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]

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 Elizabeth M. Devane, ALJ, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: January 18, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Deidre A. Chuckrow, Esq.
[redacted], Subject
Jacquelyn Hadam, 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: Brian T. Hughes
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
4 Burnett Boulevard
Poughkeepsie, New York 12601
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: Deidre A. Chuckrow, Esq.

[redacted]
By: Jacquelyn Hadam, Esq.
New York State United Teachers
800 Troy-Schenectady Road
Latham, New York 12110

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) 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 New York State Social Services Law (SSL) § 494 and Part 700 of 14 New York Codes, Rules, and Regulations (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 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 2[1]

> It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed abuse (deliberate inappropriate use of restraints) and/or neglect when you conducted a restraint with improper technique, which included shoving and/or holding a service recipient against a wall, and/or holding him between your legs.
>
> These allegations have been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

[1] Allegation 1 was previously unsubstantiated in the Report of Substantiated Finding. (Justice Center Exhibit 1)

4. The facility, [redacted], located at [redacted], is a residential boarding and day school for children with emotional and behavioral problems and is certified by the New York State Education Department (SED), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted] (Investigator); Justice Center Exhibit 6)

5. At the time of the alleged abuse and neglect, the Subject was employed as a Crisis Counselor and had been employed by the facility for approximately twenty years. (Hearing testimony of Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged abuse and neglect, the Service Recipient was a diminutive nine-year-old boy and was a residential student at the facility. (Hearing testimony of Subject) The Service Recipient was diagnosed with Disruptive Mood Disorder, Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Intermittent Explosive Disorder. (Justice Center Exhibit 9)

7. On [redacted], at approximately 2:04 p.m., the Service Recipient became disruptive in his classroom at the facility and threw a chair. The Service Recipient was then escorted from the classroom to the support room by two staff members (Staff 1 and Staff 2) and the Subject. (Hearing testimony of Investigator; Justice Center Exhibit 14) The support room (also known as the time out room) was a small room utilized to de-escalate a child during a behavioral episode by providing a safe and non-stimulating environment. An office was located adjacent to the support room and was also utilized for de-escalation. (Hearing testimony of Investigator; Justice Center Exhibit 11)

8. Once escorted inside the support room the Service Recipient dropped to the floor

and immediately kicked Staff 1. Staff 1 momentarily stepped on the Service Recipient's ankle in response before exiting the room. A second service recipient (SR 2) was also in the room at that time and was supervised by a staff member (Staff 3). Staff 3 was seated outside the room in a rolling chair. (Justice Center Exhibit 14) The Service Recipient attempted to exit the support room and go to the office next-door. (Justice Center Exhibit 15: Audio of interview with Service Recipient) The Subject prevented the Service Recipient from leaving by positioning himself in the doorway and moving laterally to block the Service Recipient with his lower body. The Service Recipient then attempted to crawl between the Subject's legs and punched Staff 3's foot. Staff 3 responded by moving her foot away from the Service Recipient. Meanwhile, the Subject kept his hands in his pockets and continued to block the Service Recipient's exit. The Service Recipient then pushed against the Subject's shins and removed his head from between the Subject's legs. The Service Recipient then pulled and punched the Subject's legs before he attempted to crawl past the Subject for a second time. The Service Recipient's neck was held between the Subject's ankles. (Justice Center Exhibit 14)

9. The Subject then rolled his ankles outward to release the Service Recipient's head from between the Subject's legs. The Service Recipient began to strike the Subject's knees with his fists. After several punches the Subject abruptly lifted the Service Recipient from the floor and brought him to his feet. The Subject forcefully grabbed the Service Recipient's arms behind his back and placed him against the wall of the support room. After witnessing the incident, Staff 3 wheeled her chair away from the opening of the support room and out of the line of sight of the Subject and Service Recipient. After approximately ten seconds, the Subject released the Service Recipient and the Service Recipient dropped to the ground and again attempted to exit the support room. The Subject placed his body against the doorframe, briefly pinning the Service Recipient's

arm against the doorframe. The Subject then stepped on the Service Recipient's hand briefly as the Service Recipient attempted to crawl past the Subject. The Service Recipient continued to struggle against the Subject until a third service recipient (SR 3) was escorted into the room. (Justice Center Exhibit 14)

10. SR 3 kicked the Service Recipient as she entered the support room. The Service Recipient then got up from the floor and retaliated by kicking and pushing SR 3. The Subject intervened and placed his hand on the Service Recipient's arm. The Service Recipient then dropped to the floor and attempted to kick the Subject. The Subject stepped on the Service Recipient's left foot for several seconds, preventing the Service Recipient from kicking him. (Justice Center Exhibit 14) Eventually, the Service Recipient became calm and was returned to the classroom. (Hearing testimony of Subject)

11. At the time of the alleged abuse, the facility utilized Therapeutic Crisis Intervention (TCI), which were approved physical intervention techniques used to manage service recipients' aggressive behavioral episodes. The Policy allowed for the use of physical restraints when there was an imminent risk of a child physically harming themselves or others. (Justice Center Exhibit 11) The Service Recipient's Individual Crisis Management Plan (ICMP) allowed for the use of physical restraints on the Service Recipient based upon his history of running away from the facility. (Justice Center Exhibit 9) At the time of the alleged abuse and neglect, the facility required staff members to call for approval prior to initiating a restraint from either the Principal, the Educational Coordinator, or the CSE/Curriculum Coordinator. (Justice Center Exhibit 12)

12. Chapter 3 of the facility's Policies and Procedures Manual (the Policy) stated that the use of time out or time away must be a voluntary choice by the youth and could not be imposed by staff. The Policy also stated in pertinent part that "[a] client in time out must never be physically

prevented from leaving the time away area. The client's freedom of movement must be preserved." (Justice Center Exhibit 11)

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 (deliberate inappropriate use of restraints) 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 (deliberate inappropriate use of restraints) or neglect occurred…" (Title 14 NYCRR § 700.3(f))

The abuse (deliberate inappropriate use of restraints) and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1), as follows:

> (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.
>
> (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 abuse (deliberate inappropriate use of restraints) and/or neglect shall be 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 (deliberate inappropriate use of restraints) 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 (deliberate inappropriate use of restraints) and neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse (deliberate inappropriate use of restraints) 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 act of abuse (deliberate inappropriate use of restraints) and neglect cited in the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) and neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse (deliberate inappropriate use of restraints) and 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 abuse (deliberate inappropriate use of restraints) in "Allegation 2" in the substantiated report. The Justice Center has also established by a preponderance of the evidence that the Subject committed an act, described as neglect in "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation. (Justice Center Exhibits 1 - 13 and 16 - 24) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject, and video of the alleged incident from the facility. (Justice Center Exhibits 14 and 15) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted] (Investigator), who testified at the hearing on behalf of the Justice Center. Justice Center Investigator [redacted] (Investigator 2) also testified for the Justice Center. The Subject testified in his own behalf and presented several documents. (Subject Exhibits 1 - 5)

Allegation 2 - Abuse (deliberate inappropriate use of restraints)

In order to prove abuse (deliberate inappropriate use of restraints) the Justice Center must establish that the Subject used a restraint on the Service Recipient in which the technique used, the

amount of force used or the situation in which the restraint was used, 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. The term "restraint" is defined by statute as any manual, pharmacological or mechanical measure or device used to immobilize or limit the ability of a service recipient to freely move his or her arms, legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL §488(1)(d))

The Justice Center argued that holding the Service Recipient's head between the Subject's legs as well as the Subject's improper technique of holding the Service Recipient's arms behind his back while placing him against the wall constituted a deliberate inappropriate use of a restraint and therefore abuse. In his defense, the Subject argued that his actions were not deliberately inconsistent with the Service Recipient's plan or facility policy because the restraint was quickly aborted and did not rise to a level to be considered deliberate as required by statute. Essentially, the Subject argued that the ten second physical intervention was self-corrected and de minimis. The Subject also argued, in the alternative, that the restraint was performed as a reasonable emergency intervention because the Service Recipient continued to assault him.

It is clear from the evidence in the record that the Service Recipient's ability to freely move his body was limited by the Subject on several occasions. The surveillance video provided compelling evidence in this case. The video showed the Subject visibly rolled his ankles outward as the Service Recipient's head was released from between the Subject's legs. (Justice Center Exhibit 14) It was evident that the Service Recipient could not freely move his head until the Subject released him. Additionally, the Subject forcefully grabbed the Service Recipient from the

floor and held the Service Recipient's arms behind his back, thereby limiting the Service Recipient's ability to move his arms. The Subject then pinned the Service Recipient against the wall of the support room. (Justice Center Exhibit 14) Consequently, the Subject's conduct constituted a restraint under the statute. It was evident that the Subject's conduct was intentional and, therefore, deliberate. The fact that the Subject aborted the restraint after approximately ten seconds did not excuse his actions.

The Justice Center presented credible evidence that the technique used by the Subject was deliberately inconsistent with the Service Recipients Individual Crisis Management Plan (ICMP) as well as TCI protocol. The ICMP authorized a physical intervention when the Service Recipient was in danger of absconding from the facility. (Justice Center Exhibit 9) There was no evidence in the record that the Service Recipient was absconding from the facility. Rather, the Service Recipient explained when interviewed, that he merely wanted to go to the office next-door to the support room. (Justice Center Exhibit 15: Audio of interview with Service Recipient) Investigator 2 testified credibly at the hearing that TCI protocol did not authorize a child to be picked up from the floor to initiate a restraint. Investigator 2 further testified that the Subject's technique of holding the Service Recipient's arms behind his back was improper under TCI because of the potential of injury to the child's shoulders. (Hearing testimony of Investigator 2) Finally, the Justice Center presented a document entitled "Stipulation of Settlement" in which the Subject admitted to having performed a restraint with improper technique on the Service Recipient. (Justice Center Exhibit 24)

It was also established by the Justice Center that the Service Recipient's actions did not present an imminent risk of harm to himself or others. The Subject's argument that the restraint was necessary to prevent the Service Recipient from assaulting himself or others was unpersuasive.

The video showed the actions of the Subject and the small size and stature of the Service Recipient. (Justice Center Exhibit 14) The Subject deliberately prevented the Service Recipient from exiting the support room which was a direct violation of the facility's written policy prohibiting such conduct by staff members. (Justice Center Exhibit 11 and 14) As a result, the Subject's actions directly escalated the Service Recipient's behavior and therefore did not constitute a situation warranting emergency intervention. Furthermore, Investigator 2 testified credibly that, after reviewing the video, the Service Recipient did not present an imminent risk of harm requiring an emergency physical intervention. (Hearing testimony of Investigator 2)

As such, the Subject's conduct did not qualify as a reasonable emergency physical intervention necessary to prevent the imminent risk of harm. Consequently, the Justice Center has established by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints).

Allegation 2 - Neglect

To prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a duty that 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 Recipients. (SSL §488(1)(h))

The Justice Center argued that the Subject breached a general duty to keep the Service Recipient safe and cared for by placing the Service Recipient in an improper restraint. The Justice Center further argued that the improper restraint was likely to result in harm to the Service Recipient. The Subject contended that there was neither physical injury to the Service Recipient nor any conduct likely to result in physical injury as required under the statute.

The Subject was employed at the facility as a Crisis Counselor, and therefore was a

custodian as defined in SSL § 488(2). As a custodian, the Subject owed a general duty to keep the Service Recipient safe and cared for while at the facility. Included within the duty to keep the Service Recipient safe and cared for was an implicit duty to comply with agency policies and training when performing a physical restraint.

The Subject breached the general duty when he failed to adhere to the facility policy regarding restraints, and by failing to comply with TCI protocol. The Subject violated the facility's policy and TCI training by holding the Service Recipient's head between his legs as well as picking the Service Recipient up off the floor and holding the Service Recipient's arms behind his back. Clearly, the Subject's actions of abruptly lifting the Service Recipient from the floor, forcefully grabbing the Service Recipient's arms behind his back while placing him against the wall, and stepping on his hand and foot, were likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, the Justice Center has established by a preponderance of the evidence that the Subject committed neglect.

Because the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse (deliberate inappropriate use of restraints) and 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 abuse or neglect set forth in the substantiated report. 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 3 act.

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], 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 neglect.

The substantiated report of abuse (deliberate inappropriate use of restraints) and neglect is properly categorized, as a Category 3 act.

This decision is recommended by Brian T. Hughes, Administrative Hearings Unit.

DATED: January 11, 2019
Schenectady, New York

Brian T. Hughes, ALJ