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

[redacted]
By: Stewart Karlin, Esq.
9 Murray Street, Suite 4W
New York, NY 10007

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 granted.

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: Schenectady, New York
May 30, 2014

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 Office of Children and Family Services
Bureau of Special Hearings
163 West 125th Street, 14th Floor
New York, NY 10027
On: March 26, 2014

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

[redacted]
By: Stewart Karlin, Esq.
9 Murray Street, Suite 4W
New York, NY 10007

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (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 the service recipient, [redacted] 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 [redacted] when he punched him in the lower torso with a closed fist.

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 by [redacted] Hospital which is an Agency or Provider that is subject to the jurisdiction of the Justice Center.

6. [redacted] was a patient and was hospitalized due to psychiatric problems

including behavioral issues and acute aggression.

7. On the morning of [redacted] began exhibiting aggressive behaviors and he was given two PRN medications.

8. [redacted] threw items, spat on and hit staff members. [redacted] was placed in a restraint on the floor by four staff members. A nurse staff administered an IM, PRN medication.

9. Four staff members lifted [redacted] on to a stretcher. Between seven and nine staff members attempted to secure the sheet restraint on the stretcher.

10. The Subject was near [redacted] upper body and the Subject leaned over the [redacted] body when he was attempting to tighten the sheet restraint. The Subject was punched in the groin by [redacted].

11. The Justice Center took statements from the nine staff members present during the restraint, and one staff member reported that the subject punched [redacted] in the groin area after he was hit. Another staff member indicated that she saw the Subject raise his arm after being hit but did not see any contact.

12. The Subject described how the sheet restraint is supposed to work and described how the restraints are tightened around a service recipient. The Subject testified that [redacted] grabbed ahold of his shirt and told [redacted] that was ok. The Subject then leaned over [redacted] to help tighten his other arm in the restraints and the Subject was punched in the groin by the [redacted] The Subject testified that he lowered his hands as a reflex and any contact he made with [redacted] was inadvertent.

13. [redacted] underwent a medical exam after the incident. [redacted] did not complain of pain in his groin area and did not mention to the medical staff that he was hit in the

groin.

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 not established by a preponderance of evidence that the Subject committed the abuse in the substantiated report.

The Justice Center presented one witness and introduced into evidence the statements of eight staff members, including the Subject, that were present during the restraint, and a video of the incident. The Appellant testified on his own behalf.

The witness for the Justice Center was the [redacted] investigator, [redacted] summarized her investigation and introduced the video of the incident. Of the seven staff members [redacted] interviewed, only one witness indicated that she saw the Subject hit [redacted] One other staff member indicated she saw the Subject raise his arm up after being hit in the groin but did not witness the Subject make contact with [redacted] The other staff members indicated that they did not see the Subject hit [redacted]

The Justice Center presented the video as evidence. The video clearly shows that [redacted] was struggling both on the floor and when he was placed on the stretcher. Between seven and nine staff members surrounded the stretcher and attempted to place [redacted] in the sheet restraint. The video shows the Subject getting hit and the Subject moving his hands downward. The video does not clearly show the Subject hitting [redacted]

The Subject testified credibly in his own defense. The Subject described how the sheet restraint is supposed to work and described how the restraints are tightened around a service recipient. The Subject testified that [redacted] grabbed ahold of his shirt and he told [redacted] that was ok. The Subject then leaned over [redacted] to help tighten the [redacted] other arm in the restraints and the Subject was punched in the groin by [redacted] The Subject testified that he lowered his hands as a reflex and any contact he made with [redacted] was

inadvertent.

The Justice Center admitted into evidence statements from nine staff members and only one states that the Subject hit [redacted]. The staff members closest to the Subject all stated that they did not see the Subject hit [redacted]. None of the staff members said that [redacted] yelled or screamed in pain. [redacted] was examined by a physician after the restraint and did not complain of any pain in the groin area.

The Justice Center also admitted a statement from the treating doctor who states that [redacted] is not a [redacted]. Because of this, the statement made by [redacted] to the investigator cannot be afforded any weight.

Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances Gray v. Adduci, 73 N.Y.2d 741 (1988), 300 Gramatan Avenue Associates v. State Division of Human Rights, 45 N.Y.2d 176 (1978), Eagle v. Patterson, 57 N.Y.2d 831 (1982), People ex rel Vega v. Smith, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it depending upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

The statement from the one co-employee who said that she saw the Subject hit [redacted] was uncorroborated by the 8 other employees. The other employees were located closer to the

Subject and had a better vantage point to see what occurred after the subject got hit. In addition, the Subject testified credibly.

Additionally, it is well established that hearsay evidence cannot prevail against a witness's sworn and not inherently incredible testimony. *Matter of Perry* 37 AD2d 367 (3rd Dept. 1971). E.g., *In the Matter of the Claim of Lucy Lopez v. the Commissioner of Labor*. Slip Opinion 514794 (3rd Dept. January 17, 2013).

The Justice Center has not met its burden to prove by a preponderance of the evidence that the Subject abused [redacted].

Accordingly, it is determined that the Agency has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse alleged. The substantiated report will be sealed.

DECISION: The request of [redacted] that the substantiated report [redacted] be amended and sealed is granted. This decision is recommended by Diane Herrmann, Administrative Hearings Unit.

DATED: Schenectady, New York

Diane Herrmann