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: Todd Sardella, Esq.

[redacted]
By: Richard J. Washington, Esq.
100 Church Street, Suite 800
New York, NY 10007

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed the abuse and neglect alleged.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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 25, 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: Elizabeth M. Devane
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
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JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of abuse and neglect 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 sexual abuse when you engaged in sexual contact and/or conduct, including sexual intercourse, with a service recipient in violation of Penal Law Article 130.

This allegation has been SUBSTANTIATED as Category 1 sexual abuse pursuant to Social Services Law §493(4)(a).

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you breached a duty by failing to maintain a professional relationship with a service recipient, including engaging in sexual contact and/or conduct with her.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

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

4. [redacted], located at [redacted], is a municipally operated teaching hospital affiliated with [redacted] and has a psychiatric unit (Unit) that is licensed by the Office of Mental Health (OMH), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator II [redacted])

5. At the time of the alleged abuse and neglect, the 31 year old male Subject had been employed by [redacted] for two years as a Patient Care Associate (PCA). His duties included assisting service recipients with activities of daily life such as meals and hygiene, day room activity facilitation and taking vital signs. (Hearing testimony of Justice Center Investigator II [redacted]; Hearing testimony of Subject)

6. At the time of the alleged abuse and neglect, the female Service Recipient, whose age was not specified, had been an inpatient psychiatric service recipient at [redacted] since [redacted] 2014. (Hearing testimony of Justice Center Investigator II [redacted]; Justice Center Exhibit 5)

7. The Service Recipient was diagnosed as psychotic which manifests as disorganized, sexually impulsive and preoccupied with sexuality and pregnancy. (Hearing testimony of Justice Center Investigator II [redacted]; Justice Center Exhibits 5, 6, 9, 10; Subject Exhibits A – C)

8. From [redacted] to [redacted] the Service Recipient was under 15C supervision on the Unit, meaning that her whereabouts had to be confirmed every 15 minutes. (Hearing testimony of the Subject; Justice Center Exhibits 5 and 10)

9. On [redacted], the Subject reported to the Registered Nurse (RN) that the Service Recipient had been following him and brushed up against him and two other staff reported to the RN that the Service Recipient had grabbed the genitals of another service recipient. As a result of these and other incidents, the Service Recipient was counseled, and on [redacted] at 4:00 p.m., the Service Recipient's supervision level was changed from 15 minute checks to constant one to one supervision. (Hearing testimony of Justice Center Investigator II [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 6 and 10; Subject Exhibits A – C)

10. On [redacted], at around 3:00 p.m., the Service Recipient stated to a Creative Art Therapist (CAT) that her ovaries hurt because she was raped by a male staff member in the staff bathroom. In response to the CAT's questions, the Service Recipient could not specify the date, other than "2 or 3 days ago" and said it was a staff member with a beard. As the CAT and the Service Recipient were talking, the Subject, who has a beard, entered the activity room. The CAT pointed to the Subject and asked the Service Recipient if he was the person the Service Recipient was referring to and the Service Recipient replied yes. (Hearing testimony of Justice Center Investigator II [redacted]; Justice Center Exhibits 5, 6, 9 and 10)

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 and neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and 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 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)(b) and 488(1)(h) to include:

> "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.
>
> "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 Categories 1 and 2, which are defined as follows:

> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes:
>
> > (v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
>
> (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.

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 and neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse and 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 acts of abuse and neglect cited in the substantiated report constitute the category of abuse and neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed acts, described as “Allegation 1” and “Allegation 2” in the substantiated report.

In support of its substantiated findings, the Justice Center presented documents obtained during the investigation (Justice Center Exhibits 1-10) as well as a visual only video (Justice Center Exhibit 11). The investigation underlying the substantiated report was conducted by Justice Center Investigator II [redacted] (Investigator), 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 four documents (Subject Exhibits A-D).

Allegation 1 – Sexual Abuse

In order to sustain the allegation of sexual abuse as alleged, the Justice Center must prove that the Subject was a custodian and that he subjected the Service Recipient, a person receiving services, to "any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law". (SSL § 488(1)(b)) In this case, the allegation presented by the Justice Center is that the Subject committed an act which met the elements of either Penal Law §130.25, Rape in the Third Degree, by engaging in sexual intercourse with the Service Recipient who is incapable of consent by reason of some factor other than being less than seventeen years old or Penal Law §130.20, Sexual Misconduct, for engaging in sexual intercourse with the Service Recipient without her consent.

New York State Penal Law §130.05(3)(i) deems a person incapable of consent when, among other factors, he or she is:

> A resident or inpatient of a residential facility operated, licensed or certified by (i) the office of mental health . . . and the actor is an employee of the facility not married to such resident or inpatient.

(NYS PL §130.25; NYS PL §130.20; NYS PL §130.05 (i))

Initially, it is determined that the Service Recipient lacked the requisite consent to engage

in sexual activity with the Subject as, at the time of the alleged abuse and neglect, the Service Recipient was an inpatient of [redacted], a facility licensed by OMH. The Subject was a custodian as well as an employee of [redacted]. At issue is whether the alleged sexual intercourse occurred. The Subject denies that any such sexual contact occurred.

The Justice Center argued that the Service Recipient was consistent in her statements regarding the allegations, while the Subject argued that the Service Recipient's statements were inconsistent.

In this regard, the Service Recipient initially reported to the CAT that she was raped, and did not know when it occurred other than two or three days prior to her report. The following day, the CAT, MD and RN met together and interviewed the Service Recipient. The only account of that interview with any detail is contained in an email by the CAT. The CAT wrote that the Service Recipient indicated consensual contact occurred in the locked staff bathroom. However, at one point in the interview, the Service Recipient indicated the rape occurred in the shower room, which is in a separate location. The CAT wrote that "throughout the interview, the patient made a few statements about things that were irrelevant to the conversation and didn't make a great deal of sense." (Justice Center Exhibit 9) The Investigator summarized information, from what is seemingly the NYPD interview with the Service Recipient, which indicated that the Service Recipient said that the Subject unlocked the bathroom door for her, that he placed an object on the door to keep it from locking, that the Subject used a condom and that the Subject swallowed the condom after the rape. The issue is not consent but whether the sexual intercourse occurred. Inconsistencies in statements are not uncommon and here are not dispositive.

The only account of the Service Recipient identifying the Subject was set forth in that same email written by the CAT. The CAT wrote that the Service Recipient told the CAT that her ovaries

hurt because she was raped by a staff member, and that when asked by the CAT who the perpetrator was, the Service Recipient responded only that he had a beard. The CAT wrote further, "As we were sitting there, a nurse tech (male staff) walked in and as he had a beard, I pointed to the Staff [redacted] and asked her if this was the person she's referring to. She stated, 'Yes, that's him'." There is no indication that the Service Recipient's identification, in response to a suggestive and leading question, was ever verified by any party other than the CAT or that any follow up investigation was pursued.

Video of the Unit hallway from the morning of [redacted], particularly between 9:30 a.m. to 9:40 a.m., was heavily relied on by the Justice Center. The Justice Center argued that the Subject and Service Recipient are off the video for 4 minutes and 56 seconds and this was when the incident occurred in the bathroom on hallway B. The video depicts a main hallway (hallway A) with rooms on both sides of the hallway. According to evidence, another area (hallway B) is perpendicular to the right (from the vantage point of the video shown at the hearing) off hallway A. A staff bathroom, where the incident is alleged to have occurred, and a conference room are located on hallway B and there is no other egress from hallway B other than through hallway A. The nurse's station, behind a plexiglass window, is located in hallway A and either, according to the evidence, diagonal to or across from the entrance to hallway B.

At a number of points, segments of the video are missing. At 9:31:31 the Service Recipient is seen on video walking toward an area to the right, presumably hallway B, on the screen. The video skips to 9:31:52 and depicts the Subject and four others in hallway A and the Service Recipient is no longer on the video. Over the next few minutes the video shows hallway A activity and seven to ten people, including the Subject, in hallway A. At 9:33:47 the Subject is seen in hallway A and facing toward hallway B. The video skips to 9:34:04 a.m. and the Subject is not

seen on the video. Neither the Subject nor the Service Recipient are seen again on the video until between 9:39:00 and 9:39:09 when both the Subject and Service Recipient enter the video one after the other. As they do so, two others are in the hallway. When the video is replayed in real time, it skips quite a bit and depicts portions of time running a total of 2 minutes and 46 seconds between 9:34:04 and 9:39:00 as opposed to the full 4 minutes and 56 seconds cited.

Based on the allegations, it is important to have a clear understanding of the layout of hallway A and hallway B and the view from hallway A and the nurse's station to hallway B and the bathroom area. The video depicts the view down hallway A but does not depict the entire area in question. The Investigator did not go to the Unit at [redacted], and therefore, could not testify as to the layout of the nurse's station, the layout of, or exactly what was located in, hallway B or whether hallway A contained service recipient rooms, offices, dayrooms or something else. Photos, a video or a labeled diagram of the area in question would have been enormously helpful.

The video depicts almost constant traffic and activity in hallway A during the time of the alleged incident. A number of people, staff and residents, are seen moving in and out of the area during the period of time captured on the video. At one point six or seven people are congregated and talking in the area near the bathroom in question. The Subject testified he recalled speaking to the Service Recipient in the hall for some period of time, and that he was visible during that time to anyone behind the plexiglass in the nurse's station or to anyone in the hallway. None of the other parties on the video in the area are identified and none were interviewed. Again, further information, such as who was in the area and what, if anything, they observed, would have been very helpful.

The Subject testified that the bathroom in question was locked at all times and was for staff use only. The Subject said nurses held a key for that bathroom and if he wanted to use that

bathroom, the Subject had to get a key from a nurse. That bathroom was not for use by service recipients. There is no evidence in the record contradicting the Subject's testimony in this regard.

The Investigator did not interview the Subject. The Investigator testified that he did try to call a phone number given to him for the Subject, but that the number was not in service. The Investigator testified that he also asked another investigator, located closer to [redacted], to speak with the Subject. However, his recollection was that the Subject was either not at home or did not respond to the card left by the [redacted] investigator.

At the time the incident is alleged to have occurred, the Service Recipient's supervision level was 15C, meaning that she was checked upon every 15 minutes. There is no evidence in the record as to when, whether or by whom the 15C checks of the Service Recipient were done during the two or three day timeframe the Service Recipient cited, and no evidence specifically regarding 15C checks of the Service Recipient around the time frame reportedly in question, [redacted] 9:30 a.m. to 9:40 a.m. There are no details regarding what staff was assigned to the Service Recipient when she was on one to one supervision during a portion of the two to three day time period and what, if any, incidents may have occurred. The Justice Center's focus was only on the time indicated in the video.

It is not suggested in any manner that the Service Recipient's allegations are untrue but that the sum of the unanswered questions make it impossible to determine by a preponderance of the evidence that the allegation, as substantiated, occurred.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the sexual abuse alleged.

Allegation 2 – Neglect

In order to sustain an allegation of neglect as alleged, the Justice Center must prove that

the Subject was a custodian who owed a duty to the Service Recipient, that he breached that duty by failing to maintain a professional relationship with the service recipient, including engaging in sexual contact and/or conduct with the Service Recipient, and that his breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

The Subject was a custodian of the Service Recipient as that term is defined in Social Services Law § 488(2). The question is whether the Subject breached his duty by engaging in sexual contact and/or sexual conduct with the Service Recipient.

For all of the reasons set forth above, it cannot be determined by a preponderance of the evidence whether or not the neglect as alleged occurred. Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged.

It is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse and neglect alleged. The substantiated report will be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed the abuse and neglect alleged.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: April 6, 2017
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge