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

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**Adjud. Case #:** [redacted]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision in its entirety is hereby adopted by the Executive Director.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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

Dated: August 31, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject

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: Gerard D. Serlin
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York, 14623-2755
On: [redacted]

Parties: 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]

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] of abuse 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 a custodian, you committed abuse (deliberate inappropriate use of restraints) when you conducted an unwarranted restraint with improper technique, resulting in an injury to the service recipient's thumb.
>
> 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, the [redacted], located at [redacted], is a secure institution, which includes a residential program for challenged

youth.[1] The facility is operated by the [redacted], and is licensed by the New York State Office of Children and Family Services (OCFS), a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse, the Subject was employed by the facility in the title of CCW. (Justice Center Exhibit 7) The Subject was custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged abuse, the Service Recipient was a teenage male, with a pending matter in Family Court. Before the incident, the Service Recipient had a history of aggression toward staff and service recipients. (Hearing testimonies of the OCFS Investigator and the Subject)

7. The facility utilized the Handle With Care (HWC) Behavior Management System, and facility staff were provided with the pertinent training. (Justice Center Exhibit 24) HWC policy and training included prescribed restraint techniques and concepts, and techniques for de-escalation. Other than the HWC policy and training, the facility did not have a written restraint policy and did not provide the staff with any written guidance as to when it was appropriate to perform restraints. (Hearing testimonies of the Subject and ALJ Exhibit 1) As a matter of practice, facility staff were instructed that a restraint was warranted to prevent destruction of property, self-harm or danger to others. (ALJ Exhibit 1)

8. On [redacted] the Subject, Staff 1, the Service Recipient and several other service recipients were in the recreation room of the facility. The Service Recipient became

[1] The Administrative Law Judge took judicial notice of the information provided on the New York State Children and Family Services website concerning the level of security, and the operator of the facility. The information can be found at:
[redacted]

angered during a pool game and, ultimately, made threats to harm the Subject with pool balls and/or a pool stick and further threatened to punch the Subject. (Hearing testimony of the Subject and Justice Center Exhibit 7) The Subject called his supervisor and called for other staff to respond to the recreation room to assist. (Hearing testimony of the Subject and Justice Center Exhibits 7, 11 and 12)

9. The Subject approached the Service Recipient and asked him to sit down at least twice. The Service Recipient refused. The Subject stepped back from the Service Recipient to provide him with space. (Justice Center Exhibit 15 and Hearing testimony of the Subject) The Service Recipient continued to verbally threaten the Subject. The Service Recipient then pulled his pants up. (Justice Center Exhibit 15)

10. Based upon the Service Recipient's gesture of pulling up his pants, and the situation as a whole, the Subject concluded that the Service Recipient was going to attack him. The Subject then stepped toward the Service Recipient from the front and made contact with him. (Hearing testimony of the Subject and Justice Center Exhibit 7) The Subject's initial contact with the Service Recipient was swift and violent and the Service Recipient ended up in a chair pinned to the wall. (Justice Center Exhibit 15) The initial physical intervention technique was not an approved technique. (Hearing testimony of the OCFS Investigator and Justice Center Exhibit 14) The initial physical intervention technique limited the ability of the Service Recipient to freely move his arms. (Justice Center Exhibit 15)

11. At the onset of the restraint, Staff 1, who was standing nearby, did not react to the situation. (Justice Center Exhibit 15) Thereafter, Staff 1 became involved in the physical intervention. Eventually the Subject successfully transitioned to a sanctioned HWC care restraint technique, a hip drop, to bring the Service Recipient to the ground. (Hearing testimonies the OCFS

Investigator and the Subject and Justice Center Exhibit 14) During the intervention, the Service Recipient punched the Subject and bit the Subject's lower lip. (Hearing testimony of the Subject and Justice Center Exhibit 7) During the restraint the Service Recipient sustained a laceration to his right thumb. (Justice center Exhibit 7, p. 2)

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/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or 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 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 is defined by SSL § 488(1)(d) as:

> "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 are categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that 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 act of 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 an act, described as "Allegation 1" 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 1-16) The investigation underlying the substantiated report was conducted by OCFS Investigator [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 somewhat helpful with respect to the substantiated allegations. (Justice Center Exhibit 30) It is noteworthy that the video evidence starts thirty-two seconds before the restraint occurred. However, there is evidence in the record that a series of events, which led up to the restraint, occurred approximately 5 minutes before the restraint and that part of the video was not preserved. Additionally, as the facility was unable to copy the video, the Justice Center's evidence of the video was a copy recorded with another camera as the original played on a monitor.

In his testimony, OCFS Investigator [redacted] acknowledged that he did not review a written facility restraint policy, and, as the evidence ultimately established, the facility did not have such a policy. (ALJ Exhibit 1)

The OCFS Investigator testified that he concluded that the situation did not warrant a restraint as the situation was "not a serious, or life threatening matter." However, the OCFS Investigator testified that this standard was not the standard adopted by the facility, and that he had never, during the course of his career, investigated a facility that allowed restraints, but had no corresponding written policy.

During re-direct, the OCFS Investigator referred to the last page of Justice Center Exhibit 7, specifically, the Supervisor Review of Class II Incident. The Subject's supervisor concluded, perhaps after watching the video, that "there was no reason for [… the Subject] to walk towards the youth and this could have easily have be[en] avoided if he called for help when he felt threatened by the youth."

As facts illustrated, the Subject did call for help, and assistance was en route at the time he approached the Service Recipient, or shortly thereafter. Additionally, it is unclear from the statement of the Supervisor whether the Supervisor was referring to the initial approach when the

Subject walked over to the Service Recipient, or if the Supervisor was referring to the beginning of the physical intervention.

In any event, the OCFS Investigator concluded, based upon the Supervisor's statement, that the situation under which the restraint was initiated was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies.

Ultimately, because no written facility restraint policy was produced and there was inconsistent evidence as to facility restraint practices, the Administrative Law Judge presiding over the hearing held the record open for two weeks to allow the Justice Center Attorney to obtain the facility restraint policy or confirm that none existed. On the same date as the hearing, the Administrative Law Judge received an email from the Justice Center Attorney that included correspondence of [redacted] between the Investigator and the Assistant Coordinator (the Coordinator) of the facility. (ALJ Exhibit 1) In this email chain, the Investigator asked the Coordinator to produce the facility policy for restraints and implementation of the HWC training. The Coordinator responded as follows:

"We are in the process of updating and developing policies. In regards to when staff should use Handle with Care, I have the following:

What situations justify physical restraint?

1. Destruction of property, self-harm, danger to others
2. What methods of Physical Intervention are permitted?

Handle with care

This information is discussed in Module 5. The responses have been adopted into practice as when to use Handle with Care-Handle With Care Training Manual." (ALJ Exhibit 1)

The response of the Coordinator appears to reference Module 5 of the HWC training manual. (Justice Center Exhibit 14) Module 5 consists of one single page in the HWC training manual and reads as follows:

> Module 5-Use of Force Policy
>
> Place your written policy and procedure document in this section.
> Instructor's Notes
>
> Lead a review discussion of your agency's written policies and procures:
> 1. What situations justify physical restraint.
> 2. What methods of physical intervention are permitted.
> 3. The agency's policies and legal ramifications for improper use of physical restraint.
> 4. Any other pertinent information contained in the Policies and Procedures of your agency.

At the hearing, the Subject testified that in his HWC training sessions he was instructed that a restraint was warranted if a Service Recipient twice refused directives to be seated. The Subject also testified that any threatening physical gesture made by a service recipient toward another person was explained as a situation that could justify a restraint. The Subject testified that there was specific discussion that the gesture of pulling one's pants up can be a signal that an attack is coming.

The absence of a written facility policy on physical intervention and restraints is problematic at many levels, making the analysis very challenging. In any event, the evidence in the record was that the facility standard for initiating a restraint would be met when a service recipient engaged in destruction of property, self-harm or presents a danger to others. (ALJ Exhibit 1)

Additionally, the unrebutted and credible evidence in the record was that during HWC restraint training, assumedly which occurred in the module 5 instruction of the HWC workbook, staff were taught that any threatening gesture of physical harm by a service recipient warranted a

restraint. Additionally, staff were instructed that a restraint was justified when a service recipient twice refused staff directives to sit down. (Hearing testimony of the Subject)

Much of the proof and a significant point of contention at the hearing centered on what happened before the time when the video evidence begins. At the hearing, the Subject testified that the Service Recipient had thrown the pool stick before the Subject approached the Service Recipient. In a statement prepared by the Subject shortly after the event, he noted that the Service Recipient threatened to punch him in the face and hit him with pool balls, but he did not allege that the Service Recipient had thrown a pool stick. (Justice Center Exhibit 7)

After the Investigator interviewed the Subject, the Investigator documented that the Subject told him that prior to the restraint, the Service Recipient had slammed the pool stick down, which deviated from the Subject's testimony that the Service Recipient had thrown the pool stick. (Justice Center Exhibit 13) The Subject explained this discrepancy by testifying that he had told the Investigator that the Service Recipient threw the stick, but that the Investigator was mistaken in his characterization. OCFS does not obtain statements signed from the person they interview or obtain audio recordings of witness interviews. (Hearing testimony of the Investigator)

Ostensibly, Staff 1 did not mention during the course of the interview that the Service Recipient either slammed or threw a pool stick. Additionally, the Service Recipient apparently did not make any admission to doing so when interviewed. (Justice Center Exhibit 10)

In a report made shortly after the incident, the Subject did note that the Service Recipient made threats to hit him with a pool ball and or sticks. When interviewed and during his testimony, the Subject made similar allegations. Staff 1 did corroborate that the Service Recipient was escalated and made threats to the Subject. The testimony of the Subject on this issue, as well as the documented interview with Staff 1 are credited evidence. It is concluded that the Service

Recipient made threats to hit the Subject and threatened to strike him with a pool ball and pool stick. While not pivotal to the outcome of the case, the evidence does not support the conclusion that the Service Recipient threw a pool stick at the onset of the event.

The facility standard for initiating a restraint requires that a service recipient engage in destruction of property, self-harm or presents a danger to others. Applying the restraint standard of this facility, once the Service Recipient made threats to do physical harm, and considering his behavior history, proximity to pool balls and sticks, as well as his escalation, in this case, a restraint was warranted.

The Restraint Technique

The Justice Center took the position that the initial physical intervention was inconsistent with HWC physical intervention and restraint training, and therefore the technique used was deliberately inconsistent with generally accepted treatment practices.

The HWC manual sets forth images and descriptions of physical interventions, in relevant part, as follows: two person escorts and take down restraints on pages 9-6 through 9-10, and single person take down restraints on pages 7-11 through 7-19. (Justice Center Exhibit 14)

In his hearing testimony the Subject acknowledged that the restraint was "sloppy" and also indicated that the Service Recipient was well acquainted with the technique of raising his arms to avoid staff getting a hook in, which is what the Subject testified occurred during this restraint. However, a review of the video is not consistent with the Subject's characterization and it is clear that the Subject tackled the Service Recipient.

It is concluded that the restraint, while authorized under the facility standard, was executed with a technique that was deliberately inconsistent with generally accepted treatment practices. Additionally, the evidence in the record established that the restraint was not a reasonable

emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person.

The Justice Center further proved by a preponderance of the evidence that the Subject committed the act of abuse (deliberate inappropriate use of restraints) as alleged. The substantiated report will not be amended or sealed.

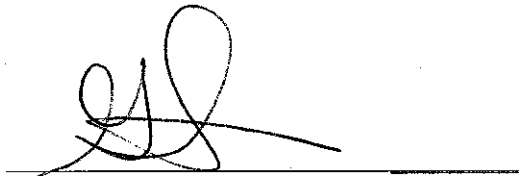
Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report should be properly categorized as a Category 3 act. A substantiated Category 3 finding of abuse will not result in the Subject's name being placed on the VPCR 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 NY SSL § 496(2). This report will be sealed after five years.

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

The substantiated report should be properly categorized as a Category 3 act.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

DATED: August 18, 2017
Schenectady, New York



Gerard D. Serlin, ALJ