involved in, or participated in, one or possibly two physical interventions with [redacted]. After [redacted], [redacted] had little to no contact with [redacted] until on or about the summer of [redacted] when [redacted] was assigned to work about eight hours per week at [redacted] current residence, [redacted].

[redacted] testified that a service recipient's behavior plan was typically updated at least annually, or semi-annually, and that he [redacted] was not, at the time of the physical intervention, familiar with [redacted] *Behavior Support Program*. [redacted] testified that he worked about eight hours per week at [redacted] during the approximate two to three week period before this incident. On cross-examination, [redacted] admitted that, based on his history with [redacted], he was aware of the type of situations which could agitate [redacted]. Also on cross-examination, [redacted] acknowledged that he was trained in SCIP procedures, despite the fact that he was three months past due for his refresher training, at the time of this incident.

Hearsay Statement of [redacted]

On [redacted], an investigator with the Justice Center interviewed [redacted]. The interview was recorded. A transcript of this interview appears in the record as Justice Center Exh. 11[5]. An audio recording of the interview was admitted into record as well. (Justice Center Exh. 10)

[5] The Justice Center represented that the transcript had gaps in transcription owing to uncertainty by the stenographer as to what was being said on some portions of the audio recording. However, the Administrative Law

[redacted] was employed with the [redacted] for 12 years and, during his entire tenure of employment, he was assigned to the [redacted] where the incident at issue occurred. [redacted] worked from 12 a.m. until 9 a.m. on [redacted]. [redacted] was typically reactive in the morning and would often verbally challenge staff. The morning of [redacted] was no exception. [redacted] was attending to the needs of a resident in the first floor bathroom which was located off of the kitchen. [redacted] requested that [redacted] assist [redacted] with his morning hygiene. A brief time thereafter, [redacted] heard [redacted] screaming "I want him out of here," followed by [redacted] swearing and cursing. [redacted] emerged from the bathroom and observed that [redacted] shirt collar was disheveled. [redacted] then took off his shirt and threw it in the garbage.

DSP Supervisor [redacted] sat [redacted] down in the kitchen and told [redacted] that "we will attend to it." At about that time, [redacted] entered the area dining–kitchen area. [redacted] then returned to the bathroom to assist the other resident. A short time thereafter, [redacted] heard a sound in the kitchen at which time he emerged from the bathroom and observed [redacted] supine, holding [redacted] shirt at the collar and twisting it. [redacted] then observed [redacted] grab [redacted] wrist at the hand which [redacted] was using to grasp [redacted] shirt collar. [redacted] was trying to choke [redacted] and [redacted] said, "Let my shirt go."

[redacted] also attempted to punch [redacted] with his free hand and also kicked [redacted] At that point [redacted] intervened, and [redacted] let go of [redacted] hand. However, [redacted] did not release [redacted] shirt. [redacted] then secured [redacted] hand and broke [redacted] grip on [redacted] [redacted] then turned his back on [redacted] and began to walk away. As [redacted] did so, [redacted] kicked [redacted] in the rear-end. [redacted] turned around, put his hand on [redacted] head and twisted [redacted] wrist.

Judge who presided over the hearing found the audio recording of the interview to exceed minimum standards of intelligibility on all material points. (See Justice Center Exh.10)

Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances Gray v. Adduci, 73 N.Y.2d 741 (1988), 300 Gramatan Avenue Associates v. State Division of Human Rights, 45 N.Y.2d 176 (1978), Eagle v. Patterson, 57 N.Y.2d 831 (1982), People ex rel Vega v. Smith, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross-examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it depending upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

In this case, the entirety of [redacted] hearsay statement is credited evidence. [redacted] had no apparent motive to fabricate. The Administrative Law Judge who presided over the hearing had the opportunity to listen to the recorded statement of [redacted] as he was interviewed by the Justice Center investigator. This interview occurred five days after the incident. It is clear that [redacted] candidly recalled details and was not coached or led to specific answers during the interview. Additionally, on the critical issue of whether [redacted] and [redacted] had disengaged, [redacted] hearing testimony is not credited evidence. Therefore, there is no credible evidence in the record that, at the time when [redacted] twisted [redacted] wrist and placed his hand on [redacted] head, [redacted] actions were an emergency intervention necessary to protect the safety of any person, including [redacted].

The next issue to be resolved is whether the Justice Center proved by a preponderance of the evidence that [redacted] engaged in the deliberate inappropriate use of a restraint. In order

to establish this element, the Justice Center must prove by a preponderance of the evidence that [redacted] used a restraint technique with an amount of force which was deliberately inconsistent with [redacted] individual treatment plan or behavioral intervention plan.

In support of this finding, the Justice Center presented the *Behavior Support Program* for [redacted] (Justice Center Exh. 15); the [redacted] *Residential Services Individual Plan for Protective Oversight* (Justice Center Exh. 16); and *Strategies for Crisis Intervention and Prevention* (Justice Center Exh. 22).

The Justice Center also called as a witness [redacted], Residential Coordinator for the [redacted]. [redacted] testified that he was, until 2013, a certified SCIP trainer. [redacted] testified that, if a service provider was kicked while the provider was walking away from a service recipient, SCIP procedures dictate that the service provider simply walk away because the contact (kick) was not ongoing. [redacted] testimony was corroborated by the *Annual Refresher Strategies for Crisis Intervention and Prevention (Revised) Manual* which appears in the record. (Justice Center Exh. 22 p.9) Additionally, [redacted] testified SCIP training never prescribes inflicting joint manipulation as an SCIP technique or operating against the natural range of motion of the service recipient's joints. [redacted] testified that SCIP is not a "martial arts course, it's not a self-defense course."

On cross–examination, [redacted] acknowledged that [redacted] *Behavior Support Program* states as follows:

> Assault: [redacted] can become physically aggressive (hitting, kicking, pulling hair, scratching, digging and spitting) at times.
>
> -Should he engage in these behaviors staff must take immediate action to stop him, using the least restrictive SCIP-R interventions.

> -Sometimes this can be limited to arm control or a standing arm control or a standing seat wrap, for the safety of [redacted] and other's in area. (Justice Center Exh. 15 p.6)

It was further acknowledged that [redacted] was a non-permanent employee and only worked a few hours per week at [redacted]. Additionally, although all of the [redacted] staff are required to have SCIP refresher training annually, [redacted] refresher training had not been timely completed and [redacted] was, at the time of the incident, three months delinquent in completing his refresher training.

Conclusion on Abuse

[redacted] denied in his testimony that he was familiar with [redacted] behavioral management/intervention plan as in effect on [redacted]. [redacted] counsel argued that therefore, [redacted] could not have used a restraint technique which was deliberately inconsistent with [redacted] individual treatment plan or behavioral intervention plan.

This argument fails because [redacted] *Behavioral Support Program*[6] specifically incorporates by reference SCIP techniques. Clearly, [redacted] was not protecting himself or others when he engaged in this physical intervention with [redacted] and utilized techniques which were not specifically authorized by SCIP. [redacted] was an approximately five year employee of the [redacted] Additionally, irrespective of the fact that [redacted] SCIP training lapsed, in his testimony [redacted] acknowledged being familiar with the requirements of SCIP. Further, [redacted] was very familiar with [redacted] propensity to be assaultive and to act out. In fact, [redacted] testified that in [redacted] he had been involved in a physical intervention with [redacted] which ultimately required police intervention and the removal of [redacted] to an in-patient psychiatric emergency center.

[6] [redacted] *Behavior Support Program* (Justice Center Exh. 15) was referred to throughout the hearing record as the document which is the functional equivalent to the statutory terms "behavioral intervention plan" and "individual treatment plan."

After considering all of the evidence, including [redacted] intimate knowledge of [redacted] behaviors, [redacted] SCIP training and the fact that [redacted] *Behavior Support Program* specifically requires the use of SCIP techniques, [redacted] intentional use of a non-SCIP prescribed technique is tantamount to using a restraint technique which is deliberately inconsistent with [redacted] behavioral intervention plan.

Regarding the substantiation for *physical abuse*, after considering all of the evidence, the Justice Center did not establish that [redacted] use of a non-SCIP prescribed physical intervention injured [redacted]. The medical records do indicate that [redacted] suffered from a wrist strain. (Justice Center Exh. 12) However, [redacted] reported to [redacted] staff that he injured his wrist when he fell to the floor during the intervention. (Justice Center Exh. 14) Additionally, DSP [redacted] reported that he himself had secured [redacted] hand and broke [redacted] grip on [redacted] when [redacted] was potentially choking [redacted] The Justice Center has not established by a preponderance of the evidence that [redacted] caused [redacted] wrist injury when [redacted] bent the wrist and placed his hand on [redacted] head. Simply stated, [redacted] may have been injured before [redacted] retaliated or may have been injured when DSP [redacted] intervened. The evidence on this issue is inconclusive.

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 under SSL § 488(1)(d) Deliberate inappropriate use of restraints. However, the Justice Center has not me its burden of proving abuse pursuant to SSL § 488(1)(a) Physical abuse. The substantiated report will not be amended or sealed as it pertains to the finding under SSL § 488(1)(d) Deliberate inappropriate use of restraints.

Substantiation Category

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes a category two level of abuse**.**

The legal issue to be addressed is whether Calvo's conduct in grasping the wrist and head of [redacted] and placing [redacted] in a supine position, seriously endangered the health, safety or welfare of [redacted].

The substantiated report is properly categorized as a level two category finding. [redacted] did, when he re-engaged [redacted] in a physical conflict, seriously endanger the health, safety or welfare of [redacted].

The record is clear that [redacted] propensity for agitation is significant. Any physical restraint with [redacted] has the real potential to harm [redacted] because his disability contributes to extreme reactivity and a propensity for agitation and physical retaliation in situations like the one presented in this case. Stated another way, once [redacted] is physically engaged, it is clear that he is likely to remain engaged and that his behavior will escalate physically. A non-SCIP physical intervention is capable of seriously endangering the health, safety or welfare of [redacted].

DECISION: The request of [redacted] that the substantiated report [redacted] be amended and sealed is granted in part and denied in part. The Justice Center has established by a preponderance of the evidence the finding of *Deliberate inappropriate use of restraints*. Therefore, the Subject's request to amend and seal is denied as to the finding of *Deliberate inappropriate use of restraints*. However, as to the finding of *Physical abuse, which is also a variant of abuse*

contemplated under the relevant statute, the Subject has not been shown by a preponderance of the evidence to have committed *Physical abuse*. Therefore, the Subject's request to amend and seal the report as to *Physical abuse* is granted pursuant to SSL § 494(1) (a) and Title 14 NYCRR § 700.6 (a).

The substantiated report is properly categorized as a level two category.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register. Category two conduct 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 not elevated to a category one finding shall be sealed after five years pursuant to SSL § 493(4)(b).

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

Dated: March 11, 2014

