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: Todd M. Sardella, Esq.

[redacted]

By: Barbara A. Ryan, Esq.
Andrew C. Tobman, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP
600 Third Avenue
New York, New York 10016

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 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 abuse (deliberate inappropriate use of restraints) and physical abuse. The substantiated report will not be amended or sealed.

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

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

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

DATED: January 30, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeals 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 (deliberate inappropriate use of restraints). The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted] of abuse 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], while in the television room on the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you used an inappropriate technique to restrain and lift a service recipient onto a stretcher.

This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints), pursuant to Social Services Law § 493(4)(c).

Allegation 2

It was alleged that on [redacted], while in the television room on the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you placed a hand over a service recipient's mouth and/or chin during a restraint.

This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) and Category 3 physical abuse, 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, [redacted], [redacted], located at [redacted], is a mental health unit of a hospital which is operated by the [redacted] and licensed by the NYS Office of Mental Health (OMH), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the incident, the Subject was employed by [redacted] as a Patient Engagement Specialist (PES) with fifteen years of service. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of the Subject; Hearing testimony of OMH Risk Manager [redacted][1]; Justice Center Exhibit 24)

6. At the time of the incident, the Service Recipient was fifteen years of age, and had been admitted to the facility on two occasions during the preceding two months. He had a history of aggression, self-mutilating behavior and most recently, homicidal acts toward his parents. He was diagnosed with Asperger's syndrome, pervasive development disorder and post-traumatic stress disorder. He was re-admitted on [redacted]. (Hearing testimony of [redacted], M.D.; Hearing testimony of OMH Risk Manager [redacted])

7. On [redacted], the Service Recipient became extremely violent. Other staff performed a physical restraint during which the Service Recipient was taken to the floor in order to protect his safety and that of other persons. The Subject became involved after the Service

[1] Formerly [redacted]

Recipient was on the floor. The Service Recipient remained very agitated, spitting and attempting to bite staff. The Subject initially appeared with a towel intending to deflect saliva from the Service Recipient and thereby protecting himself and his co-workers. He was instructed by [redacted], the Assistant Nurse Manager on the scene, not to use the towel, but rather to hold his gloved hand a few inches away from the Service Recipient's mouth but not touching his mouth. The video evidence and the hearing testimony indicate that the Subject initially complied with that instruction. (Hearing testimony of the Subject; Hearing testimony of [redacted] Assistant Nurse Manager [redacted]; Justice Center Exhibits 24, 28)

8. Staff, including the Subject, monitored the Service Recipient's breathing and spoke with him while the Service Recipient remained in the prone position, attempting to calm and de-escalate him while protecting his head and ensuring his face was to the side and not facing down. The Service Recipient remained in the prone position for approximately seven minutes, during which time he was administered prescribed medication via intramuscular (IM) injection to the buttock. (Hearing testimony of OMH Risk Manager [redacted]; Hearing testimony of the Subject; Hearing testimony of [redacted], M.D.; Hearing testimony of [redacted], R.N., M.S.N.; Justice Center Exhibits 23, 24, 25, 28, 29)

9. While being restrained on the floor, the Service Recipient injured a female staff. During the transfer portion of the incident, he also injured a male staff. (Hearing testimony of [redacted] Mental Health Worker (MHW) [redacted]; Hearing testimony of [redacted] Assistant Nurse Manager [redacted]; Justice Center Exhibits 24, 28)

10. Although the Service Recipient had received a sedative, he remained combative. Four staff, including the Subject, grasped the Service Recipient by his limbs and lifted him from the floor to a wheeled stretcher, but did so without sufficient support to the Service Recipient's

torso and hips. The Subject was lifting the Service Recipient's left arm, PES [redacted] was lifting the right arm, MHW [redacted] was lifting the right leg and MHW [redacted] was lifting the left leg. The Subject attempted to support the Service Recipient's torso at the same time, but the Service Recipient thrashed about and this prevented him from adequately securing or supporting the Service Recipient's torso. Once on the stretcher, the Subject along with other staff employed a sheet restraint to control the Service Recipient's continued violent behaviors. (Hearing testimony of OMH Risk Manager [redacted]; Hearing testimony of the Subject; Hearing testimony of PES [redacted]; Justice Center Exhibits 23, 24, 28)

11. Once the Service Recipient was lying supine on the stretcher, the Subject and other staff employed a sheet restraint to control his continued violent behavior. During this time, the Subject gripped the Service Recipient's chin and held his hand in front of the Service Recipient's mouth, leaving visible space between his hand and the Service Recipient's mouth. The Service Recipient continued to move his head back and forth as he resisted the restraints being utilized. The Subject's hand then covered the Service Recipient's mouth for approximately one or two seconds. (Justice Center Exhibit 28)

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 reports.
- Whether the substantiated allegations constitute abuse.
- Pursuant to Social Services Law § 493(4), the category of abuse 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 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))

Physical abuse of a person in a facility or provider agency is defined by SSL § 488(1)(a) to include:

> (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 abuse (deliberate inappropriate use of restraints) of a person in a facility or provider agency is defined by SSL § 488(1)(d) to include:

> (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category three, 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 alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of abuse as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

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 acts of abuse cited in the substantiated report constitute the category of abuse as set forth in the substantiated report.

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

DISCUSSION

Allegation 1 – The Restraint and Lift onto the Stretcher

The Justice Center has established by a preponderance of the evidence that the Subject committed a prohibited act, described as "Allegation 1" in the substantiated report. Specifically, the evidence establishes that the Subject and other staff used an improper technique to restrain and lift the Service Recipient onto a wheeled stretcher. The Justice Center alleged and the proof at the hearing established that the transfer of the Service Recipient from the floor to the stretcher was performed using technique so poor that it violated SSL § 488(1)(d).

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-36) The investigation underlying the substantiated report was conducted by [redacted], RN, [redacted] Quality Management

Coordinator. [redacted], NYS Office of Mental Health (OMH) Clinical Risk Manager, was the sole witness who testified at the hearing on behalf of the Justice Center.

The Justice Center produced a visual-only copy of the surveillance recording of the incident made by the facility (Justice Center Exhibit 28), which was compelling evidence and extremely helpful in arriving at the conclusions herein. Substantial weight was given to this evidence.

The Subject offered eight exhibits which were received into evidence as Subject Exhibits A – H. The Subject testified in his own behalf and called two expert witnesses: [redacted], R.N., M.S.N., and [redacted], M.D. Six additional witnesses, all of whom were employees of [redacted], testified at the hearing: MHW [redacted], MHW [redacted], MHW [redacted], Assistant Nurse Manager [redacted], MHW [redacted] and PES [redacted].

In order to show abuse (deliberate inappropriate use of restraints), the Justice Center must prove by a preponderance of the evidence that either the technique used, the amount of force 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, and limits the ability of a person receiving services to freely move his or her arms, legs or body. (SSL § 488(1)(d))

Specifically, the Subject and other staff grasped the Service Recipient by his ankles and wrists and lifted him from the floor to the stretcher without adequately supporting his torso, which is an improper technique. OMH Risk Manager [redacted] testimony in this regard is credited. The video evidence clearly shows that the Subject, while lifting the Service Recipient by the arm, was also attempting to support the Service Recipient's torso, which proved to be an inadequate safeguard. During this transfer, the Service Recipient continued to thrash, which caused the Subject to lose his grip on the torso area. At that point, the thrashing Service Recipient

was in danger of being dropped to the floor, striking the metal frame of the stretcher, or being otherwise injured, perhaps seriously. It is thus concluded that the technique used by the Subject, combined with the amount of force necessarily used in lifting this heavy individual only by his limbs, was deliberately inconsistent with generally accepted treatment practices for safely lifting a service recipient from the floor to a stretcher. (Hearing testimony of OMH Risk Manager [redacted]; Justice Center Exhibit 28)

The Subject takes the position that this was an emergency intervention and therefore justified under the statutory exception set forth in SSL § 488(1)(d) for such conduct. During this portion of the incident, the Service Recipient was still resisting the efforts of staff, and was still spitting and attempting to bite those involved. Nevertheless, at this point he was under their control, and had been given medication as described above. In addition, the Subject could have requested additional assistance in performing the lift. The evidence does not support a conclusion that the Service Recipient still posed the level of danger to himself, staff or other persons that is contemplated by the statute. Therefore, it is concluded that the emergency exception was not applicable to the conduct described in Allegation 1. (Hearing testimony of the Subject; Hearing testimony of OMH Risk Manager [redacted]; Justice Center Exhibit 28)

Accordingly, it is concluded that the actions of the Subject constituted abuse (deliberate inappropriate use of restraints) in violation of SSL § 488(1)(d), with respect to the restraint and lift of the Service Recipient onto the stretcher.

Although that portion of the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse 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 as to Allegation 1 is properly categorized as a Category 3 act.

Allegation 2

Allegation 2 charges the Subject with having committed two different violations of SSL § 488(1); the first being abuse (deliberate inappropriate use of restraints) and the second being physical abuse. Both allegations arise from the same alleged act, which is that the Subject placed his hand over the Service Recipient's mouth and/or chin during the underlying restraint.

The Justice Center established by a preponderance of the evidence that the Subject committed a prohibited act, described as "Allegation 2" in the substantiated report. Specifically, the evidence shows that the Subject used his gloved hand to grip the Service Recipient's chin while the Service Recipient was lying on the stretcher. The evidence further shows that the Subject's hand then briefly covered the Service Recipient's mouth. The Subject's conduct during the incident constituted abuse (deliberate inappropriate use of restraints), in violation of SSL § 488(1)(d), and physical abuse, in violation of SSL § 488(1)(a). (Justice Center Exhibit 28)

Abuse (deliberate inappropriate use of restraints)

In order to show abuse (deliberate inappropriate use of restraints), the Justice Center must prove by a preponderance of the evidence that either the technique used, the amount of force 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, and limits the ability of a person receiving services to freely move his or her arms, legs or body. (SSL § 488(1)(d))

During the prone portion of the restraint, the Subject brought a towel to the scene. His testimony on this point, which was corroborated and is credited evidence, is that he was then

instructed by Assistant Nurse Manager [redacted] not to use it, but rather, to place his hand several inches away from the mouth of the Service Recipient to block the saliva without touching his mouth. The video camera angle does not depict the Service Recipient's face while he was on the floor, but it does show that the towel was set aside and not employed. There were several staff involved in the restraint who were near the Subject at the time, and they testified consistently that the Subject did not place his hand on the Service Recipient's mouth or chin. Thus, the preponderance of the evidence provides no basis for concluding that, during this portion of the restraint, the Subject committed any violation of SSL § 488(1)(a) or (d). (Hearing testimony of the Subject; Hearing testimony of [redacted] Assistant Nurse Manager [redacted]; Hearing testimony of MHW [redacted]; Hearing testimony of PES [redacted]; Justice Center Exhibit 28)

Conversely, after the Service Recipient was transferred to the stretcher, the video evidence clearly depicts the Subject's hand gripping the chin of the Service Recipient, and resisting the Service Recipient's efforts to move his head. The Subject testified that he was attempting to keep the Service Recipient from hitting his head on the stretcher rails while thrashing about, and to block saliva being spit at staff by the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 24, 28)

Gripping the chin of a service recipient to restrain his or her head from moving is not an authorized or accepted method of restraint, due to the risk of neck injury. (Hearing testimony of OMH Risk Manager [redacted]) For reasons set forth above, there is also no basis for concluding that this conduct fits under the emergency exception set forth in the statute.

It is concluded that by using this technique to restrain the Service Recipient, the Subject committed an act of abuse (deliberate inappropriate use of restraints).

Physical Abuse

The third allegation contained in the report, alleged as part of Allegation 2, is that the Subject also committed physical abuse by virtue of the same act of placing his hand on the Service Recipient's mouth and/or chin.

In order to prove physical abuse, the Justice Center must prove that a custodian intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or caused the likelihood of such injury or impairment. In relevant part, such conduct may include smothering or choking.

The video evidence supports a conclusion that the Subject placed his hand so close to the Service Recipient's mouth and chin area as to block his airway or cause a substantial likelihood that such would occur. The Subject testified that he was placing his hand in front of the Service Recipient's mouth as a shield, in such a way as to block the saliva being spit at staff by the Service Recipient, but not tightly over the mouth or even so close as to risk blocking his airway. This testimony is controverted by the video evidence, which shows that the Subject was gripping the chin of the Service Recipient, thereby making physical contact. At one point the video shows that the Subject's hand slipped over the mouth of the Service Recipient for approximately one or two seconds. This last act was likely not intentional, since it was clear that staff were faced with a difficult patient and at the time were attempting to utilize a sheet restraint that required multiple staff, including the Subject, to employ. Nevertheless, under the circumstances, it was reckless conduct to permit the Service Recipient's airway to be blocked, even for a second. SSL § 488(16) indicates that the word "recklessly" has the same meaning as provided in New York Penal Law § 15.05. Under New York Penal Law § 15.05(3), a person acts "recklessly with respect to a result or to a circumstance" when the person is "aware of and consciously disregards a substantial and

unjustifiable risk that such result will occur." Thus, it is concluded that this conduct constitutes a violation of SSL § 488(1)(a), and was therefore physical abuse.

Again, for reasons set forth above, this conduct cannot be excused as a reasonable emergency intervention.

Accordingly, it is determined that the Subject did commit an act of physical abuse against the Service Recipient, as alleged in Allegation 2 herein.

Although Allegation 2 will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

A substantiated Category 3 finding of abuse will not result in a Subject's name being placed on the VPCR Staff Exclusion List and the fact that a Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

DECISION: The request 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 abuse (deliberate inappropriate use of restraints) and physical abuse. The substantiated report will not be amended or sealed.

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

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

DATED: January 20, 2017
Schenectady, New York

Louis P. Renzi, ALJ