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 of the Subject that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints). The substantiated report will be amended and sealed.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons Central Register, pursuant to SSL § 493(3)(d).

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 23, 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: Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
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 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 participated in an inappropriate prone restraint of a service recipient.

This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints), 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], 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 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 an Assistant Nurse Manager with seven 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. The Subject and two other staff attempted to de-escalate the Service Recipient but were unsuccessful. They ultimately 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. (Hearing testimony of Subject; Justice Center Exhibits 24, 28)

8. Once on the floor, the Subject and other staff, including staff who had just arrived, continued to attempt de-escalation techniques, specifically verbal communication with the Service Recipient. The objective was to allow the Service Recipient to stand and be released from the restraint. The Subject and other staff obtained a commitment from the Service Recipient that he was calm and would cooperate. (Hearing testimony of the Subject; Justice Center Exhibit 28)

[1] Formerly [redacted].

9. The Service Recipient was allowed to stand, but became immediately combative again and was returned to the floor on his side. The Service Recipient, who was lying on his left side, rolled himself onto his stomach, otherwise referred to as the prone position. (Hearing testimony of the Subject; Justice Center Exhibit 28)

10. 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)

11. While being restrained on the floor the Service Recipient injured a female staff member. (Hearing testimony of the Subject; Justice Center Exhibits 24, 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))

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

The Justice Center did not establish by a preponderance of the evidence that the Subject committed the prohibited acts with respect to her participation in an inappropriate prone restraint of the Service Recipient as alleged in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-36) 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 seven exhibits which were received into evidence as Subject Exhibits A – G. The Subject testified in her 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: Mental Health Worker (MHW) [redacted], MHW [redacted], PES [redacted], MHW [redacted], MHW [redacted] and Patient Engagement Specialist (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))

[redacted] testified that in his expert medical opinion, the restraint was performed and concluded within the bounds of the standards of care observed by the medical community, and was not in violation of any law, regulation, policy, rule or protocol then applicable to the [redacted] facility. [redacted] testimony is credited.

The testimony of [redacted], RN, MSN, essentially aligned with that of [redacted] in that having observed the video evidence, she found no fault with the actions of staff during the prone portion of the restraint. This testimony is also credited evidence.

SSL § 488(1)(d) contains an exception to a finding of abuse (deliberate inappropriate use of restraints). It is not a violation "…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." Here, the evidence showed that the Service Recipient was a physically strong individual whose behavior was extremely violent at the time of the incident. The Subject testified credibly that staff had attempted unsuccessfully to de-escalate him and had no option but to perform a physical restraint in order to protect other persons in proximity as well as the Service Recipient, who staff feared would injure himself by his own actions. In addition, both expert witnesses testified that the restraint was both justified and appropriate. Therefore, it is determined that this exception applies to the allegation herein.

During her testimony, OMH Risk Manager [redacted] stated that it was her opinion that a prone restraint was "unacceptable," that staff are prohibited from using such a technique, and further, if a service recipient causes himself or herself to become prone, staff are "…supposed to flip them to a supine[2] position." (Hearing testimony of OMH Risk Manager [redacted])

OMH Risk Manager [redacted] was unable to identify an applicable statute, regulation or policy where this prohibition is written, but she testified that the hospital itself has such a policy and that prone restraints are also prohibited by a program called Preventing and Managing Crisis Situations (PMCS). Ultimately, although the parties were provided sufficient opportunity to produce a provider agency policy prohibiting prone restraints, no such document was presented as evidence. There is also no evidence in the record pertaining to the content of the Service Recipient's individual treatment plan, behavioral intervention plan or some equivalent, and in the absence of such evidence there is no basis to conclude that the prone restraint of the Service Recipient was deliberately inconsistent with his individual treatment plan or behavioral intervention plan.

After considering all of the evidence, it is determined that the Justice Center did not prove by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints) by participating in a prone restraint of the Service Recipient under the facts and circumstances established by this record.

Accordingly, the substantiated report against the Subject will be amended and sealed.

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

[2] Face up.

The Subject has not been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints). The substantiated report will be amended and sealed.

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

DATED: January 12, 2016
Schenectady, New York

Louis P. Renzi, ALJ