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: Theresa Wells, Esq.

[redacted]

By: Sam Alba, Esq.
Friedman & Ranzenhofer, PC
74 Main Street, P.O. Box 31
Akron, New York 14001

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

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

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

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: March 6, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
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] (Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that she 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 Subject of two Service Recipients.

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

Allegation 3[1]

> It was alleged that on [redacted], while on the agency van on an outing from the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to two service recipients by not following their transportation plans, during which time one service recipient had sexual contact with another service recipient.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The [redacted], located at [redacted]

[1] Allegations 1 and 2 of the said report were unsubstantiated against the Subject at some point prior to the hearing.

[redacted] provides day habilitation services for disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. The facility also oversees the [redacted] work program that provides jobs for disabled individuals.

5. At the time of the alleged neglect, the Subject was employed at the facility as a full-time Habilitation Specialist 1 for approximately two years. The Subject's job duties entailed functioning as the acting site Pre-vocational Supervisor for those service recipients employed through the [redacted] work program at the facility. During the [redacted] work program, the Subject also supervised Staff 1, a Direct Support Assistant (DSA). Staff 1 was a shared staff person that worked at [redacted] and the [redacted] which was the residence for some of the service recipients who participated in the [redacted] work program. (Hearing testimony of the Subject)

6. At the [redacted] work program, service recipients from various group homes performed various job duties, such as facility landscaping services, piece work for companies in the community as well as some vending tasks. While under the supervision of the Subject and Staff 1, there were times during the [redacted] work day when the service recipients traveled by van into the community in order to retrieve or deliver completed piece work. At the end of their work day, the service recipients were transported to their respective group homes. Due to her employment, the Subject was a custodian of the Service Recipients as that term is so defined in SSL §488 (2). (Hearing testimonies of the Subject and former OPWDD Office of Investigations and Internal Affairs (OIIA) Investigator [redacted]; Justice Center Exhibit 6 and Justice Center Exhibit 14: an audio recording of the Subject's interrogation)

7. At the time of the alleged neglect, Service Recipient 1 was a twenty-three year old male who resided at the [redacted], located at [redacted], since [redacted] 2009. During [redacted] work day mornings, Service Recipient 1 was transported by van from the [redacted] to the facility. Service Recipient 1 had diagnoses of moderate intellectual disability, attention deficit hyperactive disorder (ADHD), impulse control disorder, bipolar disorder and other medical conditions. Service Recipient 1's [redacted] Risk Management Plan addressed his behavior of the inappropriate sexual touching of minors for which he was under active psychological and relapse prevention treatment. (Justice Center Exhibits 6 and 11-13)

8. Service Recipient 1's [redacted], Plan Of Protective Oversight (POPO) outlined specific required levels of supervision designed to protect him from sexual exploitation. It is noted in the POPO that Service Recipient 1 is not capable of consenting to sexual relationships. Service Recipient 1's POPO also mandated that, during transport, staff was to maintain "range of scan" supervision of him through the use of "strategic seating," which required staff to be seated in the center row seats of the van when two or more other service recipients were riding in the van with Service Recipient 1. Additionally, Service Recipient 1's POPO stated that he had a history of inappropriate sexual conduct and that he should have limited contact with children when on supervised family visits. He also was prohibited from having access to media that is child-centered, violent or contains inappropriate sexual material. (Hearing testimony of former OPWDD OIIA Investigator [redacted]; Justice Center Exhibits 6 and 11-13)

9. At the time of the alleged neglect, Service Recipient 2 was a twenty-four year old male who also resided at the [redacted] since 2005 and worked at [redacted] along with Service Recipient 1. Service Recipient 2 had diagnoses of moderate intellectual disability, sexual disorder,

seizure disorder and other medical conditions. (Justice Center Exhibits 6 and 8-10)

10. According to Service Recipient 2's Behavior Support Plan and Psychiatric/Behavioral Guidelines revised on [redacted] and Risk Management Plan dated [redacted], Service Recipient 2 had a history of engaging in inappropriate sexually deviant behaviors, which included allegations of sexual abuse. Service Recipient 2's Psychiatric/Behavioral Guidelines noted that should his targeted behaviors increase in "intensity or frequency," the psychologist should be notified for an assessment and treatment. Additionally, Service Recipient 2's Risk Management Plan noted that staff needed to consistently implement the behavior guidelines and "stress prevention of relapse behavior and reinforcement of replacement behaviors." (Justice Center Exhibits 8 and 10)

11. Service Recipient 2's POPO dated [redacted], noted that he is capable of independently fastening and unfastening a seat belt. The POPO mandated that when Service Recipient 2 rode in the back rows of the van along with other service recipients, staff was to maintain range of scanning supervision of Service Recipient 2 by using strategic seating based upon the number of other service recipients and their particular behaviors. (Hearing testimonies of OPWDD OIIA Investigator [redacted], the Subject and Staff 1; Justice Center Exhibits 6 and 9)

12. Sometime during the day on [redacted], four service recipients (including Service Recipient 1 and Service Recipient 2), Staff 1 and the Subject were riding in the van while on an [redacted] work assignment. The van that was used to transport service recipients during [redacted] work days belonged to the [redacted]. It was a twelve passenger van that had two captain seats in the front for the driver and a passenger. Behind the front seats were three rows of bus-style bench seats that could accommodate two persons on each bench. Staff 1 was seated in

the driver's side captain seat driving the van and the Subject was seated in the passenger's side captain seat. Service Recipient 1 was seated in the far back bench seat of the van and Service Recipient 2 was seated in the middle bench seat directly in front of Service Recipient 1's seat. The two other service recipients were seated in the first row of bench seats directly behind the two front captain seats. (Hearing testimonies of the Subject and Staff 1; Justice Center Exhibit 6; Justice Center Exhibit 14: an audio CD of interviews and interrogations; and Justice Center Exhibit 19)

13. At some point during the van ride, Service Recipient 2 reached his arm around the side of his seat and, with his hand, he touched Service Recipient 1's "privates" (penis and testicles) over his pants. Service Recipient 1 and Service Recipient 2 were the only witnesses to the incident. (Hearing testimony of former OPWDD OIIA Investigator [redacted]; Justice Center Exhibit 6; Justice Center Exhibit 14: an audio CD of interviews and interrogations; Justice Center Exhibits 19 and 26)

14. On [redacted], Service Recipient 1 reported the incident to his psychologist during his psychological interview and assessment. The psychologist found no actual diminution of Service Recipient 1's condition due to staff's actions, and he was unable to determine if the alleged incident caused the likelihood of a diminution of his emotional, social or behavioral development or condition. (Justice Center Exhibits 26 and 29)

15. The day after the incident, Service Recipient 1's body check was performed by the [redacted] nurse and no physical injuries were found. (Justice Center Exhibit 18)

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), which states as follows:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4)(c) as follows:

> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the act of neglect, described as "Allegation 3" 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 1-13; Justice Center Exhibit 14: audio CD of interviews and interrogations; and Justice Center Exhibits 15-31) The investigation underlying the substantiated report was conducted by former OPWDD OIIA Investigator [redacted] who is presently employed as a Justice Center Investigator. [redacted] was the only witness who testified at the hearing on behalf of the Justice Center.

At the hearing, the Subject testified in her own behalf and Staff 1 also testified.

In order to prove neglect, the Justice Center must establish by a preponderance of the

evidence that the Subject breached her custodian's duty to the Service Recipients.

At the hearing, the Subject's testimony was similar to Staff 1's testimony. The Subject testified that she believed that Staff 1 was driving the van on the day of the incident, that she never heard or saw anything happen and that Service Recipient 1 never reported an incident to her. The Subject further testified that there were occasions when she sat in the front passenger seat while Staff 1 was driving, but that occurred when there was only one service recipient riding in the van. The Subject testified that when Service Recipient 2 rode in the van with other service recipients, particularly Service Recipient 1, she always practiced "strategic seating" because the two Service Recipients fought often. The Subject also testified that she did not have an independent recollection of the van ride on the date of the alleged incident, but she could recall that Service Recipient 1 usually sat in the far back bench seat of the van.

During Staff 1's hearing testimony, she stated that she was driving the van on the day in question but she did not recall whether or not the Subject sat in the front of the van that day. Staff 1 testified that, when traveling in the van at [redacted], about ninety percent of the time the Subject usually practiced "strategic seating" and sat in the back seats in order to maintain the proper level of supervision of all of the service recipients. (Hearing testimonies of the Subject and Staff 1)

For the most part, the testimony of the Subject and Staff 1 was consistent with what they told the investigator during their interrogations. (Justice Center Exhibits 6 and 14) Additionally, investigatory interviews were conducted with all four service recipients who rode in the van during [redacted] on the day in question. Service Recipient 1 stated in his interview that, while Staff 1 was driving the van and the Subject was in the front passenger seat, Service Recipient 2 inappropriately touched him. Service Recipient 1's statement was substantially consistent with his initial report to [redacted] staff and his psychologist. However, Service Recipient 1's interview was

inconsistent with his initial report concerning where he sat in the van and his earlier allegation that Service Recipient 2 had exposed his genitals to him. These inconsistencies are addressed in more detail later.

Service Recipient 2's investigative interview corroborated Service Recipient 1's version of events. Service Recipient 2 admitted to the investigator that during a recent [redacted] transportation, he reached behind his center bench seat and inappropriately touched Service Recipient 1 who was sitting behind him in the rear bench seat. Service Recipient 2 also told the investigator that staff did not see him improperly touch Service Recipient 1. Although Service Recipient 2 could not recall the exact date that he did this, he did recall that Staff 1 was driving and that the Subject was sitting up front next to Staff 1. Also, Service Recipient 1's psychological report noted that [redacted] staff was present during Service Recipient 1's psychological interview and assessment and reported that Service Recipient 2 apologized to Service Recipient 1 for inappropriately touching him during the van ride.

The third service recipient, who was in the van at the time of the incident, told the investigator that he did not witness the incident, that he thought but was not certain that Staff 1 was driving and that there were times when he saw both the Subject and Staff 1 sitting in the front seats during the ride.

The fourth service recipient, who was also in the van at the time of the incident, stated that Service Recipient 1 usually sits on the most rear bench seat and that Service Recipient 2 usually sits on the middle bench seat during the van ride. He did not recall anything remarkable that happened on the date of the incident. (Justice Center Exhibits 6, 14 and 26)

The Subject denied the allegations and raised various assertions at the hearing. The Subject contends that the incident never happened, and in support of her contention, the Subject notes that

the time of incident was not alleged nor presented as evidence in the hearing, that there are many factual inconsistencies in the record, that there were no independent eyewitnesses to the incident, that given the van's bench seat arrangement, Service Recipient 2 could not have reached around the seat and inappropriately touched Service Recipient 1, and that the Service Recipients' credibility is questionable.

Although there is some merit to the Subject's assertions, her arguments are unpersuasive. The record establishes some inconsistencies between Service Recipient 1's initial report concerning where he sat in the van and his interview statement that added the new allegation that Service Recipient 2 had exposed his genitals to him. However, these inconsistencies do not automatically negate Service Recipient 1's claim that he was inappropriately touched by Service Recipient 2.

Concerning the issue of where Service Recipient 1 sat in the van, Service Recipient 2 and the fourth service recipient stated that Service Recipient 1 usually sat in the far rear bench seat of the van. The Subject and Staff 1 also testified that Service Recipient 1 normally sat in the most rear bench seat of the van. (Justice Center Exhibits 6 and 14)

Regardless of where Service Recipient 1 sat in the van or whether or not Service Recipient 2 exposed his genitals to him, the record establishes that Service Recipient 1's initial reports and statements were consistent relative to the inappropriate touching allegation involving Service Recipient 2.

The Subject's assertion that the incident could not have happened because of the bus-style van seats is speculative. Service Recipient 2 told the investigator that he reached behind his seat to improperly touch Service Recipient 1. Because Service Recipient 2 was capable of independently fastening and unfastening his seat belt, it is conceivable that he moved into a

position that enabled him to improperly touch Service Recipient 1.

The Subject's other assertions that the incident did not happen because there was no exact time alleged and that there were no independent witnesses lack merit. The Subject and Staff 1 testified that there were times during the [redacted] work day when they rode in the van with the service recipients. Staff 1 even told the investigator that the [redacted] service recipients began work about 9:00 a.m. and headed back to their residences by 2:00 p.m. Therefore, the incident had to have occurred at some point during that time frame on [redacted]. Also, the fact that there were no independent witnesses is consistent with Service Recipient 2's admission. Service Recipient 2 told the investigator that when he inappropriately touched Service Recipient 1, staff did not see him do this and the other service recipients were seated in front of his seat. (Justice Center Exhibit 9)

The record further establishes that when recalling the incident to [redacted] staff and his psychologist, Service Recipient 1 became visibly upset, started to cry and stated that he felt "uncomfortable" when Service Recipient 2 improperly touched him. Service Recipient 1 also stated that he "felt bad" when the Subject and Staff 1 did not believe him when he reported the incident to them, that after reporting the incident to [redacted] staff he "felt good" because they believed him and that he "told the truth." [redacted] staff had also reported to the psychologist during Service Recipient 1's psychological assessment that Service Recipient 2 had offered an apology to Service Recipient 1 as to what he had done and Service Recipient 2's account of the incident to the investigator corroborates Service Recipient 1's account. Moreover, none of the plans for either Service Recipient 1 or Service Recipient 2 indicated a history of fabricating or that fabricating was a target behavior. (Justice Center Exhibits 14, 26 and 28-29)

Consequently, the eyewitness accounts of the incident from Service Recipient 1 and

Service Recipient 2 are credited evidence. Additionally, that part of the Subject's testimony and Staff 1's testimony, indicating or surmising that, on the day of the incident while riding in the van with the Service Recipients, the Subject sat in the rear van seats and practiced strategic seating to properly maintain "range of scan" supervision is not credited evidence.

Given Service Recipient 1's reported emotional and mental state due to the incident, the Subject's conduct would have likely caused a setback in his psychological treatment. Also, given Service Recipient 2's expressions of guilt or remorse about the incident, the Subject's conduct would have likely caused a deterioration of Service Recipient 2's mental health and increased his risk of a relapse had the incident remained undiscovered and undisclosed. Service Recipient 2's [redacted] Psychiatric/Behavioral Guidelines noted that there were no substantiated incidents of sexual offending, but warned that if Service Recipient 2's behavior increased in intensity or frequency, his psychologist would need to be contacted for him to receive treatment. Furthermore, the Subject's conduct and non-discovery of the incident resulted in her inability to comply with Service Recipient 2's Risk Management Plan, which required the consistent implementation of his behavioral guidelines that stressed the "prevention of relapse behavior" in order to ensure that a relapse would not occur. (Justice Center Exhibits 12-13, 8-10 and 26)

Therefore, the Subject breached her duty to properly supervise both Service Recipients by failing to maintain "range of scan" supervision by using "strategic seating" while riding in the van with them. The Subject's conduct resulted in Service Recipient 2 being able to inappropriately touch the intimate body parts of Service Recipient 1. The Subject's conduct was likely to have resulted in serious or protracted impairment of the physical, mental or emotional condition of both Service Recipients in accordance with SSL § 488(1)(h).

Accordingly, it is determined that the Justice Center has met its burden of proving by a

preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated against the Subject, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

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

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

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: February 28, 2017
West Seneca, New York

Mary Jo Lattimore-Young,
Administrative Law Judge