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

Adjudication Case #: [redacted]

Held at:

New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
On: [redacted]

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
Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Todd M. Sardella, Esq.

[redacted]
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject), for serious physical abuse and other serious conduct (neglect) against a Service Recipient. The Subject invoked an internal administrative review which was denied. An administrative hearing was then held, on [redacted], in accordance with the requirements of Social Services Law § 494 and Part 700 of 14 NYCRR.

PROCEDURAL HISTORY

The VPCR contains a substantiated report, [redacted], for serious physical abuse and other serious conduct (neglect) against a Service Recipient. The report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center). The substantiated report as against the Subject, dated [redacted], concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed serious physical abuse when you pushed a service recipient into his room, causing him to fall and collide with his bed and to sustain physical injury and/or serious disfigurement and/or serious impairment of health and/or loss or impairment of the function of a bodily organ or part, including facial fractures and lacerations.

These allegations have been SUBSTANTIATED as Category 1 serious physical abuse pursuant to Social Services Law § 493(4)(a)(i).

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed other serious conduct (neglect) when you breached a duty by pushing a service recipient into his room, causing him to fall and collide with his bed and to sustain physical injury and/or serious disfigurement and/or serious impairment of health and/or loss or impairment of the function of a bodily organ or part, including facial fractures and lacerations; or causing the likelihood of such result.

These allegations have been SUBSTANTIATED as Category 1 other serious conduct (neglect) pursuant to Social Services Law § 493(4)(a)(ii). *Justice Center Exhibit 1.*

An Administrative Review was conducted at the request of the Subject to amend the report and the Justice Center Administrative Appeals Unit denied the request. On [redacted], a Hearing (the Hearing) was held.

The Administrative Law Judge issued a Recommended Decision after Hearing (Recommended Decision). The Recommended Decision recommended that the allegation of serious physical abuse remain substantiated as a Category 1 act and that the allegation of other serious conduct (neglect) remain substantiated, but recommended that this allegation be reduced from a Category 1 act to a Category 2 act. That Recommended Decision is rejected in part and adopted in part by the Executive Director pursuant to 14 NYCRR 700.13.

The Executive Director adopts the Recommended Decision insofar as it recommends that the allegation of serious physical abuse remain substantiated as a Category 1 act and that the allegation of other serious conduct (neglect) remain substantiated, and incorporates the attached Recommended Decision into this Final Determination and Order after Hearing to the extent that the Recommended Decision recommended that the allegation of serious physical abuse remain substantiated as a Category 1 act and that the allegation of other serious conduct (neglect) remain substantiated. The Executive Director rejects that portion of the Recommended Decision that recommended that the substantiated allegation of other serious conduct (neglect) be reduced from a Category 1 act to a Category 2 act and for the reasons set forth herein determines that the substantiated allegation for other serious conduct (neglect) remain substantiated as a Category 1 act.

As the allegation of serious physical abuse in the Recommended Decision is being

adopted and incorporated herein, in its entirety, for the reasons and Conclusions of Law set forth therein, and the allegation of other serious conduct (neglect) in the Recommended Decision is being adopted and incorporated herein, as to substantiation only, this Final Determination and Order after Hearing will only substantively address the appropriate category level of the allegation of other serious conduct (neglect). The following constitutes the Final Determination of the Executive Director under 14 NYCRR 700.13.

FINDINGS OF FACT

The Executive Director adopts the "Findings of Fact" set forth in the Recommended Decision and incorporates them herein.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed serious physical abuse and other serious conduct (neglect) against a Service Recipient, as defined in Social Services Law § 488(1)(a) and (h) and that the serious physical abuse and other serious conduct (neglect) against the Service Recipient are properly categorized as Category 1 offenses under Social Services Law § 493(4)(a)(i) and (ii) respectively. As set forth above, as the Executive Director has adopted and incorporated the Recommended Decision insofar as it recommends that the allegation of serious physical abuse remain substantiated as a Category 1 act and also adopts and incorporates the Recommended Decision that the allegation of other serious conduct (neglect) remain substantiated, this Final Determination and Order after Hearing will only substantively address the appropriate category level of the allegation of other serious conduct (neglect).

Other Serious Conduct (Neglect) under Social Services Law § 493(4)(a)(ii)

Category 1 conduct is defined in Social Services Law § 493(4)(a). The Subject herein,

was substantiated for Category 1 conduct for serious physical abuse and other serious conduct (neglect) under Social Services Law § 493(4)(a)(i) and (ii) respectively. As relevant to the present analysis, Social Services Law § 493(4)(a)(ii) defines Category 1, other serious conduct (neglect) as follows:

> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
>
> > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death: causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

As set forth in the Recommended Decision the Subject pushed the Service Recipient into a room and as a result the Service Recipient hit his head on the corner of his wooden bed frame and fell to the floor unconscious. The Service Recipient was then taken to the [redacted] Emergency Department where he was diagnosed with face bone fractures, a head injury, lacerations, and a concussion. The Service Recipient received stitches for the laceration which were described as a cut from the top of his nose, to the bone around his left eye, both above and beside his eye. *Recommended Decision, Findings of Fact ¶¶ 9, 10 and 11and Justice Center Exhibits 11, 12 and 15.*

The Recommended Decision also found that the Subject's conduct in pushing the Service Recipient into a room, which caused the Service Recipient to hit his head on a wooden bed frame, rendering the Service Recipient unconscious was a reckless act. *Recommended Decision at pages 8, 12, and 13.*

Additionally, the Recommended Decision found that, as a result of the Subject's reckless conduct, the Service Recipient sustained "serious physical injuries", including face bone fractures, a head injury, lacerations, and a concussion. *Recommended Decision at pages 8 and 12.*

Moreover, the Recommended Decision found that, in the context of Category 1 physical abuse, the Service Recipient sustained "physical injury" as defined in penal law § 10.00 (9). *Recommended Decision at page 13.*

However, the Administrative Law Judge in the Recommended Decision, recommended that the allegation of other serious conduct (neglect) under Social Services Law § 493(4)(a) (ii) be reduced to Category 2 neglect, essentially based on the ground that the record did "not contain evidence that [the] injuries created a substantial risk of death, or serious disfigurement, or a serious impairment of health. The record does reflect that the Service Recipient did not die, or lose a bodily organ. There was no evidence presented to show that the Service Recipient was permanently disfigured, or that his health was seriously impaired." *Recommended Decision at pages 13 and 14.*

This rationale of the ALJ is rejected. It is clear from the record that the Subject recklessly failed to perform a duty that resulted in serious impairment of the health of the Service Recipient, or at the very least, recklessly failed to perform a duty which was likely to result in a serious impairment of the health of the Service Recipient, serious disfigurement or loss or impairment of the function of a bodily organ or part. In other words, the record plainly demonstrates, by a preponderance of the evidence, that the Subject committed Category 1, other serious conduct (neglect) under Social Services Law § 493(4)(a)(ii), and also necessarily

demonstrates that the neglect elements under Social Services Law § 488(1)(h) have also been met.

In short, the Subject pushed the Service Recipient into a room and as a result the Service Recipient hit his head on the corner of his wooden bed frame and fell to the floor unconscious. The Service Recipient was then taken to the [redacted] Emergency Department where he was diagnosed with face bone fractures, a head injury, lacerations, and a concussion. The Service Recipient received stitches for the laceration which were described as a cut from the top of his nose, to the bone around his left eye, both above and beside his eye. *Recommended Decision, Findings of Fact ¶¶ 9, 10 and 11 and Justice Center Exhibits 11, 12 and 15.* As set forth above, this factual context sufficiently establishes, under Social Services Law § 493(4)(a) (ii), that the Subject recklessly failed to perform a duty that resulted in serious impairment of the health of the Service Recipient, or at the very least, recklessly failed to perform a duty which was likely to result in a serious impairment of the health of the Service Recipient, serious disfigurement or loss or impairment of the function of a bodily organ or part.

Finally, the Recommended Decision, fails to address at all that under Social Services Law § 493(4)(a)(ii), actual injury as set forth therein, which certainly can support a Category 1 finding, is not a required element. Rather, Category 1, other serious conduct (neglect) under Social Services Law § 493(4)(a)(ii), may be established where the requisite conduct is "likely" to result in "...physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed

mental health counselor..." *Social Services Law* § 493(4)(a)(ii). Here it has been determined that the Subject recklessly failed to perform a duty that resulted in serious impairment of the health of the Service Recipient, or at the very least, recklessly failed to perform a duty which was likely to result in a serious impairment of the health of the Service Recipient, serious disfigurement or loss or impairment of the function of a bodily organ or part.

Accordingly, based on the foregoing it is hereby:

ORDERED: 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 serious physical abuse and other serious conduct (neglect).

The substantiated report for both serious physical abuse and other serious conduct (neglect) are properly categorized as Category 1 acts.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register.

This decision is ordered by Davin Robinson, Chief of Staff, who has been designated by the Executive Director to make such decisions.

DATED: July 27, 2016
Delmar, New York

Davin Robinson
Chief of Staff

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: 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: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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New York State Justice Center for the Protection of People with Special Needs
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By: Todd M. Sardella, Esq.

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By: Sarah M. Coligan, Esq.
Lippes Mathias Wexler Friedman LLP
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Albany, New York 12207-2527

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of abuse and 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 [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed serious physical abuse when you pushed a service recipient into his room, causing him to fall and collide with his bed and to sustain physical injury and/or serious disfigurement and/or serious impairment of health and/or loss or impairment of the function of a bodily organ or part, including facial fractures and lacerations.

These allegations have been SUBSTANTIATED as Category 1 serious physical abuse pursuant to Social Services Law § 493(4)(a)(i).

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed other serious conduct (neglect) when you breached a duty by pushing a service recipient into his room, causing him to fall and collide with his bed and to sustain physical injury and/or serious disfigurement

and/or serious impairment of health and/or loss or impairment of the function of a bodily organ or part, including facial fractures and lacerations; or causing the likelihood of such result.

These allegations have been SUBSTANTIATED as Category 1 other serious conduct (neglect) pursuant to Social Services Law § 493(4)(a)(ii).

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

4. The facility, located at [redacted], is a secure psychiatric hospital, and is operated by the New York State Office of Mental Health (OMH), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 5)

5. At the time of the alleged abuse and neglect, the Subject had been employed by [redacted] since [redacted] 2013. The Subject worked as a Security Hospital Treatment Assistant (SHTA). (Hearing testimony of Subject)

6. At the time of the alleged abuse and neglect, the Service Recipient was 48 years old, and had been a resident of the facility since [redacted] 1990. The Service Recipient is an adult male with diagnoses of delusional disorder, paranoia, and poly-substance abuse. (Justice Center Exhibit 6)

7. Due to his history of assaultive behavior, the Service Recipient required two staff to supervise him at all times. On [redacted], SHTA [redacted] and SHTA [redacted] were assigned that duty. The Service Recipient had spent the majority of the day in his room, so when he requested to go to the day room to watch television, staff agreed. The protocol for the Service Recipient to watch television included setting up a bean bag chair for him to sit on and then placing a weighted blanket over him. (Hearing testimony of Subject, Justice Center Exhibits 5 and 18)

8. A few minutes after getting settled in and watching television, the Service Recipient

threw off his blanket and lunged at SHTA [redacted]. The Subject told the Service Recipient to lay back down or he would have to go back to his room. The Service Recipient settled down, but a few minutes later, he went after SHTA [redacted] again. SHTA [redacted] was about to place the Service Recipient in a hold, but the Subject tapped him out; a procedure that is often used to remove the target of a service recipient's aggression in order to de-escalate the situation. (Hearing testimony of Subject, Justice Center Exhibit 18: Interviews with SHTA [redacted] and SHTA [redacted])

9. Thereafter, the Subject and SHTA [redacted] escorted the Service Recipient to his bedroom, which is the first room in the hallway outside the day room, on the left. At the threshold of the Service Recipient's bedroom, SHTA [redacted] released his hold on the Service Recipient's elbow and wrist, and the Subject pushed the Service Recipient into the room. SHTA [redacted] asked the Subject if he pushed the Service Recipient. The Subject replied that it was an accident. (Justice Center Exhibit 18: Interviews with SHTA [redacted], RN [redacted])

10. After being pushed into the room, the Service Recipient hit his head on the corner of his wooden bed frame and fell to the floor unconscious. SHTA [redacted] called a medical emergency to which RN [redacted] responded first, finding the Service Recipient stretched out on his stomach on the floor in front of his bed, and unresponsive. As the Service Recipient regained consciousness, he told RN [redacted] that the Subject pushed him. The Service Recipient repeated this statement several times as more staff responded to the medical emergency call. (Justice Center Exhibits 5 and 18: Interview with RN [redacted])

11. The Service Recipient was taken to the [redacted] Emergency Department where he was diagnosed with face bone fractures, a head injury, lacerations, and a concussion. The Service Recipient received stitches for the laceration that was

described as a cut from the top of his nose, to the bone around his left eye, both above and beside his eye. He also was prescribed pain medication and instructed to follow up with his primary physician at the facility. (Justice Center Exhibits 5, 11, and 15)

12. The Service Recipient stands about 6 foot 3 inches. The distance between the threshold of the Service Recipient's bedroom and the edge of the bed is 9 feet 3 inches. The Service Recipient's injuries were consistent with being pushed from the threshold of the room, and were inconsistent with the Service Recipient tripping and falling after stepping into the room. (Hearing testimony of Justice Center Investigator [redacted][1], and Justice Center Exhibit 5)

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])

[1] When Investigator [redacted] testified at the hearing, he was no longer working at the Justice Center and had started working as an investigator for the Office for People With Developmental Disabilities)

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1), to include:

> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> (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 1, which is defined as follows:

> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
>
> > (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

> (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
>
> (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 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 acts, described as “Allegation 1” and “Allegation 2” 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 1-18) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. In addition, [redacted], Supervising Investigator with the Justice Center testified on behalf of the Justice Center.

The Subject testified in his own behalf. In addition, [redacted], an SHTA at [redacted] testified on behalf of the Subject.

Allegation of Physical Abuse

In order to sustain a substantiation of physical abuse, the Justice Center must show that the Subject acted either recklessly or intentionally; with physical contact; and caused physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The statute enumerates several forms of such physical contact, including shoving. (SSL § 488[1][a])

In this case, the Justice Center proved that the Subject recklessly shoved the Service Recipient into his bedroom, causing the Service Recipient to fall and hit his face on the corner of the bed frame, knocking the Service Recipient unconscious and causing serious physical injuries.

The Service Recipient had a history of aggression and assaultive behavior. The Service Recipient was also at risk of falling. For these reasons, the facility required two staff members to supervise him at all times. (Justice Center Exhibits 6 and 18; and Hearing testimony of Subject) The Subject was aware of the Service Recipient's history, and on previous occasions had taken steps to avoid being injured by the Service Recipient. For example, the Subject testified that while in his bedroom, the Service Recipient would sometimes attempt to punch an SHTA who was opening the bedroom door. In an effort to thwart this behavior, the Subject would hold the door

closed to keep the Service Recipient from opening the door and punching him. (Hearing testimony of Subject)

The Service Recipient's bedroom door opened into the bedroom, and the doorway was not wide enough for three people to pass through at the same time. As a result, when the Subject and SHTA [redacted] escorted the Service Recipient to his bedroom on the day of the incident, it would have been impossible for all three to enter the bedroom while maintaining their restraint of the Service Recipient. The evidence indicates that the Service Recipient was positioned slightly in front of the Subject when they arrived at the bedroom doorway. SHTA [redacted] stated that after he released his hold, the Service Recipient went forward at an accelerated speed, past SHTA [redacted] into the room. SHTA [redacted] asked the Subject if he had pushed the Service Recipient, and the Subject responded that it was an accident. Two other service recipients observed the incident from the day room. Both reported that the Subject pushed the Service Recipient into his bedroom from the threshold of the room. (Hearing testimony of Justice Center Investigator [redacted], Justice Center Exhibits 5, and 18)

In addition, the evidence shows that the SHTAs, including the Subject, were concerned about their safety when escorting the Service Recipient into his bedroom. Because the door opened into the room, it was foreseeable for the Service Recipient to attempt to assault the SHTAs as they attempted to pull the bedroom door shut behind them. (Justice Center Exhibit 18) However, by pushing the Service Recipient into his room, the Subject could remain in the doorway and pull the door shut before the Service Recipient could turn on him.

Further, the Service Recipient was knocked unconscious by the fall. When he regained consciousness, he immediately said that he had been pushed by the Subject. These statements are credited evidence as an excited utterance. It is not likely for a person to fabricate upon regaining

consciousness. (Justice Center Exhibits 5, and 18)

The Subject denies pushing the Service Recipient. At the hearing, the Subject testified that he and SHTA [redacted] were inside the room approximately 3 to 4 feet when they released the Service Recipient. However, the Subject could not remember how they entered the room, or who went in first. In addition, three other witnesses, including SHTA [redacted], reported that the Service Recipient was pushed into the bedroom from the threshold; not from inside the bedroom. (Hearing testimony of Justice Center Investigator [redacted], Justice Center Exhibits 5 and 18) The Subject also testified that when he and SHTA [redacted] released the Service Recipient, the Service Recipient's legs gave out and he crumpled to the floor, hitting his head on the wooden bedframe. (Hearing testimony of Subject)

There are several inconsistencies in the Subject's statements. At the hearing, the Subject testified that the Service Recipient pulled away as he was being released from the restraint. The Subject thought that the Service Recipient was going to turn and elbow the Subject. (Hearing testimony of Subject) During his interview with Investigator [redacted], the Subject said that after the Service Recipient was released from the restraint, and the SHTAs were backing out of the room, the Service Recipient made a motion and his leg gave out, or he slipped. When Investigator [redacted] asked for more details regarding the type of motion, and whether it was a slip or trip, the Subject said that he could not remember due to the trauma of seeing the Service Recipient fall. (Justice Center Exhibit 5) On the incident report completed by the Subject on the day of the incident, the Subject stated that the Service Recipient lost his balance while attempting to turn around, and fell forward, hitting his head on the edge of the bed. (Justice Center Exhibit 9)

However, none of the scenarios posited by the Subject could have occurred given the

injuries suffered by the Service Recipient. If the Service Recipient had fallen while turning, he would have fallen away from the bed, not on the edge of the bedframe. If the Service Recipient's leg had given out, he would have fallen where he stood, not into the bedframe. If the Service Recipient was in his bedroom and pulled away from the SHTAs, he would have either fallen onto the bed or hit the back wall of his bedroom, not the front edge of the bedframe. (Justice Center Exhibits 5, 18, and Hearing testimony of Justice Center Investigator [redacted])

RN [redacted] was the first person to respond to the emergency call. She found the Service Recipient sprawled on the floor, on his stomach, with his head near the bed and his feet pointing toward the door. If the Service Recipient had tripped, he would have tried to break his fall. However, the lack of marks on either his arms or hands, indicates that he did not try to break his fall. In addition, the Service Recipient was 6 feet 3 inches tall. The distance from the doorway of his bedroom to the bedframe is 9 feet 3 inches. If the Service Recipient had fallen while standing inside his bedroom, he would have either landed on top of his bed, or hit the back wall of his room. (Hearing testimony of Justice Center Investigator [redacted], Justice Center Exhibits 5 and 18) Therefore, the Subject's testimony is not credited evidence.

The preponderance of the evidence introduced at the hearing shows that the Subject committed physical abuse by recklessly pushing the Service Recipient into his bedroom, causing the Service Recipient to fall, knocking him unconscious, and causing physical injury.

Allegation of 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 his 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])

There is no doubt that the Subject was a custodian as defined in SSL § 488(2). He had been working at [redacted] for ten months when the incident occurred. Furthermore, the Subject was fully familiar with his duties and obligations as an SHTA working with this vulnerable population; and had been trained in proper techniques for escorting service recipients. (Hearing testimony of Subject)

The Subject owed a duty to the Service Recipient to maintain his safety. The Subject breached his duty by pushing the Service Recipient into his bedroom. At the very least, the Subject acted recklessly by pushing the Service Recipient. The Subject knew that the Service Recipient was at risk of falling, and was unsteady on his feet. (Justice Center Exhibit 18) The act of pushing the Service Recipient demonstrates the Subject's conscious disregard of the risk to the Service Recipient that he could lose his balance and fall. The evidence establishes that as a result of the Subject's actions, the Service Recipient suffered physical injuries, including a concussion, fractured face bones, and other injuries requiring stitches to his face. (Justice Center Exhibit 4) Consequently, the Justice Center has sufficiently established that the Subject committed neglect.

Because 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 neglect alleged, the substantiated report will not be amended or sealed.

Categorization

Having established that the reports will remain substantiated, the next question to be decided is whether the substantiated reports constitute the category of abuse and neglect set forth in the substantiated reports. The allegation of physical abuse was substantiated as a Category 1

act based on "intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur". SSL § 494[(4)(a)(i)] The penal law (PL) defines physical injury as an impairment of the physical condition or substantial pain. There is no requirement to show that the injuries sustained were serious. (PL §10[9]) Here, the Service Recipient suffered facial fractures and required stitches, which is sufficient to show physical injury pursuant to penal law § 10.09. (Justice Center Exhibit 11) Those injuries were caused by the Subject's reckless action in pushing the Service Recipient into his bedroom. Therefore the Justice Center has shown that the physical abuse alleged was properly categorized as a Category 1 act.

The allegation of neglect was substantiated as a Category 1 act based in pertinent part on "a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part". SSL § 494[(4)(a)(ii)] The Subject acted recklessly and, as a result, the Service Recipient was injured. However, the record does not contain evidence that those injuries created a substantial risk of death, or serious disfigurement, or a serious impairment of health. The record does reflect that the Service Recipient did not die, or lose a bodily organ. There was no evidence presented to show that the Service Recipient was permanently disfigured, or that his health was seriously impaired. A Pain Screening and Assessment Form indicated that the Service Recipient was in no pain 11 days after the incident. (Justice Center Exhibit 12) Therefore the Justice Center did not show that

the Subject's actions, along with the Service Recipient's injuries, meets the criteria for a Category 1 act.

However, the Social Services Law defines Category 2 as "substantiated conduct by custodians that is not otherwise described in Category one, but conduct in which the custodian seriously endangers the health, safety and welfare of a service recipient by committing an act of abuse or neglect." (SSL § 493[4][b]) Here, the Subject breached his duty to the Service Recipient by pushing him, despite knowing that the Service Recipient was unsteady on his feet. This action seriously endangered the Service Recipient because it resulted in the Service Recipient hitting his head on a wooden bedframe and knocking him unconscious. In addition, the Service Recipient suffered from facial fractures and required stitches. While the evidence does not reflect the severity of the injuries, it may be inferred from the evidence that being knocked unconscious by the Subject's recklessness seriously endangered the Service Recipient's welfare. Thus, the Subject's neglect should be properly categorized as a Category 2 act.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report of physical abuse is properly categorized as a Category 1 Act; and the substantiated report of neglect should be properly categorized as a Category 2 act.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed physical abuse and neglect.

The substantiated report of physical abuse is properly categorized as a Category 1 act.

The substantiated report of neglect should be properly categorized as a Category 2 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: June 21, 2016
Schenectady, New York