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

Adjud. Case #:
[redacted]

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: Jennifer Oppong, Esq.
Juliane O'Brien, Esq.

[redacted]
By: D. Jeffrey Gosch, Esq.
120 East Washington Street, Suite 731
Syracuse, New York 13202

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 allegations are properly categorized as Category 3 acts.

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

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
November 24, 2015

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

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street
Syracuse, New York 13202
On: [redacted]

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 of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Jennifer DeStefano, Esq.
Juliane O'Brien, Esq.

[redacted]
By: D. Jeffrey Gosh, Esq.
Suite 731
120 East Washington Street
Syracuse, New York 13202

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (the Subject) for abuse and 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 report "substantiated" on , dated and received on of abuse and/or neglect by the Subject of a Service Recipient.

2. After investigation the Justice Center substantiated the report against the Subject, and concluded that:

Offense 1

> It was alleged that on , at , located at , while acting as a custodian, you committed neglect when you failed to notify a supervisor that a service recipient wrote a suicide note, thereby preventing the supervisor from placing the service recipient on suicide watch.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

Offense 2

> It was alleged that on , at , located in while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you wrote a report that falsely indicated you notified a supervisor that a service recipient wrote a suicide note.

This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) 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, , located at , 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 alleged abuse and/or neglect, the Subject was employed by the New York State Office of Children and Family Services. The Subject worked as a Youth Division Aide (YDA) and was a custodian as that term is so defined in Social Services Law § 488 (2).

6. The Subject successfully completed an OCFS Suicide Risk reduction training program on . (Justice Center Exhibit 19) On , the Subject was assigned to work at building (the Unit), at the facility. (Justice Center Exhibit 17) Four staff members, including the Subject, worked the 3:00 p.m. to 11:00 p.m. shift at the Unit on that date. The Service Recipient was a resident of the Unit. The Unit is a mental health unit. (Hearing testimony of the Subject)

7. , was employed as a Youth Counselor 1 (YC), at the facility on . At the time of the incident, was the Administrator on Duty (AOD), and as such is, at times, referred to as AOD in the record, while his actual job title was that of a Youth Counselor (YC). On , YC worked the 3:00 p.m.to 11:00 p.m. shift and was the AOD at the facility. YC supervised the

Subject, and approximately 14 other staff members. (Hearing testimony of YC)

8. At the facility, the processing or administration of paperwork required for a "suicide watch" can only be done by the Administrator on Duty (AOD). However, pursuant to OCFS policy, staff members who become aware of a service recipient's suicidal ideations, must place the service recipient on suicide watch. The mechanics of suicide watch require, among other actions, direct "eye–ball" supervision of the service recipient subject to the suicide watch. Additionally, staff must notify the AOD of the ideation, and the bedroom of the Service Recipient on suicide watch must be cleared of all contents. Staff must then be stationed outside the bedroom door and the bedroom door must remain open. Only clinical staff can remove a service recipient from suicide watch. (Justice Center Exhibits 14 and 20 and Hearing testimony of YC) The Service Recipient had a history of suicidal ideations and was placed on suicide watch a number of times before this incident. (Hearing testimony of YC and Hearing testimony of the Subject)

9. The Service Recipient, at times, made suicidal ideations to ensure that specific staff members were posted at his door as the Service Recipient was aware of, or at least believed that he knew, which staff would be "mandated to overtime" and therefore posted at "his door." The Service Recipient made no known attempts at suicide while at the facility. (Hearing testimony of YC) The Service Recipient sought attention from female staff. (Hearing testimony of the Subject)

10. On , at approximately 9:30 p.m., the Service Recipient "locked-in -to his room" on the Unit for bed time, without incident. Later in the evening, the Service Recipient required some attention from staff, in the "form of hurdle help" and other

calming techniques. (Hearing testimony of Subject and Justice Center Exhibit 18, Page 4 time entries: 10:20 p.m., 10:40 p.m., and 10:56 p.m.)

11. At approximately 8:30 to 8:45 p.m., YC responded to a code call for assistance in the "Welcome Unit" located in building of the facility. While addressing the code, he received a radio transmission from YDA , who was stationed on the Unit with the Subject and the Service Recipient. YDA stated that she wanted to speak to YC by phone as there was an issue with the Service Recipient. (Justice Center Exhibit 15: audio interrogation of YC and hearing testimony of YC)

12. YC stated to YDA that he needed to address the "code" and would communicate with her later. During this conversation, YDA did not express that there was an issue which needed immediate attention. (Hearing testimony of YC)

13. Sometime during the evening of , YC spoke on the telephone with the Subject and granted her permission to leave the unit to briefly go to her car. YC testimony suggested that the request was made before 9:00 p.m. The Subject testified that the request was made between 9:30 p.m. and 9:45 p.m. The actual time when the request was made, and where that request fell in the order of the events of the evening, is not clear in the record.

14. The Subject was absent from the unit for between 15 and 30 minutes. During that time, the Service Recipient slipped a suicide ideation note (the note), under his bedroom door, to Unit staff member . (Hearing testimony of Subject) The note stated that the Service Recipient was going to kill himself at 10:00 p.m. (Justice Center Exhibit 7)

15. Upon returning to the Unit, YDA and staff member informed the Subject about the note. The Subject read the note. The other staff members suggested throwing the note into the garbage. YDA told the Subject that she had attempted to contact YC but YDA did not specify if she had spoken with him, and she did not volunteer any further details. The Subject did not inquire further of YDA . The Subject opted to keep the note, so that she could "document the pattern" of the Service Recipient's ideations. (Hearing testimony of the Subject)

16. Thereafter, YC received a radio transmission from the Subject asking him to contact the Subject by telephone. YC testified that he contacted the Subject by land line, and the Subject stated to YC "something like, [the Service Recipient] was missing momma and he's all fine now." The Subject did not report to YC that the Service Recipient had expressed a suicidal ideation. There was no further communication between the Subject and YC during the evening shift of . (Hearing testimony of YC) The Service Recipient remained secured in his bedroom, for at least the remainder of the Subject's shift. (Hearing testimony of the Subject)

17. The Subject next prepared an activity report and attached the note to the activity report. The Subject also wrote in the activity report that: "[t]his note attached is from [Service Recipient] at above time and date. Resident expresses no suicidal thoughts and was 'just kidding.' AOD notified and observation made to ." (Justice Center Exhibit 6) The date noted on the activity report is at 10:35 p.m. The date and time appear at the bottom of the document, and not above or at the top. (Justice Center Exhibit 6) The Subject placed the activity report and the note into the log book on the page of the log book pertaining to the date of .

18. The Subject never discussed the note or the Service Recipient's emotional condition with the Service Recipient on the evening of . Instead, the Subject relied upon the characterization of the Service Recipient's mindset, as provided to her by other unit staff members. (Justice Center Exhibit 6 and Hearing testimony of the Subject) No staff members from the unit, including the Subject, initiated a suicide watch for the Service Recipient on the 3:00 p.m. to 11:00 p.m. shift on . (Hearing testimony of the Subject)

19. The following day, the Service Recipient's suicide note was discovered in the log book by other staff members. Ultimately, this notation led to an internal inquiry of YC as to why he had not placed the Service Recipient on suicide watch and ultimately a report to the VPCR was made. As a result of that report, YC was the target of an investigation by the Justice Center based upon the allegation that he failed to place the Service Recipient on suicide watch in contravention of OCFS policy. After interrogating YC Justice Center Investigator determined that YC was not made aware of the note and focused his investigation on the Subject. (Hearing testimony of Justice Center Investigator and YC)

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.
- 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 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 and 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 the evidence that the alleged act or acts of abuse and/or neglect occurred…" (Title 14 NYCRR 700.3(f))

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

> "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 Center, 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.

> "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.

Substantiated reports of abuse and/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 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.

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 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 neglect as set forth in the substantiated report. If, as in this matter, a Category 3 finding of neglect and obstruction of reportable incidents (abuse) is upheld, the Subject will not be placed on the Justice Center's Staff Exclusion list (SEL) and the record will 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

The Justice Center has established by a preponderance of the evidence that the Subject committed prohibited acts described as "Offense 1" and "Offense 2" in the substantiated report. The act committed by the Subject in "Offense 1" constitutes neglect. The act committed by the Subject in "Offense 2" constitutes abuse.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-21) The investigation underlying the substantiated report was conducted by Justice Center Investigator . Additionally, for the Justice Center, facility YC testified. The Administrative Law Judge who presided over the hearing, also admitted into evidence, ALJ Exhibit 1.

The Subject testified on her own behalf and submitted one exhibit. (Subject Exhibit 1).

Offense 1

The Justice Center proved by a preponderance of the evidence that after becoming aware that the Service Recipient had communicated a suicidal ideation, the Subject failed to initiate a suicide watch of the Service Recipient and also failed to report the note to her supervisor which precluded her supervisor from placing the Service Recipient on suicide watch, all in contravention of OCFS policies. The Subject's conduct constitutes neglect.

Initially, during her direct testimony the Subject testified that YDA informed her that they had attempted to contact YC , but that she (the Subject), never clarified if staff was successful in contacting YC . Later in her testimony, on cross-examination the Subject testified that YDA claimed to have spoken with YC

but had not disclosed whether she (YDA) had reported to YC the existence of the note. During YC interrogation with the Justice Center he told the Justice Center investigator that YDA had contacted him by radio and requested a landline to discuss an issue with the Service Recipient, but that the landline contact never occurred. (Justice Center Exhibit 15: audio interrogation and Hearing testimony of YC)

The Subject further testified that she did notify YC by phone of the contents of the Service Recipient's suicide note on the evening of . The Subject testified that after learning of the note and its contents, she radioed to, and ultimately spoke on the phone with, YC . The Subject testified that she informed YC of the contents of the note, and also that she had returned to the unit. The Subject testified that she and YC made a joke that the Service Recipient was "magically cured" now that she was back on the unit. The Subject also wrote in the activity report that YC was notified. (Justice Center Exhibit 6) The Subject's testimony was not credible and was directly contradicted by the credible hearing testimony of YC . (Justice Center Exhibits 14 & 20)

Counsel for the Subject argued that, based on the testimony of YC , only the first staff member to become aware of the suicidal ideation was obligated to initiate a suicide watch. Counsel argued that the Subject was the third staff to become aware of the suicidal ideation, and therefore had no obligation to correct the failure of the first staff member who became aware of the suicidal ideation. The Subject testified that she had no duty to "right the wrong" of another employee, but that she "could have" placed the Service Recipient on suicide watch. The Subject's suggested interpretation of the relevant OCFS policies is absurd. All facility staff members are vested with the authority to place a service recipient on suicide watch, and any staff member who becomes aware of a suicidal ideation must place the service recipient

on suicide watch, if a suicide watch has not already been initiated. Upon learning of the suicidal ideation and recognizing that the other staff members had not initiated the watch, the Subject had an absolute obligation to place the Service Recipient on suicide watch. (Hearing testimony of YC)

The Subject's counsel also argued in the alternative, that because any staff could have placed the Service Recipient on suicide watch, even if the Subject did not tell her supervisor of the suicidal ideation, the Subject's failure did not prevent the Service Recipient from being placed on suicide watch by other staff. The substantiation letter, in relevant part, states that the Subject "… committed neglect when [she] failed to notify a supervisor that a service recipient wrote a suicide note, thereby preventing the supervisor from placing the service recipient on suicide watch." (Justice Center Exhibit 1) The Subject's argument is, therefore, that even if she failed to notify YC of the note, her failure did not prevent the Service Recipient from being placed on suicide watch. This argument amounts to a distinction without a difference.

Additionally, the Subject testified that the actual practice in this facility was to throw suicide notes, written by the Service Recipient, into the garbage. This testimony is not corroborated in the record and is contradicted by the Subject's own testimony that this Service Recipient had been placed on suicide watch at least ten times previous to this incident. The Subject's testimony on this point is not credited evidence.

Finally, counsel for the Subject also argued that because the Service Recipient expressed repetitive and chronic suicidal ideations but never followed through, there was no evidence in the record that failing to place the Service Recipient on suicide watch was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of this Service Recipient. The process of suicide watch includes direct "eye–ball" supervision of the

service recipient by staff members. Additionally, the bedroom of a service recipient on suicide watch must be cleared of all contents and staff must notify the AOD of the ideation. Ultimately, clinical staff evaluates the situation and only clinical staff can remove a service recipient from a suicide watch.

In a scenario where a service recipient is confined to his bedroom, the most important component of suicide watch is the removal of all items from the service recipient's bedroom. Removing the contents of this Service Recipient's bedroom would have greatly diminished the possibility of a suicide attempt, or an actual suicide by the Service Recipient. However, no items were removed from the Service Recipient's bedroom by the Subject, or any unit staff member on the relevant shift.

The Unit is a mental health unit. After the Service Recipient, a resident on this unit, made a suicidal ideation, the Subject did not place the Service Recipient on suicide watch. Specifically, the Subject did not notify YC and she failed to empty the contents of the Service Recipient's room. It is concluded that this omission was likely, meaning reasonably probable, to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the Service Recipient.

By failing to notify YC of the note, the Subject effectively prevented YC from initiating a suicide watch of this Service Recipient. YC testified credibly that had he been advised of the note, there is no question that he would have initiated a suicide watch of the Service Recipient.

The Justice Center also argued that based on the proof in the record, the Subject had both the ability and the obligation to place the Service Recipient on suicide watch. While it is true that the Subject was never specifically alleged to have failed to place the Service Recipient on

suicide watch, the clear implication of "Offense 1" is that the Subject's failure to notify her supervisor resulted in the Service Recipient not having been placed on suicide watch. It is not a violation of due process for the ALJ to rely on facts adduced at hearing that were not specifically alleged in the charging document. (Justice Center Exhibit 1) In this case, the substantiation letter[1] alleges that the Subject failed "… to notify a supervisor that a service recipient wrote a suicide note, thereby preventing the supervisor from placing the service recipient on suicide watch." However, the facts adduced at the hearing establish both that the Subject failed to notify her supervisor of the suicide note and the Subject should have, on her own initiative, placed the Service Recipient on suicide watch, but failed to do so. The facts adduced at hearing establish all of the necessary elements of neglect and satisfy due process concerns. (See eg., *Langhorne v. Jackson* , 213 A.D.2d 909 [3d Dep't 1995]).

Offense 2

As a result of this report, the Subject was also substantiated for "Offense 2," obstruction of reports of reportable incidents. The Justice Center proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when she falsely noted that she notified YDA that the Service Recipient had written a suicide note

The hearing proof established that this false entry impeded the investigation of the treatment of this Service Recipient. The false entry culminated in a call to the VPCR and investigation of YC , when in fact the Subject's actions were at issue and not YC actions. This false entry constitutes "Obstruction of reports of reportable incidents," as the Subject's conduct impeded the discovery, reporting, or investigation of the treatment of this Service Recipient, when the Subject falsified records related to the safety, treatment or supervision of this Service Recipient.

[1] See "Offense 1" Justice Center Exhibit 1.

Request for Recusal of the ALJ

At the first hearing date, the Subject's Counsel requested that the ALJ presiding over the hearing recuse himself as Counsel took the position that the ALJ presiding over the hearing was assisting the Justice Center Counsel in their questioning of a witness. At that time the entirety of the "recusal portion" of the relevant promulgated regulation[2] was read into the record by the ALJ who presided over the hearing. Despite the fact that the applicable regulations require that applications for recusal are to be made in writing,[3] the Subject's Counsel did not do so.

Several months elapsed between the second and third day of the hearing,[4] and the Subject's Counsel made no written application. During Counsel's closing argument he argued that he was not provided an opportunity to make a written application. The ALJ presiding over the hearing indicated that he would accept a written application until such time as the ALJ presiding over the hearing had submitted his decision for review to the Executive Director. However, Counsel never submitted a written application for recusal, in conformity with the applicable regulations.

Conclusion

The Justice Center proved by a preponderance of the evidence that the Subject committed abuse and neglect. As to the finding of neglect, the evidence established that after becoming aware that the Service Recipient had made a suicidal ideation, the Subject failed to initiate a suicide watch of Service Recipient and also failed to report the note to her supervisor. The

---

[2] See 14 NYCRR Part 700.9.

[3] If a party has a good faith basis to believe that an administrative law judge cannot render a fair and impartial decision in a particular case, such party may request that the administrative law judge recuse himself or herself. Such request must be in writing and include an affidavit indicating the specific grounds on which the party claims interest or bias. (14 NYCRR Part 700.9 (h))

[4] The first day of hearing testimony was held on , day two was held on and day three was held on .

Subject's failure prevented her supervisor from placing the Service Recipient on suicide watch, all in contravention of OCFS policies. The Subject's conduct was likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the Service Recipient.

The Justice Center further proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents). Specifically, the evidence establishes that the Subject falsified a record related to the safety, treatment or supervision of this Service Recipient and her conduct impeded the discovery, reporting, or investigation of the treatment of this Service Recipient.

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

Moreover, based upon the totality of the circumstances contained in the evidence and testimony presented, it is determined that substantiated acts of abuse and neglect were properly substantiated as Category 3 acts.

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

DECISION: The request of that the report "substantiated" on , dated and received on

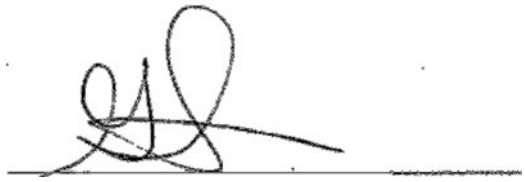
[redacted]

[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 allegations are properly categorized as Category 3 acts.

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

DATED: October 26, 2015
Schenectady, New York



Gerard D. Serlin, ALJ