

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

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In the Matter of the Appeal of

██████████<sup>1</sup>

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER  
HEARING**

**Adjud. Case #:**

██████████

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

Parties:

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

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████████████████

By: Simon Moody, Esq.  
11 Court St  
Auburn, NY 13021

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<sup>1</sup> The Subject's first name appears to be incorrectly spelled "██████" in the records maintained by the Justice Center.

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] [REDACTED] dated [REDACTED] be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed deliberate inappropriate use of restraints.

The substantiated report properly categorized as a level three 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:** Schenectady, New York  
November 18, 2014



David Molik  
Administrative Hearings Unit

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

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In the Matter of the Appeal of

██████████<sup>2</sup>

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

██████████

Before:

Gerard D. Serlin  
Administrative Law Judge

Held at:

New York State Office Building  
333 East Washington Street  
Room 115  
Syracuse, New York 13202  
On: ██████████

Parties:

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

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By: Simon Moody, Esq.  
11 Court St  
Auburn, NY 13021

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<sup>2</sup> The Subject's first name appears to be incorrectly spelled "██████" in the records maintained by the Justice Center.

### JURISDICTION

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

### FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report [REDACTED] dated [REDACTED] of abuse and/or neglect by the Subject of [REDACTED]
2. The initial report alleges, in pertinent part, that: "... [o]n [REDACTED] ... [the subject] committed an act of physical abuse when [he] punched a service recipient in the stomach during a restraint."<sup>3</sup>
3. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).
4. On or about [REDACTED], the Justice Center substantiated the report for abuse under the theory that the Subject engaged in the *deliberate inappropriate use of restraints*.

The Justice Center concluded that:

...[O]n [REDACTED], at the [REDACTED], located at [REDACTED] [REDACTED], while acting as a custodian (Youth Counselor 1), you committed acts of abuse (deliberate inappropriate use of restraints) when you violated policy during your interactions with the subsequent restraint of a service recipient. You violated approved agency policy to exhaust all "pro-active, non-physical behavioral management techniques" when you used physical force to restrain a service recipient even though the service recipient's behavior was not

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<sup>3</sup> This allegation was unsubstantiated after investigation.

placing anyone at risk of harm. You also violated approved agency policy to use the intervention in a service recipient's Individual Interventions Plan when you used an unlisted intervention on a service recipient. (Justice Center Exhibit 1)

This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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

6. At the time of the alleged abuse, the Subject was employed by the New York State Office of Children and Family Services (NYS OCFS), at the [REDACTED]. The service recipient, [REDACTED] was a minor who was a resident at the [REDACTED]. The [REDACTED] is a limited secure residential facility which houses male youths. The Subject worked as a Youth Counselor 1 and was employed by a *facility or provider* that is subject to the jurisdiction of the Justice Center.

7. On the morning of [REDACTED] at approximately 06:35 a.m., [REDACTED] chose not to leave his assigned residential unit to eat breakfast with other members of his unit in the cafeteria. [REDACTED] became disgruntled sometime later that morning, after he was not provided with a second opportunity to eat breakfast. (Hearing record-throughout) [REDACTED] was not allowed to eat breakfast with members of another unit because of facility protocol which prohibited the intermingling of unit residents. The policy was implemented to avoid the possibility of fighting in the cafeteria between rival or enemy residents. (Hearing testimony of the Subject) [REDACTED] then demanded that breakfast be brought to him on the residential unit and that request was denied.

8. The Subject was the Administrator-On-Duty, (AOD) and, as such, was the highest ranking staff member on duty at the facility at the relevant time. The facility director or assistant facility director was scheduled to report to work at 0900 on the date at issue. (Hearing testimony

of Subject) Protocol at this facility dictated that when an issue with a resident, which could result in a restraint or physical intervention arose, staff was required to notify the AOD, and the AOD was expected to respond to the unit. (Hearing testimony of the Subject) The Subject responded to the unit after being alerted by staff that ██████ had become agitated.

9. The Subject arrived at the unit and talked with ██████ in an attempt to de-escalate ██████. De-escalation was somewhat successful but the Subject decided that ██████ should leave the unit because ██████ made threats to assault staff at some point during the incident. The Subject was concerned that ██████ would incite other residents who were in transit, returning from the cafeteria, after eating their breakfast. (Hearing testimony of the Subject)

10. ██████ had a history of fighting with others and causing physical injury. ██████ Individual Intervention Plan (IIP) indicates that ██████ has a “[high Incident] of fights resulting in injury to others [;] [high incident] of bullying and intimidation in school ... The resident reports blackening out when mad and not realizing what he [is] doing ...” (Justice Center Exhibit 12)

11. After some negotiation with the Subject and ██████ staff, ██████ agreed to walk on his own accord to the medical wing of the building. As he walked to the medical wing, ██████ was supervised by the Subject and one other facility staff member.<sup>4</sup> The Subject chose the medical isolation room and the medical wing, because it ensured that no other residents would be present. Therefore, ██████ would not have an “audience” and he would presumably calm down sooner. (Hearing testimony of the Subject)

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<sup>4</sup> The Justice Center investigator testified at the hearing that he concluded based upon his investigation that ██████ voluntary walked from the unit, to the medical wing.

12. At some point after arriving on the medical wing ██████ became angry, tensed up and resisted moving into a specific medical isolation room. ██████ may have verbally threatened to punch staff, if they were to “touch him” (Justice Center Exhibit 22) and may have made physical threats. (Hearing testimony of the Subject)

13. The Subject then called a “code yellow”, which is essentially a call for more staff to respond because of a pending physical intervention. (Hearing testimony of the Subject & Justice Center Exhibit 22: recorded interview with ██████) All of the staff members whom responded and staff member ██████ in particular, attempted to persuade ██████ to go into the isolation room, but he resisted. (Hearing testimony of the Subject & Justice Center Exhibit 22: recorded interview with ██████) A total of 6 staff members including the Subject were in the medical wing with ██████. (Justice Center Exhibit 23: video surveillance footage V1 CS 44) ██████ positioned himself into a corner to prevent staff from being able to easily escort him into the isolation room.<sup>5</sup> While standing in the corner, ██████ blocked access to a room which was used for patient care. (Hearing testimony of Justice Center investigator)

14. The Subject directed two of the staff to initiate a standing escort to move ██████ to the isolation room. (Justice Center Exhibit 23: video surveillance footage-V1 CS 44) The movement of ██████ from the point where physical contact was initiated to the point where he was forced into the medical isolation room was well controlled. (See Justice Center Exhibit 23: video surveillance footage CS 42 V3). The mechanics of the standing escort of ██████ from the point of first physical contact until the point where he was forced into the isolation room were executed in a manner consistent with OCFS physical intervention training.

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<sup>5</sup> Although surveillance video of activity which occurred on the units and in the hallways, generally exist at the ██████, the Justice Center investigator was not provided with any surveillance video of events which occurred on the unit or during the walk to the medical wing. The video surveillance evidence in the record begins chronologically when ██████ has “dug himself” into a corner in the medical wing.

(Hearing testimony of the Justice Center investigator) After being moved into the isolation room, ██████ attempted to exit and a “restraint” was executed on ██████ within the medical isolation room. The isolation room door did not close. (Justice Center Exhibit 23: video surveillance footage CS 43 V4)

### **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.

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

## DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed the abuse or neglect alleged in the substantiated report. The category level of abuse or neglect that such act or acts constitute is Level 3.

In support of its substantiated findings, the Justice Center presented the Justice Center report, narrative summary conclusion, case notes, recorded interviews, video evidence and documents gathered during the course of investigation. (Justice Center Exhibit 1-23). The Justice Center investigator testified on behalf of the agency and was credible in all aspects of his testimony. The Appellant testified on his own behalf as well.

## ANALYSIS

Individual Intervention Plan (IIP) specifies in pertinent part that:<sup>6</sup>

Crisis Prevention & Management Plan (in response to indications of crisis, staff will):

Strategy 1. Provide youth with personal space when upset (at least arm's length)

Strategy 2. Offer to speak with the youth about his concerns (time to vent); not to exceed 15 minutes.

Strategy 3. If staff available allow youth 10 minutes to use boxing bag.

NYS OCFS Crisis Prevention and Management (PPM 3247.12): Effective date: (Justice Center Exhibit 7) delineates three situations where physical force may be used. The first two justifications pertain to AWOL situations, which was not an issue here. The third policy

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<sup>6</sup> Effective . See Justice Center Exhibit 12.

justification for the use of a physical intervention arises “where an emergency physical intervention is necessary to protect the safety of any person.” (Justice Center Exhibit 7. P 8)

Hearing evidence regarding events which occurred on [REDACTED] unit consisted almost exclusively of documentation generated by [REDACTED] staff and interviews provided by [REDACTED] staff. The only non-staff generated documentation was the Justice Center investigator’s interview with [REDACTED]. During this interview, [REDACTED] told the investigator that he “was mad” and that staff directed him from the unit to the medical isolation room. (Justice Center Exhibit 4) There was no video made available to the investigator of the walk from the unit to the medical wing. There was no video provided of [REDACTED] interaction with staff on the unit. (Hearing testimony of Justice Center investigator)

In his written statement, [REDACTED] provided few details about the events on the unit and he provided no details regarding staff interaction with him on the unit. When interviewed by the Justice Center, [REDACTED] verbally provided detailed allegations, primarily pertaining to his treatment while on the medical wing, and in the isolation room, but no details about events which had transpired on the unit. (Justice Center Exhibit 22: recorded interview with [REDACTED])

Staff member [REDACTED] wrote in his incident report that while on the unit [REDACTED] asked where his breakfast was and [REDACTED] told him that food could not be delivered to the unit. [REDACTED] then said “I should punch you in the face right now.” [REDACTED] then told [REDACTED] to go to his room and shut the door because it was time for hygiene; [REDACTED] replied “fuck you.” (Justice Center Exhibit 18)

Staff [REDACTED] told the Justice Center investigator that [REDACTED] was upset because he wasn’t provided a second opportunity for breakfast after he initially refused to eat breakfast with his unit. [REDACTED] described [REDACTED] as threatening staff on the unit and having clenched fists

while making threats to punch staff. Staff convinced ██████ to voluntarily walk from his unit to the medical wing.<sup>7</sup> (Justice Center Exhibit 22: recorded interview with ██████)

During the course of the investigation, no witnesses, involved persons, or ██████ alleged that ██████ was “physically escorted” from his housing unit to the area where the physical intervention occurred in the medical wing. The undisputed evidence in the record established that ██████ voluntarily walked from the unit to the medical wing.

The evidence in the record established that the first time that staff members physically intervened with ██████ was in a hallway in the medical wing. (Hearing testimony of Justice Center investigator) The video cameras in the ██████ do not record audio. Ultimately, through physical contact, ██████ staff moved ██████ in to “Medical Room 1”, located within the medical wing. (Justice Center Exhibit 22: recorded interview with ██████) “Medical Room 1” room was typically used for the medical treatment of residents. (Hearing testimony of Justice Center investigator) ██████ acknowledged in an interview that, after reaching the medical wing, he refused to proceed to the medical isolation room. ██████ stated that staff then “pushed” him into the room. ██████ further stated that when he resisted staff’s attempts to place him on the floor, the Subject hit him two times in the stomach with a closed fist.<sup>8</sup> (Justice Center Exhibit 4)

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<sup>7</sup> The record is sparse as to whether ██████ was aware that his intended destination was “medical room 1”, also known as medical isolation. Medical isolation was used when a resident was threatening others. If the resident voluntarily walked to medical isolation, then the resident would not be locked in to the room. However, if the resident did not walk voluntarily to the “medical isolation room”, the resident would be locked in to the room. (Justice Center Exhibit 22: recorded interview with ██████)

<sup>8</sup> The Justice Center did not substantiate this report based upon the conclusion that the Subject punched ██████. The investigator testified at the hearing that the physical intervention that occurred in the medical wing, while not authorized by OCFS policy, was executed in a manner consistent with OCFS trained physical intervention techniques. This physical interaction was clearly captured by the video (Justice Center Exhibit 23)

Staff ██████ told the Justice Center investigator that he and other staff attempted for 5 to 10 minutes to convince ██████ to lock into “Medical Room 1.”<sup>9</sup> While speaking with ██████ staff alluded to the possibility that ██████ could receive a meal<sup>10</sup>, as an enticement to persuade ██████ to go into the medical isolation room. ██████ continued to refuse to “lock-in” and threatened to punch staff in the face. The Subject then gave the directive to initiate the physical interaction.<sup>11</sup>

The video captures the physical contact outside of a room in the medical wing. ██████ can be seen on the video standing with his back to an open door at the end of a hallway. Nearby is a reception desk of some type. ██████ appears in the video to be standing straight up with his feet together, or nearly together. A complete view of his hands was not captured, however there is no indication that ██████ hands were raised from his side. After some time, two staff members initiated a standing escort to move ██████ to the isolation room. (Justice Center Exhibit 23: video surveillance footage-V1 CS 44) A female staff member, presumably a medical provider walked about, behind the reception desk. Another staff member, who also appears to be stationed in the medical wing, was seated at a small desk across from reception desk. These two staff members appeared from the video to be uninterested in the situation with ██████ and the six ██████ staff members (Justice Center Exhibit 23: video surveillance footage- V2CS 39)

The movement of ██████ into the isolation room was captured by video. The mechanics of the escort appear well controlled. (See Justice Center Exhibit 23: video surveillance footage CS 42 V3). There is also video evidence of events which occurred in the isolation room. However, the camera perspective failed to capture much of what transpired in

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<sup>9</sup> This is presumed to be the medical isolation room.

<sup>10</sup> Facility rules dictated that youth in isolation are guaranteed a meal.

<sup>11</sup> Staff ██████ also told the Justice Center investigator that when aYDA believes that a resident presents “any unsafe situation- then we are able to put them in a restraint.”

the isolation room, but it is clear that a “restraint” did occur in the isolation room. The isolation room door did not close. (Justice Center Exhibit 23: video surveillance footage CS 43 V4)

The Subject testified and argued that [REDACTED] was starting to “get more aggressive” with staff in the hall of the medical wing and that [REDACTED] fists were clenched as he resisted voluntarily going into medical isolation. On cross-examination the Subject acknowledged that he did not, during the recorded interview with the Justice Center investigator, state that [REDACTED] fists were clenched. Additionally, the Subject failed to note this fact in the “Incident Report” which he completed. (Justice Center Exhibit 19) Likewise, the Subject failed to note that [REDACTED] fists were clenched in the “Staff Debriefing Report” which he authored. (Justice Center Exhibit 14) The Subject’s hearing testimony is not credited evidence on this point.

At the hearing, the Subject argued that when [REDACTED] stood his ground in the hallway of the medical wing that [REDACTED] effectively shut down the use of the medical wing. However, the Subject also admitted that he chose the medical wing because there was little likelihood of residents being in the medical unit and the Subject further admitted on cross-examination that no other residents were in the medical wing at the time of the physical intervention. There was likewise no proof in the record that a medical emergency was unfolding which required that the medical wing be “cleared” of [REDACTED]

The involved staff members appear to have largely followed steps 1 and 2 of [REDACTED] IIP. There is convincing evidence that the Subject and [REDACTED] staff employed techniques such as *direct appeal*, *hurdle help*, *ventilation*, *validation* and *time away* - throughout this incident. Indeed the relevant OCFS policy governing physical intervention dictates that staff must exhaust all “pro-active, non-physical behavioral management techniques.” (See generally NY OCFS Crisis Prevention and Management (PPM 3247.12) Effective date: [REDACTED] (Justice

Center Exhibit 7). The Subject argues that these techniques were tried and exhausted and that [REDACTED] was increasingly escalating in the hallway, displaying threatening body language and making verbal threats to harm staff.

Staff member [REDACTED] and the Subject stated that at one time or another during the incident, [REDACTED] threatened staff. The record is unclear as to whether [REDACTED] made these threats only while on the unit, before he voluntarily walked to medical wing, or whether he also made the threats to staff once he arrived on the medical wing. [REDACTED] stated during an interview with the Justice Center investigator that he told staff that “if you touch me, I am going the start swinging.” (Justice Center Exhibit 22). Unfortunately the record is unclear as to where [REDACTED] was physically located, when he made this threat.

There is compelling evidence in the record that [REDACTED] was capable of intense fits of anger. For example, [REDACTED] IIP indicates that [REDACTED] has a “[high Incident] of fights resulting in injury to others [and a high incident] of bullying and intimidation in school ... The resident reports blackening out when mad and not realizing what he is doing ...” (Justice Center Exhibit 12)

Irrespective of this factor, the Justice Center argued that mere “verbal threats” to harm staff can never rise to the level of requiring “[an] emergency physical intervention [which] is necessary to protect the safety of any person.” (Justice Center Exhibit 7. P 8) Stated another way, a mere threat to harm without an actual attempt to harm, does not justify a physical intervention under the relevant NY OCFS policy.

The Subject argued that, in essence, a “totality of the circumstances analysis” must be performed on a case-by-case basis. The Subject argued that there can be no blanket rule or presumption that threats to harm, without action, will never justify a physical intervention under

the OCFS policy. This policy was issued by the Commissioner of the New York State Office of Children and Family Services. No representative of the Commissioner was present at hearing to assist in the interpretation of the policy and OCFS is not a party to this hearing.

It is clear from a review of the video that in the nine seconds preceding the first physical contact between staff and ██████████, ██████████ was not displaying the body language of someone intent on attacking and was not attempting physical contact with staff. (Justice Center Exhibit 23)<sup>12</sup> ██████████ may have been “dug in” but in the nine seconds before the physical intervention, he did not make any gestures suggestive of attack. There was no emergency which necessitated access to the examination room which ██████████ blocked while he “dug in.” There were no other residents in the medical wing who might have been “incited” to act out based on ██████████ behavior.

When the Subject authorized the escort, physical contact with ██████████ was not “necessary to protect the safety of any person.” The relevant OCFS policy on physical interventions has been in effect since February 27, 2012. The previous policy (see Use of Physical Restraint PPM 3247.13: effective February 27, 2007)<sup>13</sup>, allowed for the use of a “physical escort” when the “youth’s behavior [was] escalating to the point that further de-escalation techniques need[ed] to take place in another location.” The current and applicable restraint policy specifically superseded and eliminated the afore-cited policy and justification for an escort. While it is assumed that all staff were trained in the 2012 policy, it is clear that some re-training on the 2012 policy may be in order; see foot note 8 herein.

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<sup>12</sup> For reasons which were not clarified in the record, the relevant video perspective begins nine second before the first physical contact with ██████████. However, evidence in the record suggests that ██████████ had been “dug in” for a significantly longer period of time than nine seconds.

<sup>13</sup> This policy was superseded by the current OCFS policy regarding physical restraints.

The Subject also argued that the restraint was reviewed and approved by the [REDACTED] facility director. (Justice Center Exhibit 13) The Subject was the acting AOD and “authorized” the restraint. The Subject implied that the facility director or his or her designee, including presumably the assistant director or AOD may authorize a restraint or escort to physically relocate a resident who has “dug-in” at some location within the facility. From a plain reading of NY OCFS Crisis Prevention and Management (PPM 3247.12): Effective date: 02/06/12<sup>14</sup>, it is clear that the NY OCFS Commissioner has not authorized the facility director or his or her designee to initiate a physical intervention in the absence of AWOL behavior or a showing that the restraint is “necessary to protect the safety of any person”.

The Justice Center argued that placing [REDACTED] in the isolation room was contrary to [REDACTED] IIP and the OCFS policy concerning “Room Confinement-PPM 3247.15.” (Justice Center Exhibit 5) The relevant OCFS “Room Confinement” policy states in pertinent part that room confinement is an “interim measure designed to control dangerous behavior [and] [a]s required by NYCRR Section 168.2, room confinement shall not be used as punishment. It shall be used only when a resident constitutes a serious and evident danger to him/herself or others ...” (Justice Center Exhibit 5)

The standard required for “Room Confinement”, to wit, that the resident “constitutes [a] serious and evident danger to him/herself or others,” is functionally equivalent to the standard required for a physical intervention, which is that the physical intervention is “necessary to protect the safety of any person.” In as much as the behavior of [REDACTED] in the medical wing did not warrant a physical intervention, his behavior likewise did not meet the threshold for “Room Confinement.” Further, forced room isolation is clearly not a vehicle for providing

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<sup>14</sup> Justice Center Exhibit 7

██████████ “... with personal space when upset ...” as was contemplated in his IIP. The room isolation was clearly contrary to the IIP under the facts of this case.

The Agency proved by a preponderance of the evidence that the Subject engaged in the *deliberate inappropriate use of restraints* by authorizing ██████████ staff to physically escort-restrain ██████████ when this escort was not justified under the relevant OCFS policy. Additionally, the Agency further proved by a preponderance of the evidence that the Subject caused ██████████ to be isolated in an isolation room at ██████████ when ██████████ behavior did not meet the threshold for isolation under the relevant NYS OCFS “Room Isolation” policy. The Subject’s violation of the statute should properly be categorized as neglect. Accordingly, it is determined that the Agency has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of inappropriate restraint set forth in the substantiated report.

The Subject violated OCFS policy concerning the use of restraints and room isolation. The physical interactions as executed were mechanically consistent with OCFS restraint training. There was convincing evidence in the record that the Subject, either as result of poor training or because of poor enforcement of the policy by OCFS, believed that a facility supervisor or his or her designee could authorize a physical restraint, even in the absence of factors giving rise to a restraint justification as set forth under NY OCFS Crisis Prevention and Management (PPM 3247.12) Effective date: 02/06/12. (Justice Center Exhibit 7) The existence of the afore-cited

██████████ factors reinforces the conclusion that this report is properly categorized as a level 3 category and constitutes neglect.

A substantiated Category 3 finding of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

**DECISION:**

The request of ██████████ that the substantiated report ██████████  
██████████ dated ██████████ be amended and sealed is denied.  
The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, or should be categorized as a level 3 category.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Bureau.

**DATED:** November 3, 2014  
Schenectady, New York

  
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Gerard D. Serlin, ALJ