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

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**FINAL DETERMINATION AND ORDER AFTER HEARING** **Adjudication Case #:** [redacted]

Held at: Adam Clayton Powell Jr. State Office Bldg.
163 West 125th Street, NY, NY
On: [redacted]

Parties: Justice Center for the Protection of People with Special Needs
By: Tracy Steeves, Esq.
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[redacted]

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject), and another custodian, [redacted], for physical abuse against a Service Recipient. The Subject invoked an internal administrative review which was denied. An administrative hearing was then held, on [redacted], in accordance with the requirements of Social Services Law § 494 and Part 700 of 14 NYCRR.

PROCEDURAL HISTORY

The VPCR contains a substantiated report, [redacted], of physical abuse by the Subject against the Service Recipient**.** The report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center). The substantiated report as against the Subject, dated [redacted], concluded that:

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian (DSA), you committed an act of physical abuse when you kicked a service recipient multiple times while she was being held on the ground.
>
> This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493. *Justice Center Exhibit 1.*

An Administrative Review was conducted at the request of the Subject to amend the report and the Justice Center Administrative Appeals Unit denied the request. On [redacted], upon consent of both the Subject and [redacted], their attorney, and the Justice Center, a joint Hearing (the Hearing) was held.

The Administrative Law Judge issued a Recommended Decision after Hearing (Recommended Decision). That Recommended Decision is rejected by the Executive Director pursuant to 14 NYCRR 700.13 and the following constitutes the Final Determination of the Executive Director under 14 NYCRR 700.13.

FACTS

At the time of the alleged abuse, the Subject was employed at the [redacted] (the Facility), which is operated by the New York State Office for People With Developmental Disabilities (OPWDD), and is a facility or provider agency subject to the jurisdiction of the Justice Center.

On [redacted], the Subject was working the 3pm- 11:30pm shift and was assigned to Wing [redacted]. Wing [redacted] was a multiple diagnostic unit (the Unit) and the residents had both developmental and psychological diagnosis. On the evening of [redacted] the Service Recipient was involved in a verbal altercation with the Subject and there was a physical altercation, involving the Service Recipient, the Subject and [redacted].

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegation constitutes physical abuse.
- Pursuant to Social Services Law § 493(4), the category level that the physical abuse constitutes.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in facilities and provider agencies. Social Services Law § 492(3) (c) and 493(1) and (3). Pursuant to Social Services Law § 493(3), the Justice Center determined that the initial report of physical abuse presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a

preponderance of the evidence that the alleged act or acts of abuse or neglect occurred …" (14 NYCRR 700.3(f))

Pursuant to Social Services Law §§ 494(1)(a)(b) and (2) and 14 NYCRR 700.13 this Final Determination of the Executive Director will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitutes physical abuse; and pursuant to Social Services Law § 493(4), the category level that the physical abuse constitutes.

Physical abuse of a service recipient is defined by Social Services Law § 488 (1)(a) as:

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

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 physical abuse alleged in the substantiated report and that such act or acts constitute the category level of physical abuse set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

As is relevant to this proceeding, substantiated reports of abuse or neglect shall be categorized pursuant to Social Services Law § 493(4) (a-c). The Subject has been substantiated for a Category 3 level offense, which is abuse and/or neglect committed by a custodian, not otherwise described in categories one and two. Social Services Law § 493 states in pertinent part:

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

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

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

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

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

If the Justice Center proves the alleged physical abuse, the report will not be amended and sealed. Pursuant to Social Services Law § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of physical abuse cited in the substantiated report constitutes a Category 3 level offense, as set forth in the substantiated report.

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

THE HEARING

The Justice Center called one witness, a supervising investigator and offered thirteen exhibits which were admitted into evidence. The Justice Center investigated the subject report of physical abuse and the investigation report was admitted into evidence as *Justice Center Exhibit 4.* *Justice Center Exhibit 13* is a CD which contains recorded statements of eighteen individuals obtained during the course of the investigation and the Justice Center played the recorded statements of two residents of the Facility who witnessed the subject incident (the incident), (Resident A and Resident B) and one staff member, [redacted] at the Facility, who witnessed the incident as well.

The Service Recipient, at the time of the incident, was a twenty-eight year old woman, functioning in the mild range of intellectual disabilities, with a secondary psychiatric diagnosis and had insulin dependent diabetes and chronic gastritis. *Justice Center Exhibit 4.*

The Justice Center Investigation Report, authored by Investigator [redacted] (who was no longer employed by the Justice Center at the time of the Hearing), documents the investigation into the incident and recommended that the allegation of physical abuse against the Subject be substantiated. In part, this recommendation was based on the investigative conclusion that three independent eyewitnesses (Resident A, Resident B and [redacted]) corroborated that [redacted] held down the Service Recipient while the Subject kicked/stomped the Service Recipient multiple times. The Justice Center Supervising Investigator who testified at the Hearing, also testified that [redacted] held the Service Recipient down while the Subject kicked/stomped her multiple times.

Resident A gave a recorded statement to the Justice Center Investigator on [redacted], three days after the incident. Resident A stated that during dinner on [redacted], the Service Recipient was angry at the Subject and was cursing at and attempting to attack her. The Subject then "lost it" and "took it to the street" throwing the Service Recipient to the floor and kicking the Service Recipient in the stomach/leg area, while [redacted] was holding the Service Recipient down. Resident A also stated that the Subject used a SCIP-R technique to take the Service Recipient down and at one point indicated that the Service Recipient tripped on the Service Recipient's feet/shoelaces and fell to the ground. Resident A did not recall the Service Recipient screaming or crying during the incident. Resident A added that the Subject had the "right" to kick/stomp on the Service Recipient because she was "defending herself". Resident A, during the recorded interview, was consistent, a number of times reiterating the core allegations, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted]. *Justice Center Exhibit 13.*

Resident B gave a recorded statement to the Justice Center Investigator on [redacted], three days after the incident. Resident B gave a similar account of the incident as to the core allegations. Resident B stated that the Service Recipient, during dinner, was swearing and throwing chairs and trying to get at the Subject. Resident B did not see the Service Recipient choke the Subject. Resident B remembered that the Service Recipient was on the floor being kicked/stomped by the Subject, while she was being held down by [redacted]. Resident B also stated that while on the floor, being kicked/stomped by the Subject and held down by [redacted], the Service Recipient was crying and complaining that her side hurt. Finally, Resident B indicated that the Subject and [redacted] did not get along. *Justice Center Exhibit 13.*

[redacted] was interviewed over the phone by the Justice Center Investigator on [redacted], one day after the incident and gave a recorded statement to the same Investigator on [redacted]. [redacted] stated that she was working on the Unit on [redacted] and witnessed the incident. The Service Recipient wished to leave the wing and was arguing with and cursing at the Subject, challenging her with statements to the effect of "you think you're bad" and "I am tired of you". The Subject responded that the Service Recipient was not going anywhere and by asking the Service Recipient "who the fuck do you think you are". Shortly thereafter, the Subject pushed the Service recipient to the floor. [redacted] then ran to the Service Recipient, who remained on the floor, and grabbed the Service Recipient by the arm and held the Service Recipient down while the Subject kicked/stomped on the Service Recipient several times on the chest area. While the Service Recipient was being held down by [redacted] and kicked/stomped by the Subject, the Service Recipient was screaming and saying words to the effect of asking the Subject why she was doing this and to let her go. [redacted] stated that no SCIP-R technique was utilized, but rather that the Subject pushed the Service Recipient to the floor. She also never saw the Service Recipient throw a chair.

[redacted] further stated that she told [redacted] and the Subject that they could not act that way and [redacted] and the Subject replied that [redacted] should "shut up". [redacted] then advised that she wished to leave the Unit which she did. She then reported the incident to her supervisor [redacted] and requested that [redacted] go to the Unit, which he declined to do, stating that he was busy with other matters. As [redacted] was leaving the grounds, she saw Resident B and told Resident B, who was present during the incident, that staff members are not allowed to "beat" on residents and advised Service Recipient B to make a report if that happens to her. Before leaving

the Facility on [redacted], [redacted] went to the Clinical Control Unit of the Facility, and reported the incident to [redacted]. *Justice Center Exhibit 13.*

[redacted] also indicated that she followed Facility protocol, which included filling out a portion of the OPWDD 147 form, on [redacted], which states in relevant part "I [redacted] witness supervisor [redacted] holding down [the Service Recipient] while staff [redacted] stomped and kick [the Service Recipient] with her foot. [The Service Recipient] was crying saying I want to leave the wing and tell. They refused to let [the Service Recipient] off. told [the Service Recipient] they would bye (sic) [the Service Recipient] snacks". *Justice Center Exhibit 12.*

[redacted] recorded statement was taken by the Justice Center Investigator on [redacted]. [redacted] was working on the date and time of the incident as the Core Supervisor of Building [redacted]. [redacted] stated that he did not have much of a recollection of [redacted] as it was a challenging day. He did recall that at approximately 5 pm he received a call from [redacted] from Clinical Control, during which [redacted] informed him that someone was in her office telling her that the Service Recipient was beaten up.

[redacted] went to the Unit to advise the Subject and [redacted] that they were the subjects of an abuse allegation and that they were being placed on administrative leave. The Subject and [redacted] indicated to [redacted] that they did not know what he was talking about and when [redacted] asked them what happened, the Subject replied words to the effect that the " [Service Recipient] is going to be the [Service Recipient] and she is going to do what she wants to do". The Subject then filled out a "Minor Occurrence" form (*Justice Center Exhibit 9)* and provided it to [redacted].

[redacted] did not recall signing the OPWDD 147 form, but when presented with the form (*Justice Center Exhibit 12),* he did acknowledge his signature on the form. *Justice Center Exhibit 13.*

The "Minor Occurrence" form completed by the Subject states, in essence, that the Service Recipient was agitated and attempted to attack staff and did grab the Subject around the neck. Staff intervened and performed a SCIP-R technique to calm the Service Recipient down and to prevent her from further attacking staff. The form also notes that the Service Recipient refused to be examined by medical personnel. *Justice Center Exhibit 9.* [redacted], in his recorded statement indicated that neither the Subject nor [redacted] told him which SCIP-R technique they had utilized. *Justice Center Exhibit 13.*

[redacted] testified at the Hearing, in relevant part, as follows: The Service Recipient, at the time of the incident, was angry and verbally aggressive during dinner. The Service Recipient swore at the Subject and picked up a chair in an attempt to throw it at the Subject. [redacted] stepped in front of the Service Recipient to stop her, but after a few minutes she was unable to hold her back. [redacted] let go of the Service Recipient and warned the Subject. The Service Recipient went after the Subject and attempted to punch and hit her. The Subject did a SCIP-R spin move and together they attempted to do a two person take down. While on the floor the Service Recipient grabbed the Subject's legs and the Subject, by moving her legs, like she was taking four or five steps, was able to escape the Service Recipient's grasp. While [redacted] denied holding the Service Recipient down, she testified that she reached down and touched the Service Recipient while attempting to calm the Service Recipient down. Finally, [redacted] testified that [redacted] was present during the incident.

The Subject testified at the Hearing, in relevant part, as follows: During dinner she became concerned that residents were going to hurt a nurse on the Unit. She talked to the nurse and a decision was made that the nurse would stay in the treatment room instead of coming on the Unit. The Service Recipient was very upset, verbally aggressive and was yelling and threatening the Subject. [redacted] was attempting to calm her down. The Service Recipient then picked up a chair and threw it. [redacted] was attempting to hold her back so that she was unable to attack the Subject. [redacted] finally had to step aside and the Service Recipient went after the Subject and put her hands around the Subject's neck. The Subject performed a SCIP-R spin move and along with [redacted] attempted to do a two person take down. The Service Recipient dropped to the floor and put her arms around the Subject's legs and she had to get her legs out from the Service Recipient's embrace which she did, but lost a shoe in the process. The Service Recipient was then held down on her upper body by [redacted] while attempting to calm the Service Recipient down.

The Service Recipient was then restrained by [redacted] who held down her upper body while attempting to calm the Service Recipient down.

As a result of the incident, police from the NYPD arrived on the scene and the Service Recipient denied that anything had occurred to the responding officers. She also refused all medical care and would not allow any examination or photographs of her body. *Justice Center Exhibits 4, 9 and 10.*

On [redacted], three days after the incident, the Service Recipient, provided a recorded statement to the Justice Center Investigator. She stated that nothing happened; the Subject did not hit her, she was not kicked by anyone and she was not held down. Notably, she

also specifically denied that anyone put any hands on her, that there was a restraint and that there was any SCIP-R technique utilized. She also acknowledged that she refused to be seen by medical personnel following the incident and stated that "she will be all right". *Justice Center Exhibit 13.*

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a), against the Service Recipient and that the physical abuse is properly categorized as a Category 3 offense under Social Services Law § 493(4)(c).

Three independent eyewitnesses (Resident A, Resident B and [redacted]), were unwavering as to the core allegations in the report, specifically, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted].

Moreover, while the Service Recipient denied that anything occurred on [redacted], her denial is not only in direct conflict to the above three eyewitness accounts of the incident, but is also contrary to the accounts provided by the Subject and [redacted], which renders the Service Recipient's denial fundamentally implausible. Notably, three days after the incident, the Service Recipient gave a recorded statement to the Justice Center Investigator in which she stated that nothing happened, the Subject did not hit her, she was not kicked by anyone and she was not held down. She also specifically denied that anyone put any hands on her, that there was a restraint and that there was any SCIP-R technique utilized. *Justice Center Exhibit 13.* The Subject and [redacted] both stated that they had their hands on the Service Recipient, that they attempted to conduct a takedown and that the Subject utilized some type of SCIP-R technique.

Additionally, statements attributed to the Service Recipient by eyewitnesses to the incident further undermine the reliability of the Service Recipient's denial and, in fact, support the consistent accounts provided by eyewitnesses Resident A, Resident B and [redacted], that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted]. For instance, Resident B stated that while on the floor, being kicked/stomped by [redacted] and held down by the Subject, the Service Recipient was crying and complaining that her side hurt. *Justice Center Exhibit 13.* According to [redacted], while the Service Recipient was being held down by [redacted] and kicked/stomped by the Subject, the Service Recipient was screaming and asking the Subject why she was doing this and to let her go. *Justice Center Exhibit 13.*

These statements of the Service Recipient, coupled with conditions under which they were made, lead to the conclusion that they are reliable. In addition, these statements, taken together with the consistent accounts of Resident A, Resident B and [redacted], as to the core allegations in the report, specifically, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted], and the inherently unreliable account provided by the Service Recipient, among other proof, establish by a preponderance of the evidence, the Subject's alleged conduct in the substantiated report. *Justice Center Exhibit 1.* It is also worthy of note that the recorded statements of Resident A, Resident B and the Service Recipient, were all taken within three days of the incident.

Resident A's statements that the Subject "lost it" and "took it to the street" throwing the Service Recipient to the floor and kicking her in the stomach/leg area, while [redacted] was holding the Service Recipient down and that the Subject had the "right" to kick/stomp on the Service Recipient because she was "defending herself" also constitute reliable evidence. They are

consistent with other accounts of the incident, that the Service Recipient was attempting to get to the Subject, and they describe, in plain language, the conduct, and the mind-set of the Subject and even demonstrate that Resident A felt the Subject was justified in such conduct as she was simply defending herself.

[redacted] statement, that she observed the Service Recipient asking to leave the wing and arguing with and cursing at the Subject, challenging her with words to the effect of "you think you're bad" and "I am tired of you" in conjunction with the Subject's response to the Service Recipient that she "was not going anywhere" and asking the Service Recipient "who the fuck do you think you are", were made under conditions which promote reliability. These statements are also relevant and probative as to the mind-set of the Subject and are consistent with the accounts of the incident provided by Resident A and Resident B.

Immediately following the incident [redacted] followed Facility protocol, which she had a duty to do, by completing a portion of the OPWDD 147 form, on [redacted], which states in relevant part "I [redacted] witness supervisor [redacted] holding down [the Service Recipient] while staff [redacted] stomped and kick [the Service Recipient] with her foot. [The Service Recipient] was crying saying I want to leave the wing and tell. They refused to let [the Service Recipient] off. told [the Service Recipient] they would bye (sic) [the Service Recipient] snacks". *Justice Center Exhibit 12.* Again, the statements made by [redacted] on the OPWDD 147 form, provide yet another consistent account of the operative, core allegations against the Subject, and were also made under conditions which support their reliability.

In short, the statements of Resident A, Resident B and [redacted], as to the operative facts, of what occurred on the floor, are strikingly similar and consistent with the core allegations in the substantiated report, that the Subject was kicking/stomping on the Service Recipient, while the

Service Recipient was being held down by [redacted]. These reliable accounts, coupled with the other proof admitted into evidence at the Hearing, clearly establish by a preponderance of the evidence, the Subject's alleged conduct in the substantiated report. *Justice Center Exhibit 1.*

While the Subject and [redacted] denied the core allegations in the substantiated report, both testified, in essence, that the Service Recipient was on the floor being held down and that the Subject's legs were moving while she was attempting to escape the Service Recipient's grasp.

The Subject testified, in pertinent part, that she did a SCIP-R spin move and along with [redacted] attempted to do a two person take down. The Subject testified that the Service Recipient dropped to the floor and put her arms around the Subject's legs and that she was getting her legs out from the Service Recipient's embrace which she did, but lost a shoe in the process. The Service Recipient was then held down on her upper body by [redacted] while attempting to calm the Service Recipient down.

[redacted] testified that the Subject did a SCIP-R spin move and together they attempted to do a two person take down. While on the floor the Service Recipient grabbed the Subject's legs and the Subject, by moving her legs, like she was taking four or five steps, was able to escape the Service Recipient's grasp. While [redacted] denied holding the Service Recipient down, she testified that she reached down and touched the Service Recipient while attempting to calm the Service Recipient down.

Even the Subject and [redacted] admit to physical contact, holding the Service Recipient down and the Subject's legs moving and in contact with the Service Recipient. Their bare, conclusory denials that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted], are simply not enough the overcome the reliable, consistent and unwavering accounts provided by Resident A, Resident B and [redacted], as

to the operative core allegations in the substantiated report, specifically that, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted].

Finally, physical abuse, in relevant part, is defined by Social Services Law § 488(1)(a) as "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".

The service recipient refused all medical care and would not allow any examination or photographs of her body (*Justice Center Exhibits 4, 9 and 10),* so that no actual injury or impairment was documented, however actual injury or impairment is not a necessary element of physical abuse under Social Services Law § 488(1)(a). While physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient can certainly establish an element of physical abuse, "causing the likelihood of such injury or impairment", is also an element of physical abuse, which when accompanied by the requisite conduct, establishes physical abuse under Social Services Law § 488 (1)(a).

Here, it is clear from the record that the Subject caused, by physical contact the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Clearly, the Subject kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted], in and of itself

is sufficient to establish the likelihood of this conduct causing physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Moreover, Resident B stated that during the incident the Service Recipient was crying and complaining that her side hurt (*Justice Center Exhibit 13*), and [redacted] stated that while the Service Recipient was being held down by [redacted] and kicked/stomped by the Subject, the Service Recipient was screaming and saying words to the effect of asking the Subject why she was doing this and to let her go. *Justice Center Exhibit 13*. These statements provide further support that such conduct produced the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Not only has the Justice Center established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a), against the Service Recipient, but it has also established that the physical abuse is properly categorized as a Category 3 offense under Social Services law § 493(4)(c).

The Administrative Law Judge in the Recommended Decision, recommended that this case be unsubstantiated, essentially based on two grounds: 1) The Justice Center did not established by a preponderance of evidence that the Subject abused the Service Recipient and 2) that the alleged abuse did not lead to an injury.

As to the portion of the recommendation, based on the premise that there was no actual injury established, this is plainly a misapprehension of Social Services Law § 488 (1)(a), which, as set forth above, does not require actual injury or impairment as an element.

The portion of the recommendation based on the failure of the Justice Center to establish the physical abuse by a preponderance of the evidence was largely based on perceived

inconsistencies in the Justice Center recorded statements which were admitted into evidence and that the recorded statements were hearsay.

As to the inconsistencies in the recorded statements the Administrative Law Judge noted that Service Recipient A stated that the Service Recipient attacked the Subject and she used a SCIP-R technique to get away from the Service Recipient and also that the Service Recipient ended up on the floor because she tripped on her own shoelaces. The Administrative Law Judge also indicated that according to [redacted] there was no SCIP technique and that [redacted] said she went immediately to [redacted] office to report the incident, and [redacted] said she never came to his office. Finally the Administrative Law Judge noted that Service Recipient B stated that the Service Recipient threw chairs, [redacted] said she did not.

Initially, these inconsistencies do not directly involve the core allegations in the substantiated report, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted]. Moreover, these inconsistencies do not implicate the operative facts involved in what occurred on the floor. In contrast, three independent eyewitnesses (Resident A, Resident B and [redacted]), were steadfast in their accounts as to the core allegations in the report, specifically, that the Subject was kicking/stomping on the Service Recipient, while the Service Recipient was being held down by [redacted].

Finally, hearsay is admissible in administrative proceedings and hearsay evidence can form the basis of an administrative determination. *Gray v. Adduci*, 73 N.Y.2d 741 (1988). Here, for the reasons set forth above, the evidence offered by the Justice Center and admitted into evidence, including, but not limited to the recorded statements of eyewitnesses Resident A, Resident B, the Service Recipient and [redacted] and the OPWDD 147 form (*Justice Center Exhibit 12),* were sufficiently relevant and probative to establish, by a preponderance of the evidence,

that the Subject committed physical abuse and that such physical abuse is properly set at Category 3.

Accordingly, based on the foregoing it is hereby:

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed physical abuse.

The substantiated report is properly categorized as Category 3 physical abuse.

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

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

DATED: August 5, 2015
Delmar, New York

_____
Davin Robinson
Chief of Staff

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #: [redacted]

Before: Diane Herrmann
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Bldg.
163 West 125th Street, NY, NY
On: [redacted]

Parties: Justice Center for the Protection of People with Special Needs
By: Tracy Steeves, Esq.
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[redacted]
By: Eric Wilkie, Esq.
CSEA, Inc.
143 Washington Ave.
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Albany, NY 12224

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (the Subject) for abuse and/or neglect. The Subject requested that the Justice Center, Administrative Appeals Unit (AAU) amend the report to reflect that the Subject is not a subject of the substantiated report. The AAU 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, [redacted], of abuse by [redacted] (subject) against a service recipient**.** The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

2. The initial report alleges, in pertinent part, that: on [redacted] the Subject committed an act of physical abuse when she kicked service recipient (SR) [redacted] (SR [redacted]) several times while she was being held on the ground by Subject [redacted].

3. The Justice Center substantiated the actions as a Category 3 offense pursuant to Social Service Law

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

5. At the time of the alleged abuse, the Subject was employed as a Care Aide at [redacted], a facility run by OPWDD, which is an Agency or Provider that is subject to the jurisdiction of the Justice Center.

6. On [redacted] the subject was working the 3pm- 11:30pm shift and was assigned to Wing [redacted].

7. Wing [redacted] is a multiple diagnostic unit and the residents have a developmental and psychological diagnosis.

8. On the evening of [redacted] SR [redacted] got involved in a verbal altercation with the Subject and became aggressive and there was a physical altercation.

9. As a result of the incident the police were called and SR [redacted] told the police that nothing happened.

10. On [redacted], upon consent of both the Subject [redacted] and Subject [redacted] and their attorney, and the Justice Center, a joint hearing was held.

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 or neglect that such act or acts constitute.

APPLICABLE LAW

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 or neglect presently under review was substantiated. A "substantiated report" means a report made "… if 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.

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

DISCUSSION

The Justice Center has not established by a preponderance of evidence that the Subject abused SR [redacted] and that abuse led to an injury.

The Justice Center called one witness, a supervising investigator. The witness did not complete the investigation or interview any of the witnesses but reviewed the investigation documents and evidence. The witness testified that on the evening in question Subject [redacted] held down SR [redacted] while Subject [redacted] kicked her. The Justice Center played the recording of three witnesses, SR [redacted], SR [redacted] and employee [redacted]

SR [redacted] told the investigator that SR [redacted] argued with Subject [redacted] and was yelling at her. She stated that SR [redacted] threw a chair at Subject [redacted]. SR [redacted] ended up on the ground and Subject [redacted] stomped on her stomach. She also testified that Subject [redacted] and worker [redacted] do not get along.

SR [redacted] told the investigator that SR [redacted] was attacking Subject [redacted] and grabbing at her clothes. She said that Subject [redacted] did a SCIP technique and SR [redacted]

[redacted] fell to the ground when she tripped on her own shoelaces. She said that Subject [redacted] was holding SR [redacted] down and that Subject [redacted] kicked her two times.

Employee [redacted] told the investigator that Subject [redacted] pushed SR [redacted] down and kicked her while Subject [redacted] held her down. She testified that she asked to leave the Unit and went immediately to Supervisor [redacted] to report the incident.

Subject [redacted] testified in her own defense. Subject [redacted] testified that during dinner she became concerned that residents were going to hurt the nurse. Subject [redacted] talked to the nurse and decision was made that the nurse would stay in the treatment room instead of coming on the unit. SR [redacted] was very upset and verbally aggressive. SR [redacted] was yelling and threatening Subject [redacted]. Subject [redacted] was attempting to calm her down. SR [redacted] then picked up a chair and threw it. Subject [redacted] was attempting to hold her back so that she couldn't attack her. She testified that Subject [redacted] finally had to step aside and SR [redacted] went after her and put her hands around her neck. Subject [redacted] said she did a SCIP spin move and her and Subject [redacted] attempted to do a two person take down. She said that SR [redacted] was put in a restraint and Subject [redacted] was held down her upper body and attempted to calm her down and she held on to her legs to stop her from kicking.

Included in the Justice Center evidence were multiple interviews. Investigator [redacted] testified that employee [redacted] did not come to speak to him after the incident. SR [redacted] testified that nothing happened.

In order to substantiate the case the Justice Center needs to prove by a preponderance of the evidence that Subject [redacted] committed an act of abuse against the SR. The testimony provided by the JC was inconsistent and contradictory. The witness's statements varied and were not consistent. SR [redacted] testified that SR [redacted] attacked Subject [redacted] and

she used a SCIP technique to get away from SR [redacted]. She also said that SR [redacted] ended up on the floor because she tripped on her own shoelaces. [redacted] said that there was no SCIP technique. [redacted] also said she went immediately to [redacted] office to report the incident, and [redacted] said she never came to his office. SR [redacted] said that SR [redacted] threw chairs, [redacted] said she did not.

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 would depend 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 hearsay evidence was not consistent and cannot be given enough weight to substantiate the charge of abuse. Only two witnesses with firsthand knowledge testified and that was Subject [redacted] and Subject [redacted]. Their testimony concerning the events of the evening was similar and plausible. The hearsay evidence is wholly refuted by direct and credible testimony. It is well established that hearsay evidence cannot prevail against a witness's sworn and not inherently incredible testimony. *Matter of Perry* 37 AD2d 367 (3rd Dept. 1971). E.g., *In the Matter of the Claim of Lucy Lopez v. the Commissioner of Lab*or. Slip Opinion 514794 (3rd

Dept. January 17, 2013).

The Justice Center has failed to prove by a preponderance of the evidence that the Subject abused SR [redacted] The substantiated report will be sealed.

DECISION: The request of [redacted] that the substantiated report [redacted] are amended and sealed is granted.

This decision is recommended by Diane Herrmann, Administrative Hearings Bureau.

DATED: August 27, 2014
Schenectady, New York

Diane Herrmann, ALJ