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: Jennifer Oppong, Esq.

[redacted]
By: Nathaniel K. Charny, Esq.
Charny & Associates
9 West Market Street
Rhinebeck, New York 12572

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], [redacted] 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 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: February 2, 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 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: Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive
Spring Valley, New York 10977
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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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], [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 maintain proper supervision of a service recipient, during which time he injured himself on a window.
>
> 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 inpatient psychiatric hospital for children and adolescents, operated by the NYS Office of Mental Health (OMH), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was working as a Mental Health Therapy Aide (MHTA) and was assigned 1:1 constant observation with the Service Recipient. The Subject had been working at the facility for 23 years and had been an MHTA for 16 years. (Hearing Testimony of Subject; Justice Center Exhibit 9)

6. At the time of the alleged neglect, the Service Recipient was a 14 year old male who was admitted to the facility on [redacted] from the [redacted]. The Service Recipient had a history of violence and was insulin dependent. The Service Recipient had several aggressive outbursts at the facility and was placed under constant observation on [redacted]. The Service Recipient was assigned to Cottage [redacted] and was residing behind the unit's partition to ensure the safety of the Service Recipient and others. (Justice Center Exhibits 10 and 14)

7. At the time of the alleged neglect, the Subject was inside the play/activity room and the Service Recipient was in the adjoining corridor. The Service Recipient had access to his bedroom and to the play room, however was separated from the other service recipients by a partition door in the corridor. The partition door had a window through which the Service Recipient could view the other service recipients in the common area. (Justice Center Exhibits 5 and 26)

8. At approximately 4:10 p.m., the Service Recipient began pulling at the partition door's window frame. The Subject was in the play room, exited briefly and went into the hall close to the Service Recipient. The Subject then returned to the play room. At approximately 4:21 p.m., the Service Recipient resumed pulling on the window frame. The Service Recipient then entered the play room, came back out and resumed pulling the window frame of the partition door at 4:25 p.m. The Subject remained in the play room. At approximately 4:39 p.m. the

Subjected activated his Personal Alarm Locator (PAL), calling for assistance. (Justice Center Exhibit 5)

9. At approximately 4:42 p.m., the Service Recipient entered his bedroom, came back out quickly, entered the play room, exited and resumed pulling at the partition door. At approximately 4:43 p.m., the Service Recipient walked down the hallway, attempting to open other doors and kicked his bedroom door open. At approximately 4:45 p.m., the Service Recipient began to pull at the partition door's window frame more forcibly. The Subject remained in the play room. At approximately 4:48 p.m., the Service Recipient opened his bedroom door, exited and resumed pulling forcibly at the partition door's window frame. The Subject is seen in the doorway of the playroom adjacent to the Service Recipient at approximately 4:55 p.m. (Justice Center Exhibit 5)

10. By the time the team arrived in response to the Subject's call for assistance, the Service Recipient had already broken off a piece of the door and was able to stick his hand in the glass, causing minor lacerations and bleeding to his hands. The Service Recipient had a piece of the door in his hand and was threatening to hit someone. The Service Recipient continued to pull at the door to get more pieces and when the team was unable to de-escalate the situation, the Service Recipient was restrained. (Justice Center Exhibit 5)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), to include:

> (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.

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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the 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 an act, described as "Allegation 1" in the substantiated report. Specifically, the evidence establishes that the Subject committed neglect when the Subject failed to maintain proper supervision of a service recipient, during which time he injured himself on a window.

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))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-28) The investigation underlying the substantiated report was conducted by OMH Risk Manager [redacted], who was the only

witness who testified at the hearing on behalf of the Justice Center.

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

The Justice Center submitted visual only videos of the incident, which were extremely helpful and illuminating evidence with respect to the substantiated allegation. (Justice Center Exhibit 27)

On the day of the alleged neglect, the Subject was working as an MHTA at the facility and was a custodian as that term is defined in Social Services Law § 488(2). The Subject was assigned constant observation of the Service Recipient, whereby one staff member is assigned the responsibility to observe one service recipient on a constant basis. (Hearing Testimony of Subject; Justice Center Exhibits 9 and 25) The Subject acknowledged that he had to watch the Service Recipient all of the time. (Justice Center Exhibit 24) The Subject owed a duty to the Service Recipient to constantly observe the Service Recipient at all times. (Justice Center Exhibit 25)

At approximately 4:10 p.m., the Service Recipient began pulling at the partition door. At approximately 4:16 p.m. the Subject is seen in the hallway close to the Service Recipient for a few seconds. The Subject then returns to the play room, were he remains until after the response team arrives. (Justice Center Exhibit 5) There was conflicting evidence at the hearing as to whether or not the Subject could see the Service Recipient while the Subject was in the play room. The Subject testified that he could see the Service Recipient. OMH Risk Manager [redacted] testified that the Subject's line of vision to the partition door from where the Subject was seen sitting in the playroom was obstructed by a wall. Additionally, OMH Risk Manager [redacted] testified that the Subject was not able to see the Service Recipient when the Service Recipient entered his bedroom. The testimony of OMH Risk Manager [redacted] is credited based upon the video evidence presented by the Justice Center.

The Subject breached his duty to the Service Recipient by not observing the Service Recipient on a constant basis. The Subject remained in the play room for almost the entire time that the Service Recipient was pulling at the partition door, pulling on the window frame and kicking his bedroom door, without being able to constantly observe the Service Recipient. The Service Recipient stated that the Subject was in the activity room with the door closed, watching TV and that no one tried to stop him from breaking the door. (Justice Center Exhibit 5)

The Subject did not activate his PAL until approximately 29 minutes after the Service Recipient began pulling at the partition door. OMH Risk Manager [redacted] testified that the PAL should have been activated as close to the event as possible. In his defense, the Subject testified that he did not activate his PAL earlier because there was only imminent danger to property and not imminent danger to the Service Recipient. The credited evidence does not support this claim. The Subject was trained to ensure the safety of the Service Recipient at all times. The reason that the Service Recipient was on constant observation was to ensure his safety. MHTA [redacted] stated that the Service Recipient was pounding on the windows for quite a while. Had the Subject been constantly observing the Service Recipient, surely he would have activated his PAL long before 29 minutes had elapsed. It is thus concluded that the Subject breached his duty to constantly observe the Service Recipient.

The Subject's breach resulted in physical injury and the protracted impairment of the physical, mental and emotional condition of the Service Recipient. When MHTA [redacted] arrived after the Subject activated his PAL, the Service Recipient's hand was already bleeding and the Service Recipient was holding a piece of the door in his hand, threatening to hit someone with it. [redacted] stated to the investigator that when he arrived, the Service Recipient was visibly agitated and had minor lacerations to the fingers of both hands. Accordingly, the Subject

committed neglect when he failed to maintain proper supervision of the Service Recipient, during which time the Service Recipient injured himself. (Justice Center Exhibit 5 at p. 10)

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 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 or 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 is properly categorized as a Category 3 act.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the 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 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 neglect.

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

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

DATED: January 27, 2017
Schenectady, New York