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 is hereby adopted in its entirety.

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: April 6, 2018
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Steven M. Klein, Esq.

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: New York State Justice Center for the Protection of People With Special Needs
401 State Street
Schenectady, New York 12305
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: Todd M. Sardella, Esq.

[redacted]
By: Steven M. Klein, Esq.
CSEA, Inc.
143 Washington Avenue
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for 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], of 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], while at the [redacted], located at [redacted], while a custodian, you committed neglect when, after driving residents to the day habilitation program, you breached a duty by failing to complete a sweep of the agency van, as a result of which a service recipient was left on the van unattended.
>
> 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. The Facility, the [redacted], located at [redacted], is a day habilitation program for individuals with developmental disabilities and is operated by the [redacted]

[redacted], which is operated by the Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6 and 23)

5. At the time of the alleged neglect, the Service Recipient was a 41-year-old male who lived at the [redacted] and attended a day program at [redacted]. He had diagnoses including profound intellectual disability, autism spectrum disorder and bipolar I disorder. His target behaviors included physical aggression, self-injurious behavior and taking food and food items. He was non-verbal and communicated through signing and facial expressions. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 19, 20, 21, 22, 23, 24, 25 and 29)

6. The Service Recipient's level of community supervision was line-of-sight supervision as he had no street survival skills. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 22, 23, 25 and 29)

7. At the time of the alleged neglect, the Subject was employed part time as a Developmental Support Aide (DSA) since 2002 at the [redacted]. Her schedule at the IRA was [redacted], Monday and Tuesday one week and Monday, Tuesday and Wednesday the next week, alternating thereafter week to week. The Subject's duties included assisting service recipients with activities of daily living and care plans. The Subject also worked extra hours, generally Thursdays, Fridays and sometimes Wednesdays, at [redacted]. The Subject began driving the van for [redacted] approximately five years prior to incident, in [redacted]. (Hearing testimony of the Subject; Justice Center Exhibits 16 and 31)

8. The [redacted] Policy regarding Safety in Transportation, dated [redacted]

[redacted], states, among other procedures, that at the conclusion of a trip or when the vehicle is vacated, the driver is to perform a "back to front on-board inspection (sweep) to ensure no individual remains in the vehicle." (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6 and 13)

9. OPWDD Human Resources training records show that the Subject received training in numerous areas from 2011 to 2015 including AMAP, Medication Administration and Safety, AED use, Blood Pathogens, Privacy and Security including Cybersecurity, Fire Safety, Nutrition, Prevention of Choking, SCIP and Workplace Safety, to name a few. (Justice Center Investigator [redacted]; Justice Center Exhibit 15)

10. An OPWDD Human Resources Specialist wrote that the Subject "would have" received vehicle training when she started with OPWDD, but the Specialist had "not been able to track down a signed form" for the Subject regarding vehicle training. (Justice Center Investigator [redacted]; Justice Center Exhibit 15)

11. On [redacted], the Subject arrived at the [redacted] at 6:00 a.m. to work extra hours. At approximately 8:15 a.m., the Subject left the [redacted] and at approximately 8:30 a.m. arrived at [redacted]. The Subject picked up the assigned passenger van and began the daily van run. The van had five rows of seats, four rows were bench seats and the front row had two captain-type chairs, one being the driver seat. (Hearing testimony of Subject; Justice Center Exhibits 9, 11, 12 and 31)

12. The Subject stopped at the first IRA and picked up one staff, DSA-1 who was a Job Coach as well as a DSA, and four service recipients. DSA-1 sat in the second row of the van. The Subject then stopped at the second IRA where she picked up two service recipients. Last, the Subject stopped at the [redacted]. There, the Subject picked up the Service Recipient

and one other service recipient, both of whom entered the van and sat in the last row. There was a total of eight service recipients and two staff, including the Subject, in the van. (Hearing testimony of Subject; Justice Center Exhibits 9, 11, 12 and 31)

13. A Habilitation Specialist I (HS-I), who was also a supervisor at [redacted], greeted the vehicles arriving at [redacted], including the van that the Subject drove, and checked off the arrival of each of the service recipients on the Bus Checklist/Attendance Sheet as they got off the vehicles. The Subject arrived at [redacted] at 9:30 a.m. and stopped the van to let off the service recipients and DSA-1. The passenger side sliding van door was opened, passengers disembarked over the next minute and twenty seconds and then HS-I shut the sliding door from the outside. The Subject drove the van a few feet then backed the van into a parking spot, exited the van and entered [redacted] to work with an assigned group of service recipients. (Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 9, 11, 12 and 31)

14. On the [redacted] Bus Checklist/Attendance Sheet, the HS-I checked off seven service recipients, including the Service Recipient, as having arrived at [redacted] via the van that the Subject drove. (Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 9, 11, 12 and 31)

15. About 15 to 20 minutes after the drop off, a coworker (DSA-2) entered the van, drove to a Chevrolet dealer for service and left the van at the dealer. Five to ten minutes after the van was dropped off, an employee at the dealership saw the Service Recipient sitting in the back of the van. At 10:30 a.m., the Chevrolet dealer called [redacted] to report that the Service Recipient was found alone in the van. A [redacted] representative said the person discovered was not a service recipient as they were all accounted for. At 10:40 a.m., DSA-2 returned to the dealership, picked up the Service Recipient and took him to [redacted]. (Justice Center Investigator [redacted];

Justice Center Exhibits 6, 7, 9 and 11)

16. A body check of the Service Recipient was completed. He had no injuries and it appeared that the Service Recipient had been sleeping for most the time that he was in the back seat of the van. (Justice Center Investigator [redacted]; Justice Center Exhibits 6, 7 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/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 neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR § 700.3(f))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), as follows:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical

> care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is 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.

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

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

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject

committed neglect, 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 through 30) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject as well as video of the interior of the van. (Justice Center Exhibit 31) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented one document (Subject Exhibit A).

The Justice Center alleged that the Subject committed neglect when, after driving the service recipients to [redacted], the Subject breached her duty by failing to complete a sweep of the agency van and, as a result, the Service Recipient was left on the van unattended.

The Subject stated that, at the time of the incident, she was never notified of or trained in any policy requiring the van driver to complete a vehicle sweep and had no knowledge that this duty was incumbent upon her.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her 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))

At the time of the alleged neglect, the Subject was employed as a DSA at the [redacted] and worked extra hours at [redacted]. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Justice Center Investigator [redacted]

[redacted]; Hearing testimony of the Subject; Justice Center Exhibits 2, 6, 9, 11, 12 and 31)

The [redacted] Transportation Policy dated [redacted] requires a vehicle driver to perform a back-to-front on-board inspection of the vehicle at the conclusion of a trip or at any point that the vehicle is vacated. (Justice Center Exhibit 13) It is not clear whether the policy was in effect when the Subject began working for OPWDD in 2002, when she began to operate the van in [redacted] or if it first became policy in 2013. However, this was the policy on the day of the alleged neglect. The Investigator testified to his understanding that employees are not allowed to drive a van unless specifically trained on the vehicle policy. (Hearing testimony of Justice Center Investigator [redacted])

OPWDD Human Resources provided records of numerous trainings that the Subject received, however none of those trainings regarded the vehicle policy. (Justice Center Exhibit 15) The only evidence to support the supposition that the Subject received training in the vehicle policy was on the fax cover sheet attached to her training records in which an OPWDD Human Resources Specialist stated that the Subject would have had vehicle training and "it would have been in New Employee Training or at the house" she was first assigned to. However, it further stated that "I have not been able to track down a signed form" yet for the Subject, verifying she participated in that training. (Justice Center Exhibit 15)

HS-I stated in his interview that he was responsible for completing the Bus Checklist/Attendance Sheet (Checklist) to confirm the arrival of service recipients to [redacted]. HS-I said that he saw the service recipients exiting the van out of his peripheral vision, he looked in the van and it appeared empty so he shut the door and that he mistakenly indicated that the Service Recipient arrived via the van. (Justice Center Exhibit 31) The Justice Center Investigator testified that HS-I's duty at the time of the incident was to "ensure that the … individuals got off the

vehicle" and indicate on the checklist "that they were actually present when exiting that vehicle." (Hearing testimony of Justice Center Investigator [redacted]) Notably, although the [redacted] Checklist listed seven service recipients on the Subject's van run, there were eight service recipients on the van. (Justice Center Exhibit 12)

The Subject testified that she had operated the van numerous times over five years and the drop off of the service recipients at [redacted] on the day of the incident was a typical drop off. The Subject understood that the van aide (DSA-1) was responsible for supervising the service recipients and making sure that they exited the van and entered the day program building. The Service Recipient required line-of-sight supervision while in the community. The Subject testified that DSA-1, as the van aide, was responsible for supervising the Service Recipient. Because the Subject was operating the van, she could not have been responsible for such supervision. HS-I checked the arrival of each service recipient from the van. HS-I then shut the van door, indicating to the Subject that all the service recipients exited the van, as was typical. (Hearing testimony of the Subject; Justice Center Exhibit 31)

The Subject testified that, other than being given the route to follow and which staff and service recipients to pick up, she was given no training or instruction of any further specific requirements incumbent upon her as the van driver. Furthermore, a special license was not required to operate the van. The Subject testified that, after driving the van for five years, the first time she learned of the requirement that the driver "sweep" the van was on the afternoon of [redacted], after the incident occurred. When asked by the ALJ whether common sense would dictate that she should check the van to make sure that no service recipients remained on the van, the Subject answered that she "had no reason to believe that anyone would be left on because you have the van aide and then you have the Supervisor, the Rehabilitation Specialist, that will double check

to make sure the individuals are getting off the van and into the day program." (Hearing testimony of the Subject; Justice Center Exhibit 31)

The Subject admitted that she drove the van, that she did not complete an inspection of the van after the trip and that the Service Recipient was left unattended on the van. While the Service Recipient required line-of-sight supervision, there is no evidence in the record that the Subject, as the van driver, was responsible for maintaining the Service Recipient's supervision level. Furthermore, while operating the van, the Subject necessarily could not have maintained such supervision. The Subject testified that she was not trained in the policy requiring the van driver to do a vehicle sweep and had no knowledge that this was a duty expected of her. For lack of credible evidence to the contrary, the Subject's testimony is credited evidence.

As there is no credible evidence in the record supporting the contention that the Subject was trained in the van policy, the Subject cannot be found to have breached her duty by failing to complete a sweep of the van. Consequently, the Justice Center has not established that the Subject breached a duty.

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. The substantiated report will be amended and sealed.

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

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

DATED: March 19, 2018
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge