

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

In the Matter of the Appeal of

██████████

Pursuant to § 494 of the Social Services Law

**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: Thomas C. Parisi, Esq.

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By: Steven M. Klein, Esq.
CSEA Local 1000
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224-0125

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The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED:

The request of █ that the report "substantiated" on █
█ dated and received on █
█ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents) and neglect.

The substantiated report is properly categorized as a Category 2 act.

NOW THEREFORE IT IS DETERMINED that 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 the Subject engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. 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)(b).

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: November 6, 2015
Schenectady, New York

A handwritten signature in black ink, appearing to read "David Molik", written over a horizontal line.

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

██████████

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

██████████

Before:

Gerard D. Serlin
Administrative Law Judge

Held at:

New York State Office Building
333 East Washington Street, Hearing Room 115
Syracuse, New York 13202

On: ██████████

Parties:

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

New York State Justice Center for the Protection
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161 Delaware Avenue
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By: Steven M. Klein, Esq.
CSEA Local 1000
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224-0125

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 a 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 report "substantiated" on [REDACTED] [REDACTED], dated and received on [REDACTED] of abuse and/or neglect by the Subject, [REDACTED] of a Service Recipient. The report resulted in two substantiated allegations as to the Subject [REDACTED].

2. The New York State Justice Center for the Protection of People with Special Needs (Justice Center) concluded that:

Offense 1

It was alleged that on [REDACTED], on Unit [REDACTED] at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian (YDA-3), you committed neglect when you failed to intervene to protect a service recipient whom you witnessed being abused by another staff member.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493. (Justice Center Exhibit 1)

Offense 2

It was alleged that on [REDACTED], on Unit [REDACTED] at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian (YDA-3), you committed abuse when you obstructed the

report of a reportable incident, in that as a mandated reporter who is a custodian you witnessed another staff member abusing a service recipient and you failed to report the incident.

This allegation has been SUBSTANTIATED as Category 2 obstruction of a report of a reportable incident pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

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

4. The facility, [REDACTED], located at [REDACTED], is a limited secure facility for male youths who are placed in the custody of the New York State Office of Children and Family Services (OCFS), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the report addressed herein, the Subject was employed by the OCFS at the [REDACTED] in the title of Youth Division Aide -3 (YDA-3) and the Service Recipient was a young person who was residing at the [REDACTED]

6. On or about [REDACTED] at approximately 4:37 p.m., the Subject was working on Unit [REDACTED] of the facility. The alleged abused and/or neglected Service Recipient was in his bedroom on Unit [REDACTED] at the time of the incident. (Justice Center Exhibit 7)

7. Another YDA-3, [REDACTED], entered the Service Recipient's room to confront the Service Recipient about his negative behaviors. Subject [REDACTED] arrived and remained in the doorway during the interaction between YDA-3 [REDACTED] and the Service Recipient. (Justice Center Exhibit 21: video surveillance)

8. After entering the bedroom¹, YDA-3 [REDACTED] directed that the Service Recipient

¹ OCFS Policy limits those instances where a staff member may enter a Service Recipient's bedroom to emergency situations in order to prevent harm, OCFS PPM 3247.03.

■■■■

“lock-into” his room, and when the Service Recipient failed to do so, YDA-3 ■■■■ physically engaged the Service Recipient and executed a maneuver on the Service Recipient’s hand and wrist. (Justice Center Exhibit 21: audio recorded interview with the Service Recipient)

Eventually, YDA-3 ■■■■ and the Service Recipient ended up in a tug-of-war over control of the Service Recipient’s bedroom door. At some point during the conflict, the Service Recipient kicked at YDA-3 ■■■■. However, the Service Recipient is the person who sustained an unspecified, but minor leg injury. (Justice Center Exhibit 21) The entirety of these events was observed by Subject ■■■■. YDA-3 ■■■■ remained in the bedroom for approximately 2 minutes and 25 seconds. During this time, YDA-3 ■■■■ was not in view of the facility surveillance camera perspective which was ultimately obtained by the Justice Center.² (Justice Center Exhibit 21)

9. At approximately 4:40 p.m. YDA-3 ■■■■ exited the bedroom, and shut the door. At 4:48 p.m., Subject ■■■■ opened the Service Recipient’s bedroom door. The Service Recipient exited his bedroom and as he walked past Subject ■■■■, he was noticeably limping. (Justice Center Exhibit 21: video surveillance) The Service Recipient sustained a minor and unspecified leg injury during the altercation in his bedroom and was seen by a nurse for the leg injury two days later. (Testimony of Justice Center Investigator ■■■■ and Justice Center Exhibit 13)

² More than one, and perhaps as many as three, video surveillance perspectives of the incident were captured by OCFS cameras. It is likely that a perspective was captured of some portion of the activity which occurred in the Service Recipient’s bedroom. Justice Center Investigator ■■■■ relied on a facility staff member to preserve the video perspectives and to transfer the video perspectives to a CD for review by Justice Center Investigator ■■■■. However, the video system parameters employed by this OCFS facility caused a re-write over all video after 7 days. There was a significant delay in the report to VPCR (5 days), and consequently a delay in initiating the investigation. Justice Center Investigator ■■■■ requested the video (day 7 post-incident) from OCFS, but relied upon an OCFS employee to review the existing video perspectives and determine which video perspectives if any, revealed information about what occurred in the bedroom. The OCFS employee ultimately represented to the Investigator that only the perspective ultimately admitted into evidence at the hearing provided useful information. While other video perspectives existed, the Investigator did not review or secure those perspectives because of the representation made by the OCFS employee.

10. YDA-3 [REDACTED] made several entries in the unit activity log before and after the incident occurred. A log entry made by YDA-3 [REDACTED] at 5:20 p.m. indicated that unit staff called other facility staff for assistance because the Service Recipient and another youth were fighting over the television. The log entry also stated that the Service Recipient grabbed YDA-3 [REDACTED] who then “grabbed his hand off, and shut the door to his room until Code [call for assistance] was over.” (Justice Center Exhibit 13)

11. Subject [REDACTED] is a mandated reporter and a custodian. Subject [REDACTED] did not report the actions of the YDA-3 [REDACTED] either to his supervisor or to the Justice Center.

ISSUES

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

APPLICABLE LAW

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

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(f) and (h), to include:

"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.

"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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2 neglect and obstruction of a report of a reportable incident. Category 2 is defined as follows:

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.

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The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/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/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, 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 and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report. If a Category 2 finding of abuse or neglect is upheld, under this paragraph it shall be elevated to Category 1 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 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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

DISCUSSION

This decision addresses one substantiated report against the Subject █; a report which is shared in common with YDA-3 █. YDA-3 █ actions are discussed in a separate decision.

In support of its case, the Justice Center presented numerous documents obtained during the course of its investigation. (Justice Center Exhibits 1-21) The most pertinent exhibits include audio recorded interviews and a video perspective of the incident. (Justice Center Exhibit 21)

Justice Center Investigator ██████████ testified on behalf of the Justice Center and was the only Justice Center witness, as to this report, to testify on behalf of the Justice Center. Both YDA-3 ██████████ and Subject ██████████ testified at the hearing.

The Justice Center alleged that YDA-3 ██████████ committed physical abuse against the Service Recipient and also engaged in the deliberate inappropriate use of a restraint against the Service Recipient on ██████████

The Justice Center alleged that Subject ██████████ witnessed the abuse and failed to report a reportable incident to the VPCR and therefore obstructed the report of a reportable incident. The Justice Center also substantiated the allegation of neglect based upon Subject ██████████ failure to intervene to stop the abuse.

The Justice Center has proven by a preponderance of the evidence that the Subject, ██████████ committed prohibited acts, described as Offense 1 and Offense 2 in the substantiated report. Those acts constitute neglect and abuse (obstruction of reports of reportable incidents.)

Subject ██████████ testified at the hearing that he was not present when the Service Recipient began acting out in his bedroom and that he arrived at the unit only after YDA-3 ██████████ had entered the Service Recipient's bedroom. Subject ██████████ testified that his role was to make sure that everyone was "being safe" and to ensure that the resident cannot make "an allegation on YDA-3 ██████████ and that the YDA-3 ██████████ cannot make an allegation on the resident." Subject ██████████ testified that sometime after the bedroom incident, he let the Service Recipient out of his bedroom to use the bathroom, but did not notice that the Service Recipient was limping.

During both his interrogation (Justice Center Exhibit 21), and his hearing testimony, Subject ██████████ had little recall of what he undoubtedly witnessed in the Service Recipient's

bedroom. Yet, Subject [REDACTED] was able to recall many seemingly minor and irrelevant details including that one of the resident's shined a flashlight on-and-off in the office, shortly after the incident. Although the door pulling or tug-of-war was captured on the video, Subject [REDACTED] testified that he had no recall of that portion of the incident, despite the fact that he was standing in the bedroom doorway or close proximity thereto, watching the incident.

During his hearing testimony, Subject [REDACTED] was sparse on details about what he observed while standing in the doorway, but was quick to testify that he did not observe YDA-3 [REDACTED] or any staff "abuse" the Service Recipient or doing anything "inappropriate." Even during his interrogation, Subject [REDACTED] did not recall observing YDA-3 [REDACTED] "pulling" on anything (such as the door) until he was shown the video. (Justice Center Exhibit 21: recorded audio statement of the Subject [REDACTED])

The convincing evidence establishes that Subject [REDACTED] stood in the Service Recipient's doorway and watched YDA-3 [REDACTED] physically engage the Service Recipient, in a struggle and then engaged the Service Recipient in a tug-of-of war over control of the bedroom door. Later, Subject [REDACTED] watched the Service Recipient limp out of his bedroom and failed to report that injury or even seek medical attention for the Service Recipient. Subject [REDACTED] initially claimed that he did not see the Service Recipient limping. At the hearing, the video was played as Subject [REDACTED] testified and he testified unconvincingly that he did not know why he had not noticed the Service Recipient's limp.

Having had the opportunity to witness, consider, and evaluate the testimony of Subject [REDACTED], the Administrative Law Judge presiding over the hearing concludes that Subject [REDACTED] hearing testimony is not credited evidence.

As a custodian who is a mandated reporter, the elements necessary to substantiate a

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report for Obstruction of Reports of Reportable Incidents are, and the evidence must establish that:

- the mandated reporter is a custodian as defined by SSL § 488 (2);
- the mandated reporter discovered that a Service Recipient may have been subjected to a reportable incident;
- the mandated reporter failed to report that reportable incident.

As a mandated reporter, Subject ■■■■ is obligated to report a reportable incident upon discovery. (See SSL §488(1)(f)) Based on the credible evidence, Subject ■■■■ committed obstruction by failing to report this reportable incident. Additionally, Subject ■■■■ failed to intervene and take action to stop the conflict, or protect the Service Recipient.

Pursuant to SSL§ 488(1)(h), neglect is defined as “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.” By Subject ■■■■ own admission, his role in observing the situation was to make sure that everyone was “being safe” and to insure that the resident cannot make “an allegation on YDA-3 ■■■■ and that YDA-3 ■■■■ cannot make an allegation on the resident.” (Hearing testimony: Subject ■■■■) Therefore, Subject ■■■■ had a duty to intervene in the incident, but failed to do so. Consequently, Subject ■■■■ inaction resulted in physical injury (a leg injury) to the Service Recipient.

After considering the entire record, it is determined that the substantiated allegations are properly categorized as Category 2 acts. 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 the Subject engaged in Category 2 conduct. Reports that result in a Category 2

finding not elevated to a Category 1 finding shall be sealed after five years.

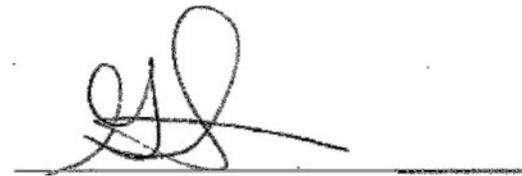
DECISION:

The request of [REDACTED] that the report “substantiated” on [REDACTED] [REDACTED] dated and received on [REDACTED] [REDACTED] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents) and neglect.

The substantiated report is properly categorized as a Category 2 act.

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

DATED: September 8, 2015
Schenectady, New York



Gerard D. Serlin, ALJ