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: April 19, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Alliah Rozan, Esq.
[redacted], Subject, Pro se

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: Susanna Requets
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
9 Bond Street – 3rd Floor
Brooklyn, New York 11201
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: Alliah Rozan, Esq.

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for physical 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], of physical 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 or about [redacted], while in the community and away from the [redacted], located at [redacted], while a custodian, you committed physical abuse and/or neglect when you dragged and/or pulled a service recipient.
>
> This allegation has been SUBSTANTIATED as Category 3 physical abuse 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.

4. The facility, located at [redacted], is an Intermediate Care Facility (ICF) operated by [redacted] and certified by the New York State 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 Supervising Investigator [redacted] [Investigator] and Justice Center Exhibit 6)

5. At the time of the alleged physical abuse and neglect, the Subject was twenty-three years old and employed by [redacted] as a Medical Coordinator for one year and three months. The Subject was responsible for scheduling and taking the service recipients to their medical and dental appointments. (Hearing testimonies of the Subject and the Investigator) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged physical abuse and neglect, the Service Recipient was fifty-four years old, and had been a resident of the facility for almost twenty-five years. (Justice Center Exhibit 8) The Service Recipient was an adult female with a diagnosis of autism and functioned within the profound range of intellectual disability. The Service Recipient's challenging behaviors included self-injurious behavior (SIB), elopement, spitting on clothes, taking food from others and exhibiting tantrums by throwing herself on the floor. (Hearing testimony of the Investigator; Justice Center Exhibits 8 and 9)

7. The Service Recipient was placed on 1:1 supervision on [redacted]. (Justice Center stipulation on the record) 1:1 supervision required the assignment of one staff member to one service recipient. The Service Recipient was removed from 1:1 supervision on [redacted] and placed on general supervision which did not require a specific staff to service recipient ratio. (Hearing testimony of the Investigator; Subject Exhibit C)

8. On [redacted], the Subject arrived at the facility for her [redacted] shift. (Justice Center Exhibit 11) The Subject used the agency vehicle to transport the Service Recipient for a 9:30 a.m. appointment at a health clinic in [redacted]. The Subject parked the vehicle two blocks from the clinic. (Hearing testimony of the Subject)

9. While the Subject and the Service Recipient walked along [redacted], the Service Recipient became distracted by a grocery store at the corner. The Service Recipient gazed at the grocery store but did not move toward it. Without looking back at the Service Recipient, the Subject with her arm fully extended behind her, dragged and pulled the Service Recipient by her wrist for eighty to one hundred feet along the street. The Service Recipient was behind the Subject, unsteady and unable to maintain the Subject's pace. (Hearing testimonies of the Investigator and the Subject; Justice Center Exhibit 14: [redacted], audio recording of Justice Center interviews of the Detective[1] and first recording of Witness 1[2])

10. At approximately 9:15 a.m., a [redacted] Police Detective (Detective) was on her way to work at the [redacted] on [redacted] and was diagonally across the street from the Subject. Concerned about the Subject's conduct, the Detective crossed the street and speed walked to the Subject and passed by Witness 1. The Detective stopped the Subject, identified herself as a police officer and obtained the necessary contact information from the Subject. (Justice Center Exhibit 14: [redacted]; audio recordings of Justice Center interview of the Detective and the facility Vice-President[3]) [redacted] (Justice Center Exhibit 14: [redacted]

11. After the appointment, the Subject drove the Service Recipient to the day habilitation program where she was evaluated by the Registered Nurse[4]. (Hearing testimony of

[1] The Detective was [redacted].
[2] Witness 1 was [redacted].
[3] The Vice-President was [redacted].
[4] The Registered Nurse was [redacted].

the Subject) The Registered Nurse, in the presence of Staff 1[5], conducted a body check and found that the Service Recipient did not have any bruising, redness, swelling, discomfort or pain. (Justice Center Exhibits 13, 14: audio recording of Justice Center interview of Staff 1; Subject Exhibit F)

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

> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

[5] Staff 1 was [redacted].

> (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 physical abuse and 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 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 physical 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 act of physical abuse and neglect cited in the substantiated report constitutes the category of abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the physical abuse 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 "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 13) The Justice Center also presented audio recordings of Justice Center Investigator [redacted] (Investigator [redacted]) interviews of witnesses and interrogation of the Subject. (Justice Center Exhibit 14) The investigation underlying the substantiated report was conducted by Investigator [redacted]. At the time of the hearing, Investigator [redacted] no longer worked for the Justice Center. Justice Center Investigator [redacted] (Investigator) was the supervisor assigned to the investigation and testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented six documents. (Subject Exhibits C, E, F, G, H and I)

Allegation 1 – Physical Abuse

In order to sustain an allegation of physical abuse in this matter, the Justice Center must show that the Subject had physical contact with the Service Recipient; that such contact was either intentional or reckless; and that such contact caused either physical injury or serious or protracted impairment of a Service Recipient's physical, mental or emotional condition; or caused the likelihood of such injury or impairment. Dragging is included in the definition of physical abuse. The statute allows, as an exception, the use of physical contact as a reasonable emergency intervention necessary to protect the safety of any person. (SSL § 488[1][a])

Social Services Law defines “intentionally” and “recklessly” as having the same meaning as provided in New York Penal Law § 15.05. (SSL § 488[16]) Under the New York Penal Law, a person acts “intentionally” with respect to a result or conduct when a person has a “... conscious objective ...” to cause a result or engage in such conduct. (PL § 15.05[1]) Under the New York Penal Law, a person acts “recklessly with respect to a result or to a circumstance” when the person is “aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstances exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.” (PL § 15.05[3])

The credible evidence establishes that the Subject made physical contact with the Service Recipient when she dragged and pulled the Service Recipient by her wrist. (Justice Center Exhibit 14: audio recordings of [redacted], [redacted], Justice Center interviews of the Detective and Witness 1)

The Subject denied that she dragged and/or pulled the Service Recipient. The Subject claimed that she escorted the Service Recipient by interlocking her arm with the Service Recipient’s arm like a daisy chain after the Service Recipient attempted to snatch coffee from a pedestrian. According to the Subject, her arm was always interlocked with the Service Recipient’s arm, even when the Service Recipient was behind the Subject. (Hearing testimony of the Subject; Justice Center Exhibit 14: audio recording of Justice Center interrogation of the Subject)

The Subject’s testimony is in stark contrast to the Detective’s statement that the Subject’s arm was fully extended behind her and Witness 1’s statement that the Subject was pulling the Service Recipient by her wrist. The Detective consistently reported observing the Subject dragging the Service Recipient like a mother would drag her child. Witness 1 was six inches from

the Subject and the Service Recipient and observed the Subject dragging and pulling the Service Recipient. (Justice Center Exhibit 14: [redacted], [redacted], audio recording of Justice Center interviews of the Detective and the Vice-President) After giving due consideration to the evidence in the record, it is determined that substantial weight must be given to the independent and corroborating statements from the Detective and Witness 1.

The Subject's conduct was reckless. The Subject consciously disregarded the substantial and unjustifiable risk of injury by dragging and pulling a fifty-four-year-old Service Recipient for eighty to one hundred feet along [redacted]. (Justice Center Exhibit 14: audio recording of Justice Center interview of the Detective, Vice-President, first and second recording of Witness 1)

While there is no evidence of an injury (Justice Center Exhibit 13), the credible evidence establishes that the Subject's conduct caused the likelihood of a physical injury. The Subject dragged the Service Recipient on a public concrete sidewalk for eighty to one hundred feet and did not look back to see that the Service Recipient was unsteady and struggling to keep up with the Subject's pace. Any misstep by the Service Recipient could have resulted in a fall and physical injuries to the Service Recipient. (Justice Center Exhibit 14: [redacted], [redacted], first audio recording of Justice Center interview of Witness 1)

The Subject's conduct was not a qualified exception as a reasonable emergency intervention necessary to protect the safety of any person under SSL § 488(1)(a). The Subject testified that the Service Recipient did not attempt to elope or enter the grocery store at the corner of [redacted]. (Hearing testimony of the Subject) The Subject needlessly pulled the Service Recipient without looking behind her to ensure the Service Recipient's safety. (Justice Center Exhibit 14: first audio recording of Justice Center interview of Witness 1)

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 physical abuse alleged. The substantiated report will not be amended and sealed.

Allegation 1 – Neglect

In order 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 Recipient. (SSL § 488(1)(h))

The evidence demonstrates that the Subject had a duty to supervise the Service Recipient while taking her to the medical appointment and respond to the Service Recipient's behavior according to the Service Recipient's Behavior Support Plan (BSP) and Annual Comprehensive Functional Assessment (CFA). (Justice Center Exhibits 8 and 9; Subject Exhibit C)

The Subject's contention that the Service Recipient required 1:1 supervision in the facility and 2:1 supervision in the community is unpersuasive. (Justice Center Exhibits 2 and 14: audio recording of Justice Center interrogation of the Subject) The Subject was aware, as demonstrated by her own evidence, that the residential Behavior Intervention Specialist (BIS[6]), who was responsible for determining the level of supervision required for the Service Recipient, removed the Service Recipient from 1:1 supervision one month before the incident. (Hearing testimony of the Investigator; Justice Center Exhibit 8; Subject Exhibit C) There is therefore, no evidence of such enhanced supervision for the Service Recipient at the time of the neglect.

On [redacted], the Subject did not inform anyone from management that she needed additional staff to complete the Service Recipient's medical appointment. The Subject's claim that Staff 2[7] called the Residential Manager on [redacted] to find out if additional staff could

[6] The BIS was [redacted], MA, ABA.

accompany the Subject and the Service Recipient is unpersuasive. The Subject contacted the Residential Manager multiple times, yet she did not contact her on [redacted]. The Subject took the Service Recipient to the medical appointment by herself on [redacted] despite her concern that she could not simultaneously drive and manage the Service Recipient's behavior and despite her claim that the Residential Manager promised to provide additional staffing for the medical appointments because of an incident that occurred during a medical appointment three days earlier. (Hearing testimony of the Subject; Justice Center Exhibits 2, 12 and 14: audio recording of Justice Center interrogation of the Subject; Subject Exhibit E)

The Subject breached her duty to supervise the Service Recipient by dragging and pulling the Service Recipient instead of guiding her to participate in walking to the medical appointment. (Justice Center Exhibits 9 and 14: audio recordings of [redacted], [redacted], Justice Center interviews of the Detective and Witness 1) The Subject's attempt to blame the facility for not renewing a parking plaque and being forced to park two blocks away does not mitigate the Subject's duties when walking with the Service Recipient in the community.

As discussed previously, the Subject's conduct was likely to cause physical injuries to the Service Recipient who was fifty-four years old, unable to keep up with the Subject's pace and was unsteady on her feet. (Justice Center Exhibit 14: [redacted])

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 and sealed.

Since 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.

[7] Staff 2 was [redacted]

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 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 physical abuse and neglect.

The substantiated report is properly categorized, as a Category 3 act.

This decision is recommended by Susanna Requets, Administrative Hearings Unit.

DATED: April 17, 2019
Brooklyn, New York

Susanna Requets

Susanna Requets, ALJ