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

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

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

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

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: October 3, 2016
Schenectady, New York

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

Adjud. Case #: [redacted]

Before: Louis P. Renzi
Administrative Law Judge

Held at: Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

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

FINDINGS OF FACT

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

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

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

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when, after becoming aware that a service recipient was injured and/or assaulted, you failed to report the incident to the Vulnerable Persons Central Register.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).[1]

Allegation 2

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

[1] This substantiation should have said abuse. The Subject had notice and defended against abuse (obstruction of reports of reportable incidents).

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

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

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

5. At the time of the alleged abuse and neglect, the Subject was employed by OPWDD for approximately twenty years and had been at the [redacted] for seventeen years. The Subject worked as a Developmental Assistant 2 Day Shift Supervisor and had been in that position for approximately ten years. (Hearing testimony of Subject).

6. At the time of the alleged abuse and neglect, the Service Recipient was a sixty five year old female with a diagnosis of diabetes and profound mental retardation. She was a resident of the [redacted] for at least seventeen years, according to the Subject. (Justice Center Exhibit 14; Hearing testimony of Subject)

7. On [redacted], the Subject arrived at the [redacted] at approximately 7:30 a.m. and was informed by the Night Shift Supervisor that the Service Recipient had been scratched by another service recipient. The Subject went to see the Service Recipient and noticed scratches under both of her eyes that were red and bruising. The Subject directed staff to apply cold compresses and made one unsuccessful attempt to reach an agency nurse. At 8:00 a.m., which was the usual time for service recipients to leave the [redacted] for their day program(s), the Subject decided to not send the Service Recipient to her program due to the appearance of her facial injuries. The Subject made no further attempts to obtain medical attention for the Service

Recipient until approximately 3:30 p.m., when he called agency nurse [redacted] R.N., on her personal cell phone and requested her to come to the [redacted] to check on the Service Recipient. Nurse [redacted] arrived at the [redacted] at approximately 4:45 p.m., examined the Service Recipient, found scratches around both of her eyes and the areas swollen, and instructed the staff to take the Service Recipient to the Emergency Room. (Hearing Testimony of Subject; Hearing testimony of Investigator [redacted]; Justice Center Exhibits 8, 18, 22)

8. RN [redacted] also telephoned Treatment Team Leader (TTL) [redacted] who arrived at the [redacted] TTL [redacted] photographed the Service Recipient and reported the incident to the Justice Center. (Justice Center Exhibits 6, 8, 18 and 22)

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

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made

as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

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

> (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
>
> (h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Social Services Law § 488(1) defines a "reportable incident" in relevant part as conduct which must be reported to the Vulnerable Persons' Central Register by a mandated reporter; such

conduct is further described in subsections (a) through (i) thereof, which define abuse, neglect and significant incidents.

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

> (h) "Significant incident" shall mean an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but shall not be limited to:
>
> (1) Conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian[.]

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

> (a) Mandated reporters shall report allegations of reportable incidents to the vulnerable persons' central register…and in accordance with the requirements set forth therein.
>
> (b) Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery. For purposes of this article, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another person, including the vulnerable person, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse and neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect 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 acts of abuse and/or neglect cited in the substantiated report constitute the category of abuse and 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 acts, described as "Allegation 1" and "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1- 21, 23) The Justice Center also presented an audio recording of the interrogation of the Subject. (Justice Center Exhibit 22) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted] who was the only witness who testified at the hearing on behalf of the Justice Center.[2]

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

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

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

The record establishes that the Subject was a custodian, and therefore a mandated reporter, who pledged to abide by the Code of Conduct for Custodians of People with Special Needs (Code

[2] The investigation was begun by Investigator [redacted] who subsequently left the Justice Center.

of Conduct). (Justice Center Exhibits 7, 23) At the time of the alleged abuse, the Subject was working at the facility as a Day Shift Supervisor and was a custodian as that term is defined in Social Services Law § 488(2). The Subject admitted that he did not report the incident. (Hearing Testimony of Subject; Justice Center Exhibit 22) The only issue to be decided here is whether the incident was reportable upon discovery.

SSL § 488(1) defines a "reportable incident" as abuse, neglect (488(1)(a-h)) or a "significant incident" (488(1)(i)), which is an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services.

The threshold for reporting an incident to the VPCR under SSL § 491 is significantly less than that for substantiating a report of abuse or neglect. The threshold for reporting is triggered when a mandated reporter witnesses a suspected reportable incident, or when another person comes before the mandated reporter in the mandated reporter's professional or official capacity, and provides the mandated reporter with reasonable cause to suspect that the vulnerable person (service recipient) has been subjected to a reportable incident. (SSL §§ 491(1)(b))

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

The risk of harm to this Service Recipient, who suffers from diabetes, from a scratch to her

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

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

When the Subject was questioned by Investigator [redacted], and again during his testimony at the hearing, as to why he did not report the incident, the Subject stated that he was very distracted; that he "...had so much going on…" at the time between work and home that the Subject was not thinking to his fullest capacity. (Hearing testimony of Subject; Justice Center Exhibits 8, 22) The Subject testified that he did not believe that this was a reportable incident because there were only scratches and the source of the injury to the Service Recipient was never established with any certainty. (Hearing Testimony of Subject) The fact that the Subject was distracted does not relieve him of the responsibility for reporting the incident. Additionally, the Subject needed only reasonable cause to suspect that the Service Recipient had been subject to a reportable incident and not certainty as to the source. Even if the Subject believed that the Service Recipient's scratches did not rise to the level of abuse, the Subject had an obligation to report the incident as a significant incident. (SSL §§ 488(1), 491(1)(b))

Accordingly, the Justice Center has proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when, after becoming aware that the Service Recipient was injured and/or assaulted, he failed to report the incident to

the Justice Center's Vulnerable Persons' Central Register (VPCR).

Allegation 2 - Neglect

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that he breached that duty, and that his breach either resulted in, or was likely to result in, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

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

The Subject arrived at the [redacted] at 7:30 a.m. and was immediately informed by the Night Shift Supervisor that the Service Recipient had been scratched by another service recipient. (Hearing Testimony of Subject) The Subject went to check on the Service Recipient and saw the scratch marks on her face along with the redness and bruising. (Hearing Testimony of Subject; Justice Center Exhibit 22) The Subject attempted to call Nurse [redacted] but could not get through to her and instructed the staff to apply cold compresses to the Service Recipient. (Hearing

Testimony of Subject) This was insufficient, particularly given the Service Recipient's diagnosis of diabetes, which the Subject understood can exacerbate even minor wounds. The Subject did not notify his supervisor, did not try to call other [redacted] nearby to contact a nurse and did not telephone the agency on-call nurse that is available 24 hours a day. According to the statement given to the investigator by Nurse [redacted] the Subject had multiple options for obtaining medical assistance. (Justice Center Exhibit 22) Instead, the Subject testified that he was distracted because his family was repeatedly calling him and there was a lot to do at the [redacted] The Subject did not send the Service Recipient to her day program because he was not going to send the Service Recipient to program "looking like that". (Justice Center Exhibit 22) It is inconsistent that the Subject would recognize the facial wounds as serious enough to keep her home, but not make adequate efforts to summon the nurse or notify the VPCR.

The Subject testified that he left the [redacted] taking other service recipients to their medical appointments and did not try the nurse again until his shift was almost over. RN [redacted] stated that she did not receive a call from the Subject, asking her to go and check on the Service Recipient until 3:30 p.m. and that by the time she arrived at the [redacted] it was 4:45 p.m. and the Subject had already left. The Service Recipient was then photographed, sent to the hospital, and the VPCR was notified. (Hearing testimony of Subject; Justice Center Exhibits 6, 16, 18 and 22)

When the Subject was shown the photograph of the Service Recipient (Justice Center Exhibit 6) taken by staff, he testified that the scratches did not look that bad when he first saw her. However, the Subject acknowledged that the bruising and redness worsened throughout the day and that the practice would have been to send the Service Recipient to the hospital as opposed to leaving her at the [redacted] all day. When asked during the interrogation: "When you saw this individual as a supervisor what are you supposed to do?" The Subject answered "Send her out to

the hospital". (Hearing Testimony of Subject; Justice Center Exhibit 22)

The evidence establishes that the Subject's breach of his duty to the Service Recipient resulted in the serious and protracted impairment of the physical condition of the Service Recipient, in violation of SSL § 488(1)(h). In failing to promptly follow up and ensure medical help was forthcoming early in the day, the Subject's breach of duty caused her injury to worsen throughout the day. The Subject arrived at the [redacted] at 7:30 a.m. and was made immediately aware of the Service Recipient's injuries, yet the Service Recipient was not seen by a nurse until 4:45 p.m. TTL [redacted] report states that the Service Recipient was taken to the Emergency Department for medical evaluation. (Justice Center Exhibit 16)

The evidence supports the conclusion that the Subject committed neglect when the Subject failed to promptly seek and obtain medical attention for the Service Recipient under these circumstances.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse and neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse and neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report of abuse and neglect is properly categorized as Category 3 conduct.

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is

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

The substantiated report is properly categorized as Category 3 conduct.

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

DATED: September 14, 2016
Schenectady, New York

Louis P. Renzi, ALJ