

**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
AFTER
HEARING**

Adjudication Case #:

[REDACTED]

Justice Center for the Protection of People with
Special Needs

By: Julie O'Brien, Esq.
161 Delaware Avenue
Delmar, New York 12054-1310

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

By: Aaron Kaplan, Esq.
CSEA, Inc.
143 Washington Ave.
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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 [REDACTED] that the substantiated report, [REDACTED], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse or neglect. Therefore the Subject's request to amend and seal is denied.

The substantiated report is properly categorized as a level two category.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Person's Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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: August 25, 2014
Schenectady, New York

David Molik,
Director

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**

Adjudication Case #:

[REDACTED]

Before: Diane Herrmann
Administrative Law Judge

Held at: NYS Justice Center
Administrative Hearings Unit
401 State St.
Schenectady, NY 12305
On: [REDACTED]

Parties: Justice Center for the Protection of People with
Special Needs
By: Julie O'Brien, Esq.
161 Delaware Avenue
Delmar, New York 12054-1310

[REDACTED]
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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 Justice Center, Administrative Appeals Unit (AAU) amend the report to reflect that the Subject is not a subject of the substantiated report. The AAU 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, [REDACTED], of abuse by [REDACTED] (Subject) against a service recipient. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).
2. The initial report alleges, in pertinent part, that: On [REDACTED], the Subject abused a service recipient when he initiated a solo restraint using an inappropriate restraint technique known as a full nelson.
3. The Justice Center substantiated the actions as a Category 2 offense pursuant to Social Service Law
4. An Administrative Review was conducted and as a result the substantiated report was retained.
5. At the time of the alleged abuse, the Subject was employed as a YDA [REDACTED] at [REDACTED], Office of Children and Family Services, which is an Agency or Provider that is subject to the jurisdiction of the Justice Center.

6. Service recipient, [REDACTED] (hereinafter SR) was a resident at [REDACTED] and assigned to Unit [REDACTED].

7. Unit [REDACTED] was a discrete unit that housed a small number of residents who had been assigned to the unit due to fighting or gang affiliation.

8. The Subject was working the 2:30pm-10:30pm shift and was assigned to the Safety and Security Unit (SSU). The SSU responds to problems throughout the facility and assists when units are moving within the facility.

9. On the evening of [REDACTED] two residents began fighting at the end of a hallway on Unit [REDACTED].

10. Two staff members were attempting to break up the fight when the SSU staff responded.

11. Staff ordered all service recipients to return to their rooms.

12. Subject [REDACTED] spoke to SR and tried several times to convince him to return to his room. SR refused to go to his room and stated that he wanted to make sure his peer was OK.

13. Staff member [REDACTED] brought one of the two individuals who were fighting to his room. The other resident who was involved in the fight was restrained on the ground. There were no other residents in the hallway.

14. In addition to the Subject, four other staff members were standing by the SR.

15. The Subject initiated a standing escort of the SR. A standing escort involves a staff member standing behind the service recipient and wrapping the service recipient's hands behind his back.

16. Almost immediately, the SR resisted and kicked the wall and dropped to the floor

17. Subject [REDACTED] lifted the SR up and as a result the Subject's hands moved to the

SR's neck area into what is commonly referred to as a full nelson. The Subject continued to escort the SR down the hallway in this position.

18. In addition to Subject [REDACTED] four other staff members were in the hallway. One other staff member was alongside SR and briefly touched his arm.

19. SR was brought to his room and later complained that he could not move his neck. SR was brought to the facilities' nurse and then transported to the hospital.

20. At the hospital x-rays were taken and the ER physician indicated that the SR suffered a strained neck.

21. SR stated that he had a history of neck and shoulder problems and was hurt because he was moving too much when he was escorted to his room.

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 or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL § 492(3) (c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "... if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

- 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
 - (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.
 - (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.
 - (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, 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 causing the likelihood of such diminution. Such conduct

may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

- (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.
- (e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.
- (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
- (g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a

controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

- (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.

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

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:
 - (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;
- (iii) threats, taunts or ridicule that is likely to result in 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;
- (iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in 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;
- (v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
- (vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
- (vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
- (viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
- (ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

- (x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
 - (xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
 - (xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
 - (xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
 - (xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.
- (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.
 - (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.
 - (d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

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 level of abuse set forth in the substantiated report. The Justice Center will inform any inquiring licensing or provider agency that the Subject is substantiated in the report. If applicable, its existence is subject to disclosure to licensing and provider agencies making inquiry concerning the Subject pursuant to SSL §§ 495(2) and 424-a.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed. Its existence will not be disclosed to licensing and provider agencies.

DISCUSSION

The Justice Center has established by a fair preponderance of evidence that the Subject committed the abuse in the substantiated report and it was properly categorized as a category two level of abuse.

The Justice Center presented one witness and admitted into evidence the statements of six staff members that were present during the restraint and a video of the incident. The Subject testified on his own behalf, admitted into evidence statements from three witnesses, including the SR and called three witnesses.

The witness for the Justice Center was the case investigator, [REDACTED]. [REDACTED] summarized her investigation and introduced the video of the incident. [REDACTED] testified that when the Subject initiated the restraint, one staff member loosely held on to the SR's arm and four staff members followed them down the hall. Investigator [REDACTED] testified that according to her investigation, a review of the OCFS manual, a restraint was permissible. [REDACTED] testified that the type of restraint/escort was not permissible and violated the OCFS handbook.

The Subject testified in his own defense. The Subject testified that the SR was an individual who called the shots and controlled other residents. The Subject stated that the SR told him he was in a gang and one of the residents involved in the fight was a fellow gang member. The Subject testified that the SR was an opportunistic individual that could be violent. The Subject said that he was ordered to get the SR into his room and that is why he initiated the escort. The Subject was thrashing about and dropped to the floor and that is why the escort resulted in an inappropriate escort/restraint.

The Subject testified that he did not know why his fellow staff members did not assist. The Subject testified that he could not let go of the SR because he was afraid someone would get hurt. The Subject stated his only goal was to get the SR to his room at the end of the hallway.

The first witness the Subject called was employee [REDACTED]. [REDACTED] was assigned to the SSU and responded to the fight. [REDACTED] testified that the Duty Office (DO) ordered the staff to clear the floor. [REDACTED] testified that at first it appeared that the SR would cooperate but when he dropped to the floor the restraint went bad. [REDACTED] testified that it was too dangerous to let the SR go and adjust the restraint because the SR was a violent individual and there was a chance staff could get hurt.

The next witness was [REDACTED], also assigned to the SSU that night. [REDACTED] testified that it was not a textbook restraint but it was necessary because the SR wanted to get involved in the fight. If the Subject had released the SR staff would have gotten hurt.

The last witness was the DO, [REDACTED]. [REDACTED] testified that when she arrived on the unit her priority was to assist the staff involved in the restraint of the two residents who were fighting. [REDACTED] testified that one of the residents had a telephone cord wrapped

around a staff member's neck. ██████ testified that she ordered staff to clear the floor and get the residents to their rooms. ██████ said that she did not witness the restraint and escort but that restraints sometimes go bad and do not go according to the text book.

All of the witnesses testified that the restraint/escort was justified and started out with the correct technique. All parties agreed that because the SR was resisting, the restraint went bad. The Subject's witnesses all testified that the Subject was left with no choice but to continue the inappropriate restraint so that the Subject was brought to his room.

The Subject's attorney argues that the restraint was not deliberate so there can be no wrong doing. This is not correct, the Subject chose to do a solo escort when multiple staff members were standing in the hall. The result was not deliberate but the escort/restraint was. The OCFS manual indicates that solo escorts/restraints are not to be performed unless the staff member has no alternatives. The Subject had a choice; he could have asked staff members for assistance. When the restraint went bad the Subject could have released the SR and attempted to convince him to cooperate or start the restraint again utilizing staff members. The Subject was never in an emergency situation and he is responsible for what occurred.

At the time the SR was restrained the fight between the residents was over. The Subject's witness, ██████, testified that he brought one of two residents that were fighting to their rooms as soon as he responded to the unit. The video clearly shows ██████ bringing the resident to his room and closing the door before the SR was restrained. In fact the hallway was cleared of residents when the SR was brought down the hall. There were five staff members surrounding the SR. Once the restraint went bad the risk of injury to the SR was very high. The actions the Subject took were against OCFS policy and it was not an emergency situation that justified a solo restraint/escort. The Subject had fellow staff members within arm's

length. Five staff members were present and they all appear to be twice the size of the SR, this was not an emergency situation that necessitated a solo escort/restraint.

Accordingly, it is determined that the Agency has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse alleged. The SR was injured and was brought to the hospital. A review of the records indicated that the SR had a strained neck.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes a category two level of abuse.

The legal issue to be addressed is whether [REDACTED] conduct in initiating a solo restraint using an inappropriate restraint technique known as a full nelson, seriously endangered the health, safety or welfare of SR. The fact that the SR was injured, brought to a hospital and suffered a strained neck is evidence of the fact that SR suffered a serious endangerment of his health, safety or welfare.

The substantiated report is properly categorized as a level two category finding. The JC met its burden to show that it was a Category Two level. The substantiated report will not be sealed.

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

The substantiated report is properly categorized, as a level two category.

This decision is recommended by Diane Herrmann, Administrative Hearings Unit.

DATED: August 25, 2014
Schenectady; New York

Diane Herrmann, ALJ