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: Jason Wolf, Esq.
Rutkin & Wolf, PLLC
203 East Post Road
White Plains, New York 10601

[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 (deliberate inappropriate use of restraints).

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: May 4, 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: New York State Justice Center for the Protection of People with Special Needs
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 (VPCR) maintains a report substantiating [redacted] (the Subject) for abuse . 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 that:

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], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you dragged a service recipient by his arm across the floor.
>
> This allegation has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints), pursuant to Social Services Law § 493(4)(c).

3. [redacted], located at [redacted], is a residential treatment facility for children aged 5 through 21, and is licensed by the NYS Office of Children and Family Services (OCFS), which is a provider agency that is subject to the jurisdiction of the Justice Center. The investigation of this matter was conducted by Investigator [redacted] of the NYS Office of Children and Family Services (OCFS). (Hearing testimony of Investigator [redacted]; Justice Center Exhibit 5)

4. At the time of the alleged abuse (the incident), [redacted], the Subject had been employed by [redacted] for seventeen (17) years, the most recent four (4) years of which was as a Direct Care staff member at [redacted], a unit designated for youthful sex offenders. The Subject had no history of disciplinary matters involving the care and treatment of residents in his charge. (Hearing testimony of the Subject)

5. At the time of the incident, the Service Recipient was an adolescent boy, and had been a resident of the facility since [redacted]. The Service Recipient was assigned to [redacted]. (Hearing testimony of Subject; Justice Center Exhibit 15)

6. At the time of the incident, the Subject was acting as a custodian. (Hearing testimony of Subject; Hearing testimony of [redacted], M.D.; Hearing testimony of Investigator [redacted])

7. During the morning of the incident, the Service Recipient was having a very difficult time following his program requirements. He appeared dressed inappropriately for the weather, he refused his medications, he refused breakfast during the scheduled serving time, he subsequently refused the Subject's offer of substitute breakfast food, refused to get his shoes on and ultimately refused to leave the cottage with the Subject to be escorted to school with the other residents of the cottage. (Hearing testimony of Subject; Justice Center Exhibits 5, 6, 7 and 8)

8. At the time of the incident, the Service Recipient was calm and seated on a chair located along a wall in the carpeted, first floor common area of the cottage. The Subject grasped the Service Recipient by his right arm. The Subject pulled the Service Recipient by the arm to the floor, and dragged him across the floor and out the door. (Justice Center Exhibit 4)

9. The Subject initially stated to Investigator [redacted] that the allegations were

false. (Justice Center Exhibit 5). He subsequently stated to Investigator [redacted] that he had not dragged the Service Recipient in order to hurt him. He further stated that on the evening prior to the incident, the residents of [redacted] had engaged in a physical altercation with the residents of [redacted]. (Justice Center Exhibits 5 and 7)

10. The Subject had been trained in the proper methods for addressing the needs of children in crises, and in the proper methods and circumstances under which a physical restraint may be utilized. These are found in the handbook on Therapeutic Crisis Intervention (TCI), the [redacted] Sociotherapy Manual and the Restraint Policy appended thereto. The applicable policies state that any restraint must be used only as a last resort, and then only with appropriate force. (Hearing testimony of [redacted] Training Specialist; Justice Center Exhibits 9, 10, 11, 12 and 13)

11. On [redacted], the Service Recipient was seen by facility medical staff for a physical examination. The examining nurse found no evidence, symptom or complaint by the Service Recipient of pain or injury as a result of the improper restraint by the Subject. The Service Recipient denied any physical injury. (Justice Center Exhibits 6, 14, 19 and 21)

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/or 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 of a person in a facility or provider agency by deliberate inappropriate use of restraints is defined by SSL § 488(1)(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 two, which is defined by SSL § 493(4)(b) as follows:

> 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. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one 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/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 or 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 abuse by deliberate inappropriate use of restraints, described as "Allegation 1" 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). The investigation underlying the substantiated report was conducted by Investigator [redacted] of the NYS Office of Children and Family Services (OCFS), who testified at the hearing in behalf of the Justice Center. The Justice Center also called [redacted], M.D., Medical Director of [redacted] and [redacted], Training/Learning Specialist for [redacted], to testify in its behalf.

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

The Justice Center submitted a visual-only video of the incident, which was extremely helpful and illuminating with respect to the substantiated allegations. (Justice Center Exhibit 4)

In order to establish abuse under the theory that a custodian committed an act of deliberate inappropriate use of restraints, the Justice Center must prove three elements: (1) that a custodian used any manual, pharmacological or mechanical measure or device; (2) to immobilize or limit the ability of a service recipient to move his or her arms, legs or body freely; (3) that the technique used, the amount of force used and/or the situation in which the restraint was used was deliberately inconsistent with a service recipient's treatment or behavioral plan, generally accepted practices and/or federal or state laws, regulations or policies.

Social Services Law § 488(1)(d) also offers an exception to the violation charged, which applies in very specific circumstances. A restraint which is used as a reasonable emergency intervention to prevent imminent risk of harm to a service recipient or another person would not violate SSL 488(1)(d). This exception does not apply in this case, since the Subject never claimed that his actions were justified by any emergency which is contemplated by the statute.

The report involving the Subject was substantiated based upon an allegation that he dragged a young male Service Recipient by the arm across the floor of the youth's residential cottage (the incident). [redacted] seeks to amend the Justice Center's substantiated finding against him, arguing (a) that he was required by both staffing ratio requirements and the potential for a confrontation between the residents of [redacted] and another cottage, all of whom were being moved to school at that time, to get himself and the Service Recipient out of the building to join them without further delay; (b) that he meant the Service Recipient no harm by his actions; and (c) that there was no resulting physical injury to the Service Recipient.

None of Subject's contentions here, even if true, offer a valid defense to an allegation of deliberate inappropriate use of restraints. Further, the totality of the circumstances supports the classification of this conduct as category two, as defined in SSL § 493(4)(b). The Justice

Center's substantiation of the VPCR report should be upheld as to both the violation and the classification as Category two conduct.

The preponderance of the evidence established that the Subject, by his intentional and/or reckless conduct, used a manual restraint that immobilized or limited the service recipient's ability to move his body freely. The video evidence showed that the Subject intentionally reached out and grabbed the Service Recipient's right arm, and pulled him off the chair which caused him to fall to the floor, then dragged him across the floor to the doorway and out the door. The video evidence also showed clearly that during the moments leading up to the incident complained of, the Service Recipient was able to ambulate normally. Thus, by grabbing and dragging the Service Recipient, thereby exerting physical control over him, the Subject eliminated any possibility that the Service Recipient could have controlled his own movements. (Justice Center Exhibit 4)

The testimony of [redacted], M.D., clearly outlined the types of physical injury likely to be inflicted upon a person being dragged by his or her arm. He described the primary risk as a dislocation of the elbow and/or shoulder, potentially causing further injury to the brachial plexis (a series of nerves running from shoulder and neck area to the spine). [redacted] described these as common injuries in any "traction" situation.

The Subject testified in his own behalf. During that testimony, he admitted that on the date and time of the incident, he was acting as a custodian in [redacted], and that the Service Recipient was one of the resident youth to whom he was assigned. He further admitted that he had pulled and dragged the Service Recipient by the arm as alleged, asserting that he had been unsuccessful in several attempts to gain the cooperation of the Service Recipient in getting properly dressed and exiting the building for school. The record supports this, indicating that the

Service Recipient was having a very difficult time adhering to program requirements on the morning in issue and leading up to the incident. (Justice Center exhibits 5, 6 and 7)

The Subject testified that he was faced with an "out of ratio" staffing situation, there being only 2 staff on duty at the time, and further asserting his concern that he would shortly be needed by the group already assembled outdoors in preparation for going to school because of a possible risk of confrontation between the residents of [redacted] and the residents of another cottage, since these two groups of service recipients had engaged in a confrontation the previous day. The Subject testified that he therefore believed it was very important for him to join the staff member waiting outside the cottage.

The credible evidence in this record shows that the use of a physical restraint of a service recipient is permitted at [redacted] in only very narrow circumstances, as defined by OCFS and [redacted] policy under the Therapeutic Crisis Intervention (TCI) model. Under these policies, the primary restriction is that a physical restraint is a last resort, intended only to prevent a youth in crisis from causing pain or injury to self or to others, or in an emergency situation such as a fire. Secondly, once a restraint is called for and initiated, a custodian is required to execute proper technique and to use only the minimum amount of force necessary under the circumstances. Lastly, a restraint is to be non-punitive and non-damaging to the service recipient. (Justice Center Exhibits 12 and 13) Consistent with his training and experience in TCI, the Subject made several attempts to counsel the Service Recipient to join the rest of the residents lining up for school, which efforts were largely rejected by the Service Recipient. (Hearing testimony of Subject; Justice Center Exhibits 5, 6, 7, 9 and 10). The evidence at the hearing showed that the proper procedure for the Subject to have followed when faced with this circumstance would have been to phone for assistance, advise his supervisors of

the staff ratio issue and wait for additional staff to assist in handling the Service Recipient and his behavioral issues. Instead, the Subject chose to force the Service Recipient to comply by physical means. (Hearing testimony of [redacted])

The Subject's statements to the investigator given at or near the time of the alleged abuse were somewhat inconsistent as to his motives, but at no time did the Subject deny that he had deliberately and intentionally placed his hands on the Service Recipient and pulled or dragged him. His second written statement states that he "… didn't drag [the Service Recipient in order] to hurt him." (Justice Center Exhibit 7). This is a clear admission of his conduct. While credible, this statement presents no defense to the allegation of abuse. It is reasonable to accept the Subject's claim that he did not have any intent to physically harm the Service Recipient, but he certainly did form an intent to deliberately take hold of his arm and drag him across the floor, thereby placing him at risk of serious injury. At a minimum, then, this record supports a finding that the Subject's conduct seriously endangered the health, safety or welfare of the Service Recipient . (Justice Center Exhibits 4, 5, 6 and 7)

The preponderance of the evidence further established that both the technique used by the Subject, and the situation in which it was used, were deliberately inconsistent with generally accepted practices and policies. The Subject acknowledged having had training in the policies and procedures governing the utilization of restraints, and the evidence further showed that he had been trained in the Justice Center regulations approximately six weeks prior to the incident. (Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibit 10).

The record supports a conclusion that restraints, in the absence of emergencies and as a last resort, are prohibited. As a result, a preponderance of the evidence establishes that both the

technique used and the situation in which the restraint was used were inconsistent with generally accepted practices and/or federal or state laws, regulations or policies.

A preponderance of the evidence also establishes that the Subjects use of the restraint was deliberately inconsistent with those practices, laws, regulations or policies. Although the term "deliberately inconsistent" is not defined in statute, an act is generally considered to be "deliberate" if it is done purposefully, consciously and not accidentally. Review of the video wherein the Service Recipient is seen sitting quietly in a chair in the moment before the incident, makes it clear that the Subject intervened not for the safety or well-being of the Service Recipient, but for his own convenience, a reason that is deliberately inconsistent with accepted justifications for using a restraint. Thus, a preponderance of the evidence establishes that the Subject's use of the restraint was not only inconsistent with generally accepted practices and/or federal or state laws, regulations or policies, but was deliberately so.

Accordingly, the Justice Center proved the elements of deliberate inappropriate use of restraints by a preponderance of the evidence.

Accordingly, the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse 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 set forth in the substantiated report**.** Here, despite the fact that the Service Recipient sustained no apparent physical injury as a result of the Subject's conduct, the finding of Category 2 conduct is justified where that conduct seriously endangers the health, safety or welfare of the Service Recipient, as described by [redacted]

[redacted]. Based upon the totality of the evidence presented, it is determined that the Subject's conduct, as described in the substantiated report, is properly categorized as Category 2 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 (deliberate inappropriate use of restraints).

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

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

DATED: April 21, 2016
Schenectady, New York

Louis P. Renzi, ALJ