**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: Thomas C. Parisi, Esq.

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

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 with respect to Allegation 1, dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

The substantiated report shall be amended and categorized as a Category 3 act.

The request of [redacted] that the substantiated report with respect to Allegation 2, dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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

NOW, THEREFORE, IT IS DETERMINED that the record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(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 20, 2017
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**

**Adjud. Case #:** [redacted]

Before: Louis P. Renzi
Administrative Law Judge

Held at: Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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## JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse (deliberate inappropriate use of restraints). The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

## FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of abuse (deliberate inappropriate use of restraints) by the Subject of a Service Recipient.

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

### Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you engaged in an unwarranted restraint, failed to use proper de-escalation techniques, utilized excessive force and an improper technique to restrain a service recipient from a seated position.

This allegation has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) pursuant to Social Services Law § 493(4)(b).

### Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you failed to use proper de-escalation techniques and when you utilized excessive force and an improper technique to restrain a service recipient in a prone position.

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

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

4. The facility, located at [redacted], is a juvenile detention center for male youth ages 11 to 18 years old, operated by the [redacted] and licensed by the NYS Office of Children and Family Services (OCFS), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OCFS Child Abuse Specialist I (CAS) [redacted])

5. At the time of the alleged abuse, the Subject had been employed by [redacted] for six weeks. The Subject worked as a Juvenile Counselor. (Hearing testimony of the Subject; Justice Center Exhibit 22)

6. At the time of the alleged abuse, the Service Recipient had been a resident of the facility for an unknown length of time. (Hearing testimony of OCFS CAS [redacted])

7. At the opening of the hearing of this matter, the Subject stipulated to the fact that he was a custodian as that term is defined in Social Services Law § 488(2). He further stipulated that he had taken part in both of the manual restraints underlying the allegations presented here.

8. The two restraints of the Service Recipient took place within a few moments of each other within the same common area of the Service Recipient's assigned residence unit. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibit 21)

9. At the time of the alleged abuse described in "Allegation 1", the Service Recipient was seated in an upholstered armchair. The Service Recipient had refused to comply with a directive by another staff member (Staff A) to line up for breakfast and instead sat in the chair. The Service Recipient was then directed to accompany Staff A to his room for counseling, which

the Service Recipient refused to do. (Hearing testimony of OCFS CAS [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 12, 21)

10. Staff A initiated a restraint of the Service Recipient by grasping his upper arm and torso, and attempted to pull him out of the chair as the Service Recipient resisted. Staff A then directed the Subject to assist. The Subject grasped the Service Recipient's ankle. Together, the two staff pulled the Service Recipient out of the chair, whereupon the Service Recipient slid to the floor. Staff A and the Subject then stood the Service Recipient up between them. The Subject disengaged and Staff A escorted the Service Recipient to an adjacent bathroom for counseling. (Hearing testimony of OCFS CAS [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 8, 11, 12, 21)

11. At the time of the alleged abuse described as "Allegation 2", after being counseled by Staff A as noted in paragraph number 10 above, the Service Recipient walked past the Subject, verbally taunting him as he passed and continued walking away. The Subject then walked towards the Service Recipient, grabbed him by the upper arms, and pushed him to the floor. Staff A intervened and both staff momentarily ended up on top of the Service Recipient. (Hearing testimony of OCFS CAS [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 12, 21)

12. The Service Recipient sustained a minor physical injury during the two restraints performed upon him by the Subject and Staff A, but from the evidence in this record it is not possible to determine which of the restraints actually caused the injury. (Hearing testimony of OCFS CAS [redacted]) The evidence indicates that the injury was diagnosed by medical staff as mild tenderness of the right shoulder with no loss of range of motion. The prescribed remedy was the application of a hot pack. The Service Recipient was not referred for further diagnosis or treatment. The two restraints occurred no more than a few moments apart. (Hearing

testimony of OCFS CAS [redacted]; Justice Center Exhibits 10, 21)

13. The policies and procedures for responding to negative behaviors of service recipients in the facility, including the use of physical restraints, are set forth in Safe Crisis Management (SCM), which is a guidance manual supplied by OCFS. SCM requires staff to attempt verbal de-escalation techniques as a prerequisite to a physical restraint. SCM further prohibits restraints in the prone position. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibit 20)

14. The Subject is 6'4" tall and weighs approximately 270 lbs. The Service Recipient is approximately 5 feet tall and slightly built. (Hearing testimony of the Subject; Justice Center Exhibit 21)

## ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse.
- Pursuant to Social Services Law § 493(4), the category of abuse that such act or acts constitute.

## APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse (deliberate inappropriate use of restraints) of a person in a facility or provider agency is defined by SSL § 488(1)(d) to include:

> (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

Substantiated reports of abuse shall be categorized into categories pursuant to SSL § 493(4), including Category (2) and Category (3), which are defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.
>
> (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

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

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

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

## DISCUSSION

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-22) The investigation underlying the substantiated report was conducted by OCFS Child Abuse Specialist I (CAS) [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified in his own behalf and provided no other evidence.

The Justice Center submitted a visual only video of the incident, which was extremely helpful and illuminating evidence with respect to the substantiated allegations. (Justice Center Exhibit 21) In order to substantiate an allegation of abuse (deliberate inappropriate use of restraints), the Justice Center must prove by a preponderance of the evidence that either the technique used, the amount of force used, or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, and limits the ability of a person receiving services to freely move his or her arms, legs or body. (SSL § 488(1)(d))

The generally accepted treatment practices of OCFS with respect to restraints are reflected in the OCFS program entitled "Safe Crisis Management" (SCM). Once staff determines that a restraint is warranted, they are required to follow the proper methods for performing a restraint; those methods are set forth in SCM. Prone restraints are prohibited. Further, prior to physically engaging with a service recipient, staff are required to utilize substantial de-escalation techniques which are embodied in SCM. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibit 20)

**Allegation 1 – Abuse (deliberate inappropriate use of restraints)**

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

Specifically, the video evidence depicts the Service Recipient sitting in an upholstered chair placed against one wall of the facility common area. Staff A stated that the Service Recipient refused to comply with staff's verbal directives to get in line for breakfast, and instead sat in a chair and asked Staff A for a few moments to collect himself. Staff A refused that request and directed the Service Recipient to go to his room for counseling. When the Service Recipient did not move out of the chair, the Subject and Staff A physically pulled the Service Recipient out of the chair and he slid to the floor. Staff A continued the restraint and the Subject backed out. Staff A then escorted the Service Recipient to the closest unlocked room, the bathroom, for the counseling session. (Justice Center Exhibits 12, 21)

Staff A and the Subject both stated to OCFS CAS [redacted] that they attempted to utilize verbal de-escalation with the Service Recipient prior to the restraint, a statement repeated by the Subject during his testimony. CAS [redacted] testified that Staff A and the Subject should have continued to use non-physical de-escalation techniques to resolve the matter, and should not have attempted to utilize a physical restraint in the absence of any threat by the Service Recipient to harm himself or others. CAS [redacted] concluded that no restraint was called for. (Hearing testimony of OCFS CAS [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 8, 9, 10, 11, 12, 21) Here, although the Service Recipient had refused to comply with the directives of staff, he did not present any threat to his own health, safety or well-being or that of anyone else in the vicinity. Therefore, no physical restraint was warranted.

The Subject participated with Staff A in an unwarranted physical restraint of the Service Recipient by forcibly pulling him out of a chair by his ankle, arm and shoulders, thereby

immobilizing or limiting the Service Recipient's ability to move his body freely. There is no technique described in SCM which authorizes staff to pull a service recipient out of a chair by his legs or in such a manner as to cause a service recipient to fall to the floor, as happened here. The Subject had received four days of training in SCM approximately one month prior to these incidents. None of the methods used here by the Subject are sanctioned by SCM. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibits 20, 21)

Therefore, it is also concluded that not only was the restraint performed by the Subject and Staff A on the Service Recipient unwarranted, but it was also performed using excessive force and an unauthorized technique.

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 abuse (deliberate inappropriate use of restraints) as alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report of the Subject's conduct constitutes the category level of abuse set forth in the substantiated report. The Subject became involved in the restraint at the direction of Staff A. The Subject's role in the restraint was limited to securing the Service Recipient's ankle and assisting Staff A to pull the Service Recipient from the chair, at which time the Service Recipient was pulled from the chair onto the floor. The video evidence shows that the conduct of the Subject in performing the restraint, although unnecessary and performed with poor technique, was not overly aggressive. After considering all of the evidence, it is concluded that the Subject's role in the non-prescribed restraint technique did not seriously endanger the health, safety or welfare of the Service Recipient. Accordingly, the category of abuse is hereby amended to be a Category 3 offense.

A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

**Allegation 2 – Abuse (deliberate inappropriate use of restraints)**

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 2" in the substantiated report.

Specifically, the preponderance of the evidence proved that the Subject failed to attempt any de-escalation techniques with the Service Recipient, as is required by SCM prior to performing a manual restraint. (Justice Center Exhibit 21) There is no credible evidence in this record which justifies the restraint. It is thus concluded that the Subject used excessive force. The Subject also forced the Service Recipient to the floor initially in a prone position, a technique that was contrary to SCM, the restraint methodology governing the facility. Such restraint is required to be performed in the supine position. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibits 20, 21)

The evidence proved that immediately prior to the restraint, the Service Recipient was verbally taunting the Subject and walking away, but taking no further action. In response to the taunting, the Subject is seen in the video recording immediately following and then manually restraining the Service Recipient. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibits 6, 21)

The Subject admitted that he was a custodian as that term is defined in SSL § 488(2) and that he used a manual restraint which involved taking the Service Recipient to the floor, which immobilized or limited the Service Recipient's ability to move his body freely. The video record

of the incident showed the Subject intentionally grasping the Service Recipient's upper arms and forcefully pushing the Service Recipient to the floor onto his chest and face, with the Subject lying partially on top of his torso. Staff A also intervened and either fell or placed his weight on the Service Recipient's legs. As noted in the discussion above, the Service Recipient sustained physical injury as a result of one or both of these restraints. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibits 10, 16, 21)

In his defense, the Subject testified that the Service Recipient had assumed a fighting posture with fists up to strike the Subject. The Subject testified that he believed that the Service Recipient was about to strike him because the Service Recipient performed a "bounce" with his legs. The Subject perceived this motion as an indication that the Service Recipient was about to strike the Subject.

This testimony is not supported by the video evidence depicting the Service Recipient's actions. There is no credible evidence in this record which would tend to prove that the Service Recipient presented any threat of harm to himself or others at the time in question. Therefore, it is concluded that there was no justification for the restraint. Further, by taking the Service Recipient to the floor in the prone position, even for a short time, the Subject violated OCFS and [redacted] policy and training which prohibits prone restraints. As a result, a preponderance of the evidence establishes that the technique used, the amount of force used and the situation in which the restraint was used were all deliberately inconsistent with the Service Recipient's behavioral plan, generally accepted practices and/or federal or state laws, regulations or policies. (Hearing testimony of OCFS CAS [redacted]; Justice Center Exhibits 20, 21)

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 abuse (deliberate inappropriate use of restraints) alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of abuse 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 as to Allegation 2 is properly categorized as a Category 3 act.

A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

**DECISION:** The request of [redacted] that the substantiated report with respect to Allegation 1, dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

The substantiated report shall be amended and categorized as a Category 3 act.

The request of [redacted] that the substantiated report with respect to Allegation 2, dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a

preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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

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

**DATED**: March 10, 2017
Schenectady, New York

Louis P. Renzi, ALJ