

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**  
Adjud. Case #: [REDACTED]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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

Dated: January 27, 2020  
Schenectady, New York



Elizabeth M. Devane, Esq.  
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register  
Jennifer McGrath, Esq.  
[REDACTED], Subject  
Nathaniel Charny, Esq.

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Keely D. Parr  
Administrative Law Judge

Held at:

Administrative Hearings Unit  
New York State Justice Center for the Protection  
of People with Special Needs  
Poughkeepsie State Office Building  
4 Burnett Blvd. – 2nd Floor  
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: Jennifer McGrath, Esq.

[REDACTED]

By: Nathaniel Charny, Esq.  
Charny & Wheeler  
9 W Market St  
Rhinebeck, NY 12572-1402

### **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 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], in the agency vehicle away from the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you drove in an unsafe manner while transporting a service recipient.

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, located at [REDACTED], is an individualized residential alternative (IRA) operated by [REDACTED], and certified by the Office for People With Developmental Disabilities (OPWDD),

which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by [REDACTED] as a Residential Specialist (RS) and had worked at the facility full time since 2004. The Subject completed his Article 19-A Biennial Behind the Wheel Road Test in 2004. (Hearing Testimony of Subject; Justice Center Exhibit 20)

6. At the time of the alleged neglect, the Service Recipient was an 87-year old male, functioning in the mild range of intellectual disability with a diagnosis of catatonic schizophrenia and osteopenia. The Service Recipient had resided at the facility since 1987. (Justice Center Exhibits 11 and 12)

7. At the time of the alleged neglect, the Subject was driving the agency vehicle southbound on the New York State Thruway (thruway), returning from taking the Service Recipient to a medical appointment in [REDACTED], New York. The Subject was driving 65 m.p.h. in the right-hand lane of a “long straight flat stretch” of the two-lane portion of the thruway. The Service Recipient was sitting in the front passenger seat and Staff #1<sup>1</sup> was sitting behind the Service Recipient. The Subject asked Staff #1 where they should go for lunch and Staff #1 did not respond. The Subject turned his head to look at Staff #1, as she was unresponsive to his questions. The Subject “looked only enough to check”. When the Subject tuned back around, the traffic ahead of him had stopped, due to an accident up ahead. The Subject rear-ended the vehicle in front of him, then drove onto the shoulder and struck the thruway boundary fence and some trees. Both the Subject and the Service Recipient were not injured; however, Staff #1 was airlifted to [REDACTED] Medical Center, where she was admitted. (Hearing Testimony of Subject; Justice Center Exhibits 6, 7, 8, 17 and 22)

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<sup>1</sup> [REDACTED]

8. The Service Recipient was assessed at the [REDACTED] Hospital emergency room where a head computed tomography (CT) scan was performed and came back negative and the Service Recipient was given Tylenol. The Service Recipient was “shaken up” by the accident. He was subsequently taken to the doctor for a follow up visit two days after the alleged neglect and was found to have no injuries. (Justice Center Exhibits 6, 8 and 19)

9. Staff #1 stated that she heard the Subject call her name, that she looked up, saw the windshield crack, remembers being whipped around and then seeing trees. She further stated that the paramedics had to break the window on the opposite side of the van to get the door open to get to her. Staff #1 remembered having an IV inserted, being placed on a stretcher, taken by ambulance to the helicopter and transported to the hospital. Staff #1 had internal injuries and a back injury and stated that she was terrified. (Justice Center Exhibit 22)

10. The police accident report indicated that the Subject was following the vehicle in front of him too closely and that after the Subject hit that vehicle, it went off of the left shoulder and hit the guide rail. (Justice Center Exhibits 17 and 24)

11. As a result of the accident, the agency vehicle sustained significant damage to the front end along with cracks to the windshield. (Hearing Testimony of Investigator; Justice Center Exhibit 21)

### **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 abuse and neglect presently under review was substantiated. A “substantiated report” means a report “... wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred...” (Title 14 NYCRR 700.3(f))

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

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

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2 as found in SSL § 493(4)(b), which is defined 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.

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 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 established by a preponderance of the evidence that the Subject committed an act, described as “Allegation 1” in the substantiated report. Specifically, the evidence establishes that the Subject committed neglect.

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))

In support of its substantiated findings, the Justice Center presented a number of documents

obtained during the investigation. (Justice Center Exhibits 1-24) The investigation underlying the substantiated report was conducted by Justice Center Criminal Investigator [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented no other evidence.

On the day of the alleged neglect, the Subject was employed as a Residential Specialist by [REDACTED] and was acting as a custodian as that term is defined in Social Services Law § 488(2). The Subject had a duty to drive safely which duty he breached by taking his eyes off of the road, not looking far enough ahead of his vehicle to be aware of traffic patterns and following the vehicle in front of him too closely. (Hearing Testimony of Investigator and Subject; Justice Center Exhibits 13 and 20)

The Subject testified that he called back to Staff #1 to ask her where they should stop for lunch; that she was non-responsive; that he adjusted his seat and looked in the rearview mirror to position his voice to reach back to Staff #1. He further testified that when he looked back to the road, the car in front of him had either stopped or slowed considerably. The Subject then stepped on his brakes as hard as he could but could not avoid hitting the vehicle in front of him. He tried to get off into the right shoulder and struck the rear passenger side of the vehicle in front of him with the front driver's side of the agency vehicle. He then struck the thruway boundary fence and some trees. (Hearing Testimony of Subject; Justice Center Exhibit 17)

There is conflicting evidence in the record as to whether the Subject turned around to look at Staff #1 or adjusted his seat and used the rearview mirror to look at Staff #1. The Subject's testimony and statements made during his interrogation support the use of the mirror. The police accident report states that the Subject turned his head to look at the back-seat passenger, the general events report filed by the Subject states "I looked only enough to check" and Staff #1's mother



stated that the Subject told her that he turned around to speak to Staff #1. In either case, it is clear from the record that the Subject took his eyes off the road in order to speak to Staff #1. (Hearing Testimony of Subject; Justice Center Exhibits 8, 17 and 22)

The Subject further testified that he was not looking at the road ahead to see if there were brake lights and stated that it was a “long straight flat stretch” of the thruway. There was an accident up ahead of the road, which is why the vehicle in front of the Subject was stopping. If the Subject was paying attention to the road, he would have noticed multiple vehicles braking, with their red brake lights gleaming, and applied the brakes of his own vehicle long before he rear-ended the vehicle in front of him. Although the Subject testified that he was driving five car lengths behind the vehicle in front of him, the police accident report indicates that the Subject was following too closely, and the police issued a traffic ticket for this. The Subject argued that the ticket was ultimately dismissed for a failure to prosecute however that is not a determination on the merits. (Hearing Testimony of Investigator and Subject; Justice Center Exhibits 6, 13, 17, 22 and 24)

Although the Service Recipient was not physically injured, there was a likelihood that the Subject’s breach would result in physical injury and serious or protracted impairment of the physical, mental and emotional condition of the Service Recipient. The Subject testified that he was traveling the speed limit which was 65 m.p.h. when he slammed on his brakes to try to avoid hitting the vehicle in front of him. The photographs of the vehicle that the Subject was driving show significant damage to the front end and cracks to the windshield, evidencing that the impact with the vehicle in front was considerable. The police accident report evidences that the vehicle that was hit by the Subject in turn went off the left shoulder and hit the guide rail. Staff #1 had to be airlifted to [REDACTED] Medical Center because of the severity of her injuries and stated that she

was terrified. The Service Recipient was sitting in the front seat of the vehicle and witnessed the accident in its totality; the crunch of metal on metal had to negatively impact the Service Recipient who very likely feared for his life as the accident transpired. Not only did the Subject hit the vehicle in front of him he also hit the thruway boundary fence as a result of the impact. Accordingly, there was a likelihood that the Subject's breach would result in physical injury and serious or protracted impairment of the physical, mental and emotional condition of the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibit 17, 21, 22)

The evidence establishes that the Subject committed neglect when the Subject drove in an unsafe manner while transporting the Service Recipient.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended 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 conduct by a custodian that seriously endangers the health, safety or welfare of a service recipient. The Subject was traveling 65 m.p.h. with the Service Recipient in the front passenger seat and hit the vehicle in front of him. The impact was so severe that the front end of the vehicle folded like an accordion and the windshield cracked. He then proceeded to hit the thruway boundary fence and Staff #1 stated that she was "whipped around". Staff #1's injuries were so severe that she was airlifted to [REDACTED] Medical Center. The Service Recipient could have easily been killed or seriously injured. The Subject seriously endangered the health, safety and welfare of the Service Recipient by taking his eyes off of the road, not paying attention to traffic patterns and following the vehicle in front of him too closely. The Service Recipient was

dependent upon the Subject to safely transport him to his residence, not to place his life in jeopardy.  
(Hearing Testimony of Investigator and Subject; Justice Center Exhibits 10, 17, 21 and 22)

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 substantiated Category 2 finding of 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] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

This decision is recommended by Keely D. Parr, Administrative Hearings Unit.

**DATED:** January 16, 2020  
Brooklyn, New York

  
Keely D. Parr, ALJ