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: Thomas C. Parisi, Esq.

[redacted]
By: David N. Goldin, Esq.
39 North Pearl Street
Albany, New York 12207-2767

[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 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: July 20, 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
401 State Street
Schenectady, New York 12305
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 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 neglect by the Subject of a Service Recipient.

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

Offense 1

> It was alleged that on [redacted], on Wing [redacted] at the [redacted], located at [redacted], while acting as a custodian, you neglected a service recipient who had a history of making suicidal threats, in that you were told that he remained in the unit on room confinement and that all staff and other service recipients were leaving the wing, and you made no efforts to supervise or assure that the service recipient was safe, resulting in him being locked in his room for approximately six minutes with no one supervising or monitoring him.
>
> The allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493

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

4. [redacted], located at [redacted]

[redacted], is a secure detention facility for male youth up to 21 years old, and is operated by the NYS Office of Children and Family Services (OCFS), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by OCFS as a Youth Counselor I (YC-1). He had been in that position for approximately eight (8) years. He had been employed at the [redacted] facility for fourteen (14) years. On the day of the alleged neglect, the Subject was functioning as the facility Duty Officer (DO) and was therefore responsible for the safety and security of the entire facility. This includes, but is not limited to, all movements by residents and staff within the facility. The Duty Officer's immediate work group is referred to as the Special Services Unit (SSU) or the Central Services Unit (CSU), located in what is referred to by staff as the "Hub". Verbal communications between the Hub and direct care staff on the units are conducted by telephone and 2-way radio. (Hearing testimony of Subject; Justice Center Exhibits 4, 4-a)

6. At the time of the alleged neglect, the Service Recipient was sixteen (16) years old, and had been a resident of the facility since [redacted]. The Service Recipient had diagnoses of conduct disorder, attention deficit hyperactivity disorder (ADHD) and learning disorder. He had a history of not following rules, fighting, bullying and carrying a weapon to school. His admission file reflects no prior history of suicidal ideation or behaviors. His record at [redacted] reflects continued aggressive and negative behaviors. During his residency at [redacted], the Service Recipient made numerous suicidal statements and gestures, characterized by facility staff as a ploy for differential treatment rather than an actual intent to self-harm. Facility clinicians have not recommended enhanced supervision levels for the Service Recipient. (Hearing testimony of Subject; Justice Center Exhibits 4, 4-a, 6, 7, 8)

7. The Service Recipient was assigned to a [redacted] residence unit known as Wing [redacted] ("wing" or "unit"), shared with several other service recipients. The wing has 15 separate bedrooms off a common area, most have a bathroom facility. There are also separate toilet/shower facilities adjacent to the common area. Each service recipient on the wing has his own bedroom. There are usually two direct care staff on duty at all times; these staff have a title of Youth Development Aide (YDA). (Hearing testimony of Subject; Justice Center Exhibit 13)

8. On [redacted], at approximately 7:30 A.M., the Service Recipient was restrained by means of a two-person escort and secured in his room, after refusing to return to his room from a bathroom visit. The Subject was called to the unit by staff and was present during this early-morning intervention; he authorized room confinement of the Service Recipient. At approximately 10:30 to 11:30 A.M., the Service Recipient remained locked in his room on Wing [redacted]; he smeared feces on the inside of his room window, and made suicidal threats and gestures. (Testimony of Subject; Justice Center Exhibits 4, 4-a, 8, 9, 10, 13)

9. OCFS Room Confinement Policy (PPM 3247.15), effective date August 13, 2009, sets forth the requirements for placing a service recipient on room confinement status. Under the policy, visual observation by staff must be maintained, and recorded at least every 15 minutes. The preponderance of the evidence in this record proved that after authorizing room confinement at 7:30 A.M., the Subject did not give direct care staff any directive to maintain constant supervision and prepare a written log of regular observations. The logs which are required under this policy, and which the YDAs stated they had prepared, were requested by Investigator [redacted] but were never produced. In explaining that lack of documentation at the hearing, the Subject characterized his authorization as having been for "informal" room confinement, requiring no paperwork. (Hearing testimony of Investigator [redacted]; Hearing testimony of

Subject; Justice Center Exhibits 4, 4-a, 10, 11, 13)

10. The OCFS room confinement policy does not provide for "informal" room confinement of a resident. Whatever may have been the reason and/or justification for confining the Service Recipient to his room on the day in question, the supervision and recordkeeping protocols should have been followed, but they were not. (Justice Center Exhibits 1, 10)

11. On [redacted] at approximately 11:40 A.M., shortly before the incident, the Subject was aware that the residents of Wing [redacted] were preparing to move to recreation, scheduled for 11:45 A.M. The Subject, during his interview and again during his testimony, acknowledged being aware that the Service Recipient would remain secured in his room, and that all other residents and staff of the unit would be moving together, without the Service Recipient. (Hearing testimony of Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 4, 4-a, 13)

12. Several staff from the SSU were gathered in the hallway outside Wing [redacted] as the unit prepared to move to the gymnasium for recreation. The movement involved the two staff assigned to Wing [redacted], plus all Wing [redacted] service recipients except for the Service Recipient, who was to remain secured in his room. (Hearing testimony of Investigator [redacted]; Justice Center Exhibits 4, 4-a, 12, 13)

13. [redacted] policy and procedure requires that no service recipient is ever to be left unsupervised. Despite this, the assigned staff escorted the service recipients of Wing [redacted] out of the unit and to their recreation program, leaving the Service Recipient behind, unsupervised. At the time they departed, no staff was left to supervise the Service Recipient. The Service Recipient remained alone on the unit for approximately six minutes. There is insufficient evidence in this record to explain why the personnel from Wing [redacted] moved, or were permitted to move, to the

gymnasium in the absence of any other staff being specifically assigned to supervise the Service Recipient. (Hearing testimony of the Subject; Hearing testimony of Investigator [redacted]; Justice Center Exhibits 4, 13)

14. At approximately 11:50 A.M, another staff entered Wing [redacted] and discovered that the Service Recipient was secured in his room, unsupervised. Staff immediately notified SSU and the Subject, who went to the wing and released the Service Recipient from his room. The Service Recipient was then referred for health and mental health screening; he was examined at approximately 1:00 P.M. by facility medical staff and at 1:30 P.M. by psychological staff. Neither found any evidence of any injury or abuse. No follow-up recommendations were made. (Justice Center Exhibits 8, 9)

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 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 three, which is defined in (c) below:

> (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(s) 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 the act(s) described as "Offense 1" in the substantiated report.

The Justice Center substantiated a finding of neglect against the Subject, based upon an alleged failure to ensure that the Service Recipient was supervised and safe during an approximately six-minute period (the incident) on the day in question, occurring between 11:44 A.M. and 11:50 A.M. (Justice Center Exhibits 1, 4, 4-a)

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 his 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 1-13) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness who testified at the hearing in behalf of the Justice Center.

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

A preponderance of the hearing evidence supports the conclusion that the Subject did not adequately supervise or otherwise ensure the safety of the Service Recipient during the approximately six minutes that he was alone, locked in his room.

The evidence showed that at the time of the incident, the Subject was employed as a Youth

Counselor I (YC I) and assigned as the Duty Officer (DO), which is a rotating supervisory position. The Subject testified that as the Duty Officer, he was responsible for the workings of the entire facility, including movement of staff and service recipients. His work station, which he described as the "central hub", was some 450-600 feet distant from "Wing [redacted]", the residence unit where the Service Recipient was housed, and the wing (or unit) was out of view. He further testified that he could be anywhere in the facility at a given time, based upon the immediate need for his presence. Other staff, employed in the direct care title of Youth Development Aide (YDA), were assigned to residence wings. Their duties included the direct care and supervision of the service recipients in each unit. At the time of the incident, two YDAs were assigned to the Service Recipient's unit, Wing [redacted].

At approximately 7:30 A.M. on the day of the incident, the Subject was summoned to Wing [redacted] and he authorized placing the Service Recipient on what he referred to as "informal" room confinement, following a restraint of the Service Recipient. As a result, the Subject knew or should have known that the Service Recipient would remain secured in his room when the wing departed at approximately 11:45 A.M. the same day for the scheduled recreation period. It is concluded that the Subject did not direct staff to adhere to the OCFS room confinement policy requirements of enhanced supervision and a periodic written log of those observations. (Hearing testimony of Subject; Hearing testimony of Investigator [redacted]; Justice Center Exhibit 10)

The uncontroverted evidence also established that at approximately 11:44 A.M., the two staff members assigned to supervise Wing [redacted] both knowingly left the wing to escort the remaining service recipients to their recreation program, leaving the Service Recipient behind, unsupervised and locked in his room. The reason for this is unclear. Statements by the assigned Wing [redacted] YDAs are not credited evidence on this point. (Justice Center Exhibits 4, 4-a, 13)

Justice Center Investigator [redacted] testimony, memo and report note that prior to the incident, the Subject was aware that the Service Recipient was secured in his room, and aware of the scheduled movement of Wing [redacted] staff and residents to recreation. Investigator [redacted] conclusion, based upon the statements made to her by the Subject on [redacted], was that the Subject was aware of the circumstance and the resulting need for additional supervision on Wing [redacted], and had dispatched a subordinate SSU staff ("A") to Wing [redacted] for the express purpose of supervising the Service Recipient during the recreation period. During the hearing, the Subject initially testified as to essentially the same facts on his direct examination. The exact time that the Subject gave that directive to staff "A" was not specified. (Hearing testimony of Investigator [redacted]; Hearing testimony of Subject; Justice Center Exhibits 4, 4-a, 13)

In contrast, during cross-examination the Subject claimed he did not know that the Service Recipient was staying behind. This testimony is not credited, since it was inconsistent with his earlier, contemporaneous statements during the investigation, and during earlier testimony. In addition, statements given by the Wing [redacted] staff members claimed that they had notified the Subject by phone or radio of the circumstances prior to moving the wing to recreation. The Subject eventually admitted that he had not directed staff "A" to Wing [redacted] until being notified that the unit was found vacant of staff and with the Service Recipient alone - at approximately 11:50 A.M., or after the six minutes had expired. (Hearing testimony of Subject; Hearing testimony of Investigator [redacted]; Justice Center Exhibits 4, 4-a, 8, 13)

The evidence showed that staff "A" did not arrive at Wing [redacted] until six or more minutes after the group had departed. There is also no question that the Service Recipient should never have been left alone, since no service recipient in this secure facility is ever allowed to be without

supervision. As noted above, and for reason or reasons not credibly explained in this record, the assigned staff chose to leave the unit without waiting for relief to arrive, creating what was to become a six-minute lapse in supervision between the departure of the group and the arrival of yet another staff member who found the Service Recipient unsupervised. The Subject was then notified of the lapse and took corrective action. (Hearing testimony of Investigator [redacted]; Hearing testimony of Subject; Justice Center Exhibits 4, 4-a)

There is no doubt that the Subject was a custodian as defined in SSL §488 (2). He had been employed by OCFS for approximately thirteen years, and had been trained in the directives about proper supervision of youth and room confinement, which included the OCFS Room Confinement Policy (PPM 3247.15). By his own admission, the Subject was the Duty Officer and responsible for the facility as a whole, including staff and service recipients. Therefore, the Subject was a custodian and owed a duty of care as to the safety and security of each service recipient in the facility, including the Service Recipient here. (Hearing testimony of Subject; Justice Center Exhibits 4, 4-a, 5, 10, 13)

The evidence showed that all of the staff involved were aware that the Service Recipient was confined to his room on the morning of the incident. A preponderance of the evidence further supports the conclusion that the likely harm to the unsupervised Service Recipient falls clearly within the parameters of SSL § 488(h), and that therefore, there is no question that the lack of supervision alleged here is neglect, as defined in that statute.

In his defense, the Subject argued that he had not placed the Service Recipient on actual room confinement, and that therefore the requirements of the OCFS Room Confinement Policy are inapplicable to this matter. The Subject's argument is without merit.

Fully considered, the hearing record supports the conclusion that at or about 11:40 A.M on

the day in question, the Subject, a custodian, aware that the Service Recipient had been having substantial difficulty following program since at least 7:30 A.M., and that the Service Recipient was still secured in his room, he failed to take steps to resolve the impending lack of supervision, and at the same time permitted the staff and residents of Wing [redacted] to depart the unit, leaving the Service Recipient behind, unsupervised. The Subject then failed to follow up until at least six minutes later, when he was notified that the Service Recipient was unsupervised. As a result, the Subject's duty to ensure the supervision of the Service Recipient at all times was breached.

The next issue to be determined is whether the Subject's breach of his duty caused the harm or likelihood of harm described in SSL § 488(h). First, the record indicates that the Service Recipient sustained no discernable injury or harm according to the medical and mental health staff. That notwithstanding, OCFS maintains secure facilities for youth, and promulgates numerous policies and protocols for the operation of such facilities, for specific reasons pursuant to governing statutes and regulations. The reason most relevant to this matter is to ensure that the resident youth are cared for and kept safe from harm, arising from either their own doing or as a result of acts by others. As testified to by Investigator [redacted], OCFS policy does not permit any service recipient residing at [redacted] to be left unsupervised at any time. Therefore, it must be concluded that there exists for a service recipient left unsupervised for any length of time, no matter how brief, a likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of any such youth, whether or not such harm is actually suffered. On several occasions since his admission to [redacted], the Service Recipient had made suicidal statements and gestures, and was placed on suicide watch immediately following the incident here, due to suicidal statements and gestures being made during the morning of the incident. Although the credible evidence in this record indicates that the Service Recipient was seemingly play-acting as

to these statements and gestures in order to get himself reassigned to a different unit or to obtain other treatment which he perceived as favorable, and, on this occasion was examined by clinical staff and found not to be a credible suicide threat, it cannot be said with complete certainty that no such risk existed. Further, the circumstances during the morning in question should have created a heightened awareness in the Subject and alerted him to take greater precautions as to supervision of the Service Recipient. (Hearing testimony of Investigator [redacted]; Justice Center Exhibits 6, 7, 8, 9)

Therefore, 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 shall be not amended or sealed.

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 neglect.

Based upon a preponderance of the evidence presented, it is concluded that the substantiated report is properly categorized as a Category 3 offense.

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

DATED: June 23, 2016
Schenectady, New York

Louis P. Renzi, ALJ