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: Jacqueline Seitz, Esq.

[redacted]
By: Lawrence Schaefer, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

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 physical abuse by the Subject of the Service Recipient 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) and physical abuse.

The substantiated report shall be amended to be 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: April 7, 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

Adjudication Case #: [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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JURISDICTION

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

FINDINGS OF FACT

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

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

2. The Justice Center's substantiated report against the Subject 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) and/or physical abuse when you conducted a restraint with excessive force and improper technique, which included grabbing a service recipient by his shirt, lifting him up by his collar, pushing him to the floor, dragging him into the hallway, and/or punching him in the face.
>
> These allegations have been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) and Category 2 physical abuse pursuant to Social Services Law § 493(4)(b).

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

4. The facility, located at [redacted], is a [redacted] psychiatric facility that is operated by the New York State Office of Mental Health

(OMH), which is an agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse, the facility utilized a program entitled: Preventing and Managing Crisis Situations (PMCS) to manage service recipients' aggressive behaviors. Under PMCS, facility staff are to employ the least intrusive measures to defuse and prevent crises. The only time a manual restraint is sanctioned is when there is "imminent danger" of serious harm to someone. Even when an assessment of "imminent danger" is made and a manual restraint is employed, the least restrictive restraint should be used and the need to maintain the restraint must be reassessed on a continual basis. Under PMCS, the only type of one person restraint that is allowed is a standing wrap, which can be properly transitioned into an authorized one person removal, if necessary. (Hearing testimony of OMH Staff Development Specialist [redacted] and Justice Center Exhibit 22)

6. At the time of the alleged abuse, the Service Recipient was a fifty three year old male, who had a diagnosis and significant history of schizoaffective disorder and substance abuse. He was transferred from [redacted] on [redacted], after he was determined to be unfit for trial regarding an outstanding charge of assault. The Service Recipient was delusional and paranoid, and had a history of poor compliance with medication and treatment. (Justice Center Exhibit 18)

7. At the time of the alleged abuse, the Subject had been employed as a facility Security Hospital Treatment Assistant (SHTA) for fifteen years. The Subject was trained in PMCS techniques and he received yearly refresher trainings. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

8. At approximately 12:15 p.m. on [redacted], the Subject and SHTAs 1 and 2 were supervising twenty-seven service recipients in the dining room of facility ward [redacted] at

lunchtime. The facility ward [redacted] dining room's entrance/exit door is at one end of the room and the kitchen and serving area is at the other. The serving area has a protective metal security mesh/grate over a large window above a counter, and there is a door beside it, separating the kitchen from the dining room. Located between the serving area and the door to the kitchen is a small cart, which contains the plastic cutlery that is distributed to the service recipients at meal time and then returned to a designated SHTA, who counts the cutlery after the meal. Along the walls, there are four tables on one side and three on the other. The tables are affixed to the floor and they each have four seats, which are attached to the tables. Near the entrance/exit door, there is an emergency telephone on the wall that is used by staff to summon assistance. (Justice Center Exhibits 25.1-25.6 and 26, track 12 and Hearing testimony of the Subject)

9. At the time of the incident, the Subject and SHTA 2 were standing at the back of the dining room and SHTA 1 was at the front, facilitating cutlery distribution and collection. (Hearing testimony of SHTA 1)

10. The Service Recipient and service recipient A were eating lunch at the second of the four tables, which was closer to the end of the dining room, near the entrance/exit door. A fight between the Service Recipient and service recipient A erupted. The Subject called for assistance and then he and SHTA 1 approached the two service recipients and attempted to redirect them verbally, which went unheeded. Both service recipients had repeatedly punched each other in the face and were bleeding. The Subject then noticed that the Service Recipient was holding a plastic knife in his hand and that he was about to cut service recipient A's face with it. While SHTA 1 restrained service recipient A, the Subject, who was behind the Service Recipient, pulled the Service Recipient away from service recipient A by the back of the Service Recipient's shirt. The Service Recipient was irately yelling and threatening service recipient A. As the Subject

pulled the Service Recipient away from service recipient A, the Subject attempted to execute a standing wrap and he inadvertently backed into the table behind him, the impact of which caused the Service Recipient to slide to the floor and to drop the plastic knife. (Hearing testimony of the Subject)

11. SHTA 2 observed the knife on the floor, which had blood on it, and immediately stepped in, picked up the knife and retreated. SHTA 2 then observed that another service recipient was holding the emergency telephone and she took it from him, used it to confirm that assistance was on its way and hung it up. (Justice Center Exhibit 26, track 13)

12. As soon as the Subject realized that the knife had fallen to the floor, he grabbed the Service Recipient, who had fallen on his buttocks and was screaming and threatening service recipient A, by the back of his shirt and dragged him approximately six to eight feet backwards out of the dining room, through the entrance/exit door and into the empty adjacent hallway. During this time, the Service Recipient continued to be very agitated. Once outside of the dining room, the Service Recipient immediately accused the Subject of having punched him in the face. At that point, the response team arrived and entered the dining room. SHTA 1 then came into the hallway and the Subject released the Service Recipient's shirt, which had been torn during the intervention. (Hearing testimony of the Subject and Justice Center Exhibit 24)

13. When SHTA 1 approached the Service Recipient and the Subject, who was still sitting on the floor, he used verbal calming techniques to deescalate the Service Recipient's behavior. Once the Service Recipient found his shoe, which had fallen off in the hallway, he got to his feet and was escorted by the Subject and SHTA 1 to a facility "time out room." (Hearing testimonies of the Subject and SHTA 1)

14. Thereafter, the Service Recipient was assessed by a facility doctor and was still

irate and threatening. As the Service Recipient refused to take oral medication, he was restrained and administered an intramuscular injection of medication. (Justice Center Exhibit 9)

15. After the incident, the Service Recipient repeated the allegation that the Subject had punched him in the left side of his face to a facility RN (Justice Center Exhibits 9 and 26, track 18), a facility doctor (Justice Center Exhibits 9 and 26, track 10), and to Justice Center Investigator [redacted] (Justice Center Exhibit 26, track 1).

16. The Service Recipient sustained abrasions to his face and to his left eyebrow. (Justice Center Exhibits 8 and 9)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the 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 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 (deliberate inappropriate use of restraints) and physical 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 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, 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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4). Category 2 and 3 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.
>
> (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 (deliberate inappropriate use of restraints) and physical abuse alleged in the substantiated report that are the subject of the proceeding and that such act or acts constitute the category of abuse (deliberate inappropriate use

of restraints) and physical abuse as set forth in the substantiated report. (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 (deliberate inappropriate use of restraints) and physical abuse cited in the substantiated report constitutes 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

The Justice Center has established by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints) and physical abuse, both described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-26) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who, together with OMH Staff Development Specialist [redacted], testified on behalf of the Justice Center.

The Subject and his witness, SHTA 1, testified at the hearing in the Subject's behalf.

Abuse (Deliberate Inappropriate Use of Restraints)

A finding of abuse (deliberate inappropriate use of restraints) under SSL §488(1)(d) would include a situation in which a preponderance of the evidence shows that the Subject used a restraint that was deliberately inconsistent with generally accepted treatment practices, that was not used as

a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to any other person. The definition of "restraint" includes the use of any manual measure to immobilize or limit the ability of the Service Recipient to freely move his arms, legs or body.

Although the Subject's explanation as to the precise manner in which he restrained the Service Recipient and removed him from the dining room had been unclear and defensive in his interrogation (Justice Center Exhibit 26, tracks 6 and 7), the Subject did acknowledge in his hearing testimony that he did not follow PMCS protocol when he pulled the Service Recipient from behind, by the back of his shirt collar, and when he dragged the Service Recipient backwards by his shirt, out of the dining room. Accordingly, it is uncontroverted that the unauthorized techniques used by the Subject were deliberately inconsistent with generally accepted treatment practices and, therefore, would constitute deliberate inappropriate uses of restraints. The issue is whether these actions were reasonable emergency interventions necessary to prevent the imminent risk of harm to a person.

Regarding the Subject's act of pulling the Service Recipient away from service recipient A , the Subject testified that he determined that service recipient A was in imminent danger at the point in time when the Service Recipient introduced a plastic knife into what had been a fistfight and was holding it up against service recipient A's face.

The credible evidence in the record establishes that the Subject's act of pulling the Service Recipient away from service recipient A from behind by his shirt collar was done to protect service recipient A from being cut in the face. It is determined that this act constituted a reasonable emergency intervention to prevent imminent risk of harm to service recipient A. Accordingly, this aspect of the Subject's conduct was not a deliberate inappropriate use of restraints under SSL § 488(1)(d).

Regarding the Subject's act of dragging the Service Recipient out of the dining room by the back of his shirt, the Subject testified that, as he pulled the Service Recipient away from service recipient A, he attempted to "wrap" him, but that the impact of hitting the table behind them caused the Service Recipient to slip out of his grasp and onto the floor, and that the plastic knife fell out of the Service Recipient's hand. The Subject testified that as soon as he observed the knife on the floor, within the Service Recipient's reach, while the Service Recipient was obviously agitated and threatening further violence, he immediately decided to remove the Service Recipient from the dining room as quickly as possible. The Subject testified that he did not want to take a chance on what the Service Recipient might do, that he did not wait to reassess, and that he did not want to delay the defusing of the volatile situation. The Subject testified that, as no staff assistance was readily available and the Service Recipient, already on the floor with his back to the door, was perfectly positioned to be removed from the room by being pulled backwards a short distance, he took hold of the back of the Service Recipient's shirt and pulled him out of the dining room. The Subject testified that, because the three staff who were present in the room were greatly outnumbered by the service recipients present, he decided to act decisively and without delay.

Under PMCS, the Subject was trained that, during an incident, the least intrusive measures should be used, that de-escalation techniques should be ongoing, that during a restraint, staff should continually assess whether imminent risk of harm remains present and, if not, then to step back and employ recommended alternatives. At the point when the Service Recipient had slipped out of the Subject's grasp and landed on the floor, having dropped the knife, the Subject had a clear opportunity to reassess the need for his intervention. Because the knife was secured by SHTA 2, the risk of harm from cutting was averted. In his cross-examination testimony, the Subject conceded, "Maybe I should have waited, but because I saw the knife, I reacted." The evidence

shows that the Subject had techniques and options available to him that did not involve reengaging the Service Recipient physically and dragging him out of the room.

After considering all of the evidence, it is determined that the act of dragging the Service Recipient out of the dining room by the back of his shirt was not a reasonable emergency intervention to prevent imminent risk of harm and, therefore, constituted a deliberate inappropriate use of restraints under SSL § 488(1)(d).

Physical Abuse

For a finding of physical abuse, a preponderance of the evidence must establish that the Subject 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.

SSL § 488(16) states that "intentionally" and "recklessly" shall have the same meanings as provided in section 15.05 of the New York Penal Law.

New York Penal Law 15.05(1) states that "(a) person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his conscious objective is to cause such result or to engage in such conduct."

New York Penal Law 15.05(3) states that "(a) person acts recklessly with respect to a result or to a circumstance described by a statute defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists."

The Justice Center alleged that the Subject punched the Service Recipient on the left side of his face which, if proven, would have constituted physical abuse. During his interrogation, the Subject denied punching the Service Recipient. (Justice Center Exhibit 26, tracks 6 and 7) The

Subject testified that he did not punch the Service Recipient and that all of the numerous service recipients who watched him drag the Service Recipient into the hallway would have seen him punch the Service Recipient, had he done so. In his testimony, the Subject acknowledged that the Service Recipient had accused the Subject of punching him in the face when they were in the hallway and the timeout room, but the Subject reiterated his denial.

In support of this aspect of the allegation, the Justice Center relied on the Service Recipient's statements to the facility RN and doctor (Justice Center Exhibits 9 and 26, tracks 10 and 18) and to Justice Center Investigator [redacted] (Justice Center Exhibit 26, track 1), that the Subject had punched him, and on the fact that the Service Recipient had an injury to the left side of his face (Justice Center Exhibits 9 and 24).

Although the left side of the Service Recipient's face was injured on [redacted], he had been involved in a violent fistfight immediately prior to the time that he alleged that he had been punched by the Subject, which raises the question of whether the Service Recipient's injury emanated from the fight or from the alleged subsequent punch by the Subject.

The Subject testified that the fight between the two service recipients was intense and that blood was "everywhere," describing them as "locked in a ball" and, further, that the fight was a "brawl." The other accounts of the fight were given by SHTAs 1 and 2 and by the Food Service Worker. In SHTA 1's interview (Justice Center Exhibit 26, track 2) and his hearing testimony, he stated that both service recipients were punching each other straight in the face and that they were both bleeding. In SHTA 2's interview (Justice Center Exhibit 26, track 13), she stated that the verbal dispute between the two service recipients quickly escalated into a physical altercation and that when they were pulled apart, they were both bleeding from the blows and that there was blood "everywhere."

In the Food Service Worker's interview (Justice Center Exhibit 26, track 12), she stated that she had been serving food from behind the protective metal security mesh/grate at the far end of the dining room, that the two service recipients were fighting and that she saw the Service Recipient hitting service recipient A.

In his interview (Justice Center Exhibit 26, track 1), the Service Recipient stated that service recipient A initiated the fight and punched him one time in the right side of his face and that he responded by punching service recipient A's face twice. The Service Recipient's account of the fight, as being confined to three punches, is not credited evidence, given the copious amount of blood everywhere that was reported by the Subject and SHTAs 1 and 2, the measures that were required to break the altercation up and the three SHTA's descriptions of it. It is clear that the Service Recipient received more than one punch from service recipient A and that his left side facial injury may well have been attributable to that physical altercation.

Furthermore, taking into account the Service Recipient's several comments implying that the Subject had been targeting him, such as the Service Recipient's statement that he had "read a lot of animosity in [the Subject's] eyes," that the Subject had been "harassing" him and giving him "a lot of trouble" and that the staff had been giving him "negative vibes," it is likely that the Service Recipient was not a reliable reporter of the facts and that his perception of the events may have been impacted by the underlying fight, his anger at the Subject or his own illness.

After considering all of the evidence, the Subject has not been shown by a preponderance of the evidence to have committed the alleged punch giving rise to the substantiated report.

The Subject's act of pulling the Service Recipient away from service recipient A, while the Service Recipient held a knife near service recipient A's face, may have constituted physical abuse. However, for the same reasons as stated above, it is concluded that this action was a reasonable

emergency intervention necessary to protect the safety of service recipient A.

The final issue is whether the Subject's act of dragging the Service Recipient out of the dining room by the back of his shirt was physical abuse. The statutory definition of physical abuse specifically includes the act of dragging. The Subject's conduct involved physical contact and, as discussed above, did not constitute a reasonable emergency intervention. Furthermore, as the Subject's conscious objective was to drag the Service Recipient out of the dining room, his conduct was intentional. Although there was no evidence that the Subject's 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. A finding that the Subject's dragging of the Service Recipient intentionally or recklessly caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, also qualifies as physical abuse.

After considering all of the evidence, including evidence of the volatility and violence surrounding the incident, it is determined that the Subject's conduct of dragging the Service Recipient out of the dining room caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, a preponderance of the evidence establishes that the Subject committed physical abuse under SSL § 488(1)(a).

Conclusion

The report will remain substantiated for abuse (deliberate inappropriate use of restraints) and physical abuse. The next issue to be determined is whether the substantiated report constitutes the category of abuse set forth in the substantiated report.

In order to prove Category 2 conduct, the Justice Center must establish that the Subject

seriously endangered the health, safety or welfare of the Service Recipient. Under 14 NYCRR § 700.6 (a), the ALJ has discretion to amend the findings of the substantiated report since it is the subject matter of the hearing; namely, "whether the findings of the report should be amended." Section 700.6(b) specifically sets forth the category of abuse and/or neglect as one of the three issues to be determined at the hearing. After considering all of the evidence, it is concluded that the Subject's conduct did not seriously endanger the health, safety or welfare of the Service Recipient. Accordingly, the category of abuse (deliberate inappropriate use of restraints) and physical abuse should be amended to Category 3 conduct.

Substantiated Category 3 findings 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 dated [redacted] of abuse (deliberate inappropriate use of restraints) and physical abuse by the Subject of the Service Recipient 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) and physical abuse.

The substantiated report shall be amended to be a Category 3 act.

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

DATED: April 4, 2017
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge