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: May 1, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Arthur J. Fried, Esq.
Jennifer M. Horowitz, 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 Office Building
4 Burnett Blvd
Poughkeepsie, New York 12603
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: Arthur J. Fried, Esq.
Jennifer M. Horowitz, Esq.
Epstein, Becker & Green, P.C.
250 Park Avenue
New York, New York 10177-0073

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for physical abuse and 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 physical abuse and abuse (deliberate inappropriate use of restraints) 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], at [redacted], located at [redacted], while a custodian, you committed physical abuse and/or abuse (deliberate inappropriate use of restraints) when you conducted an unwarranted restraint with excessive force and improper technique, during which time he [sic] caused injury to a service recipient's face.

These allegations have been SUBSTANTIATED as Category 2 physical abuse and Category 2 abuse (deliberate inappropriate use of restraints) 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, [redacted] (Hospital), located at [redacted], has a [redacted] (Unit) which is an acute care adult inpatient psychiatric unit and is licensed by the New York State Office of Mental Health, 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, the Subject was employed by the Hospital as a Security Supervisor for the Emergency Department and had been employed by the facility for approximately three years. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6 and 16) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged abuse, the male Service Recipient was a 19 year old high school student. He was taken to the Unit by ambulance and admitted on [redacted] for a psychiatric evaluation due to homicidal ideation. Upon admission, the Service Recipient was aggressive, agitated, impulsive and threatening. The [redacted] Hospital Initial Screening and Assessment indicated acute inpatient treatment was required as the Service Recipient was a potential danger to himself or others. (Justice Center Exhibits 6, 7, 11 and 16; Subject Exhibit A)

7. The Hospital utilized a restraint protocol for physical interventions with service recipients. The Investigator testified that the protocol was known as Nonviolent Crisis Intervention (NCI). The Subject, witness [redacted], the Nurse Manager and the Program Director referred to that protocol as Crisis Prevention and Intervention (CPI) training.[1] The Hospital Security Guards were trained in the RP. The Subject was current with the required RP training. The Unit itself was part of [redacted], which recognizes a different but similar

[1] For purposes of this Recommendation, the Hospital restraint protocol is referred to here as the RP.

restraint method known as SECURE. Security Guards are not stationed on the Unit but are called to the Unit when needed for assistance. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 9 and 16)

8. On [redacted], at approximately 6:50 p.m., the Service Recipient was agitated and requested his nighttime medication. The request was denied as he was not scheduled to receive that medication until 9:00 p.m. The Service Recipient rejected the offer of an alternative medication by mouth to calm him and he became increasingly agitated and aggressive. The Service Recipient banged on the nurses station plexiglass, threatened staff and he ripped the electronic badge reader off of the wall. The Service Recipient was escorted to the Seclusion Room (Room). (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 11, 12, 15 and 16; Subject Exhibit A)

9. A Registered Nurse on duty contacted the Director of Psychiatry (Director) and reported the Service Recipient's conduct. The Director ordered medication for the Service Recipient be administered by intramuscular injection (IM) to control the Service Recipient's behavior. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 11, 12, 15 and 16; Subject Exhibit A)

10. Due to the Service Recipient's volatile behavior, the Unit contacted Security and requested assistance while the IM was to be administered. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 7, 11, 12, 15 and 16; Subject Exhibit A)

11. The Subject was working at the Hospital in his capacity as Security Supervisor for the Emergency Department and responded to the request from the Unit, along with five additional employees from Security. (Hearing testimony of the Investigator; Hearing testimony of the

Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 7 and 16)

12. As the Subject entered the Room, the Service Recipient, who was sitting motionless on a mat in the Room, got up and, with his hands in or near his pants pockets, went to the corner of the Room. The Subject and Security Guard [redacted] approached the Service Recipient, who backed further into the corner. The Subject moved in toward the Service Recipient's left side and put his right hand on the Service Recipient's arm as [redacted] approached the Service Recipient's right side placing himself within arm's length. At that point, four security personnel, two RNs and the Subject were present in the Room. As the Service Recipient moved forward, the Subject and [redacted] grabbed and began to restrain the Service Recipient. The two additional security staff in the Room promptly assisted in the restraint as did two more security staff who entered the Room. In total, six security personnel restrained the Service Recipient over approximately 45 seconds as he struggled. One of the RNs administered the IM medication as the Service Recipient was restrained to the mat on the floor. Thereafter, the security personnel began to back out of the Room. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 13 and 16)

13. After the injection, the Service Recipient was agitated, got up and moved toward the door as two remaining security guards were retreating out of the Room. While moving forward, the Service Recipient was holding his pants up with his hands. The Security guards quickly performed a second restraint of the Service Recipient to the same corner of the Room and then onto the mat. Security again began to back out of the Room. The Subject's hands were on the Service Recipient's right side and the Subject pushed the Service Recipient toward the wall. The Subject bent over and then crouched in front of the Service Recipient. As the Service Recipient attempted to get up, the Subject put his arms out, placed his open right hand on the Service

Recipient's face and pushed the Service Recipient back then down. During this time, the Service Recipient's left hand remained on the floor. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 13 and 16)

14. Security personnel again restrained the Service Recipient, during which time he thrashed about and at one point hit his head against the floor/wall area. Attempts continued to calm the Service Recipient and a restraint bed was brought into the Room. The hands on restraint continued until the Service Recipient was secured in a restraint bed and the Subject thereafter left the Room. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Hearing testimony of [redacted]; Justice Center Exhibits 6, 13 and 16)

15. The next day, the Service Recipient was medically examined. A CT scan of his face and head were negative for injury and positive for sinusitis. He was found to have swelling on the right side of his face and a scratch on the bridge of his nose. He was given Tylenol and refused an ice pack. (Justice Center Exhibits 6, 7, 10, 11, 12, 15 and 16; Subject Exhibit A)

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

> "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.

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

> "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 physical abuse and abuse (deliberate inappropriate use of restraints) 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 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 not established by a preponderance of the evidence that the Subject committed an act of Abuse (deliberate inappropriate use of restraints) and has established by a preponderance of the evidence that the Subject committed an act of Physical Abuse, as described in "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 7 and 9 through 15) The Justice Center also presented audio recordings of the Justice Center Investigator's interviews of witnesses and interrogation of the Subject, and a surveillance video of the incident. (Justice Center Exhibit 16) The investigation underlying the substantiated report was conducted by the Investigator, who testified at the hearing on behalf of the Justice Center. The Subject testified in

his own behalf and presented a witness, [redacted], who was a Hospital Security Guard and was present at the time of the alleged abuse. The Subject also presented medical records. (Subject Exhibit A)

A video of the Room during the time of the alleged abuse was provided by [redacted] Hospital to the Investigator and was heavily relied upon by the Justice Center. The Video had numbered frames as well as time stamps, but also had several time gaps. The Investigator testified that the video in evidence was in the same condition as supplied by the Hospital. (Justice Center Exhibit 16)

Allegation 1 – 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 Investigator testified that the Unit used, and the Subject was certified in, a restraint protocol called Nonviolent Crisis Intervention (NCI). (Hearing testimony of the Investigator) The Investigator testified that based upon his knowledge of restraint techniques, his review of the video with the Director and others and his experience, the Subject initiated a restraint of the Service

Recipient that was not warranted by NCI or any other technique. (Hearing testimony of the Investigator) The Investigator stated his opinion that the Service Recipient was not a danger to himself or anyone else when the restraint was initiated and the Subject used excessive force and improper technique in restraining the Service Recipient. (Hearing testimony of the Investigator)

The Subject testified that he responded to a call for assistance to restrain a violent patient who needed an intramuscular injection (IM). (Hearing testimony of the Subject) When the Subject walked into the Seclusion Room, the Service Recipient got up and started making threats. The Subject attempted de-escalation techniques by explaining the situation and by placing his hand on the Service Recipient's shoulder to calm him. However, the Service Recipient lifted his right hand in an assaultive motion. Therefore, the Subject and the other security personnel restrained the Service Recipient. During the restraint, staff held each of the Service Recipient's limbs so the IM injection could be safely administered. As the Subject and the other staff backed out of the Room after the IM, the Service Recipient charged at them and another restraint occurred. While the staff tried to leave the Room again, the Service Recipient lunged at the Subject. The Subject reacted defensively, raised his hands out in front of himself and the Service Recipient's head contacted the Subject's hand. The Subject argued that he applied Crisis Prevention and Intervention (CPI) restraint techniques appropriately and to the best of his ability. The restraint, as well as the contact, occurred as reasonable emergency interventions to protect the safety of the Service Recipient and staff. (Hearing testimony of the Subject)

The Subject proffered testimony of [redacted] who was present and participated in the restraint. His testimony was consistent with the Subject's testimony in all pertinent respects. [redacted] testified that the Service Recipient raised his arm which precipitated the initial restraint and that throughout the incident he was concerned that the Service Recipient would hurt himself or

others. (Hearing testimony of [redacted])

The Director stated in his interview that he was trained that during this type of restraint there needs to be enough people to take each of a service recipient's limbs so that no one gets hurt and to do only what is necessary to gain control of an out of control individual. (Justice Center Exhibit 16) When questioned whether the restraint was appropriate, the Director stated, "I think that even if you look at this film you can see that this guy was ready to go at any time … they require this many people to manage him, this is a guy that's on the edge at any moment" and the Service Recipient continued to be aggressive and volatile even after the IM. (Justice Center Exhibit 16)

The Nurse Manager, who had been a CPI instructor, stated that the Hospital used CPI and the Unit itself used a restraint protocol called SECURE and that she is the SECURE trainer. She reviewed the video with the Investigator and noted that when giving an IM, enough people are needed to keep the service recipient still so that the needle does not break off in the body or injure anyone else present. (Justice Center Exhibit 16)

None of those interviewed, including notably the Nurse Manager who was a restraint trainer, stated definitively that the restraint was inappropriate. Moreover, the allowable restraint parameters were not specified. The Investigator testified that the restraint protocol used was Nonviolent Crisis Intervention (NCI). He also testified that he was not certified in the restraint procedure and was not an expert regarding restraints. The Subject and everyone else interviewed stated the restraint protocol was Crisis Prevention and Intervention (CPI). The Nurse Manager said the Unit used a protocol called SECURE. The applicable restraint protocol for the situation was not clearly established. It is also not evident whether this particular situation, Security being called to assist as an IM is administered on the Unit, was a circumstance that required a different

or specialized type of restraint. The record is devoid of any restraint manual or other related Hospital policy.

Therefore, it cannot be determined that 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 Director's assessment of the restraint that, "I will tell you the truth it does not look good but I don't know how to interpret it" is an accurate summary of the situation. (Justice Center Exhibit 16)

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 abuse (deliberate inappropriate use of restraints) alleged.

Allegation 1 – Physical Abuse

In order to prove physical abuse, the Justice Center must establish that the Subject intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment. (SSL § 488(1)(a)) The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York State Penal Law. (SSL § 488(16)) New York State Penal Law states that "A person acts intentionally with respect to a result or to conduct ... when his conscious objective is to cause such result or to engage in such conduct." (PL § 15.05(1)) New York State Penal Law states that

> "A person acts recklessly with respect to a result or to a circumstance ... when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance 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 Investigator testified that the Service Recipient said that the Subject punched him during the incident and that the Subject physically assaulted the Service Recipient when he contacted his face and head. (Hearing testimony of the Investigator)

The Subject testified that he was lifting himself up and trying to exit the Room when the Service Recipient lunged at him. (Hearing testimony of the Subject) The Subject said his reflexive reaction due to the emergency nature of the situation was to lift his hands to avoid being assaulted by the Service Recipient. The Subject testified that after his defensive action the Service Recipient "placed his face on my hand." (Hearing testimony of the Subject)

The video evidence demonstrates that the Service Recipient was facing down on the ground with his hands on the floor when the Subject pushed the Service Recipient toward the wall. As the Service Recipient began to sit up, the Subject crouched down in front of him. The Service Recipient's left hand never left the floor when the Subject put his open right hand on the Service Recipient's face and pushed him back down. The Subject's statement that the Service Recipient placed his face on the Subject's hand is not reasonable. The Subject's use of an approach that resulted in the Service Recipient falling back against the wall then being pushed down by his face, particularly when the Service Recipient was still down, cannot be found to be reasonable and the Subject's actions were at the least reckless. The Subject's argument, that he felt threatened and feared for his safety, as the Service Recipient who had just been medicated was down on the floor and at least five additional security personnel were close by, is not convincing as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person at that juncture.

It cannot be established that the Service Recipient's injuries were due to the Subject pushing the Service Recipient to the wall or by contact between the Subject's hand and the Service

Recipient's head. The Case Summary Report stated that the Service Recipient's injury was of unknown origin and could have occurred at any time during the restraint. As opined by the Director and others, the Service Recipient could have been injured at any point, particularly when his head came into contact with the floor and wall.

However, causation of the actual physical injury is not necessary for a finding of physical abuse. The Subject, while at the least acting recklessly, pushed the Service Recipient back against the wall then directly pushed the Service Recipient's face with his hand, thereby causing the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, it is determined that the Justice Center has established by a preponderance of the evidence that the Subject committed the physical abuse alleged.

The report will remain substantiated regarding physical abuse. The next question to be decided is whether the substantiated report constitutes the category of abuse 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)) Certainly, the Subject's actions of pushing the Service Recipient's body and pushing the Service Recipient down by his face placed the Service Recipient in danger and seriously endangered the health, safety or welfare of the Service Recipient. 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] be amended and sealed is granted in part and denied in part. The Subject has not been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints) and the Subject's request to amend and seal that portion of Allegation 1 is granted. The Subject has been shown by a preponderance of evidence to have committed physical abuse and the Subject's request to amend and seal that portion of Allegation 1 is denied.

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

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

DATED: April 11, 2019
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge