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

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In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

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**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: Theresa Wells, Esq.

[redacted]
By: Jean O'Hearn, Esq.
Kreisberg & Maitland, LLP
75 Maiden Lane, Unit 603
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By: Jean O'Hearn, Esq.
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[redacted]

[redacted]

[redacted]

[redacted]

By: Jean O'Hearn, Esq.
Kreisberg & Maitland, LLP
75 Maiden Lane, Unit 603
New York, New York 10038

[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] of abuse (deliberate inappropriate use of restraints) and neglect by the Subject of a Service Recipient be amended and sealed is denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted] of physical abuse, abuse (deliberate inappropriate use of restraints), and neglect by the Subject of a Service Recipient be amended and sealed is denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed physical abuse, abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted] of physical abuse and neglect by the Subject of a Service Recipient be amended and sealed is

[redacted]

denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed physical abuse and 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**: August 3, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

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

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In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED DECISION AFTER HEARING**

**Adjudication Case #s:** [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. 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
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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[redacted]

## JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (Subject [redacted]) for abuse (deliberate inappropriate use of restraints) and neglect, [redacted] (Subject [redacted]) for physical abuse, abuse (deliberate inappropriate use of restraints) and neglect, and [redacted][1] (Subject [redacted]) for physical abuse and neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects of the substantiated report. The VPCR did not do so, and a consolidated 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 three reports of substantiated finding, all dated [redacted] of physical abuse, abuse (deliberate inappropriate use of restraints), and neglect by the Subjects of a Service Recipient.

2. The Justice Center's substantiated reports against the Subjects concluded that:

**Allegation 1** [redacted]

> 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) and/or neglect when you failed to use a proper technique while transferring a service recipient to her room by carrying her by her arms and legs.
>
> This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

[1] Since the time of the allegation [redacted] was married and has changed her name to [redacted].

[redacted]

**Allegation 1** [redacted]

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed physical abuse when you hit a service recipient in the back of the neck and pulled her by the collar of her shirt.

This allegation has been SUBSTANTIATED as Category 3 physical abuse pursuant to Social Services Law § 493(4)(c).

**Allegation 2** [redacted]

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) and/or neglect when you failed to use a proper technique while transferring a service recipient to her room by carrying her by her arms and legs.

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

**Allegation 1** [redacted]

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed physical abuse and/or neglect when you engaged in horseplay with a service recipient and hit her with a broom.

This allegation has been SUBSTANTIATED as Category 3 physical abuse and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

3. An Administrative Review was conducted and, as a result, the substantiated reports were retained.

4. The facility, located at [redacted], is a secure juvenile detention facility that is operated by the [redacted], which is licensed by the New York State Office of Children and Family Service (OCFS). The OCFS is an agency that is subject to the jurisdiction of the Justice Center.

5. The facility consists of units which house juvenile delinquents and juvenile

offenders. The allegations against the Subjects arose from an incident that occurred in the facility's [redacted] Hall, which is a sixteen bedroom area for female residents. The bedrooms form a U shape around a common area and the bathroom is in the middle. (Hearing testimonies of OCFS Investigator [redacted] and [redacted] Supervisor of Training [redacted])

6. At the time of the alleged abuse and neglect, the facility employed Safe Crisis Management (SCM), which is a holistic approach to address uncooperative or otherwise difficult behaviors of service recipients. SCM essentially provides that the least restrictive alternative should always be utilized and that physical interventions are appropriate only when service recipients are hurting themselves or others, or are causing the unsafe destruction of property. SCM was the generally accepted treatment practice at the facility on [redacted]. Every newly hired Juvenile Counselor (JC) undergoes four days of SCM training, as well as additional trainings thereafter for all JCs. (Hearing testimony of [redacted] Supervisor of Training [redacted])

7. At the time of the alleged abuse and neglect, one of the daily routines of the [redacted] Hall was for the service recipients to take showers starting at 7:00 p.m., before they were given free time to watch TV. Because there was concern regarding maintaining a safe and secure environment, the service recipients were allowed out of their individual rooms one or two at a time to take their showers, while the other service recipients remained confined in their locked bedrooms. (Hearing testimonies of Subjects [redacted] and [redacted] and [redacted])

8. At the time of the alleged abuse and neglect, the Service Recipient was fifteen years of age. (Justice Center Exhibit 8) The Service Recipient had been a resident of the facility's [redacted] Hall since at least April of 2013, and had been a resident there for an undetermined period of time prior to that. (Hearing testimonies of Subjects [redacted] and [redacted])

9. At the time of the alleged abuse and neglect, Subject [redacted] had been a JC since

[redacted], and Subjects [redacted] and [redacted] had been JCs since [redacted]. On [redacted], the three Subjects, together with JC [redacted], were working as JCs in the [redacted] Hall area of the facility, where the Service Recipient resided. (Justice Center Exhibit 7) The three Subjects were custodians as that term is so defined in Social Services Law § 488(2).

10. At the time of the alleged abuse and neglect, when it was time to start showers, the Service Recipient ignored the directions of the JCs to go to her room and stood facing the closed door of another service recipient's bedroom. It was clear to all of the JCs who thereafter attempted to compel her cooperation that the Service Recipient's behavior was a mischievous ploy for attention, rather than defiance, as the Service Recipient was laughing throughout the interactions that ensued. (Justice Center Exhibit 7 and Hearing testimonies of Subjects [redacted], [redacted] and [redacted])

11. Subject [redacted] approached the Service Recipient, tapped her on the shoulder and pulled her away from the doorway by the back of her shirt. The Service Recipient then moved away from Subject [redacted] and went into the bathroom. After the Service Recipient emerged from the bathroom approximately nine minutes later, she returned to the doorway where she had previously been loitering and again ignored the JCs' repeated directions to go to her bedroom. (Justice Center Exhibits 7 and 19, and Hearing testimony of Subject [redacted])

12. After attempting to elicit cooperation by speaking to the Service Recipient, Subject [redacted] struck the Service Recipient on the back of her neck and pulled her away from her position in the doorway by the back of her shirt collar. (Justice Center Exhibits 7 and 19)

13. The Service Recipient then moved away from Subject [redacted] and backed into another bedroom door while Subject [redacted] and JC [redacted] approached her. The Service Recipient then sank to the floor with her back against the outside of the closed door and her legs in front of

[redacted]

her. Subject [redacted] approached, interacted with the Service Recipient and then walked away. JC [redacted] approached the Service Recipient on her left side, hit her on the leg with her open hand and started pulling the Service Recipient's left hand up. Subject [redacted] then approached the Service Recipient on her right side and started pulling on that hand or arm. The Service Recipient resisted and the two JCs reestablished their hold of her arms on both sides and attempted to pull her up to her feet. The Service Recipient struggled against the JCs and pulled herself onto her back with her feet in the air. The Service Recipient then regained her position seated on the floor and JC [redacted] unsuccessfully attempted to pick her up by holding her under her left arm and leg. (Justice Center Exhibits 7 and 19)

14. In the meantime, Subject [redacted] unlocked the door to the outside terrace of the [redacted] Hall, retrieved a broom and brought it inside. Subject [redacted] then struck the Service Recipient on the buttocks with the broomstick while JC [redacted] held up the Service Recipient's legs to give her a clear target. At that point, Subject [redacted] had released her hold on the Service Recipient's arm. (Justice Center Exhibits 7 and 19)

15. After being struck with the broomstick, the Service Recipient struggled to her feet while attempting to grab the broom from Subject [redacted] and, in the melee, her slippers fell off. JC [redacted] picked up the Service Recipient's slippers and began swatting the Service Recipient with them. As the Service Recipient ran away from JC [redacted], she attempted to jump over a chair, but wound up flying through the air, falling to the floor hard on her shoulder, banging into a desk and sliding across the floor on her side, all the while being pursued by JC [redacted], who continued to hit her with the slippers. (Justice Center Exhibits 7 and 19)

16. Then, the Service Recipient sat up while still on the floor and all four JCs surrounded her. JC [redacted] dropped or threw the slippers and struggled with the Service Recipient to

[redacted]

grab her by her arms. Subject [redacted] then held onto the Service Recipient's legs and the two JCs picked the Service Recipient up by her arms and legs and carried her toward her bedroom. After taking 17 steps, the JCs lowered the Service Recipient onto the floor and Subject [redacted] took one of the Service Recipient's legs and the three JCs carried the Service Recipient the rest of the way to her bedroom. (Justice Center Exhibits 7 and 19)

## ISSUES

- Whether the Subjects have been shown by a preponderance of the evidence to have committed the acts giving rise to the substantiated reports.
- 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 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 each 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1) to include the following:

> (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,

[redacted]

> burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> (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.
>
> (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.

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 each Subject committed the act or acts of abuse and/or neglect alleged in the substantiated reports that are 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 reports. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect in a report, 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 and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

[redacted]

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 Subjects committed the acts described as Allegation 1 for Subject [redacted], Allegations 1 and 2 for Subject [redacted], and Allegation 1 for Subject [redacted] in each of their respective substantiated reports.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated reports was conducted by OCFS Investigator [redacted] who, together with [redacted] Supervisor of Training [redacted], testified on behalf of the Justice Center.

The Subjects testified at the consolidated hearing on their own behalf.

The Justice Center submitted four visual only videos of the incident, which were extremely helpful and illuminating evidence with respect to the substantiated allegations[2]. (Justice Center Exhibit 9) It was clear from the facial expressions and body language of the Service Recipient and all of the JCs that, throughout the interactions that gave rise to the allegations, there prevailed an atmosphere of playfulness, and that they were engaging in what is commonly referred to as "horseplay."

## Subject [redacted]

The substantiated report relating to Subject [redacted] contains one allegation that she committed abuse (deliberate inappropriate use of restraints) and neglect.

### Abuse (Deliberate Inappropriate Use of Restraints)

A finding of abuse (deliberate inappropriate use of restraints) would include a situation in

[2] The most relevant parts of the videos are found as follows: Tape 2 at 18:50:30 and 18:59:23, Tape 3 at 19:00:03, and Tape 4 at 18:59:20.

[redacted]

which a preponderance of the evidence shows that Subject [redacted] used a restraint that was deliberately inconsistent with generally accepted treatment practices, unless it was used as a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to someone else. The definition of "restraint" includes the use of any manual measure to immobilize or limit the ability of the Service Recipient to freely move her arms, legs or body.

The first question is whether there was a restraint. In this case, Subject [redacted] is seen on the videos (Justice Center Exhibit 9) pulling on and holding onto the Service Recipient's arm in an attempt to move the Service Recipient when she initially sank to the floor. Later, Subject [redacted] can be seen carrying the Service Recipient by holding onto and lifting her by her legs while JC [redacted] did the same with her arms. Both of Subject [redacted] acts were manual restraints. Subject [redacted] admitted to these acts in her testimony, but explained that the restraints were used to avoid an escalation of the Service Recipient's behavior and a deterioration in the tone of all of the service recipients. In any case, the manual restraints were clearly visible on the videos and admitted to by Subject [redacted].

The second question is whether the restraints were inconsistent with generally accepted treatment practices. On [redacted], SCM was the approach used by the facility to manage service recipients' difficult behaviors and, therefore, was the generally accepted treatment practice. During [redacted] Supervisor of Training [redacted] testimony, the videos of the incident were played and he testified that Subject [redacted] physical interventions were not warranted, that her contact with the Service Recipient was not authorized under SCM and that other techniques should have been used to address the Service Recipient's conduct. Accordingly, the manual restraints used by Subject [redacted] were inconsistent with generally accepted treatment practices.

The third question is whether the improper restraints were deliberately used. [redacted]

[redacted]

Supervisor of Training [redacted] testified that new JCs receive four days of SCM training. Subject [redacted] admitted in her testimony that she was aware of SCM techniques and that she had received four days of SCM training when she was hired. Subject [redacted] Training Record (Justice Center Exhibit 16) shows further that Subject [redacted] underwent an additional 14 hours of SCM recertification training on [redacted]. Subject [redacted] testified that although she knew that her contact with the Service Recipient was not authorized under SCM, she thought that it was the best way to handle the Service Recipient's behavior. Subject [redacted] testified that the Service Recipient's behavior was delaying the start of the showers for all of the service recipients, which would reduce their leisure time before bed, and it was also raising the tone in the unit; meaning that the other service recipients' attitudes were being negatively impacted by the Service Recipient's conduct. Subject [redacted] testified that because she had such a good rapport with the Service Recipient, who was just being very playful, she calculated that it would be better to play along with the Service Recipient, who really only sought attention, than to engage in a real restraint of the Service Recipient, which would have raised the tone further. Subject [redacted] testified that she participated in the unauthorized carrying of the Service Recipient because the Service Recipient said that she would only go to her room if she was carried there. It is clear that Subject [redacted] knew that she was responsible for adhering to SCM techniques that she had been trained in SCM, but that she decided to depart from SCM protocols. In short, the unauthorized manual restraints employed by Subject [redacted] were deliberately used.

The last question is whether the deliberate improper uses of restraints were reasonable emergency interventions to prevent imminent risk of harm to the Service Recipient or to someone else. It is clear, both from the videos and the testimonies of all three Subjects, that the Service Recipient posed no imminent risk of harm to herself or to anyone else. While the Service

[redacted]

Recipient's conduct was uncooperative and caused a disruption to the routine of the unit, the evidence is undisputed that she was nonthreatening and nondestructive. There was no emergency that required a physical intervention, let alone an improper restraint. Accordingly, Subject [redacted] conduct constituted abuse (deliberate inappropriate use of restrains) as defined by SSL § 488(1)(d).

**Neglect**

Regarding the allegation of neglect, a finding requires firstly that a preponderance of the evidence shows that Subject [redacted] engaged in conduct that breached her duty to the Service Recipient. In this case, Subject [redacted] duty to the Service Recipient included adhering to SCM techniques when addressing the Service Recipient's behavior. All of the evidence in the record indicates that Subject [redacted] conduct was not authorized by SCM techniques and her departure from SCM was a breach of her duty to the Service Recipient.

A finding of neglect also requires that a preponderance of the evidence shows that Subject [redacted] breach of duty 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. Despite the fact that there was no evidence that Subject [redacted] breach of duty actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect.

Subject [redacted] breach of duty involved using unauthorized physical restraints against the Service Recipient, which, by their very nature, were likely to result in physical injury to the Service Recipient. Accordingly, Subject [redacted] conduct constituted neglect as defined by SSL § 488(1)(h).

[redacted]

**Subject [redacted]**

The substantiated report relating to Subject [redacted] contains two allegations, the first of which is that she committed physical abuse against the Service Recipient, and the second of which is that she committed abuse (deliberate inappropriate use of restraints) and neglect against the Service Recipient.

**Physical Abuse**

A finding of physical abuse requires that a preponderance of the evidence shows that Subject [redacted] intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment. The videos show that when the Service Recipient was standing at the closed door of another service recipient's room, Subject [redacted] approached her from behind, struck her on the back of her neck and sharply yanked her away from her position by the back of her shirt collar. The physical abuse element of intentional physical contact is proven by evidence that Subject [redacted] struck the Service Recipient's neck and pulled at the Service Recipient's shirt collar.

Despite the fact that there was no evidence that Subject [redacted] conduct actually caused physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of physical abuse. The likelihood of physical injury to the Service Recipient occurred when Subject [redacted] struck the Service Recipient on the back of her neck and pulled her shirt collar forcefully enough to propel her backwards away from the door. Accordingly, Subject [redacted] conduct constituted physical abuse as defined by SSL § 488(1)(a).

[redacted]

**Abuse (Deliberate Inappropriate Use of Restraints)**

A finding of abuse (deliberate inappropriate use of restraints) would include a situation in which a preponderance of the evidence shows that Subject [redacted] used a restraint that was deliberately inconsistent with generally accepted treatment practices, unless it was used as a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to someone else. The definition of "restraint" includes the use of any manual measure to immobilize or limit the ability of the Service Recipient to freely move her arms, legs or body.

The first question is whether there was a restraint. In this case Subject [redacted] is seen on the videos (Justice Center Exhibit 9) participating in the carrying of the Service Recipient by holding onto and lifting her by her leg, while Subject [redacted] held the Service Recipient's other leg and JC [redacted] carried her by her arms. This act constituted a manual restraint. Subject [redacted] admitted to the act in her testimony, but explained that the restraint was used to avoid notifying her supervisor, which she thought would have caused an escalation of the Service Recipient's negative behavior and a deterioration in the tone of all of the service recipients. In any case, the manual restraint was clearly visible on the videos and admitted to by Subject [redacted].

The second question is whether the restraint was inconsistent with generally accepted treatment practices. On [redacted], SCM was the approach used by the facility to manage service recipients' difficult behaviors and, therefore, was the generally accepted treatment practice. During [redacted] Supervisor of Training [redacted] testimony, the videos of the incident were played and he testified that Subject [redacted] physical intervention was not warranted, that her contact with the Service Recipient was not authorized under SCM, that it is never sanctioned to carry a service recipient and that other techniques should have been used to address the Service Recipient's conduct. Accordingly, the restraint used by Subject [redacted] was inconsistent with

[redacted]

generally accepted treatment practices.

The third question is whether the improper restraint was deliberately used. [redacted] Supervisor of Training [redacted] testified that new JCs receive four days of SCM training. Subject [redacted] admitted in her testimony that she was aware of SCM techniques and that she had received four days of SCM training when she was hired. Subject [redacted] Training Record (Justice Center Exhibit 17) shows further that Subject [redacted] underwent an additional 14 hours of SCM recertification training on [redacted]. Subject [redacted] testified that, although she knew that her contact with the Service Recipient was not authorized under SCM, she thought that it was the best way to handle the Service Recipient's behavior. Subject [redacted] testified that the Service Recipient's behavior was delaying the start of the showers for all of the service recipients, which would reduce their leisure time before bed, and was also raising the tone in the unit, meaning that the other service recipients' attitudes were being negatively impacted by the Service Recipient's conduct. Subject [redacted] testified that because she had such a good rapport with the Service Recipient, who was just being very playful, she calculated that it would be better to play along with the Service Recipient who really only sought attention, than to call a supervisor, which she thought may have angered the Service Recipient. Subject [redacted] testified that she participated in the unauthorized carrying of the Service Recipient because the Service Recipient said that she would only go to her room if she was carried there. Subject [redacted] testified that she wanted to make sure that the Service Recipient got into her room safely and "that was how [they] did it." It is clear that Subject [redacted] knew that she was responsible for adhering to SCM techniques, that she had been trained in SCM, but that she decided to depart from SCM protocols. Accordingly, the restraint used by Subject [redacted] was deliberately inconsistent with generally accepted treatment practices.

[redacted]

The last question is whether the deliberate improper use of the restraint was a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to someone else. It is clear, both from the videos and the testimonies of all three Subjects, that the Service Recipient posed no imminent risk of harm to herself or anyone else. While the Service Recipient's conduct was uncooperative and caused a disruption to the routine of the unit, the evidence is undisputed that she was nonthreatening and nondestructive. There was no emergency that required a physical intervention, let alone an improper restraint. Accordingly, Subject [redacted] conduct constituted abuse (deliberate inappropriate use of restraints) as defined by SSL § 488(1)(d).

**Neglect**

Regarding the allegation of neglect, a finding requires firstly that a preponderance of the evidence shows that Subject [redacted] engaged in conduct that breached her duty to the Service Recipient. In this case, Subject [redacted] duty to the Service Recipient included adhering to SCM techniques when addressing the Service Recipient's behavior. All of the evidence in the record indicates that Subject [redacted] conduct was not authorized by SCM techniques and her departure from SCM was a breach of her duty to the Service Recipient.

A finding of neglect also requires that a preponderance of the evidence shows that Subject [redacted] breach of duty 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. Despite the fact that there was no evidence that Subject [redacted] breach of duty actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect.

Subject [redacted] breach of duty was the use of an unauthorized physical restraint against the Service Recipient, which, by virtue of its very nature, was likely to have resulted in physical

[redacted]

injury to the Service Recipient. Accordingly, Subject [redacted] conduct constituted neglect as defined by SSL § 488(1)(h).

**Subject [redacted]**

The substantiated report relating to Subject [redacted] contains one allegation that she committed physical abuse and neglect.

**Physical Abuse**

A finding of physical abuse requires that a preponderance of the evidence shows that Subject [redacted] intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment.

The video evidence shows that while the Service Recipient was on the floor being restrained by Subject [redacted] and JC [redacted], Subject [redacted] unlocked the door to a facility terrace, retrieved a broom, brought it inside, approached the Service Recipient and playfully struck the Service Recipient's backside with it. The element of the physical abuse allegation of intentional physical contact is met by Subject [redacted] striking of the Service Recipient with the broomstick.

It is clear from the Service Recipient's reaction that, at the time that Subject [redacted] struck her with the broom, although she was laughing, she had been hurt when the broomstick made contact with her backside. Based on the apparent pain that Subject [redacted] conduct inflicted on the Service Recipient, some degree of physical injury may have occurred. Furthermore, despite the fact that there was no other evidence that Subject [redacted] conduct actually caused physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of

[redacted]

physical abuse. The likelihood of physical injury to the Service Recipient occurred when Subject [redacted] intentionally struck the Service Recipient with a broom while the Service Recipient was already being restrained by the other two JCs. Accordingly, Subject [redacted] conduct constituted physical abuse as defined by SSL § 488(1)(a).

**Neglect**

Regarding the allegation of neglect, a finding requires that a preponderance of the evidence shows that Subject [redacted] engaged in conduct that breached her duty to the Service Recipient. In this case, Subject [redacted] duty to the Service Recipient included adhering to SCM techniques when addressing the Service Recipient's behavior. All of the evidence in the record indicates that Subject [redacted] conduct of hitting the Service Recipient with a broomstick was not authorized by SCM techniques and her departure from SCM was a breach of her duty to the Service Recipient.

A finding of neglect also requires that a preponderance of the evidence shows that Subject [redacted] breach of duty 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. It was clear from the Service Recipient's reaction that at the time that Subject [redacted] struck her with the broomstick, although she was laughing, she had been hurt when the broom made contact with her backside. Furthermore, despite the fact that there was no other evidence that Subject [redacted] breach of duty actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect.

Subject [redacted] breach of duty was the striking of the Service Recipient with a broomstick, while the Service Recipient was already being restrained by the other JCs, which was

[redacted]

likely to have resulted in injury to the Service Recipient. Accordingly, Subject [redacted] conduct constituted neglect as defined by SSL § 488(1)(h).

During the hearing, the Subjects provided arguments and explanations in their submissions and testimonies regarding their conduct. All of the arguments presented by the Subjects and their counsel were unpersuasive. Even if they thought that their conduct was innocent horseplay or was somehow a better alternative to the facility's generally accepted treatment practices, in which they were all trained, they cannot be excused for their treatment of the Service Recipient.

Based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subjects committed the acts as specified in all of the allegations of the substantiated reports. The reports will remain substantiated.

The next issue to be determined is whether the substantiated reports constitute the category of physical abuse, abuse (deliberate inappropriate use of restraints), and neglect set forth in the substantiated reports**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated reports are all properly categorized as Category 3 acts. Substantiated Category 3 findings of abuse and/or neglect will not result in the Subjects' names being placed on the VPCR Staff Exclusion List and the fact that the Subjects have Substantiated Category 3 reports will not be disclosed to entities authorized to make inquiry to the VPCR. However, the reports remain subject to disclosure pursuant to SSL § 496 (2). These reports will be sealed after five years.

**DECISION:** The request of [redacted] that the substantiated report dated [redacted] of abuse (deliberate inappropriate use of restraints) and neglect by the Subject of a Service

[redacted]

Recipient be amended and sealed is denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted] of physical abuse, abuse (deliberate inappropriate use of restraints), and neglect by the Subject of a Service Recipient be amended and sealed is denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed physical abuse, abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted] of physical abuse and neglect by the Subject of a Service Recipient be amended and sealed is denied. Subject [redacted] has been shown by a preponderance of the evidence to have committed physical abuse and neglect.

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

[redacted]

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

**DATED**: July 12, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge