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: November 9, 2020
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Daniel Sullivan, Esq.
[redacted], Subject
Lawrence Schaefer, 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: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
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: Daniel Sullivan, Esq.

[redacted]

By: Lawrence Schaefer, Esq.
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse (deliberate inappropriate use of restraints). The Subject requested that the VPCR amend the report to reflect that the Subject is not the 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 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], while at [redacted], located at [redacted], you committed Deliberate Inappropriate Restraint against/to a Service Recipient.

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

The investigation revealed the Subject conducted a restraint with improper technique and excessive force on the Service Recipient, which included wrapping his arm around the Service Recipient's neck and/or placed his weight on the Service Recipient's back.

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

4. The facility, the [redacted], located at [redacted]

[redacted] provides, in pertinent part, inpatient mental health treatment for incarcerated adults. The [redacted] is operated by the New York State Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted] (Investigator))

5. Ward [redacted] of [redacted] is an inpatient acute care ward for male patients who need to be separated from the general population on other wards of [redacted] for various reasons including mental health and behavioral issues. (Hearing testimonies of the Investigator, the Subject and Secure Hospital Treatment Assistant (SHTA) [redacted] (SHTA [redacted]); Justice Center Exhibit 39)

6. At the time of the alleged abuse (deliberate inappropriate use of restraints), the 34 year old male Service Recipient was a resident of Ward [redacted] and had been at [redacted] for three weeks. He had been admitted to [redacted] on numerous previous occasions. The Service Recipient had diagnoses including Antisocial Personality Disorder. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 17, 18, 25, 27, 29, 31, 34, 37 and 39).

7. The Service Recipient had a history of being assaultive, particularly toward Corrections Officers and staff, being impulsive, having suicidal ideations and being self-harming, including lacerating himself and swallowing objects such as an inhaler, metal and plastic pieces. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 27, 31, 34, 37 and 39).

8. At the time of the alleged abuse (deliberate inappropriate use of restraints), the Subject was employed by OMH as a SHTA and had been employed by OMH for 15 years. His duties included caring for and providing safety and supervision for service recipients. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16 and 39) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

9. [redacted] utilized, and the Subject was trained in, Preventing and Managing Crisis Situations (PMCS), the purpose of which included enhancing safety for service recipients and staff. PMCS trained staff in appropriate responses to prevent crisis situations and how to manage such situations when they occur. PMCS identified behavioral warning signs, provided verbal and nonverbal intervention strategies and de-escalation techniques, such as distraction and redirection, to prevent and defuse situations, and reviewed how to perform appropriate physical interventions. PMCS training dictated that a restraint was to be used only as a measure of last resort to avoid imminent injury to a service recipient or others and, in such event, the least restrictive method approved was to be utilized. PMCS instructed that safety concerns were elevated when someone threatened bodily harm to themselves or others, used a weapon, or displayed violent conduct and, as a result, a service recipient or other person was placed in imminent danger of physical injury. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibit 35)

10. From [redacted] at 10:00 a.m. to [redacted] at 10:00 a.m., a Constant Observation Order was prescribed for the Service Recipient. The Order required 1:1 staffing for the Service Recipient with observation of "Assaultive" and "Impulsive" behaviors noted. The Service Recipient's progress notes indicated the Service Recipient's restrictions including, "No sharps/Razor/Pen". (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 24, 30, 31, 34, 37 and 39)

11. At the time of the alleged abuse (deliberate inappropriate use of restraints), the Service Recipient was located in, what was referred to as, a "side room" on [redacted]. A SHTA (SHTA [redacted]) was assigned 1:1 of the Service Recipient and posted outside the room. The room contained a mattress with linens, a chair and paperwork. The room had a window on the wall facing outside and a window on the door facing into the hallway. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 17, 18, 19, 24, 25, 27, 30, 31, 34, 37, 38 and 39)

12. On [redacted], the Subject was assigned to Ward [redacted] for the [redacted] shift. During SHTA [redacted] 1:1 constant observation of the Service Recipient, at approximately 3:35 p.m., SHTA [redacted] provided supervision of the Service Recipient while SHTA [redacted] took a break to use the lavatory. During that time, the Subject was assigned to supervise a service recipient who was located in a side room next to the Service Recipient's side room. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 18, 24, 30, 31, 38 and 39)

13. SHTA [redacted] was supervising the Service Recipient for approximately two minutes when the Subject heard SHTA [redacted] speak to the Service Recipient and heard a commotion coming from the Service Recipient's room. The Subject looked up through the window on the Service Recipient's side room door and saw the Service Recipient swinging at SHTA [redacted]. The Subject immediately responded, went into the room, saw the Service Recipient and SHTA [redacted] involved in an altercation and attempted to restrain the Service Recipient who continued to be combative. The Subject placed his right arm around the back of the Service Recipient's neck and pushed his right hip into the Service Recipient. The Service Recipient and the Subject both fell to the ground. The Service Recipient fell face down. The Red Dot emergency telephone system was used to request additional assistance and a number of staff responded. The Service Recipient was held on the ground for approximately 75 seconds until a restraint bed was supplied. The Service Recipient was then secured in a five-point restraint in a supine position on a rolling restraint bed in the side room. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 18, 20, 23, 24, 29, 30, 31, 33, 34, 37, 38 and 39)

14. The physical examination of the Service Recipient performed at 3:50 p.m., and subsequent physical examinations completed on [redacted] and [redacted], found multiple older scars predating the restraint and no recent injuries or bruising to the Service Recipient. (Justice

Center Exhibits 17, 22, 23, 26, 31, 34, 36 and 37)

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 report of 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…" (14 NYCRR § 700.3(f))

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:

> (d) "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 abuse (deliberate inappropriate use of restraints) shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

> (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act of abuse (deliberate inappropriate use of restraints) alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report. (14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse (deliberate inappropriate use of restraints), the report will not be amended and sealed. Pursuant to SSL § 493(4) and 14 NYCRR § 700.10(d), it must then be determined whether the acts of abuse (deliberate inappropriate use of restraints) cited in the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report.

If the Justice Center did not prove the abuse (deliberate inappropriate use of restraints) 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 the abuse (deliberate inappropriate use of restraints) 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 37) The Justice Center provided a video recording of the side room during the time of the alleged abuse as well as audio

recordings of the Investigator's interviews of the Subject, SHTA [redacted] and the Service Recipient. (Justice Center Exhibits 38 and 39) 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 SHTA [redacted] also testified at the hearing. No additional documentary evidence was provided.

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 Justice Center contends that the Subject used improper technique and excessive force during a physical intervention with the Service Recipient on [redacted]. The Justice Center argues specifically that the methodologies used by the Subject, wrapping his arm around the Service Recipient's neck and placing his weight on the Service Recipient's back, were not proper restraint techniques and were performed by the Subject with excessive force. The Justice Center also argued that there was no basis for an emergency intervention.

The Investigator testified, and PMCS protocol stated, that the PMCS process initially requires the utilization of de-escalation techniques to calm a person and, if techniques are unsuccessful and an intervention becomes necessary, the utilization of the least restrictive restraint.

(Hearing testimony of the Investigator; Justice Center Exhibit 35) The Investigator testified that the restraint techniques utilized were not approved within PMCS protocol. (Hearing testimony of the Investigator) When asked whether he thought there was an emergency situation he replied, "I did not see an emergency situation until [SHTA [redacted]] entered the room and then the struggle between him and the Service Recipient ensued." (Hearing testimony of the Investigator)

The Subject conceded that the restraint was not performed as trained under PMCS and stated that "If I could have restrained him properly I would have". (Hearing testimony of the Subject) However, the Subject argued that the restraint was used as a reasonable emergency intervention to prevent imminent harm as the Service Recipient was assaulting SHTA [redacted] and, therefore, there was the likelihood of imminent danger. (Hearing testimonies of the Subject and SHTA [redacted])

The Subject testified that when he heard the commotion, and then, "saw my coworker get struck" by the Service Recipient, he immediately attempted to intervene. (Hearing testimony of the Subject; Justice Center Exhibit 39) However, because the Service Recipient was combative, the Subject could not get control of the Service Recipient and could not successfully perform a proper PMCS sanctioned restraint, such as a one man wrap or "high hooks" takedown. (Hearing testimonies of the Subject and SHTA [redacted]) He stated that the restraint was "not perhaps as how we are trained but given in that situation, I mean he is flailing his arms around I couldn't possibly put him in a bear hug and do what they want you to do" and that he used the least restrictive method possible. (Hearing testimony of the Subject) The Subject also conceded that it was against PMCS policy to restrain in a face down position however, he stated that the act was not deliberate as he and the Service Recipient fell on one another while the Service Recipient continued to resist. The Subject stated that the Service Recipient was rotated, repositioned into a supine position and placed on the restraint bed as soon as safely possible. (Hearing testimonies of the Subject and SHTA [redacted];

Justice Center Exhibits 38 and 39) The Subject stated that he strives to execute physical interventions by using the least restrictive means possible and proper technique. However, when a Service Recipient becomes physically aggressive to the point of physically injuring themselves or another person, the situation becomes an emergency. The Subject testified that "I admit it wasn't the best but it was, when my coworker is imminent danger it was the least restrictive possible way for me to help." (Hearing testimony of the Subject)

The Service Recipient said that he could not breathe during the restraint and that he was sexually assaulted during the restraint. (Hearing testimony of the Investigator; Justice Center Exhibit 39) The Subject stated that he put some weight on Service Recipient "just enough to hold him down" for less than 10 seconds in an effort to gain control of a dangerous situation. (Hearing testimony of the Subject) The video shows that two seconds after the Service Recipient fell to the ground, he stated that he could not breathe. During the restraint over the following 75 seconds the Service Recipient and staff engaged in continual communication. During that time, the Service Recipient yelled on at least five occasions that staff was putting something inside his rectum, however as evidenced by the video that was not the case. (Justice Center Exhibit 38) The video evidence supports the Subject's statement.

The Subject's version of events coincides with SHTA [redacted] version, the Investigator's testimony and the video evidence. The credible evidence in the record establishes that the Subject manually immobilized or limited the ability of the Service Recipient to freely move his body and consequently, the Subject's conduct constituted a restraint. The techniques the Subject used were not PMCS trained or authorized. However, from the Subject's credible testimony, it is evident that his actions were not deliberately inconsistent with PMCS, but were a reasonable response during an emergency situation. Based on the credible evidence, it is evident that the Subject's

conduct toward the Service Recipient was a reasonable emergency intervention to prevent imminent harm to SHTA [redacted] and the Service Recipient.

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. The substantiated report will be amended and sealed.

DECISION: The request of [redacted] that 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 abuse (deliberate inappropriate use of restraints).

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

DATED: October 20, 2020
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge