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

In the Matter of the Appeal of

FINAL
DETERMINATION
AFTER HEARING

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

Vulnerable Persons Central Register New York State Justice Center for the Protection of People with Special Needs 161 Delaware Avenue Delmar, New York 12054-1310 Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
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The Findings of Fact and Conclusions of Law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

## **ORDERED**:

The request of \_\_\_\_\_ that the substantiated report dated 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.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of this report shall be retained by the Vulnerable Persons Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

**DATED**: January 29, 2016

Schenectady, New York

David Molik

Administrative Hearings Unit

Dan Throlix

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

In the Matter of the Appeal of

RECOMMENDED DECISION AFTER HEARING

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

Before: Jean T. Carney

Administrative Law Judge

Held at: New York State Justice Center for the Protection

of People with Special Needs

401 State Street

Schenectady, New York 12305

On:

Parties: Vulnerable Persons' Central Register

New York State Justice Center for the Protection

of People with Special Needs

161 Delaware Avenue

Delmar, New York 12054-1310

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### **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (the Subject) for abuse and/or 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 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:

#### Offense 1

It was alleged that on \_\_\_\_\_, in \_\_\_\_ of \_\_\_\_\_, located at \_\_\_\_\_, while acting as a custodian (Residential On-Call Supervisor), you committed neglect when you failed to provide adequate medical care to a service recipient once you discovered that she had jumped from her second floor window.

This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law § 493.

- 3. An Administrative Review was conducted and as a result the substantiated report was retained.
- 4. The facility, located at \_\_\_\_\_\_, is a residential facility for youth, and is operated by \_\_\_\_\_\_, and licensed by the

Office of Children and Family Services (OCFS), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

- 5. At the time of the alleged abuse and/or neglect, the Subject had been employed by since 2006. The Subject worked as a Residential On Call.
- 6. At the time of the alleged abuse and/or neglect, the Service Recipient was 16 years old, and had been a resident of the facility for an unknown period of time. The Service Recipient is a young person with diagnoses of depression, anxiety disorder, substance abuse, and tobacco abuse. (Justice Center Exhibit 15)
- 7. On \_\_\_\_\_\_, at approximately 11:00 p.m., the Service Recipient jumped out her bedroom window in an attempt to elope from the facility. Earlier in the day she had been put on shadow supervision because she had disclosed to another service recipient that she wanted to elope, and that service recipient had reported her intent to staff. Shadow supervision is a higher level of supervision than eyesight supervision. When a service recipient is under shadow supervision and in her bedroom, the door must be open. (Justice Center Exhibit 4)
- 8. The Service Recipient was discovered by Direct Care Worker (DCW)

  , who alerted the staff on duty in the Service Recipient's cottage. Pursuant to policy, DCW and DCW went outside to where the Service Recipient was laying, and called the Subject, as the Residential On Call staff person, to assess the situation. (Justice Center Exhibit 4)
- 9. The Service Recipient's bedroom window was on the second floor of the cottage. When she jumped out her window, she landed on a concrete slab near a barbecue grill. The Service Recipient reported that she heard a crack when she landed, and thought that she had broken something. She was in a lot of pain, and was unable to stand or walk without assistance.

The Service Recipient described crawling up the stairs to her room because she could not walk.

The Service Recipient was not known to be a dramatic child, nor was she prone to embellish.

(Justice Center Exhibit 4, and Subject Exhibit J)

- 10. After the Subject arrived, he encouraged the Service Recipient to try standing, and to try and walk into the cottage. The Service Recipient was able to stand and ambulate with assistance. After the Service Recipient went inside, the Subject called the nurse on call. The Subject did not observe the Service Recipient go upstairs to her room; but stayed downstairs on the phone with the nurse. (Justice Center Exhibit 4)
- 11. The Subject told the nurse that the Service Recipient had jumped out of a second story window and was walking back inside. He said that she did not appear to be in a lot of pain, and that her left ankle appeared to be swollen. The nurse advised the Subject that the Service Recipient was to stop walking on it, and that staff should implement RICE: rest, ice, compression and elevation. The Subject told the nurse that the Service Recipient was resting and that the ankle appeared sprained to him. The Subject did not think that the Service Recipient needed to go to the hospital. The nurse advised the Subject that if the Service Recipient's condition changed, to call back for re-assessment. The nurse did not receive any subsequent calls that night. (Justice Center Exhibits 4 and 12)
- 12. The following morning, the Service Recipient was still in considerable pain. When the day nurse came on duty, she re-assessed the Service Recipient's injuries and determined that the Service Recipient should be transported to the hospital by ambulance. The Service Recipient was examined at the hospital and found to have sustained multiple fractures of her left foot, and fractures to both ankles. The Service Recipient required surgery, was confined to a wheelchair for a period of time, and then underwent physical therapy. (Hearing testimony of

#### **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 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(h), to include:

(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, 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(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or 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 act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or 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 a prohibited act, described as "Offense 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 1-16) The investigation underlying the substantiated report was conducted by Child Abuse Specialist , who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified on his own behalf and provided a number of documents (Subject Exhibits A-J) In addition, DCW and and Registered Nurse testified in behalf of the Subject.

The Justice Center proved by a preponderance of the evidence that the Subject neglected the Service Recipient by failing to provide her with adequate medical care. Specifically, the evidence establishes that the Subject did not accurately convey the Service Recipient's condition to the nurse on call, and encouraged her to walk even though she was in obvious pain having jumped from a second floor window onto concrete.

There is little dispute as to the facts of this case. In addition, the parties agree that the Subject was a custodian as defined in the statute and as such he owed a duty to the Service Recipient. In fact, the Subject's position as Residential On Call comes with supervisory responsibilities that require him to determine how best to proceed in an emergency situation. (Justice Center Exhibit 2)

In this case, the Subject responded to a call alerting him to the fact that the Service Recipient had either jumped or fallen out her bedroom window. Considering the fact that the Subject had placed the Service Recipient on shadow supervision earlier that day because she had evinced her intent to elope, the Subject could easily infer that the Service Recipient jumped in an attempt to run away. The credited evidence shows that he was aware that her bedroom window was on the second floor of the cottage, and in fact, it was pointed out to him that she nearly hit

the barbecue grill when she fell. In addition, he knew that the Service Recipient landed on a concrete slab, that she was teary-eyed, if not crying, and in pain. Despite these facts indicating that the Service Recipient may be seriously injured, the Subject encouraged the Service Recipient to stand and walk. (Justice Center Exhibit 4, Hearing testimony of Subject)

The evidence shows that the Service Recipient was not able to walk all the way upstairs and get in her bed on her own. However the Subject did not observe her crawl into her room because he stayed downstairs to call the nurse on call. Rather than relay all the facts and circumstances to the nurse, the Subject only said that the Service Recipient had jumped out of a window, she appeared calm and was able to walk on her own, and her left ankle was puffy. (Justice Center Exhibit 4)

At the hearing, the Subject testified that he suffers from corneal disease which affects his depth perception and he cannot see well. When the Subject responded to the call, he chose not to wear his glasses because he only had one pair. He did not want to risk getting them damaged. Instead, the Subject testified that he took another staff person, with him to the scene. However, in his statement, said that he did not get to the cottage until after the Service Recipient was in bed. Instead that he was not there to assess the Service Recipient's condition; thus was not instrumental in assisting the Subject for the nurse on call. It statement also notes that at one point the other staff in the room asked the Subject if the Service Recipient should be taken to the hospital, and the Subject suggested waiting until the morning.

In his defense, the Subject asserts that he relayed the information available to him at the time. However, the evidence admitted during the Justice Center's case in chief refutes that

assertion.<sup>1</sup> There was significant evidence at the Subject's disposal that he did not relay to the nurse on call; including the height from which the Service Recipient jumped, that she landed on concrete, that she was unable to ambulate without assistance, and that she was in considerable pain.

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 abuse and/or 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 level of abuse or neglect set forth in the substantiated report. In this case, the Service Recipient suffered numerous fractures in both ankles and her left foot. She underwent surgery, was confined to a wheelchair, and required physical therapy. 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.



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The Subject moved to dismiss after the Justice Center rested. Post-trial memoranda were submitted from both parties addressing this motion. The conduct of this hearing was governed in accordance with Title 14 of the New York Code of Rules and Regulations, Part 700 (14 NYCRR 700). The Administrative Law Judge (ALJ) is designated by the Executive Director to preside over the hearing and make a report and recommendation for the Executive Director's final determination. In order to make a thoughtful and considered recommendation, the ALJ needs to have a complete record. Notwithstanding the fact that 14 NYCRR 700.9 does not specifically grant the authority to rule on substantive motions, the ALJ presiding over the hearing finds and recommends that the Justice Center has met its burden in this matter. The Subject also asserted that his due process rights were violated because he did not receive written notice during the course of the investigation that he was the Subject of the investigation. The Subject submits that this violation warrants a dismissal of the allegations against him. However, at the close of the investigation the Subject was notified in writing of the substantiated allegations. Further, he had actual notice of every step in the review process, and was quite ably represented during that process and at the hearing. Therefore the ALJ presiding over this hearing finds and recommends that the Subject was afforded due process under the law.

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 Jean T. Carney, Administrative Hearings Unit.

**DATED:** December 14, 2015 Schenectady, New York

> Jean T. Carney Administrative Law Judge