

**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

████████████████████

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

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: Constance R. Brown, Esq.  
Associate Counsel  
CSEA, Inc.  
143 Washington Avenue  
Capitol Station Box 7125  
Albany, New York 12224

██████████

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 ██████████ that the substantiated report ██████████  
██████████ dated ██████████ be amended and sealed is  
granted in part and denied in part.

As to the substantiation for psychological abuse as it pertains to Service Recipient A and the neglect of Service Recipient B, the report is amended and sealed. The Subject has not been shown by a preponderance of the evidence to have committed abuse and neglect as to those substantiations set forth in Offenses 1 and 3.

As to the substantiation for neglect as it pertains to Service Recipient A, the Subject's request to amend the report is denied. The Subject has been shown by a preponderance of the evidence to have committed the neglect alleged in Offense 2.

The Subject's neglect of the service recipient constituted a Category 2 finding of neglect.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained in part 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  
February 20, 2015



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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

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Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case**

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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.

██████████  
██████████  
██████████

By: Constance R. Brown, Esq.  
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CSEA, Inc.  
143 Washington Avenue  
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Albany, New York 12224

## 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 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 two Service Recipients, [REDACTED] [REDACTED] (hereinafter "Service Recipient A") and [REDACTED] (hereinafter "Service Recipient B)."
2. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).
3. On or about [REDACTED], the Justice Center substantiated the report for abuse under the theory that the Subject engaged in a verbal altercation with a Service Recipient and directed derogatory language at the Service Recipient. The Justice Center concluded that:<sup>1</sup>

### Offense 1<sup>2</sup> : Psychosocial abuse SSL § 488 (1) (c)

It was alleged that on [REDACTED], at [REDACTED] ... while acting as a custodian (Youth Division Aide 3), and in the course of your job duties, you committed psychological abuse when you engaged in a verbal altercation with a Service Recipient, contributed to the escalation of the altercation, threatened the Service Recipient and directed derogatory language at the Service Recipient, resulting in, or being likely to result in, a substantial and protracted diminution of the service recipient's psychological or intellectual

<sup>1</sup> See Justice Center Exhibit 1

<sup>2</sup> Offense 1 pertains to Subject's alleged abuse or neglect of Service Recipient A. (Administrative Law Judge Exhibit1)

functioning.

These allegations have been SUBSTANTIATED as Category 1 psychological abuse ...

Offense 2<sup>3</sup>: Neglect SSL § 488 (1) (h)

... [O]n [REDACTED], at [REDACTED] ... while acting as a custodian (Youth Division Aide 3), and in the course of your job duties, you committed neglect when you engaged in a verbal altercation with a Service Recipient and directed derogatory language at the Service Recipient, resulting in a substantial and protracted diminution of the Service Recipient's psychological or intellectual functioning, or being likely to result in such diminution.

These allegations have been SUBSTANTIATED as Category 1 neglect ...

Offense 3<sup>4</sup>: Neglect SSL § 488 (1) (h)

... [O]n [REDACTED] ... while acting as a custodian ... and in the course of your duties, you committed neglect when, in the presence of other Service Recipients, you engaged in a verbal altercation with another Service Recipient, threatening, and attempting to intimidate that Service Recipient and directing derogatory language at that Service Recipient, which conduct was likely to result in a substantial and protracted diminution of the Service Recipient's psychological or intellectual functioning, or being likely to result in such diminution.

These allegations have been SUBSTANTIATED as Category 1 neglect ...

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

5. At the time of the alleged neglect and/or abuse, the Subject was employed by the New York State Office of Children and Family Services (NYS OCFS), at the [REDACTED]

[REDACTED]. Service Recipient A and Service Recipient B were minors and residents at the [REDACTED]

[REDACTED]. The Subject worked as a Youth Aide 3 and was employed by a facility or

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<sup>3</sup> Offense 2 pertains to Subject's alleged abuse or neglect of Service Recipient A. (Administrative Law Judge Exhibit 1)

<sup>4</sup> Offense 3 pertains to Subject's alleged abuse or neglect of Service Recipient B. (Administrative Law Judge Exhibit 1)

provider agency that is subject to the jurisdiction of the Justice Center.

6. Service Recipient A and Service Recipient B resided in the [REDACTED] mental health unit of the [REDACTED]. The Subject was assigned to the [REDACTED] unit for about two months previous to the time of this incident. (Hearing testimony of Subject [REDACTED])

7. During her stay at [REDACTED], Service Recipient A was on suicide watch several times. [REDACTED], L-CSW, was Service Recipient A's assigned therapist and he performed her initial facility Mental Health Assessment. (Justice Center Exhibit 27)

[REDACTED] Her father was incarcerated and her mother had surrendered or lost custody of her at a young age. Service Recipient A's father was often critical of her. Service Recipient A was sensitive to male criticism and this resulted in [REDACTED] conducting "controlled" telephone calls between Service Recipient A and her father. Service Recipient A often required physical restraint while in crisis and she had been physically aggressive on occasion. (Hearing testimony of [REDACTED], L-CSW)

8. Service Recipient A often had a "hard time" in the morning with waking up and completing her morning routine. Consequently, Service Recipient A was the first resident to be awakened in the morning. (Hearing testimony of Subject [REDACTED]) On the morning of [REDACTED], Service Recipient A told the Subject "shut my door; suck my dick." This resulted in the Subject making an entry in the unit log. The Subject accompanied Service Recipient A throughout the morning to her in-facility classes. Service Recipient A disrupted class by laughing, interrupting and cursing at teachers. The Subject asked Service Recipient A to leave the class. Service Recipient A and the Subject went to the "comfort room" where they discussed Service Recipient A's behavior. This cycling of acting-out behavior and intervention continued throughout the morning. (Hearing testimony of Subject [REDACTED])

9. At some time during the day the Subject spoke with facility Administrator on Duty (AOD), ██████████, and expressed concern. He asked for a counselor or social worker's assistance to help with Service Recipient A, or for him to be reassigned for the remainder of his shift. ██████████ responded that the Subject should contact EAP, that nothing could be done because he needed to speak to Service Recipient A's clinician and that the Subject just "needed to stick it out."<sup>5</sup> (Hearing testimony of Subject ██████████)

10. Later that day, at approximately 2:00 p.m., ██████████ teacher, ██████████, was working with other students in Service Recipient A's classroom. Service Recipient A wanted ██████████ help and she called him a "Fat Fuck," when he did not immediately assist her. The Subject stood up from his seat and moved closer to Service Recipient A, who then stated to the Subject: "Go fuck yourself and suck my dick." Some of the students laughed and encouraged this behavior; some of the students tried to help down regulate Service Recipient A. (Hearing testimony of ██████████)

11. The Subject pointed to the other residents in the classroom and said "you, you and you are idiots for following this girl (Service Recipient A) here." The Subject also cursed and used the term "fuck" at least 20 times. When Service Recipient A said to the Subject "suck my dick," he replied "you probably have a dick, you fucking transvestite." (Hearing testimony of AOD ██████████) Service Recipient B was present in the classroom throughout the interaction. (Throughout the Hearing Record)

12. After the Subject left the classroom, ██████████ and the Subject went into an adjacent classroom to speak. Service Recipient A then physically attacked another staff member in the

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<sup>5</sup> ██████████ testimony and that of AOD ██████████ differed significantly as to what time of day it was when this conversation occurred. ██████████ testified that this conversation occurred at 11:35 a.m., while ██████████ testified that he was approached by ██████████ with concerns about "5 minutes" before the incident at issue, meaning closer to 2:00 p.m. This conversation does not play largely into the outcome of the case and is therefore not a material fact which needs to be resolved.

██████████ hallway. ██████████ left the classroom and attempted to calm Service Recipient A. Service Recipient A cried and screamed, saying that she hated “this place” and wanted to get out of the facility. “It took quite a bit of time” to de-escalate Service Recipient A. (Hearing testimony of AOD ██████████ ██████████ )

13. Service Recipient A’s emotional crises would typically last about one to two hours and then Service Recipient A would return to baseline within four hours. By approximately 4:00 p.m. on ██████████, when ██████████ met with Service Recipient A, she had returned to her emotional baseline. ██████████ did not “note a substantial diminution in Service Recipient A’s functioning.” (Hearing testimony of ██████████ ██████████, L-CSW)

14. The Subject was assigned to mentor Service Recipient B. Typically, residents would go first to their mentor with issues. The residents would also meet once per week with their mentor and put these issues on to paper. Service Recipient B was sensitive to, and did not care for, loud noises. (Hearing testimony of the Subject) During the evening following the incident, Service Recipient B slept with her bedroom door open and she was “scared” and claimed that she had “kind of blacked-out.” (Justice Center Exhibit 4) Previous to being placed at ██████████, Service Recipient B had a placement at a psychiatric RTF.

### ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect or neglect.
- Pursuant to Social Services Law § 493(4), the Category of abuse and/or neglect that such act or acts constitute.

**APPLICABLE LAW**

The Justice Center is responsible for investigating allegations of abuse or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A “substantiated report” means a report “... wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse or neglect occurred ...” (Title 14 NYCRR 700.3(f))

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 a facility or provider agency 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 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 preponderance of evidence that the Subject committed the neglect alleged in Offense 2 of the substantiated report, but not the neglect and abuse alleged in Offenses 1 and 3 of the substantiated report. The category of the affirmed substantiated neglect that such act or acts constitutes, is Category 2.

In support of the substantiated findings, the Justice Center presented Justice Center Exhibits 1-27. The Justice Center investigator, two employees of the New York State OCFS and Service Recipient A's clinician testified, on behalf of the Justice Center. The testimony of the Justice Center's witnesses was credible in all respects. The Subject testified and presented two Exhibits on his own behalf.

### Subject's Hearing Testimony

The Subject testified in relevant part that he was assigned to the [REDACTED] mental health unit and had worked on the [REDACTED] unit for about 2 months at the time of this incident.

During the morning, before her first class on [REDACTED], Service Recipient A told the Subject: "Shut my door-suck my dick." This resulted in the Subject making an entry in the unit log. Throughout the morning Service Recipient A disrupted class by laughing, interrupting and cursing at the teacher. The Subject asked Service Recipient A to leave class and the two went into the "comfort room." This cycle of acting-out behavior and intervention continued throughout the morning. At approximately 11:30 a.m., the Subject spoke with AOD [REDACTED] expressed concern and asked for a counselor or social worker to assist with Service Recipient A, or for him to be reassigned for the remainder of his shift. [REDACTED] advised the Subject to contact EAP for personal assistance and that nothing could be done for Service Recipient A,

because Service Recipient A's clinician needed to be involved and that the Subject just "needed to stick it out."

While in the relevant classroom with teacher [REDACTED], Service Recipient A wanted teacher [REDACTED] assistance. However, he was working with other students and Service Recipient A called teacher [REDACTED], a "fat fuck." The Subject then stood up from his seat and moved closer to Service Recipient A. His intention was to use "proximity" as a de-escalation technique. Service Recipient A stated to the Subject: "Go fuck yourself and suck my dick." Some of the students laughed and some encouraged this behavior. Other students tried to down regulate Service Recipient A. In hearing testimony, the Subject admitted that he had cursed and was "inappropriate," but denied having said to Service Recipient A, "you probably have a dick, you fucking transvestite." He further stated that a code yellow had been called and that when AOD [REDACTED] arrived and told him that he needed to leave the classroom, he did not then immediately leave the classroom. However, eventually he did leave.

Based upon the Administrative Law Judge's observations of the Subject's hearing testimony, the Subject's denial that he never stated to Service Recipient A "you probably have a dick, you fucking transvestite" is not credited testimony

AOD [REDACTED] Hearing Testimony

[REDACTED] testified that he was the acting AOD on [REDACTED]. About five minutes prior to the incident, the Subject approached him and stated that he was stressed out and that the kids were driving him crazy. He advised the Subject that he should take a deep breath and that his shift was almost over. He also reminded the Subject that "EAP" was available to him.

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A short time later, he entered the relevant classroom after receiving a code call for assistance. Upon entry, he observed that the Subject and Service Recipient A were engaged in some type of verbal altercation. The Subject pointed to the other students in the classroom and said: “You, you and you are idiots for following this girl (Service Recipient A) here.” The Subject also cursed and used the term “Fuck” at least 20 times. Service Recipient A said to the Subject “suck my dick,” to which the Subject replied: “You probably have a dick, you fucking transvestite.”

After the Subject left the classroom, ██████████ and the Subject went into an adjacent classroom to speak. Service Recipient A then attacked another staff member in the hallway. ██████████ left the classroom and attempted to calm Service Recipient A, who was crying and screaming that she hated “this place” and wanted to get out of the facility. “It took quite a bit of time” to de-escalate Service Recipient A.

The entirety of ██████████ hearing testimony is credited evidence.

Facility Director ██████████ Testimony

Facility Director ██████████ testified in relevant part that: Typically, on the ██████████ unit three staff members would be present in the classroom. The ██████████ unit generally housed no more than ten and no less than five residents. All ██████████ unit residents attended class together. She testified that if a resident was disruptive in the classroom and had told a teacher that he was “... fat, has diabetes and will die soon,” that staff would be expected to deescalate the situation. ██████████ testified that a staff member could seek assistance from their supervisor in handling a resident who was chronically acting out, during the school day. Every resident in that unit has some type of “issue-all day long” and the supervisor or AOD must prioritize the various issues

presented by the residents. Staff must be able to regulate themselves and their own temper must not agitate residents or the situation.

The entirety of [REDACTED] hearing testimony is credited evidence.

[REDACTED] Hearing Testimony

[REDACTED] testified that he is a Licensed Clinical Social Worker (L-CSW) and was, during the relevant time period, employed by the New York State Office of Mental Health (OMH), but was assigned to the OCFS [REDACTED] facility on the [REDACTED] unit. [REDACTED] was assigned as the primary therapist for Service Recipient A and Service Recipient B. Upon admission of Service Recipient A and Service Recipient B, into [REDACTED] mental health unit, both were administered a Mental Health Assessment. (Justice Center Exhibit 27) [REDACTED] completed the initial Mental Health Assessment of Service Recipient A, but he did not complete the Mental Health Assessment of Service Recipient B. Service Recipient B's Assessment was completed by another staff member.

During Service Recipient A's stay at [REDACTED], she had been on suicide watch several times. Previous to being placed at [REDACTED], Service Recipient B had been placed at a psychiatric RTF.

[REDACTED] prepared Justice Center Exhibit 24, at the request of Justice Center staff, at the onset of their investigation. That document was generated after [REDACTED] viewed the video (Justice Center Exhibit 26) and after he reviewed Service Recipient A's treatment notes. (Justice Center Exhibit 23) [REDACTED] did not speak with Service Recipient A about the incident of [REDACTED] before drafting Justice Center Exhibit 24.<sup>6</sup>

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<sup>6</sup> Justice Center Exhibit 24 is hand written and was subsequently typed and signed by [REDACTED] and the typed version appears in the record as Justice Center Exhibit 25

██████████ testified that, between ██████████, and ██████████, he conducted weekly therapy sessions with Service Recipient A, but that he could not recall whether or not the “event” of ██████████ “figured largely in therapy sessions.” ██████████ testified that even if Service Recipient A was dysregulated before the “incident” and assuming that the words as alleged were actually said to Service Recipient A, by the Subject, those words would have continued to further deregulate Service Recipient A’s mental state.

On the date of the incident, Service Recipient A returned to her emotional baseline by 4:00 p.m. Service Recipient A’s emotional crisis period would typically last about one to two hours and Service Recipient A typically returned to baseline within four hours of emotional dysregulation. As of ██████████ at 4:00 p.m., when ██████████ met with Service Recipient A, he did not “note a substantial diminution in Service Recipient A’s functioning.” ██████████ also testified that he made therapeutic notations at the conclusion of each therapy session with Service Recipient A. The therapy notes prepared by ██████████ after weekly treatment sessions with Service Recipient A, during the time period of ██████████, through ██████████, do not document any discussion regarding the “incident” of ██████████. (██████████ Exhibit 2)

The entirety of ██████████ hearing testimony is credited evidence.

*Psychological abuse-(Service Recipient A) – Offense # 1*

*SSL § 488(1)(c) defines psychological abuse as:*

“... 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... licensed clinical or master social worker ... , 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.”

In addition to his hearing testimony, ██████████ authored a letter dated ██████████. (Justice Center Exhibit 23)<sup>7</sup> This letter was offered into the record by the Justice Center to satisfy the statutory requirement that a *clinical assessment* be tendered to *support* a substantiation for *psychological abuse*.

The letter reads in pertinent part that:

This writer had a chance to witness the video of ██████████ [sic] becoming verbally aggressive toward [Service Recipient A]. Under the current policies of the Justice Center’s legislation # § 488.1 c and # § 493.4 the action of ██████████ [sic] met the definition of emotional abuse. In policy § 493.4 it clearly states ‘actions “likely to result in a substantial and protracted diminution of the service recipient’s psychological or intellectual function are classified as emotional abuse.’ The actions of ██████████ [sic] affected [Service Recipient A’s] emotional state shortly after the incident occurred, causing her to be emotionally dysregulated. [Service Recipient A’s] history displays difficulties when criticized by important male figures such as her father. The long term effects of the incident may not be present however, the actions of ██████████ [sic] affected [Service Recipient A’s] emotional state at the time of the incident. Due to historical events in program, his actions may have resulted in further interventions that have been more detrimental to [Service Recipient A’s] emotional state.

If the alleged words used by ██████████ [sic] were stated as, ‘you probably do have a dick,’ and ‘you transvestite,’ they would cause [Service Recipient A] to become emotionally dysregulated and it also may have jeopardized what others in the unit think of [Service Recipient A]...

The Subject’s counsel argued that Justice Center Exhibits 23 and 24 do not constitute a *clinical assessment* as that term is so used in SSL § 488 (1) (c). ██████████, L-CSW, testified that before drafting Justice Center Exhibit 23, he did not speak with Service Recipient A. There is a stark contrast between the initial mental health assessment, which ██████████

<sup>7</sup> While dated ██████████ the letter was actually drafted in hand written form on the date following the incident ██████████

performed on Service Recipient A upon her admission to ██████<sup>8</sup>, and Justice Center Exhibits 23 and 24, which are offered as a *clinical assessment*, in support of this offense. After considering all of the relevant factors and evidence, it is concluded Justice Center Exhibits 23 and 24 do not constitute a *clinical assessment* as that term is so used in SSL § 488 (1) (c). Specifically, the letter proffered a legal conclusion and was not the same type of “clinical assessment” that was performed upon admission.

*Neglect of (Service Recipient A) – Offense # 2*

SSL § 488(1)(h) defines *neglect* to include:

“... 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.”

Unlike psychological abuse, the definition of neglect does **not** require the conclusion that the Subject’s conduct was likely to result in protracted impairment of the Service Recipient’s mental or emotional condition, be supported by a **clinical assessment**.

The Subject’s counsel made arguments regarding the following evidence in the record: ██████ met with Service Recipient A at 4:00 p.m. on ██████, and did not “note a substantial diminution in Service Recipient A’s functioning.”; that Service Recipient A’s emotional crisis would typically last only about one to two hours after which the Service Recipient A would return to baseline within four hours and that therapy notes do not reveal any notations regarding the incident. Counsel argues then that there was no “protracted impairment” in the aftermath of the incident of ██████. Therefore, the **Subject’s counsel argued** that there cannot be a finding that the Subject’s behavior *was likely to result in protracted impairment* either.

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<sup>8</sup> See Justice Center Exhibit 27

██████████ clarified during his re-direct testimony that Service Recipient A had a low frustration tolerance for criticism and that she was likely to become angry and emotionally dysregulated. ██████████ did not want to “speculate” about what her actual response was to the incident, assumedly because he was not present for the event. Indeed it is not necessary to speculate regarding Service Recipient A’s response to the incident because there is ample proof in the record that Service Recipient A had become emotionally dysregulated as a result of her interaction with the Subject. It is true that Service Recipient A was likely dysregulated throughout most of the day, and in particular the time period before the incident at issue. However, the Subject’s degrading response continued to further dysregulate Service Recipient A’s mental state. (Hearing testimony of ██████████, L-CSW)

By virtue of OCFS PPM 3247.12 (Crisis Prevention and Management Policy),<sup>9</sup> OCFS PPM 3442.00 (Lesbian Gay, and Bisexual, Transgender and Questioning Youth Policy),<sup>10</sup> as well as OCFS Employee Manual (Third Edition),<sup>11</sup> the Subject breached his duty to Service Recipient A when he stated to her that “you probably have a dick, you fucking transvestite.”

The Justice Center argued persuasively that a totality of the circumstances analysis should be performed and that no one fact in the record is dispositive. Indeed, the hearing record supports that almost immediately after the Subject left the classroom, Service Recipient A attacked another staff member in the hallway. Service Recipient A was crying and screaming stating that she hated “this place” and wanted to get out of the facility. Additionally, “it took quite a bit of time” to de-escalate Service Recipient A. (Hearing testimony of AOD ██████████) This Service Recipient, who is female, had longstanding and well entrenched emotional issues with male criticism. (Hearing testimony of ██████████, L-CSW)

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<sup>9</sup> Justice Center Exhibit 6

<sup>10</sup> Justice Center Exhibit 7

<sup>11</sup> Justice Center Exhibit 8

After considering all of the evidence in the record, the Agency has established by a preponderance of the evidence that the Subject stated to Service Recipient A “you probably have a dick, you fucking transvestite.” and that this action *was likely to result in protracted impairment* of the mental or emotional condition of Service Recipient A, as required by SSL § 488(1)(h). The preponderance of evidence established that Service Recipient A had a very negative reaction to this statement and incident.

*Neglect of (Service Recipient B) – Offense # 3*

*SSL § 488(1)(h) defines Neglect to include:*

“... 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.”

Service Recipient B was present for the events of [REDACTED]. The hearing record establishes that the Subject was the assigned mentor for Service Recipient B. Service Recipient B was sensitive to and did not care for loud noises. (Hearing testimony of the Subject) On the evening of the day of the incident, Service Recipient B slept with her door open and stated that she was “scared” and also that she had “kind of blacked-out.” (Justice Center Exhibit 4) Previous to being placed at [REDACTED], Service Recipient B had a placement at a psychiatric RTF. It should be noted that the Justice Center presented no evidence of any psychological impact of this event on Service Recipient B, and this Service Recipient was merely a casual observer to these events. No evidence we presented of protracted impairment or the likelihood of such impairment by the Justice Center.

After considering all of the evidence the Justice Center did not establish by a preponderance of the evidence that the witnessing of the Subject’s actions toward Service

Recipient A by Service Recipient B resulted in a serious or protracted impairment of Service Recipient B 's mental or emotional condition, or were likely to result in such impairment.

A portion of the conduct as alleged and the substantiation of that part of the report, being Offense 2, having both been substantiated after hearing, pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act cited in the substantiated report (Offense 2), constitutes the Category of abuse or neglect set forth in the substantiated report.

Pursuant to SSL § 493(4), the act cited **does not** fit within the meaning of a Category one neglect because SSL § 493(4) subsections ii, iii, and iv, require that the conclusion be supported by a *clinical assessment*. There was no such *clinical assessment* in this case.

The report should appropriately be categorized a Category two neglect.

Category 2 conduct under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category two finding not elevated to a Category one finding shall be sealed after five years.

**DECISION:** The request of [REDACTED] that the substantiated report [REDACTED] [REDACTED] dated [REDACTED] be amended and sealed is granted in part and denied in part.

As to the substantiation for psychological abuse as it pertains to Service Recipient A and the neglect of Service Recipient B, the report is amended and sealed. The Subject has not been shown by a preponderance of the

evidence to have committed abuse and neglect as to those substantiations set forth in Offenses 1 and 3.

As to the substantiation for neglect as it pertains to Service Recipient A, the Subject's request to amend the report is denied. The Subject has been shown by a preponderance of the evidence to have committed the neglect alleged in Offense 2.

The Subject's neglect of the service recipient constituted a Category 2 finding of neglect.

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

**DATED:** January 16, 2015  
Schenectady, New York



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Gerard D. Serlin, ALJ