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 28, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Jennifer McGrath, Esq.
[redacted], Subject
Edward Purser, 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: John T. Nasci
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: Jennifer McGrath, Esq.

[redacted]
By: Edward R. Purser, Esq.
P.O. Box 425
Cortland, New York 13045

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], of neglect by the Subject of two Service Recipients.

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 the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to service recipients, during which time they obtained or ingested one or more controlled substances, eloped from the residence, and/or engaged in aggressive or destructive behavior.

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

Allegation 2

It was alleged that on or about [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide adequate medical care to service recipients by not seeking medical attention for them upon discovering they may have ingested one or more controlled substances.

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

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

4. The facility, the [redacted], located at [redacted], is a nonsecure residential treatment facility which provides therapeutic services for male and female youth eleven to eighteen years of age, and is licensed by the New York State Office of Children and Family Services (OCFS), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OCFS Child Abuse Prevention Specialist [redacted] (Investigator))

5. At the time of the alleged neglect, the Subject had been employed by the [redacted] as an Awake Overnight Child Care Worker for eight months. (Justice Center Exhibit 20 and Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, sixteen year old female Service Recipient 1 had been a resident of the [redacted] since [redacted]. Service Recipient 1 was at risk of elopement (AWOL) and had a history of demonstrating impulsive suicidal ideations, self-harming behaviors, physical aggression and making false allegations. Service Recipient 1 was on AWOL "STOP" status which meant that "she should be placed in a TCI approved prone hold prior to any attempts to leave the [redacted] cottage … to ensure personal safety." (Justice Center Exhibit 11)

7. At the time of the alleged neglect, sixteen year old female Service Recipient 2 had been a resident of the [redacted] since [redacted]. Service Recipient 2 had a history of demonstrating impulsive suicidal ideations, self-harming behaviors, "cheeking" medication and AWOL. Service Recipient 2 was on AWOL "STOP" status which meant that "she should be

placed in a TCI approved prone hold prior to any attempts to leave the [redacted] cottage … to ensure personal safety." (Justice Center Exhibit 10)

8. In the event that a service recipient residing at [redacted] required medical assistance during an overnight shift, the overnight staff were required to telephone the on-call nurse. All calls placed to the on-call nurse by the overnight staff were directed to and rang on the telephone of the Administrator On Duty (AOD). AOD discussed the matter with the staff making the call and then made the determination of whether or not to telephone the on-call nurse. (Justice Center Exhibits 2 and 20; and Hearing testimony of the Subject)

9. At the time of the alleged neglect, the [redacted] Emergency Medical Care Regulation provided, in pertinent part, that "All staff must notify the Medical Clinical Staff immediately, if they believe a child is injured or ill" and that "Staff need to inform the nursing staff of all information they feel is pertinent to the situation." (Justice Center Exhibit 24)

10. At the time of the alleged neglect, the [redacted] utilized the Therapeutic Crisis Intervention (TCI) protocol for managing service recipients in crisis. (Justice Center Exhibit 22 and Hearing testimony of the Investigator) The stated purpose of TCI was to "to reduce or eliminate the need for physical intervention …" (Justice Center Exhibit 22 Bates stamp p.101)

11. The TCI protocol provided that a

> "**PHYSICAL RESTRAINT SHOULD ONLY BE USED WHEN:** (All three criteria must be met) Agency policies and state regulations approve restraint, The young person's individual crisis management plan indicates it, Our professional dynamic risk assessment indicates it," (emphasis on original). (Justice Center Exhibit 22 Bates stamp p.230)
>
> and
>
> **"PHYSICAL RESTRAINT IS <u>NOT</u> USED TO:** Demonstrate authority, Enforce compliance, Inflict pain or harm, Punish or discipline," (emphasis on original). (Justice Center Exhibit 22 Bates stamp p.231)

and

> **"DO NOT USE PHYSICAL RESTRAINT WHEN:** We cannot control the young person safely … Young person has a weapon." The TCI protocol also provided that "The destruction of property is vastly preferable to physical harm to a worker or young person." (Justice Center Exhibit 22 Bates stamp p.291)

12. The TCI protocol cautioned against using a restraint when a restraint was otherwise indicated, in the event that staff were aware of the existence of predisposing risk factors for asphyxia, which included, among other things, "Individuals under the influence of alcohol or drugs." (Justice Center Exhibit 22 Bates stamp p.292)

13. At the time of the alleged neglect, the Service Recipients and service recipient 3 resided in the [redacted] wing of the [redacted] cottage which was a residence that consisted of an [redacted] wing and a [redacted] wing, each of which housed three service recipients. The [redacted] [redacted] wing and [redacted] wing both had common areas from which extended bedroom hallways. The [redacted] wing and [redacted] wing common areas were connected together by a foyer which allowed for ingress and egress to the wings from outside. The foyer was connected to the [redacted] wing and [redacted] wing by separate closed doorways opposite each other. Each wing also had locked rear entrances located at the end of each wing's bedroom hallway. (Justice Center Exhibits 15 and 20; and Hearing testimony of the Subject)

14. The Subject and [redacted] CCW [redacted] (Staff A) were assigned to and worked the [redacted] to [redacted] overnight shift in the [redacted] wing of the [redacted]. [redacted] Awake Overnight Counselor [redacted] (Staff B) was assigned to and worked in the [redacted] wing of the [redacted]. (Justice Center Exhibits 15 and 20; and Hearing testimony of the Subject) Also assigned to the same shift in a different building was [redacted] Overnight AOD 1 [redacted] (AOD 1) who also acted as support, responding to cottages when cottage staff called for assistance. (Justice Center Exhibit 16 and Hearing testimony of the Subject)

15. On [redacted] and [redacted], the following events occurred:

a. On [redacted] at [redacted], when Staff B started her shift in [redacted] wing, all three [redacted] wing service recipients were in their bedrooms for the night. At approximately 11:45 p.m., Service Recipient 1 exited her bedroom and asked Staff B for cough medicine and a decongestant. Staff B sent Service Recipient 1 to the [redacted] wing to obtain the medication from the Subject who was responsible for medication administration for both wings during the shift. The Subject gave Service Recipient 1 Advil and cough syrup. (Justice Center Exhibits 8, 14, 15, 16, 17, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

b. After Service Recipient 1 left for [redacted] wing, Service Recipient 2 came out of her bedroom and asked Staff B for medication. Staff B refused her request and told her she would have to wait for regular staff to get her medication. (Justice Center Exhibit 15)

c. At approximately 12:29 a.m., Staff B called AOD 1 for support because the Service Recipients were in the [redacted] wing common area and refused to return to their bedrooms. At approximately 12:31 a.m., the Service Recipients started turning the [redacted] wing lights on and off. The Subject noticed the [redacted] wing lights flickering and telephoned Staff B to ask if she needed assistance, to which Staff B responded in the affirmative. The Subject entered [redacted] wing followed shortly thereafter by AOD 1 who persuaded the Service Recipients to return to their bedrooms. Thereafter, AOD 1 left the [redacted]. (Justice Center Exhibits 8, 14, 15, 16, 17, 20, and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

d. At approximately 12:43 a.m., the Service Recipients returned to the [redacted] wing common area. The Subject and Staff B attempted unsuccessfully to persuade the Service Recipients to return to their bedrooms. At approximately 12:54 a.m., the Subject returned to the [redacted] wing to document the medication she gave Service Recipient 1 earlier. Thereafter, Service Recipient 1 left the common area and returned, and handed a piece of paper to Service Recipient

2, which Service Recipient 2 put in her shirt. Staff B telephoned AOD 1 for support. (Justice Center Exhibits 8, 15 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

e. At approximately 1:02 a.m., the Subject returned to the [redacted] wing common area. At approximately 1:12 a.m., Staff B telephoned AOD 1 for support again. The Service Recipients talked with each other about having snorted crushed up Suboxone pills. The Service Recipients then ran around the common area, looking out the window, grabbing paper towels and a mop. The Service Recipients then attempted to exit the [redacted] through the [redacted] wing door to the foyer but were physically blocked by the Subject. On at least one occasion, Service Recipient 2 was able to get out of [redacted] wing and into the foyer. (Justice Center Exhibits 8, 14, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

f. Sometime before 1:34 a.m. the Service Recipients entered a laundry room in the bedroom hallway, put water and soap in a recycling bin and threw it on the Subject's face. The Service Recipients then put water and soap in a trash can and threw it on the Subject and Staff B. Thereafter, the Subject telephoned AOD 1 for support because AOD 1 had not responded after being called earlier by Staff B. (Justice Center Exhibits 8, 15, 17 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

g. At approximately 1:34 a.m., AOD 1 entered the [redacted] wing from the rear entrance. At the same time, the Service Recipients were attempting to exit the building through the same door. AOD 1 was able to prevent Service Recipient 2 from exiting the building, but Service Recipient 1 was able to exit and went outside the [redacted]. The Subject followed Service Recipient 1 outside to look for her but returned a few minutes later after having no success locating her. AOD 1 then left the [redacted] and used a facility vehicle to look for Service Recipient 1. (Justice Center Exhibits 8,

14, 15, 16, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

h. After Service Recipient 1 left the building, Service Recipient 2 reentered the [redacted] wing common area, grabbed a chair, lifted it over her head and ran back into the bedroom hallway. Service Recipient 2 returned to the common area shortly thereafter with a shower curtain rod in her hand and threatened to hit the Subject and Staff B. The Subject and Staff B got the shower rod away from Service Recipient 2 and she returned to the bedroom hallway. (Justice Center Exhibits 8, 14, 15, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

i. While Service Recipient 1 was outside, she went into an unlocked car that belonged to Staff A and found a metallic box which contained marijuana, a lighter and keys. (Justice Center Exhibits 14 and 17)

j. At approximately 1:40 a.m., while the Subject and Staff B were in the common area, Service Recipient 2 picked up a chair and threw it into the bedroom hallway. She then ran through the [redacted] wing door into the foyer, followed by the Subject and Staff B. Service Recipient 2 then reentered the common area and struggled to enter the bedroom hallway but was physically blocked by the Subject. (Justice Center Exhibit 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

k. At approximately 1:42 a.m. Service Recipient 2 tore down a window drape and attempted to open a window. The Subject attempted to physically move Service Recipient 2 away from the window, while Service Recipient 2 pushed the Subject and kicked the window. Staff B then took up a position between Service Recipient 2 and the window. Service Recipient 2 then grabbed a chair and threw it at the window but failed to break the window. Service Recipient 2 then tried again to get a chair, but the Subject physically blocked her. Service Recipient 2 then

kicked the window again, went back into the bedroom hallway briefly then reemerged in the common area and threw a chair at the window once more. Service Recipient 2 grabbed another chair which Staff B took away from her. (Justice Center Exhibits 8, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

l. At approximately 1:44 a.m., Service Recipient 2 tried to exit [redacted] wing through the [redacted] wing door to the foyer. The Subject held the door closed and Staff B and the Subject pulled Service Recipient 2 away from the door. Service Recipient 2 then ran to the window, kicked the window and threw a chair at the window, this time, breaking the window. Service Recipient 2 then picked up another chair, threw it at the Subject and Staff B and tried to approach the window again but was blocked by the Subject. Service Recipient 2 then grabbed a mop which was immediately taken away by the Subject. Service Recipient 2 then went to the window again and grabbed a chair which was taken away by Staff B. The Subject attempted to physically move Service Recipient 2 away from the window when Service Recipient 2 reached down to grab a piece of broken glass. The Subject prevented Service Recipient 2 from obtaining a piece of broken glass by putting her foot on the glass. (Justice Center Exhibits 8, 15, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

m. From approximately 1:46 a.m. to approximately 2:00 a.m., the Subject and service recipient 3 cleaned up the broken glass, straightened up the common area and vacuumed. (Justice Center Exhibit 23: [redacted] wing common area video recordings and Hearing testimony of the Subject)

n. Sometime between 1:46 a.m. and 2:01 a.m., Service Recipient 2 exited the [redacted] and found Service Recipient 1 in the parking lot. Service Recipient 1 gave Service Recipient 2 the metallic box containing marijuana, the lighter and keys. The Service Recipients saw AOD 1 searching for them and separated. Service Recipient 1 ran into the woods and attempted to gain

entrance to the male cottage, in order to see her boyfriend, by offering a male cottage staff some marijuana. The male cottage staff brought Service Recipient 1 inside and held her there. (Justice Center Exhibits 14, 17, 19 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

o. After Service Recipient 2 exited the [redacted], Staff B telephoned AOD 1 to inform him of the AWOL. At approximately 2:01 a.m., AOD 1 received a telephone call from Staff B to inform him that Service Recipient 2 had returned to the [redacted]. (Justice Center Exhibit 16)

p. At approximately 2:01 a.m., Service Recipient 2 returned to the [redacted] entering through the foyer to the [redacted] wing common area and proceeded to go back and forth between the bedroom hallway and the common area. Upon reentering the [redacted], Service Recipient 2 told Staff B and the Subject that she found marijuana in a staff's car. While Service Recipient 2 was in her bedroom, she smoked some of the marijuana. (Justice Center Exhibits 8, 14, 15, 16, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

q. At approximately 2:04 a.m., AOD 1 returned to the [redacted] and spoke with Service Recipient 2 who, to AOD 1, smelled like marijuana and who told him that Service Recipient 1 had gotten into an unlocked car and found marijuana, and that she took the marijuana and keys from the car. AOD 1 returned Service Recipient 2 to her bedroom and thereafter exited the [redacted] and resumed his search for Service Recipient 1. (Justice Center Exhibits 8, 14, 15, 16, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

r. Between 2:08 a.m. and 2:27 a.m., the Subject, Staff A and service recipient 3 cleaned, straightened up and vacuumed the [redacted] wing common area and the Subject put plastic over the broken window. During the same time period, Service Recipient 2 went back and forth several times between the common area and the bedroom hallway, looking out the window several times,

and AOD 1 entered and exited the [redacted] wing twice. (Justice Center Exhibits 14, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

s. At approximately 2:27 a.m., Service Recipient 2 stood on the chair and started playing with the [redacted] wing wall telephone. Staff B attempted to persuade Service Recipient 2 to put the telephone down. The Subject was out of the [redacted] wing common area from approximately 2:33 a.m. until approximately 2:44 a.m., and from approximately 2:45 a.m. until approximately 2:51 a.m., during which time periods Service Recipient 2 continued to play with the telephone and pace around the common area. At approximately 2:56 a.m., Service Recipient 2 hung up the telephone and left the [redacted] wing common area to the foyer. (Justice Center Exhibit 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

t. While AOD 1 was driving around looking for Service Recipient 1, he received a telephone call from a staff at a male cottage who informed him that he was holding Service Recipient 1 there. AOD 1 went to the male cottage and retrieved Service Recipient 1. AOD 1 asked Service Recipient 1 if she had any more marijuana to which she responded no. However, Service Recipient 1 had a marijuana joint in her mouth and proceeded to spit it out the window of the vehicle. Thereafter, AOD 1 returned Service Recipient 1 to the [redacted]. (Justice Center Exhibit 16)

u. At approximately 3:00 a.m., Service Recipient 1 reentered the [redacted] through the foyer to the [redacted] wing common area followed by Staff B and AOD 1. Service Recipient 1 then took a shower and changed her clothes because she was muddy from being outside. AOD 1 spoke with the Service Recipients until approximately 3:08 a.m., returned them to their bedrooms and left the [redacted]. (Justice Center Exhibits 8, 14, 15, 16, 17, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

v. At approximately 3:09 a.m., the Service Recipients exited their bedrooms and entered the bathroom. Staff B entered the bathroom, saw the Service Recipients smoking a marijuana joint and told them to stop and hand over the contraband, which they refused to do. Thereafter, the Service Recipients went into the shower room and their bedrooms where they continued to smoke the marijuana joint ignoring Staff B's directives to cease. (Justice Center Exhibits 8, 14, 15, 17, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

w. At approximately 3:26 a.m., both Service Recipients had returned to the common area and were sitting in a pair of chairs below the wall telephone, passing back and forth a marijuana joint. The Service Recipients stood on the chairs and attempted to use the telephone. Staff B attempted to physically intercede using her arm and the Service Recipients pushed her arm away several times. Staff B also attempted unsuccessfully to take the marijuana joint away from the Service Recipients. The Subject stood a few feet away from Staff B and the Service Recipients. The Service Recipients continued to play with the telephone and pass the marijuana joint back and forth. At approximately 3:30 a.m., Service Recipient 2 pulled a lighter from inside her shirt while Service Recipient 1 held the marijuana joint. Staff B continued to attempt to get the marijuana joint from Service Recipient 1. Service Recipient 1 attempted to light the marijuana joint but failed. At 3:46 a.m., the Service Recipients successfully lit the marijuana joint and smoked it. Staff B stood immediately behind the Service Recipients and the Subject sat on a seat edge a few feet away. (Justice Center Exhibits 8, 14, 15, 17, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

x. At approximately 3:53 a.m., Service Recipient 2 gave Staff B the spent marijuana joint. Shortly thereafter, AOD 1 entered the [redacted] wing common area from the foyer, walked to the

wall telephone, disconnected the telephone, took the telephone off the wall and placed it on a table on the opposite side of the room. The Service Recipients gave the remaining marijuana, the lighter and the keys to AOD 1 after he requested that they do so. AOD 1 then allowed Service Recipient 1 to speak with her mother by telephone. AOD 1 then spoke with the Service Recipients until approximately 4:00 a.m. Service Recipient 1 told AOD 1 that she got the marijuana, lighter and keys from Staff A's car. At approximately 4:11 a.m., AOD 1 returned to the common area from the bedroom hallway and exited the [redacted] wing common area. (Justice Center Exhibits 8, 14, 15, 16, 17, 20, and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

y. AOD 1 reentered the [redacted] wing common area and, from approximately 4:21 a.m. to approximately 5:00 a.m., AOD 1 talked with the Service Recipients in their bedrooms. AOD 1 then returned to the [redacted] wing common area, put the wall telephone back on the wall and exited the [redacted]. (Justice Center Exhibits 8, 15, 20 and 23: [redacted] wing common area video recordings; and Hearing testimony of the Subject)

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 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 follows:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the acts of neglect alleged in the substantiated report that is

the subject of the proceeding and that such 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 constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and a photograph obtained during the investigation. (Justice Center Exhibits 1 through 22 and 24 through 25) The Justice Center also presented video recordings of the area and timeframe encompassing the alleged incident. (Justice Center Exhibit 23) 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 her own behalf and presented no other evidence.

Allegation 1 – Failure to Provide Proper Supervision

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 Recipients. (SSL § 488(1)(h))

The Justice Center contends that the Subject had a duty to provide proper supervision of the Service Recipients and breached that duty during the [redacted] to [redacted] overnight shift by allowing the Service Recipients to obtain and ingest one or more controlled substances, by allowing the Service Recipients to elope from the residence and by allowing the Service Recipients to engage in aggressive or destructive behavior. Specifically, the Justice Center contends that the Subject and/or Staff B failed to restrain the Service Recipients and/or failed to perform an AWOL Stop on the Service Recipients, which allowed them to engage in the behavior. The Justice Center further contends that the Subject's conduct 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.

The Subject argues that she and Staff B followed [redacted] policy by attempting to deescalate the Service Recipients and by requesting help from AOD 1 (Support) at the appropriate times when the Service Recipients were agitated or acting aggressively. The Subject argues specifically that she and Staff B could not have performed a restraint on the Service Recipients because the Service Recipients were threatening to attack her and Staff B if one of them was restrained and because the Service Recipients were under the influence of drugs, a factor which prohibited the Subject and Staff B from being able to perform a restraint on them.

Both of the Service Recipients' Individual Behavior Management Plans (IBMP), the only treatment plans contained in the record, indicated that the Service Recipients were on "AWOL STOP status" at the time of the alleged neglect The plans defined "AWOL STOP status" as requiring that the Service Recipient "should be placed in a TCI approved prone hold prior to any

attempts to leave the [redacted] cottage … to ensure personal safety." (Justice Center Exhibits 10 and 11) Among the physical intervention methods contained in the TCI Activity Guide in the record, there is nothing described as a "prone hold." (Justice Center Exhibit 22) However, there is a method described as a "team prone restraint," and for purposes of this decision, the "prone hold" indicated in the Service Recipients' IBMPs will be considered as referring to the TCI described "team prone restraint." (Justice Center Exhibit 22 Bates stamped pp. 249 to 257) As its name indicates, and as described in the TCI Activity Guide, the team prone restraint required more than one person for the restraint to be performed. Consequently, in the event an AWOL STOP were required, at least two staff would necessarily have to have been present and available to perform it.

The TCI Activity Guide also indicated that a service recipient being under the influence of alcohol or drugs was a predisposing risk factor for asphyxia during a restraint. While the TCI Activity Guide did not prohibit a restraint when a service recipient was under the influence of alcohol or drugs, it cautioned against the use of a restraint in such circumstances due to the heightened risk of asphyxia. (Justice Center Exhibit 22 Bates stamped p. 292) Additionally, both the Subject and Staff B stated that, under TCI protocol, [redacted] staff were not permitted to perform a restraint on a service recipient who was under the influence of drugs. (Justice Center Exhibit 8 Bates stamped pp. 32, 36 and 40; Justice Center Exhibit 20; and Hearing testimony of the Subject)

The events of the early morning of [redacted], as described by evidence in the record, transpired over more than a four hour period of time during which the Service Recipients were highly agitated and in and out of the [redacted] wing common area, hallway, bathroom, shower and their bedrooms. The Service Recipients engaged in physical violence against the Subject and Staff B and destruction of [redacted] property. Additionally, for different lengths and periods of time, both

Service Recipients were outside the confines of the [redacted]. The Subject, Staff B and AOD 1 were also in various locations, at times together with the Service Recipients and at times alone with the Service Recipients.

The Justice Center contends that the Subject should have restrained the Service Recipients at various points in time throughout the four hour event. However, the record reflects that, as early as 1:12 a.m., the Subject and Staff B heard the Service Recipients talking about having crushed Suboxone pills and having snorted them, and the earliest a restraint might have been warranted was when the Service Recipients attempted to exit the [redacted] wing common area to the foyer, after they had discussed snorting the crushed Suboxone pills. Erring on the side of caution, the Subject and Staff B assumed that the Service Recipients were under the influence of a drug and decided not to perform a restraint, as they understood they were required to do. Additionally, the Service Recipients had told the Subject and Staff B that if they restrained one of them, the other one would attack them. Given the circumstances, the Subject and Staff B acted prudently by not attempting a restraint and used the only resource they had available to them, which was to telephone AOD 1 for support.

Thereafter, the Subject and Staff B operated under the assumption that the Service Recipients were under the influence of a drug and avoided the use of restraints. When circumstances got out of their control, the Subject and/or Staff B telephoned AOD 1 for support, which they did several times throughout the four hour event.

Given the TCI principles such as "to reduce or eliminate the need for physical intervention …" (Justice Center Exhibit 22 Bates stamp p. 101), "The destruction of property is vastly preferable to physical harm to a worker or young person" (Justice Center Exhibit 22 Bates stamp p. 291) and the caution against the use of a restraint on "Individuals under the influence of alcohol

or drugs" (Justice Center Exhibit 22 Bates stamp p.292), the Subject cannot be found to have had a duty to restrain either or both of the Service Recipients as alleged.

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 neglect alleged in Allegation 1. Therefore, Allegation 1 of the substantiated report will be amended and sealed.

Allegation 2 – Failure to Provide Adequate Medical Care

The Justice Center contends that the Subject had a duty to seek medical attention upon learning that the Service Recipients had ingested one or more controlled substances, that she breached the duty by failing to telephone the on-call nurse or otherwise failing to seek medical attention upon learning that the Service Recipients had snorted crushed Suboxone pills and smoked marijuana, and that the Subject's conduct 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.

The record reflects that on [redacted], at 1:21 a.m., the Subject and Staff B heard the Service Recipients discussing how they had crushed Suboxone pills and then snorted them. Furthermore, the Subject and Staff B assumed that the Service Recipients snorted the crushed pills and partially relied on that assumption as their basis for not restraining the Service Recipients.

The record reflects that the telephone number to the on-call nurse rang on the telephone of AOD 1. Therefore, any telephone call placed by the Subject or Staff B to the on-call nurse would have been equivalent to placing a telephone call to AOD 1 directly.

The record reflects that the Subject and Staff B telephoned AOD 1 several times throughout the four hour event starting with Staff B's call to him at approximately 12:19 a.m. and that he responded to the Subject's and Staff B's calls by becoming actively involved in attempting to rein

in the Service Recipients' behavior. However, AOD 1 stated that he had no knowledge of the Service Recipients' claim that they snorted crushed Suboxone pills. (Justice Center Exhibit 16)

The Subject testified that she did not know if Staff B told AOD 1 about the Service Recipients snorting the crushed pills. (Hearing testimony of the Subject) In her interview with the Investigator, Staff B stated "I could have called support earlier when I suspected [Service Recipient 2] and [Service Recipient 1] were using drugs and said they were high and let [AOD 1] know of this circumstance when he responded to my original call." (Justice Center Exhibit 15 Bates stamped p. 75) The record is clear that, although AOD 1 was called and responded to requests for support of the Subject and Staff B on several occasions throughout the four hour event, neither the Subject nor Staff B informed AOD 1 about the Service Recipients' claim of snorting crushed Suboxone pills. Consequently, the Subject failed to notify the on-call nurse through AOD 1 of the Service Recipients' suspected drug use.

There is no written policy included in the record that specifically required the [redacted] staff to telephone the on-call nurse in the event that a service recipient was suspected of using a non-prescribed drug. However, the [redacted] Emergency Medical Care Regulation 441.22 required staff to "… notify the Medical Clinical Staff immediately, if they believe a child is injured or ill." (Justice Center Exhibit 24)

The record reflects that the Subject heard the Service Recipients talking about snorting crushed pills and that the pills were Suboxone. Furthermore, the record reflects that the Subject had administered Advil and cough syrup to Service Recipient 1 only a short time before. Having heard the Service Recipients talking about snorting crushed Suboxone pills and knowing that Service Recipient 1 had taken medication a short while before, the Subject had sufficient cause and, therefore, duty to notify the Medical Clinical Staff, in this case, the on-call nurse through

AOD 1. Consequently, the Subject breached her duty by failing to inform the on-call nurse, through AOD 1, of the Service Recipients' claims of snorting crushed Suboxone pills, or otherwise seeking medical attention for the Service Recipients.

The Justice Center also contends that the Subject breached her duty to seek medical attention upon discovering that the Service Recipients were smoking marijuana. However, the record reflects that the Subject and Staff B telephoned AOD 1 for support and that they informed him about the Service Recipients having marijuana in their possession and that they had smoked it. Because contacting AOD 1 was the equivalent of telephoning the on-call nurse, the Subject cannot be found to have breached her duty to seek medical attention upon learning that the Service Recipients smoked marijuana.

The Service Recipients' ingestion of non-prescribed medication, by crushing Suboxone pills and snorting the crushed pills, placed the Service Recipients in danger of an adverse reaction to the Suboxone. Furthermore, Service Recipient 1 was at an even higher risk of adverse reaction having previously taken Advil and cough syrup. Consequently, the Subject's failure to seek medical attention for the Service Recipients was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in Allegation 2. Therefore, Allegation 2 of the substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) Logic dictates that the ingestion of

an unprescribed controlled substance is highly risky and potentially dangerous, especially when combined with the use of other drugs or medications. Consequently, the Subject's failure to seek medical attention for the Service Recipients upon learning that they ingested Suboxone, a controlled substance (Justice Center Exhibit 25), seriously endangered the Service Recipients' health, safety and welfare.

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.

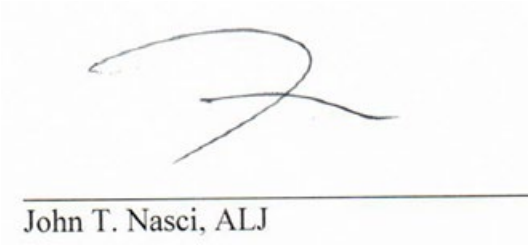
DECISION: The request of [redacted], that Allegation 1 of the substantiated report dated [redacted] be amended and sealed, is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect as alleged in Allegation 1.

The request of [redacted], that Allegation 2 of 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 neglect as alleged in Allegation 2.

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

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: October 4, 2019
Schenectady, New York



John T. Nasci, ALJ