

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**

**Adjud. Case #:**

[REDACTED]

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 27, 2018  
Schenectady, New York



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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**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

David Molik  
Supervising Administrative Law Judge

Held at:

Administrative Hearings Unit  
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: Kristin Kopach

[REDACTED]

### **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], [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 in the community and away from the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to ensure that a service recipient was properly secured in the vehicle.

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], (the facility), located at [REDACTED], operates both a residential and a day habilitation service facility, and is certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is a

facility or provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by [REDACTED] [REDACTED] for approximately two years. The Subject worked as a Direct Support Professional.

6. At the time of the alleged neglect, the Service Recipient was seventy-six years old, and had been a long-time resident of the facility. It is unknown how long the Service Recipient had resided at the facility. The Service Recipient is an adult with diagnoses of profound cognitive impairment, grand mal seizures and mild lordosis of the lumbar spine. (Justice Center Exhibits 6, 11 and 12)

7. On [REDACTED], the Subject and one other staff member were responsible for the transport of service recipients from their day habilitation program back to their residential facility. The Subject was the driver of the bus. (Testimony of the Subject; Testimony of Compliance Specialist [REDACTED] (Specialist [REDACTED]); Justice Center Exhibits 6, 8, 9 and 10)

8. The Subject wheeled the Service Recipient in his wheelchair onto the back lift, which was being operated by the other staff member. When the lift was up, the Subject then wheeled the Service Recipient into the bus. He did not strap the wheelchair down. The Service Recipient was belted into his wheelchair. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center Exhibits 6, 8, 9 and 10)

9. The Subject walked back into the day habilitation facility to retrieve another service recipient for transport. The other staff member made sure all service recipients were belted into their seats. Neither the Subject nor the other staff member checked to see if the Service Recipient's chair was strapped down. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center

Exhibits 6, 8, 9 and 10)

10. Upon returning to the bus, the Subject immediately sat in the driver's seat and asked if everyone was belted in. He heard a voice say "yes." He proceeded onto the main highway and, while turning onto the highway, the Service Recipient's wheelchair tipped over. The Service Recipient suffered a small abrasion to his left cheek. He was picked up, the wheelchair was strapped to the floor of the bus and the Service Recipient was moved to a regular seat. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center Exhibits 6, 7, 8, 9 and 10)

11. The Subject received initial and periodic training on how to secure occupied wheelchairs in a vehicle for transport. The Subject was specifically told that it was his responsibility to make sure that all service recipients are properly belted and their chairs are strapped to the floor of the bus. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center Exhibits 6, 8, 9, 10, 13, 14, 15 and 16)

12. The subject testified that all the events as testified to and presented by the Justice Center were accurate. He did state that he heard someone respond "yes" when he asked if everyone was belted.

### **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 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 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):

"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 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 Specialist [REDACTED], from the facility, 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.

In order 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 he breached that duty, 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))

In this case, the Subject was employed by a facility or provider agency as a Direct Support Professional and therefore was a custodian as that term is defined in SSL § 488(2).

The Justice Center did prove that, on [REDACTED], the Subject and one other staff member were responsible for the transport of service recipients from their day habilitation program back to their residential facility. The Subject was the driver of the bus. The Subject wheeled the Service Recipient in his wheelchair onto the back lift, which was being operated by the other staff member. When the lift was up, the Subject then wheeled the Service Recipient into the bus. He did not strap the wheelchair down. The Service Recipient was only belted into his wheelchair. The Subject went back into the day habilitation facility to retrieve another service recipient for transport. The other staff member made sure all service recipients were belted into their seats. Neither the Subject nor the other staff member checked to see if the Service Recipient's chair was strapped down. Upon returning to the bus, the Subject immediately sat in the driver's seat and asked if everyone was belted in. He heard a voice say, "yes." He proceeded onto the main highway and, while turning onto the highway, the Service Recipient's wheelchair tipped over. The Service Recipient suffered a small abrasion to his left cheek. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center Exhibits 6, 7, 8, 9 and 10)

The Subject received initial and periodic training on how to secure occupied wheelchairs in a vehicle for transport. The Subject was specifically told that it was his responsibility to make sure that all service recipients are properly belted and their chairs are strapped to the floor of the bus. (Testimony of the Subject; Testimony of Specialist [REDACTED]; Justice Center Exhibits 6, 8, 9, 10, 13, 14, 15 and 16)

The Subject acknowledged that the evidence and testimony as presented by the Justice Center is uncontroverted. (Testimony of the Subject)



The Subject owed a duty to the Service Recipient in that, as the driver of the bus he was responsible for ensuring that the passengers are properly secured in their seats and wheelchairs, and that the wheelchairs are properly secured to the floor of the bus. The Subject breached that duty by not securing the wheelchair of the Service Recipient. This breach of duty resulted in an injury to the Service Recipient. Although the injury was minor, it could have been much worse. There was a likelihood of a serious or protracted impairment of the physical condition of the Service Recipient. If the wheelchair had tipped differently, or if the bus had been going faster, this breach of duty could have caused a much more serious injury.

The Subject's only defense was that he had heard someone answer his question in the affirmative when he asked if everyone was belted in. This defense has no merit as it was his duty to ensure that all service recipients were properly secured. In addition, the Subject did not ascertain whether it was the other staff member who had uttered the "yes" comment. The Subject admitted to taking the appropriate training and refresher training regarding his duties as a bus driver which included his responsibility to secure the service recipients.

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

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) The Subject's conduct in not properly securing the Service Recipient's wheelchair seriously endangered the health and welfare of the Service Recipient. The Service Recipient sustained an injury that could easily have been

much worse. Consequently, based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 2 act.

A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

**DECISION:**

The request of [REDACTED] that the substantiated report dated [REDACTED] [REDACTED], [REDACTED], be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

This decision is recommended by David Molik, Administrative Hearings Unit.

**DATED:** April 20, 2018  
Schenectady, New York

  
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David Molik  
Administrative Hearings Unit