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

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

Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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

[redacted]

By: Edward Blodnick, Esq.
Blodnick, Fazio & Associates, P.C.
1325 Franklin Avenue
Suite 555
Garden City, New York 11530

[redacted]

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

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

The substantiated report is properly categorized as a Category 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

[redacted]

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: July 19, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #: [redacted]

Before:	Sharon Golish Blum Administrative Law Judge
Held at:	New York State Justice Center for the Protection of People with Special Needs 125 East Bethpage Road, Suite 104, Plainview, New York 11803 On: [redacted]
Parties:	Vulnerable Persons' Central Register New York State Justice Center for the Protection of People with Special Needs 161 Delaware Avenue Delmar, New York 12054-1310 Appearance Waived
	New York State Justice Center for the Protection of People with Special Needs 161 Delaware Avenue Delmar, New York 12054-1310 By: Christopher Mirabella, Esq.
	[redacted] By: Edward Blodnick, Esq. Blodnick, Fazio & Associates, P.C. 1325 Franklin Avenue Suite 555 Garden City, New York 11530

[redacted]

JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a substantiated report dated [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide required supervision to service recipients by failing to monitor and secure the basement, which resulted in an incident in which a service recipient was sexually assaulted.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. The facility, the [redacted], located at [redacted], is a forty-five bed residential substance abuse treatment facility for male youths that is operated by [redacted]. [redacted] is licensed by the New

[redacted]

York State Office of Alcoholism and Substance Abuse Services (OASAS), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. The facility is a two story residence with the staff offices on the first floor, residential accommodations on the first and second floors, and laundry facilities, a workout room, and a recreational area, including pool and ping pong tables in the basement. Facility policy states that the basement door must be kept locked and that, when it is unlocked, the service recipients in the basement must be supervised at all times. (Hearing testimony of Facility Director [redacted])

6. At the time of the alleged neglect, Service Recipient A, who was eighteen years of age, had a history of drug abuse, family problems, learning disabilities and depression. He began residing at the facility on [redacted], eleven days prior to the incident. At the time of the alleged neglect, Service Recipient B, who was almost sixteen years of age, had a history of drug abuse and behavioral issues. He began residing at the facility on [redacted]. (Justice Center Exhibits 9 and 10)

7. On the day of the alleged neglect, the Subject was a Counselor at the facility. His shift that day was from 8:00 a.m. until 8:00 p.m. The other staff members who were assigned to work that day were Counselor [redacted], whose shift was from 1:00 p.m. until 9:00 p.m. and Counselor [redacted], whose shift was from 3:00 p.m. until 12:00 a.m. (Justice Center Exhibit 7) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

8. The Counselors who are responsible for supervising the service recipients throughout the facility during a shift are designated as the "staff on" using the acronym "s/o" on the Shift Schedule Chart (Justice Center Exhibit 7). Facility Counselors are also assigned a caseload, which consists of a group of service recipients that the Counselor has been assigned the

[redacted]

responsibility to regularly meet with and monitor. (Hearing testimony of the Subject)

9. The Shift Schedule Chart for [redacted] (Justice Center Exhibit 7) indicates that both the Subject and Counselor [redacted] were designated as "staff on." For practical purposes, it was understood that the Subject was to be the "staff on" from the start of his shift until 4:00 p.m., and that after 4:00 p.m., Counselor [redacted] was to be the "staff on." This common practice allowed each Counselor to meet with and manage his own caseload for the half of the shift that he was not acting as the "staff on." (Hearing testimony of the Subject)

10. On [redacted], at approximately 9:00 a.m., the Subject first visited the basement during his shift and observed that the basement door had been left propped open. The Subject shut the door, which automatically locked. At approximately 1:30 p.m., a service recipient came to the Subject and asked for pool sticks. The Subject asked the service recipient if the basement door was open and the service recipient said "yes." The Subject provided the service recipient with the requested pool sticks and told him to "keep an eye on things." At that point, the Subject did not take any further measures. At some point thereafter, but before 3:00 p.m., the Subject went to the basement to check on the service recipients who were there. (Justice Center Exhibit 14 and Hearing testimony of the Subject)

11. Counselor [redacted] arrived at the facility at approximately 1:30 p.m. for his 3:00 p.m. shift. The Subject asked Counselor [redacted] to assume the responsibilities as the "staff on" at 3:00 p.m., an hour early, so that the Subject could begin working on his caseload then. (Hearing testimony of the Subject)

12. When Counselor [redacted] started his shift at 3:00 p.m., he called a "house standing" meeting, wherein all of the service recipients present in the facility gathered in one room. At that time, two service recipients were called up from the basement, where they had been unsupervised.

[redacted]

Thereafter, Counselor [redacted] concluded the meeting and immediately began conducting a group meeting with his caseload service recipients in an office until approximately 3:45 p.m. At 3:45 p.m., Counselor [redacted] began his "shift check-in procedures" in preparation for assuming responsibility as the "staff on" at 4:00 p.m. (Justice Center Exhibit 18 and Hearing testimony of the Subject)

13. After the 3:00 p.m. "house standing" meeting, the Subject began meeting with his own caseload service recipients individually in his office and abandoned the general "staff on" supervision of the service recipients who were in the facility. Although the Subject was aware that Counsellor [redacted] was not acting as the "staff on," as the Subject had requested, he nonetheless conducted himself as if he had been relieved of that responsibility by Counselor [redacted]. (Hearing testimony of the Subject)

14. At some point between 3:00 p.m. and 4:00 p.m., while watching television with other service recipients, Service Recipient A, who had said that he would do anything for cigarettes, was told by Service Recipient B that if he would insert a broomstick into his own anus, Service Recipient B would give him cigarettes. Service Recipient A agreed and, at approximately 4:00 p.m., he, Service Recipient B and approximately fifteen to twenty other service recipients went downstairs to the basement in furtherance of the arrangement. Once in the basement, Service Recipient A indicated that he could not go through with it. Service Recipient B reacted by insisting that the deed must be done and he volunteered to do it to Service Recipient A himself. With the other service recipients also in the basement, Service Recipient A allowed Service Recipient B to penetrate his anus with a broomstick. Service Recipient A, obviously experiencing pain, demanded that Service Recipient B stop, which he did. Thereafter, all of the service recipients went upstairs. Some service recipients vaguely disclosed to Counselor [redacted] that something had

[redacted]

happened. Service Recipient A disclosed the incident to the Subject at approximately 4:30 p.m., after he went to the bathroom and saw blood. (Justice Center Exhibits 6, 15 and 16)

15. As a result of the incident, Service Recipient A was transported to [redacted] Hospital, where he underwent various diagnostic testing and exploratory surgery to determine whether the incident had caused internal injuries, which it had not. (Justice Center Exhibit 19)

16. As a result of the incident, Service Recipient B was arrested and charged with two criminal offenses. (Justice Center Exhibit 11)

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

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

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

> "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

[redacted]

> recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision...

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2 which is defined as follows:

> (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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

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

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the

substantiated report was conducted by then Justice Center Investigator [redacted][1], who together with Facility Director of Services [redacted], testified on behalf of the Justice Center.

The Subject testified at the hearing on his own behalf.

A finding of neglect requires that the preponderance of evidence shows that the Subject engaged in conduct that breached his duty to the Service Recipients. The Subject's duty to the Service Recipients included following the schedule as set out in the Shift Schedule Chart (Justice Center Exhibit 7) and adhering to the facility policy that the basement door must be kept locked and that when it is unlocked, service recipients in the basement must be supervised at all times.

With respect to his duty to follow the Shift Schedule Chart (Justice Center Exhibit 7), the Subject testified that on [redacted], although his "staff on" shift was from 8:00 a.m. until 8:00 p.m., he was only supposed to be "staff on" until 4:00 p.m., and that Counselor [redacted] was thereafter assigned as "staff on," an arrangement that allowed each Counselor to manage his caseload for the four hours of his shift that he was not acting as the "staff on." The Subject testified that after Counselor [redacted] arrived at the facility at 1:30 p.m., the Subject asked him to change the plan and become the "staff on" at 3:00 p.m., instead of at 4:00 p.m., which he testified Counselor [redacted] had agreed to. The Subject testified that Counselor [redacted] called a "house standing" meeting at 3:00 p.m., which he submitted was proof that Counselor [redacted] was following through on his agreement to assume the "staff on" responsibility because Counselors usually start their "staff on" shift by conducting a meeting with all of the service recipients. The Subject testified that when the "house standing" meeting concluded, Counselor [redacted] immediately started a group meeting with his caseload service recipients, which lasted until approximately 3:45 p.m., and that the Subject was aware that Counselor [redacted] was not providing general supervision during this period, despite

[1] At the time of the investigation of this allegation, Investigator [redacted] was employed by the Justice Center, but subsequently became employed elsewhere.

[redacted]

his earlier agreement to do so. The Subject testified that even though he was aware that Counselor [redacted] had apparently not started supervising the service recipients as the "staff on" at 3:00 p.m., the Subject nevertheless considered himself relieved of the "staff on" responsibilities and began seeing his own caseload service recipients at 3:00 p.m.

The Subject's assertion that there was an informal agreement between the Subject and Counselor [redacted] that Counselor [redacted] would start to act as "staff on" one hour early at 3:00 p.m., was not supported by any other evidence in the record. The Subject did not mention this informal agreement in his signed statement dated [redacted] (Justice Center Exhibit 14), and, in fact, stated there that he turned the house over to Counselor [redacted] at 4:00 p.m.. Furthermore, no mention of the alleged arrangement was made by Counselor [redacted] in his signed statement dated [redacted] (Justice Center Exhibit 18) nor to Justice Center Investigator [redacted] during his [redacted] interview (Justice Center Exhibit 6).

In any case, whether or not Counselor [redacted] had agreed to assume the responsibility as the "staff on" at 3:00 p.m., he had no obligation to do so and, as the Subject knew that Counselor [redacted] had begun a meeting with his caseload and was not acting as the "staff on" at 3:00 p.m., the Subject had no reasonable basis for abandoning his responsibilities and thereafter attempting to shift the blame onto Counselor [redacted]. Accordingly, the Subject's failure to adhere to the Shift Schedule Chart (Justice Center Exhibit 7), by ensuring that the service recipients were being supervised after 3:00 p.m., was a breach of his duty and it was precisely during this period, between 3:00 p.m. and 4:00 p.m., when no one was acting as "staff on," that the misguided and deeply troubling incident occurred between Service Recipients A and B.

With respect to his duty to adhere to the facility policy that the basement door remain locked and that when it is unlocked, supervision of the service recipients is required, the Subject

made admissions in his written statement (Justice Center Exhibit 14) and in his testimony to the effect that he was aware that the facility policy was being violated and that he did not take immediate measures to restore compliance. The Subject testified that when he first went to the basement during his shift at approximately 9:00 a.m., he observed that the basement door had been left propped open. This warned him early in his shift that service recipients had gained unsupervised access to the basement. The Subject testified that when a service recipient approached him between 1:00 p.m. and 3:00 p.m., and requested pool sticks, the Subject asked the service recipient if the basement door was open, and that when the service recipient responded affirmatively the Subject told the service recipient to "keep an eye on things." The Subject testified that he did not go directly down to the basement to remedy the violation of facility policy that was occurring there, but rather, that at some point later on, the Subject went to the basement to check on the service recipients who were there. The Subject testified that when Counselor [redacted] called the "house standing meeting" at 3:00 p.m., two service recipients had been called up from the basement, where they had been unsupervised. All of these admissions establish that the Subject was aware that service recipients were gaining access to and spending time unsupervised in the basement contrary to facility policy.

The Subject testified that he was aware of the facility policy that the door to the basement remain locked and that staff members are to supervise service recipients at all times when the door is unlocked, but that he thought that Counselor [redacted] had let the service recipients into the basement at some point after Counselor [redacted] had arrived at the facility at 1:30 p.m., and that he assumed that Counselor [redacted] had given the service recipients permission to be in the basement unsupervised.

Facility Director of Services [redacted] testified that the Subject told him, on the date of the incident, that it had been the Subject himself who had let the service recipients into the

[redacted]

basement.

The Subject's counsel argued that because there was no proof that the Subject let the service recipients into the basement, someone else must have done so and, therefore, the Subject was not responsible for that which transpired thereafter.

The Subject's counsel argued that the Justice Center investigation was inadequate because the identity of the staff member who let the service recipients into the basement was never determined and, consequently, the Subject "got hung out to dry" and was simply the "fall guy."

The Subject's counsel argued that the Subject's duty as the "staff on" to supervise the "whole house" was too onerous and that, from 3:00 p.m. on there was no showing that the Subject did anything wrong.

All of the arguments presented by the Subject and his counsel were unpersuasive. As soon as the Subject became aware that service recipients were in the basement unsupervised, he had a duty to remove them from the area or to ensure that they were being supervised at all times while in the basement.

Regardless of how the service recipients gained entrance to the basement, the Subject was responsible for their supervision and he had actual knowledge of their unsupervised presence in the basement. Accordingly, the Subject's failure to adhere to the facility policy, was a breach of his duty and that breach of duty provided the opportunity for what transpired to have occurred.

A finding of neglect also requires that the preponderance of evidence shows that the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. In this case, there can be no doubt whatsoever that Service Recipient A sustained physical injury and protracted impairment of his physical, mental or emotional condition as a result of the incident. Service

[redacted]

Recipient B was also a victim of the Subject's breach of duty, as he was arrested and subjected to all of the obvious challenges that would be inevitable from having committed the act and the legal consequences thereafter. Although there was no physical injury to Service Recipient B, his arrest and prosecution were likely to cause him serious or protracted impairment of his mental or emotional condition.

Accordingly, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

The report will remain substantiated. The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Counsel for the Subject stipulated orally during the hearing that, should the allegation of neglect be substantiated, a Category 2 finding would be the appropriate disposition. Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report is properly categorized as a Category 2 act. It is clear from the record that the Subject's neglect seriously endangered the health, safety and welfare of the Service Recipients.

A substantiated Category 2 finding of abuse and/or neglect under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] of neglect by the Subject of a

[redacted]

Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

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

DATED: July 11, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge