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]

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: Jennifer McGrath, Esq.

[redacted]
By: William P. Golderman, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

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 [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) and physical abuse.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: May 22, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
On: [redacted]

Parties: Vulnerable Persons' Central Register
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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) and physical abuse. 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 (deliberate inappropriate use of restraints) and physical abuse 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 abuse (deliberate inappropriate use of restraints) and/or physical abuse when you used excessive force and unapproved restraint techniques, including use of a headlock and one-person takedown on a service recipient, whose head hit the ground or the wall.
>
> These allegations have been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) and Category 2 physical abuse 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, [redacted], located at [redacted], is a psychiatric hospital that 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 [redacted], [redacted] Risk Manager)

5. At the time of the alleged abuse, the Subject was employed by the [redacted] as a Security Hospital Treatment Assistant (SHTA) and had been employed by the facility for eight years. (Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged abuse, the Service Recipient was an adult male, and had been a patient of the [redacted] for approximately three days. The Service Recipient was criminally charged with rape but was found incompetent to stand trial by criminal court, which referred him to the [redacted] to restore his competency. The Service Recipient was diagnosed with schizophrenia and schizoaffective disorder. The Service Recipient was placed in a hospital bedroom on the first floor (F1) of the forensic unit of the [redacted]. (Hearing testimony of [redacted], [redacted] Risk Manager)

7. At the time of the alleged abuse, the Service Recipient required constant supervision by two [redacted] SHTA staff while he was awake (2:1 supervision) and one [redacted] SHTA staff while he was sleeping (1:1 supervision). (Hearing testimony of [redacted], [redacted] Risk Manager)

8. On the overnight shift of [redacted] to [redacted], the Subject was assigned together with SHTA Staff A, to provide 2:1 supervision of the Service Recipient. (Hearing testimonies of [redacted], [redacted] Risk Manager and the Subject)

9. On [redacted], a short while before 11:56 p.m., the Subject was sitting in the doorway of the Service Recipient's hospital room performing 1:1 supervision of the Service

Recipient, who was sleeping. Because the Service Recipient was sleeping, and only 1:1 supervision was required, Staff A had gone to the second floor (F2) of the [redacted] forensic unit, to assist where they were short staffed. Before going to F2, Staff A instructed the F1 nursing station to contact him in the event that the Service Recipient awoke. (Justice Center Exhibits 14 and 23: audio recording of Justice Center interrogation of Staff A and Hearing testimony of the Subject)

10. Just before 11:56 p.m., the Service Recipient got out of bed and walked to the bathroom, which was located just outside his hospital bedroom door. When this happened, the Subject notified the nursing station to have Staff A return to F1, which Nurse A did. After he exited the bathroom, the Service Recipient walked to the nursing station, arriving at approximately 11:56 p.m. Nurse A and Nurse B were seated at the nursing station and Nurse C was in the charting room located directly behind the nursing station. (Justice Center Exhibits 12, 13, 15, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses A, B, C and the Subject; and Hearing testimony of the Subject)

11. At the nursing station, the Service Recipient asked Nurse A to get him a cup of ice water. Nurse A relayed the Service Recipient's request to Nurse C in the charting room. While this was happening, the Subject stood against the wall near the entrance to the nursing station and a few feet away from the Service Recipient, who was standing against the side of the nursing station nearest his bedroom hallway and opposite where Nurse A was seated. (Justice Center Exhibits 12, 13, 15, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses A, B, C and the Subject; and Hearing testimony of the Subject)

12. At approximately 11:57 p.m., Nurse C emerged from the charting room with a cup of cold water without ice and attempted to hand it across the nursing station desk to the Service Recipient. When the Service Recipient saw that the cup did not contain ice, he swatted the cup out of Nurse C's hand with his left hand causing the cup and water to go up in the air and then to

the floor near the end of the nursing station. The Subject immediately picked the cup off the floor and placed it on the nursing station desk. (Justice Center Exhibits 12, 13, 15, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses A, B, C and the Subject; and Hearing testimony of the Subject)

13. After placing the cup on the desk, the Subject told the Service Recipient: "OK, no more, there's a fountain down the hallway or you can return to your room." (Justice Center Exhibits 16 and 23: audio recording of Justice Center interrogation of the Subject; and Hearing testimony of the Subject) The Service Recipient then walked around the corner of the nursing station desk and approached the Subject in a fighting stance and threatened the Subject by saying "get ready" and "get tough." (Justice Center Exhibits 13, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses B, C and the Subject; and Hearing testimony of the Subject)

14. The Service Recipient moved to within arm's length of the Subject, flinched his arms a couple times feinting punches, and raised his left arm and hand in the direction of the Subject's face. In response, the Subject grabbed the Service Recipient's left wrist before it hit his face. The Service Recipient then pulled his arm out of the Subject's grasp and stepped to the Subject's left and into the entrance of the bedroom hallway, remaining within a few feet of the Subject. (Justice Center Exhibits 13, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses B, C and the Subject; and Hearing testimony of the Subject)

15. The Service Recipient then feinted a few more punches while leaning in toward the Subject. The Subject then took a step toward the Service Recipient moving his upper body toward the Service Recipient, and then put his right arm over the Service Recipient's left shoulder and around the Service Recipient. The Service Recipient then turned sideways to the Subject and raised his right arm moving the Subject behind him. The Subject then compensated by pulling the Service Recipient backwards toward the wall, which caused the Service Recipient to fall to the

floor. The Subject went to the floor and secured the Service Recipient on the floor. The Subject held the Service Recipient on the floor for approximately fourteen seconds, after which time Staff A arrived from F2 and helped secure the Service Recipient. (Justice Center Exhibits 13, 15, 16, 24 and 23: audio recording of Justice Center interrogation of Nurses A, B, C and the Subject; and Hearing testimony of the Subject)

16. The Subject and Staff A then lifted the Service Recipient off the floor and started moving him toward the seclusion room, which was located opposite the nursing station. While moving the Service Recipient, the Subject and Staff A were on either side of the Service Recipient, facing the same direction as the Service Recipient and each holding one of his arms. After moving the Service Recipient a few feet, the Service Recipient tripped the Subject who, in turn, fell to the floor. Because the Subject did not release the Service Recipient's arm when he fell, the Service Recipient fell to the floor as well. When the Service Recipient fell, he hit his head on the floor and sustained a laceration to his forehead above his left eye. The Subject then regained his footing and, together with Staff A, lifted the Service Recipient back to his feet, and moved him into the seclusion room where they placed the Service Recipient in a four point mechanical restraint. (Justice Center Exhibits 12, 13, 14, 15, 16, 19, 24 and 23: audio recording of Justice Center interrogation of Nurses A, B, C, Staff A, and the Subject; and Hearing testimony of the Subject)

17. The [redacted] utilizes Preventing and Managing Crisis Situations (PMCS) for staff physical interventions with service recipients. Although PMCS allows staff to block punches, to use one hand grasp releases, and to use one person standing wraps, it does not provide for or allow a one person take down. (Hearing testimonies of [redacted], [redacted] Safety and Security Officer and [redacted], [redacted] SHTA Supervisor and PMCS Instructor; and Justice Center Exhibit 17)

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 (deliberate inappropriate use of restraints) and physical abuse 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(1)(a) and (d), 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.
>
> (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 and/or neglect shall be categorized into categories pursuant to SSL § 493(4)(b), including Category (2), which is defined as follows:

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

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

If the Justice Center proves the alleged abuse, 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 cited in the substantiated report constitutes the category of abuse as set forth in the substantiated report.

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

DISCUSSION

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

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 through 20 and 25) The Justice

Center also presented audio recordings of the Justice Center Investigator's interrogations of the Subject and other targets, and a video only recording of the incident. (Justice Center Exhibits 23 and 24 respectively) The investigation underlying the substantiated report was conducted by [redacted], [redacted] Risk Manager, who testified at the hearing on behalf of the Justice Center. [redacted], [redacted] Safety and Security Officer also testified on behalf of the Justice Center.

The Subject testified in his own behalf and presented [redacted], [redacted] SHTA Supervisor and PMCS Instructor to testify on the Subject's behalf.

Abuse (deliberate inappropriate use of restraints)

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 excessive force and an unapproved restraint technique, including the use of a headlock and one-person takedown on the Service Recipient. The Justice Center further contends that the Subject's takedown of the Service Recipient resulted in the Service Recipient hitting his head on the floor and causing the Service Recipient to sustain a laceration to his forehead. The Justice Center clarified its allegation in the hearing to include only the actions of the Subject that happened before Staff A arrived on the scene.

The Justice Center's allegation did not include any part of the incident that occurred after Staff A arrived, including the Service Recipient's fall as Staff A and the Subject were escorting the Service Recipient to the seclusion room.

The Subject contends that, at the point in time when he believed that the Service Recipient's conduct threatened his safety and the safety of other staff, he attempted a standing wrap and that, because of the Service Recipient's reaction, his attempted standing wrap was unsuccessful and resulted in the Service Recipient falling to the floor.

The evidence in the record supports a finding that the Subject's conduct limited the Service Recipient's ability to freely move his arms, legs and body, and therefore, the Subject's conduct amounts to a restraint as defined by law.

The Justice Center's evidence concerning the physical intervention technique used by the Subject on the Service Recipient includes statements from first hand witnesses of the incident: Nurses A, B and C and the Subject, as well as a video only recording of the incident. Nurse A stated that the Subject "took him down." When asked if she could describe what she saw, Nurse A stated "Not really. It just happened really quick. I don't remember. Next thing I knew, he was on the floor." (Justice Center Exhibits 15 and 23: audio recording of Justice Center interrogation of Nurse A) Nurse B stated: "I couldn't see the takedown." (Justice Center Exhibits 12 and 23: audio recording of Justice Center interrogation of Nurse B) Nurse C stated that the Subject "grabbed a hold of [the Service Recipient] and tried to put him in a wrap." (Justice Center Exhibits 13 and 23: audio recording of Justice Center interrogation of Nurse C)

The Justice Center also presented a [redacted] Safety and Security Officer as a witness to testify as to the propriety of the physical intervention technique used by the Subject. The witness testified that PMCS does not allow a one person takedown, that the Subject's technique was not approved by PMCS, and that his testimony was based solely on his review of the video evidence contained

in Justice Center Exhibit 24. The witness also states that the Subject could have backed up and waited for more help to arrive. (Hearing testimony of [redacted], [redacted] Safety and Security Officer)

The Subject presented a [redacted] SHTA Supervisor and PMCS Instructor as a witness to testify as to the propriety of the physical intervention technique used by the Subject. The witness testified that, among his employment duties, he trains trainers of PMCS. Concerning the physical intervention, the witness testified that, from his review of the video, although it was not ideal, the Subject attempted a one person wrap which resulted in the Subject and the Service Recipient losing their balance and falling to the floor. ([redacted], [redacted] SHTA Supervisor and PMCS Instructor)

In sum, two of the eyewitnesses stated that they did not see the physical intervention and one eyewitness described the Subject's conduct as an attempted wrap. Upon their review of the video, the Justice Center's witness (the [redacted] Safety and Security Officer) concluded that the Subject used an unauthorized one person takedown and the Subject's witness ([redacted] SHTA Supervisor and PMCS Instructor) concluded that the Subject attempted a standing wrap that resulted in the Subject and Service Recipient losing their balance and falling to the floor.

A review of the video evidence does not resolve the conflicting evidence concerning the restraint technique, but does reveal that the Subject did not use a head lock on the Service Recipient. A review of the video also reveals that the Service Recipient was clearly moving toward the Subject in an aggressive manner and posture with the intent of physically engaging the Subject with punches or some other violent means. Finally, the video reveals that, despite the testimony of the [redacted] Safety and Security Officer, the Subject did not have any room to retreat without putting the nurses in peril of also being attacked by the Service Recipient.

Due to the conflicting testimony concerning the technique used by the Subject, and the

propriety of the Subject's physical intervention technique, the Subject cannot be found on that evidence to have used an unauthorized technique on the Service Recipient. However, the testimonies of the [redacted] SHTA Supervisor and PMCS Instructor and Nurse C, the only eyewitness who reported that she saw the intervention, support the Subject's contention, that he attempted a standing wrap.

Consequently, the Justice Center has not proven by a preponderance of the evidence that the Subject used a restraint technique that 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. Accordingly, the Justice Center has not proven by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints).

Physical Abuse

In order to prove physical abuse, the Justice Center must establish that the Subject intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment. (SSL §488(1)(a)) The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York State Penal Law. (SSL §488(16)) New York State Penal Law states that "A person acts intentionally with respect to a result or to conduct ... when his conscious objective is to cause such result or to engage in such conduct." (PL §15.05(1))

The record is clear and there is no dispute that the Subject made physical contact with the Service Recipient and that the Subject's physical contact was intentional. Although the Justice Center argues that the Service Recipient's injury to his forehead resulted from the Subject's initial physical contact with him, there is little evidence in the record to support this contention. The

preponderance of the evidence in the record supports the conclusion that the Service Recipient's injury happened as a result of the fall he took after tripping the Subject. Nonetheless, the Justice Center must only prove the likelihood of injury resulting from the Subject's conduct. It is clear from the video and other evidence that the Service Recipient went to the floor forcefully when the Subject engaged him physically. Consequently, it is concluded that the Subject's conduct caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

However, the statute provides that physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person. The credible evidence in the record makes it clear that there was an emergency situation (the Service Recipient was aggressively attacking the Subject and the nursing staff were in close proximity of the attack) in which physical intervention by the Subject was reasonably necessary to protect himself, the nurses and the Service Recipient from physical harm.

Consequently, the Justice Center has not proved by a preponderance of the evidence that the Subject committed physical abuse.

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) and physical abuse 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) and physical abuse.

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

DATED: May 5, 2017
Schenectady, New York