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: October 21, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Holly Moynihan, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2630 North America Drive
West Seneca, New York 14224
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: Holly Moynihan, Esq.

[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 abuse and/or 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 or about [redacted], in the agency van away from the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to a service recipient.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 3

It was alleged that on or about [redacted], in the agency van away from the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to maintain professional boundaries with a service recipient.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

[1] Allegation 1 of the substantiated report was unsubstantiated.

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

4. The facility, located at [redacted], is a limited secure [redacted] residential facility for male youths [redacted] years of age. The facility is operated by [redacted], a non-profit organization that is licensed by the New York State Office of Children and Family Services (OCFS), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of the Justice Center Investigator[2]; Justice Center Exhibit 7)

5. At the time of the alleged neglect, the Subject had been employed at the facility for approximately fifteen years and was a Behavioral Health Specialist (BHS) responsible for the direct care, supervision and transportation of service recipients. On [redacted], the Subject was working overtime from [redacted] at the Service Recipient's residential cottage. The Subject was working that day with Staff 1 and other staff.[3] The Subject was familiar with the Service Recipient's treatment plans and his history of smoking marijuana. On [redacted], the Subject signed the acknowledgement form indicating that he had received and read the facility's Employee Guidebook. The Subject was a custodian as that term is so defined in Social Services Law § 488(2). (Subject's Hearing testimony; Justice Center Exhibits 7, 27, 32, 33 and 36)

6. At the time of the alleged neglect, the Service Recipient was a verbal sixteen-year-old male who was placed at the facility on [redacted] after violating the terms of his probation by failing to attend school regularly, violating curfew and smoking marijuana. According to the Service Recipient's [redacted] Individual Crisis Management Plan (ICMP), there was no

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[2] [redacted] is hereinafter referred to as the Justice Center Investigator.

[3] [redacted] (BHS) is hereinafter referred to as Staff 1. [redacted] (BHS) and [redacted], Director of [redacted] were also staff working at the facility that day.

special level of staff supervision specified. He was allowed to be unsupervised in the community under certain circumstances, however, such circumstances were not fully delineated. The Service Recipient's ICMP further noted as a safety concern and warning that he had a history of marijuana use for which he had been receiving treatment. He had smoked marijuana[4] almost daily since he was twelve years old. The Service Recipient's ICMP also specifically noted his high-risk behaviors as hitting, biting and self-injury. The Service Recipient had been diagnosed with having a depressive disorder and other medical conditions. He had a history of trauma, sexual abuse, peers bullying him, self-esteem issues, bed wetting and other behaviors. The Service Recipient received treatment from a therapist[5]. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 8, 10, 30 and 36)

7. At the time of the incident, Sections "[redacted]" and "[redacted]" of the Employee Guidebook respectively stated that "All staff are required to sign in and out whenever entering or leaving any unit, for any reason and for any length of time, and must include destination and expected time of return…" and "Staff should not bring clients to … any place not previously approved by a supervisor…" (Justice Center Exhibit 27) The facility provided a vehicle log for staff "To be completed for EVERY TRIP". (Justice Center Exhibit 11) Although not encouraged, it was an informal practice for staff to take service recipients for haircuts without prior approval and sometimes staff used their own funds to pay for the services to establish a good rapport with the service recipients. (Justice Center Exhibits 11, 27 and 36)

8. Sometime after dinner on [redacted], the Subject and the Service Recipient left the facility in the agency van, allegedly for food or a haircut. At approximately 7:00 p.m., as

[4] Marijuana contains "tetrahydrocannabinol," a psychoactive or hallucinogenic agent that can alter a person's mental state. Refer to WebMD. Also refer to Sections 3302 and 3306(d) of New York State's Public Health Law.
[5] [redacted] is hereinafter referred to as the Service Recipient's Therapist.

the Subject was driving, the Service Recipient told the Subject that he had to urinate and asked him to pull the van over immediately so that he could get out to relieve himself. The Subject drove the van onto a public access road of a park-like botanical garden near a field which was about two miles away from the facility. The Subject pulled the vehicle over to the side of the access road. The Service Recipient exited the vehicle and walked behind the van, out of the Subject's view and towards a field area to urinate. The Subject urinated too, but behind the van. After a while, the Service Recipient had not returned to the van. The Subject got out of the vehicle and found the Service Recipient smoking marijuana from a pipe. The Service Recipient also possessed a pouch containing marijuana. (Subject's Hearing testimony; Justice Center Exhibits 7 and 36)

9. The Subject and Service Recipient re-entered the van and the Subject tucked the items down on the driver's side of the vehicle. The Subject then began to drive back onto the access road and away from the botanical gardens. Shortly thereafter, a police officer pulled the van over. As the officer approached the van, he smelled the odor of marijuana emanating from the van. The officer asked them to exit the vehicle, at which time a search was conducted and the marijuana pipe and the pouch containing marijuana were discovered. The Subject was arrested for possession of marijuana and drug paraphernalia as well as trespassing upon private property. The Service Recipient was ultimately transported back to the facility by facility staff. (Subject's Hearing testimony; Justice Center Exhibits 7, 13, 21 and 36)

10. Upon his return to the facility, the nurse performed an initial assessment of the Service Recipient. The nurse documented that the Service Recipient had "no injury" but noted the "redness" in his eyes and that his "speech" was slurred. Thereafter, the Service Recipient was transported to the hospital to be examined. The Service Recipient admitted to smoking marijuana

that he had obtained from an unidentified classmate, but he denied that he had an inappropriate relationship with the Subject. The therapist noted that she had a conversation with the Service Recipient the day after the alleged neglect, [redacted], and that the Service Recipient said the Subject "brought the marijuana with him to smoke with the [Service Recipient]." (Justice Center Exhibit 28). The Service Recipient subsequently denied making that statement to the therapist when interviewed by the Investigator. There were no other documented physical injuries to the Service Recipient as a result of the incident. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 7, 12, 28 and 36)

11. On the morning after the incident, the Subject underwent two supervised drug tests that yielded negative results. (Subject's Hearing testimony; Justice Center Exhibit 7 and 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 neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made

as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

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

> "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 and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Categories 2 and 3, which are respectively defined under SSL §§ 493(4)(b) and (c) as follows:

> 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.
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> 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 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 acts of neglect cited in the substantiated report constitute 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

This report contains two substantiated allegations, Allegation 2 and Allegation 3. As the conduct alleged and the alleged consequences in Allegation 2 are so substantially similar to Allegation 3, it is determined that Allegation 2 is redundant to Allegation 3. Splitting the allegations constitutes an administrative error. As Allegation 2 is superfluous, it is determined that Allegation 2 is unsubstantiated as a stand-alone allegation and merged and subsumed within Allegation 3.

The Justice Center has established by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 3" of 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 - 5, 7 - 15, 21 and 26 - 36) The investigation underlying the substantiated report was conducted by the Justice Center Investigator, 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 one document. (Subject Exhibit A)

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))

Allegation 3 – failure to maintain professional boundaries and provide proper supervision

The Justice Center contends that the Subject breached his duty and violated the Employee Guidebook when he failed to maintain professional boundaries and provide proper supervision while interacting with the Service Recipient.

The Justice Center argues that the Subject acted too informally with the Service Recipient and breached his duty to maintain professional boundaries. The Subject failed to properly supervise the Service Recipient, failed to obtain prior approval to take the Service Recipient off facility grounds and did not follow policy regarding documentation of van use. The Subject took the Service Recipient to an unauthorized outdoor location, at which time the Subject allowed the Service Recipient to urinate outdoors, was inattentive, and failed to prevent him from smoking marijuana.

During his hearing testimony, the Subject denied that he went beyond professional boundaries with the Service Recipient but admitted he was inattentive toward him. The Subject testified that he did not document his van use because he intended to do so after they returned. The Subject testified further that he did not need permission to take the trip. The Subject testified that he was unaware that the Service Recipient had marijuana in his possession and that, when he discovered the drug, he told the Service Recipient he was going to report the incident to his supervisor and the Service Recipient's treatment team. (Justice Center Exhibit 36) The Subject admitted that he used poor judgment by allowing the Service Recipient to urinate outdoors and

that he knew that there was a public restroom at a nearby fast food restaurant that the Service Recipient could have used. The Subject explained that he was aware of the Service Recipient's bed-wetting issues and knew that he was taking medication for the problem. The Subject stated that he was trying to spare the Service Recipient from being embarrassed if he had an accident. His concern for the Service Recipient, however, was insufficient to overcome the Subject's poor judgment. (Hearing testimony of the Subject)

After a careful review, it is determined that the evidentiary record does sufficiently establish by a preponderance of the evidence that the Subject did not properly supervise the Service Recipient and failed to maintain professional boundaries with him. The therapist wrote that the Service Recipient disclosed to her, on the day after the incident, that the Subject had brought the marijuana with him to smoke with the Service Recipient. The Subject claimed they stopped at the area so that the Service Recipient could urinate. However, as the Subject himself testified he was aware, there was a restaurant nearby, and the facility was only two miles away. The Subject had a vested interest in saying that he did not provide marijuana or had no idea that the Service Recipient had marijuana and his statement that he was unaware of the presence of the drug is not credible. Had the Subject maintained appropriate supervision of and boundaries with the Service Recipient, the Service Recipient would not have been able to smoke the drug.

As the Service Recipient's custodian, particularly as a Behavioral Health Specialist, the Subject had a duty to conduct himself in a professional and trustworthy manner while the Service Recipient was in his care as well as follow facility policies that are implemented for legitimate reasons. The Subject's failure to properly document the trip was a clear violation of Section [redacted] of the Employee Guidebook. The Subject's failure to obtain prior approval from a supervisor was a direct violation of Section [redacted] of the Employee Guidebook. The Subject breached his duty by acting

unprofessionally when he took the Service Recipient to an unauthorized outdoor location, failed to properly supervise him, and allowed the Service Recipient to smoke marijuana, which was contrary to the Service Recipient's ICMP. The Subject's actions were wrongful, clearly outside of appropriate professional standards and constituted a professional failure to adhere to the explicit "Safety Concerns - Warnings" addressed in the Service Recipient's ICMP regarding his drug addiction. At the time of the incident, the Subject, who was acting unprofessionally and exercising poor judgment, was working, and the Service Recipient was under his care and supervision.

It is determined that the Subject's breach of duty under Allegation 3 was likely to have resulted in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition. By the Subject taking the Service Recipient on an unauthorized outing and allowing the Service Recipient to urinate outdoors in a field, during which time the Service Recipient smoked marijuana, it was likely that the Service Recipient could have sustained physical injury or serious or protracted impairment of his physical, mental or emotional condition while he was under the influence of the drug. 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 in Allegation 3. The substantiated report will not be amended or sealed.

Since Allegation 3 of 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.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that Allegation 3 of the substantiated report is properly categorized as a Category 2 act. The Subject's breach of duty by failing to maintain professional boundaries and to provide proper supervision seriously endangered the health, safety or welfare of the Service

Recipient. The Subject had been employed at the facility for approximately fifteen years and was a Behavioral Health Specialist (BHS) responsible for the direct care, supervision and transportation of service recipients. As a BHS, the Subject was in a specific position of trust with regard to the Service Recipient. The record also shows that the Subject was familiar with the Service Recipient's ICMP, which specifically noted his history of marijuana use as a safety concern and warning as he has used marijuana daily since the age of twelve. (Justice Center Exhibit 30) The Subject knew that the Service Recipient was receiving treatment for his drug addiction and that the Service Recipient's marijuana use was one of the reasons why he was placed at the facility. The Subject specifically admitted to "…being aware that [Service Recipient] has been caught smoking marihuana on various occasions as a resident, I allowed him out of the school van and out of my sight in a remote area…" (Justice Center Exhibit 13) The record shows that the Service Recipient had a history of numerous disorders and conditions that required him to see a therapist. The conduct on the part of the Subject seriously endangered the Service Recipient's recovery from his drug addiction as well as exposed him to the potential for arrest for an illegal act. By failing to maintain professional boundaries and to provide proper supervision, the Subject, a BHS, violated his position of trust in regard to the Service Recipient, placed the Service Recipient in a dangerous position and seriously endangered his health, safety or welfare. Therefore, a Category 2 level offense is warranted.

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. 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] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect as alleged in Allegation 3 of the substantiated report.

Allegation 2 of the substantiated report is unsubstantiated as a stand-alone allegation and is merged and subsumed within Allegation 3.

Allegation 3 of the substantiated report is properly categorized as a Category 2 act.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: August 29, 2019
West Seneca, New York

Mary Jo Lattimore-Young,
Administrative Law Judge