

**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

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**

**Adjudication Case #:**

[REDACTED]

Held at:

New York State Office Building  
333 East Washington St.  
Syracuse, NY

On: [REDACTED]

Parties:

Justice Center for the Protection of People with  
Special Needs

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

[REDACTED]

### JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject), for physical abuse and deliberate inappropriate use of restraints against a Service Recipient. The Subject invoked an internal administrative review which was denied. An administrative hearing was then held, on [REDACTED], in accordance with the requirements of Social Services Law § 494 and Part 700 of 14 NYCRR.

### PROCEDURAL HISTORY

The VPCR contains a substantiated report, [REDACTED], of physical abuse and deliberate inappropriate use of restraints by the Subject against the Service Recipient. The report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center). The substantiated report as against the Subject, dated [REDACTED], concluded that:

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian (YDA), you deliberately used an inappropriate restraint on a service recipient when you improperly and unnecessarily used a single person escort.

This allegation has been SUBSTANTIATED as a Category 3 abuse (deliberate inappropriate use of a restraint) pursuant to Social Services Law § 493.

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian (YDA), you physically abused a service recipient when you struck a service recipient in the face during a restraint, causing physical injury, serious or protracted impairment of the service recipient's physical, mental or emotional condition or the likelihood of such injury or impairment.

This allegation has been SUBSTANTIATED as a Category 3 physical abuse pursuant to Social Services Law § 493. Justice Center Exhibit 1.

An Administrative Review was conducted at the request of the Subject to amend the

report and the Justice Center Administrative Appeals Unit denied the request. On [REDACTED], a Hearing (the Hearing) was held.

The Administrative Law Judge issued a Recommended Decision after Hearing (Recommended Decision). The Recommended Decision recommended that the allegation of deliberate inappropriate use of restraints remain substantiated as a Category 3 act and that the allegation of physical abuse be unsubstantiated. That Recommended Decision is rejected in part and adopted in part by the Executive Director pursuant to 14 NYCRR 700.13.

The Executive Director adopts the Recommended Decision insofar as it recommends that the allegation of deliberate inappropriate use of restraints remain substantiated as a Category 3 act, and incorporates the attached Recommended Decision into this Final Determination and Order after Hearing with respect the allegation of deliberate inappropriate use of restraints. The Executive Director rejects that portion of the Recommended Decision that recommends that allegation of physical abuse be unsubstantiated, and substantiates the allegation of physical abuse as well, for the reasons set forth herein. As the allegation of deliberate inappropriate use of restraints in the Recommended Decision is being adopted and incorporated herein for the reasons and Conclusions of Law set forth therein, this Final Determination and Order after Hearing will only substantively address the allegation of physical abuse. The following constitutes the Final Determination of the Executive Director under 14 NYCRR 700.13.

#### **FINDINGS OF FACT**

The Executive Director adopts the "Findings of Fact" set forth in the Recommended Decision and incorporates them herein, with the exception of the last two sentences of ¶ 10 which read "[t]he Subject reacted to the Service Recipient's bite by pulling his arm back away from the Service Recipient who in turn immediately released the bite. The Subject then pushed

his arm briefly into the Service Recipient's face." and makes the following additional Findings of Fact.

When the Service Recipient bit the Subject on the right forearm, the Subject pulled his right arm free from the bite and then struck the Service Recipient in the face with the right forearm. Hearing testimony of Justice Center Investigator [REDACTED], the Subject and Justice Center Exhibit 15.

OCFS training provides, in relevant part, that when staff is bitten, they should push into the bite, not pull away from the bite. Hearing testimony of Justice Center Investigator [REDACTED], the Subject, Justice Center Exhibit 9, page 118 and Subject Exhibit 8 pages 15 and 16.

Following the incident the Subject filled out an incident report, in which he stated in relevant part "I realized the bite was occurring I pushed forward into the bite as we are trained. [The Service Recipient] had already released by the time the reaction occurred." Justice Center Exhibit 4.

### 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 physical abuse and deliberate inappropriate use of restraints.
- Pursuant to Social Services Law § 493(4), the category level that the physical abuse and deliberate inappropriate use of restraints constitutes.

### APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in facilities and provider agencies. Social Services Law § 492(3) (c) and 493(1) and (3). Pursuant to Social Services Law § 493(3), the Justice Center determined that the initial report of physical abuse and deliberate inappropriate use of restraints 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 or neglect occurred ...” (14 NYCRR 700.3(f))

Pursuant to Social Services Law §§ 494(1)(a)(b) and (2) and 14 NYCRR 700.13 this Final Determination of the Executive Director 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 physical abuse and deliberate inappropriate use of restraints; and pursuant to Social Services Law § 493(4), the category level that the physical abuse and deliberate inappropriate use of restraints constitute.

Physical abuse of a service recipient is defined by Social Services Law § 488 (1)(a) as:

- (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.

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 physical abuse and deliberate inappropriate

use of restraints alleged in the substantiated report and that such act or acts constitute the category level of physical abuse and deliberate inappropriate use of restraints set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

As is relevant to this proceeding, substantiated reports of abuse or neglect shall be categorized pursuant to Social Services Law § 493(4) (a-c). The Subject has been substantiated for a Category 3 level offense, which is abuse and/or neglect committed by a custodian, not otherwise described in categories one and two. Social Services Law § 493 states in pertinent part:

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;
  - (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.

If the Justice Center proves the alleged physical abuse and deliberate inappropriate use of restraints, the report will not be amended and sealed. Pursuant to Social Services Law § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of physical abuse and deliberate inappropriate use of restraints cited in the substantiated report constitutes Category 3 level offenses, as set forth in the substantiated report.

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

### THE HEARING

The Justice Center called two witnesses, [REDACTED], the Justice Center investigator who conducted the investigation into the subject incident and [REDACTED] OCFS training specialist and offered sixteen exhibits which were admitted into evidence. *Justice Center Exhibit 15* contains video footage of the subject incident in the relevant locations. The Subject testified and offered ten exhibits which were admitted into evidence.

As set forth above, the essential facts relevant to the allegation of physical abuse were not in dispute.

[REDACTED] testified in relevant part as follows: During the incident the Service Recipient bit the Subject on the right forearm. The Subject then pulled his arm free from the bite, the bite was released and then the Subject struck the Service Recipient in the face with the Subject's forearm. The Subject, after the incident, filled out a report (*Justice Center Exhibit 4*) in which he stated, in part, that 'when the bite was occurring I pushed forward into the bite as we are trained.' [REDACTED] further testified that he recommended substantiating both the physical abuse allegation and the

allegation regarding deliberate inappropriate use of restraints. Relative to the physical abuse allegation ██████ testified that the video (*Justice Center Exhibit 15*), clearly shows that the subject intentionally and deliberately struck the Service Recipient in the face with the Subject's right forearm. *Hearing testimony of Justice Center Investigator ██████*.

██████ testified in relevant part as follows: She is a training specialist at OCFS and has trained staff in Crisis Prevention and Management methods. ██████ testified that during the incident when the Service Recipient bit the Subject, the Subject should have pushed into the bite as staff are trained. When asked if the Subject did what he was taught to do in this situation, ██████ testified that he did not, in fact he pulled away from the bite rather than push into the bite. *Hearing testimony of ██████*.

The Subject testified in relevant part as follows: During the incident the Service Recipient hit the Subject. The Subject was trained to push into the bite, but his adrenalin was going and as even though he pulled away from the bite and the bite was released he struck the Service Recipient in the face by reaction. He further testified that the strike to the Service Recipient's face was not intentional and that he was not trying to injure the Service Recipient. *Hearing testimony of the Subject.*

### DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a) and deliberate inappropriate use of restraints, as defined in Social Services Law § 488(1)(d) against the Service Recipient and that the physical abuse and deliberate inappropriate use of restraints are properly categorized as Category 3 offenses under Social Services Law § 493(4)(c). As set forth above, as the Executive Director has adopted the Recommended Decision insofar as it recommends that

the allegation of deliberate inappropriate use of restraints remain substantiated as a Category 3 act, and incorporates the attached Recommended Decision into this Final Determination and Order after Hearing with respect the allegation of deliberate inappropriate use of restraints this Final Determination and Order after Hearing will only substantively address the allegation of physical abuse.

### *Physical Abuse*

During the subject incident, when the Service Recipient bit the Subject on the right forearm, the Subject pulled his right arm free from the bite and then struck the Service Recipient in the face with the right forearm. Hearing testimony of Justice Center Investigator [REDACTED] and the Subject. It is clear from the video tape of the incident introduced at the Hearing that after the Service Recipient released the bite the Subject struck the Service Recipient in the face with the right forearm. Justice Center Exhibit 15.

OCFS training provides, in relevant part, that when staff is bitten, they should push into the bite, not pull away from the bite. Hearing testimony of Justice Center Investigator [REDACTED] the Subject, Justice Center Exhibit 9, page 118 and Subject Exhibit 8 pages 15 and 16. It is equally plain that the Subject did not conform his conduct to the training he received, but rather stuck the Service Recipient in the face, in contravention of the training he received. That the Subject was in a situation which generated adrenaline or that he was not intentionally trying to injure the Service Recipient are not controlling factors here.

Additionally, following the incident the Subject filled out incident report, in which he stated in relevant part "I realized the bite was occurring I pushed forward into the bite as we are trained. [The Service Recipient] had already released by the time the reaction occurred." Justice Center Exhibit 4. This report, filled out by the subject shortly after the incident, is not a credible

account of what occurred during the incident, as it is not consistent with what can be viewed on the video tape or what, in large part, was testified to at the Hearing, by [REDACTED] or the Subject. Hearing testimony of Justice Center Investigator [REDACTED], the Subject and Justice Center Exhibit 15.

Finally, physical abuse, in relevant part, is defined by Social Services Law § 488(1)(a) as “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”.

Here, it is clear from the record that the Subject intentionally or recklessly caused, by physical contact the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Clearly, the Subject struck the Service Recipient in the face at a time when the Service Recipient was upset, escalated and involved in a physical intervention by the Subject in the vicinity of other staff. While it is unclear if the strike to the Service Recipients caused physical injury on the present record, it is clear that the Service Recipient did sustain physical injuries as a result of the entire incident. Accordingly, based on the foregoing it is clear that the conduct of the Subject in striking the Service Recipient in the face, at the very least caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Justice Center Exhibit 15.

Not only has the Justice Center established by a preponderance of evidence that the Subject committed physical abuse, as defined in Social Services Law § 488(1)(a), against the Service Recipient, but it has also established that the physical abuse is properly categorized as a Category 3 offense under Social Services law § 493(4)(c).

The Administrative Law Judge in the Recommended Decision, recommended that the allegation of physical abuse unsubstantiated essentially based on two grounds: 1) that although the Subject did strike the Service recipient in the face, the strike was nominal and done with little force, and; 2) that as a result of the nature of the strike to the face there was not proof that the strike to the face was likely to cause physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

This rationale of the ALJ is rejected. As set forth above, it is clear from the record that the Subject intentionally or recklessly caused, by physical contact the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Clearly, the Subject struck the Service Recipient in the face at a time when the Service Recipient was upset, escalated and involved in a physical intervention by the Subject in the vicinity of other staff. Accordingly, based on the foregoing it is clear that the conduct of the Subject in striking the Service Recipient in the face, at the very least caused the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, based on the foregoing it is hereby:

**ORDERED:** The request of [REDACTED] that the substantiated report dated [REDACTED] [REDACTED], [REDACTED] be amended and sealed is

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

The substantiated report for physical abuse and deliberate inappropriate use of restraints is properly categorized as Category 3 acts of physical abuse and deliberate inappropriate use of restraints.

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 Davin Robinson, Chief of Staff, who has been designated by the Executive Director to make such decisions.

**DATED.** April 7, 2016  
Delmar, New York



Davin Robinson  
Chief of Staff

**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

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

John T. Nasci  
Administrative Law Judge

Held at:

New York State Office Building  
333 East Washington Street, Room 115  
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: Juliane O'Brien, Esq.

[REDACTED]

**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 report substantiated on [REDACTED] [REDACTED], dated and received on [REDACTED] of neglect and/or abuse by the Subject of a Service Recipient.

2. On or about [REDACTED], the Justice Center substantiated the report against the Subject<sup>1</sup>. The Justice Center concluded that:

**Offense 1**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian (YDA), you deliberately used an inappropriate restraint on a service recipient when you improperly and unnecessarily used a single person escort.

This allegation has been SUBSTANTIATED as a Category 3 abuse (deliberate inappropriate use of a restraint) pursuant to Social Services Law § 493.

**Offense 2**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian (YDA), you physically abused a service recipient when you struck a service recipient in the face during a restraint, causing physical injury, serious or

<sup>1</sup> The Justice Center's investigation of the report resulted in three allegations. Ultimately, after review of the allegations and the investigation, the Justice Center substantiated only two allegations which are set forth in Offense 1 and Offense 2.

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protracted impairment of the service recipient's physical, mental or emotional condition or the likelihood of such injury or impairment.

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

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

4. ██████████ (the Facility), located at ██████████ ██████████, is a medium secure residential treatment facility for male youths, and is operated by 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. (See Justice Center Exhibit 1; and testimony of Investigator ██████████)

5. At the time of the alleged abuse, the Subject was employed by OCFS at the Facility as a Youth Counselor 1 (YC1), and had been employed at the Facility since ██████████ 2011. The Subject has also been a Crisis Prevention and Management (CPM) field trainer since ██████████ 2013. By virtue of the Subject's employment with OCFS at the Facility, the Subject is deemed a custodian of the Service Recipient. (See testimony of the Subject)

6. At the time of the alleged abuse, the Service Recipient, who was the object of the Subject's alleged abuse, was seventeen years of age, and had been a resident of the facility for approximately six months immediately preceding the ██████████ incident. The Service Recipient was placed at the Facility by Family Court. (See Justice Center Exhibit 14 [audio recording of interview with the Service Recipient]; and testimony of Investigator ██████████)

7. On or about ██████████ the Subject was in a visiting room located immediately adjacent to a common area of the Facility and was conducting a meeting with the Service Recipient and an aftercare worker. When the meeting was finished, the Subject remained in the visiting room while another Facility staff began to escort the Service Recipient

██████████  
from the visiting room to his unit. (See testimony of the Subject)

8. Upon entering the common area outside the visiting room, the escorting staff noticed another resident of the Facility being escorted through the common area, and diverted the Service Recipient to another visiting room in accordance with Facility policy.<sup>2</sup> The visiting room was approximately six to seven feet wide and eight feet long and contained a table and a chair. The table in the room was approximately five feet in length and three feet wide, leaving approximately one and one half to two feet of space on either side of the table. On the end of the table nearest the door was a stack of papers and a plastic water bottle. (See Justice Center Exhibit 15 VI; and testimony of Investigator ██████████)

9. Upon entering the visiting room the Service Recipient became upset and threw some of the papers and the water bottle off the table. Staff ██████████ then entered the room and confronted the Service Recipient, who in turn threw some more papers around the room. Staff ██████████ then called for help on her radio. At that point Staff ██████████ and Staff ██████████ entered the room, and Staff ██████████ approached the Service Recipient. Staff ██████████ then entered the room and the Service Recipient sat down on the table with his feet on the chair. After approximately eighteen seconds, the Service Recipient stood up and, with his back to all of the Staff, he attempted to pick up the chair which was against the far wall of the room. Staff ██████████ positioned himself immediately behind the Service Recipient and attempted to restrain him. The Subject then entered the room at a fast pace, passed by Staff ██████████ and reached around Staff ██████████ and Staff ██████████ in an attempt to reach the Service Recipient. At the same time, Staff ██████████ and Staff ██████████ were attempting a two person restraint on the Service Recipient. As the Subject inserted himself between Staff ██████████

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<sup>2</sup> Facility policy does not allow two residents to be in the common area at the same time. (See Justice Center Exhibit 14, audio interview with the Subject; and testimony of Investigator ██████████)

██████████

and the table, the table tipped up and went over onto its side, breaking a leg off. The Subject continued to physically engage the Service Recipient as Staff ██████████ and Staff ██████████ continued their attempt to restrain the Service Recipient who was physically resisting the restraint. At that point, a fifth and sixth staff (one of whom was Staff ██████████) entered the room and moved toward the Service Recipient and the other staff who were against the far wall. (See Justice Center Exhibits 14 [audio recording of interview with the Subject]; Justice Center Exhibit 15 V1; and testimony of the Subject)

10. While the Subject was facing the Service Recipient with Staff ██████████ between the Service Recipient and the rear wall of the visiting room, the Subject brought his right arm up, positioning his right hand near the Service Recipient's neck. The Subject then put his right hand behind the Service Recipient's neck and pulled the Service Recipient's head down toward his chest. At that point a seventh staff (Staff ██████████) entered the room, moved toward the Service Recipient and placed his left arm around the Service Recipient's left arm. Remaining in front of the Service Recipient, the Subject then moved his right arm into position around the Service Recipient's right arm, and both he and Staff ██████████ pushed the Service Recipient toward Staff ██████████ who was against the wall between the Service Recipient and the wall. The Service Recipient then lifted his head and bit the Subject on his right forearm. The Subject reacted to the Service Recipient's bite by pulling his arm back away from the Service Recipient who in turn immediately released the bite. The Subject then pushed his arm briefly into the Service Recipient's face. (See Justice Center Exhibits 14 [audio recording of interview with the Subject]; Justice Center Exhibit 15 V1; and testimony of the Subject)

11. After being bitten, the Subject decided to transition to a single person restraint and informed the other staff of this decision. As the Subject was attempting to get behind the Service Recipient to perform the single person restraint, the Service Recipient moved forward toward the

██████████

door with his head down. While the Subject had both of the Service Recipient's arms hooked behind the Service Recipient, the Subject moved with the Service Recipient forward through the door and into the common area. As the Subject and the Service Recipient went through the door, they fell directly forward onto the floor in the common area. The Subject never had control of the Service Recipient. The Subject landed on top of the Service Recipient who landed face down on the floor. The Subject quickly moved to the side of the Service Recipient and with the help of other staff maneuvered the Service Recipient into a two person sitting restraint. The Subject remained with the Service Recipient restraining him from behind while another staff secured the Service Recipient's legs. After several minutes, the Subject was replaced in the restraint by another staff and several minutes thereafter the Service Recipient was allowed to stand and be escorted away. (See Justice Center Exhibits 14 [audio recording of interview with the Subject], Justice Center Exhibit 15 V1 and 15 V2; and testimony of the Subject)

12. The Service Recipient had no restrictions in his Individual Intervention Plan concerning restraints. (See Justice Center Exhibit 11)

13. As a result of falling on the floor in the common area, the Service Recipient sustained abrasions or redness on the right side of his face and on his right knee. The Service Recipient also complained of a jammed thumb. (See Justice Center Exhibits 12, 13 and 14 [audio recording of interview with the Service Recipient])

14. At the time of the incident, the Subject had received the following training pertinent to the issues herein: Crisis Prevention and Management (CPM) Securing Legs on ██████████; CPM Refresher ██████████; CPM Instructor/Filed Trainer Update on ██████████; CPM Refresher 2 on ██████████; and CPM Trainer of Trainers on ██████████. (See Justice Center Exhibit 10)

### 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/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 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 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)(a) and (d):

"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.

"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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3 conduct, which is defined as follows:

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 abuse and/or neglect as set forth in the substantiated report.

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 a prohibited act described in the substantiated report as Offense 1. The Justice Center has not established by a preponderance of the evidence that the Subject committed a prohibited act described in the substantiated report as Offense 2. The proven act committed by the Subject constitutes abuse.

In support of its substantiated findings, the Justice Center presented a number of

documents obtained during the investigation (Justice Center Exhibits 1-13 and 16), audio recordings of the Justice Center investigator interrogations (Justice Center Exhibit 14), and Facility surveillance video recordings (Justice Center Exhibit 15). The investigation underlying the substantiated report was conducted by Justice Center Investigator [REDACTED], who testified at the hearing on behalf of the Justice Center. The Justice Center presented one other witness, [REDACTED]. The Subject presented ten documents (Subject Exhibits 1-10) and testified on his own behalf. The Subject also called Investigator [REDACTED] as a witness.

The Justice Center proved by a preponderance of the evidence that the Subject committed abuse by unnecessarily and improperly becoming involved in a physical restraint and attempting to perform a single person restraint and escort as alleged in Offense 1. The Justice Center did not prove by a preponderance of the evidence that the Subject committed physical abuse by striking the Service Recipient in the face as alleged in Offense 2.

#### **Offense 1**

The Justice Center contends that the Subject deliberately used an inappropriate restraint on a Service Recipient by improperly and unnecessarily using a single person escort. The Subject contends that he initiated the single person restraint because only a single person escort could have been used to remove the Service Recipient from the room.

The record establishes that when the Subject entered the visiting room, there were already three staff in the room with the Service Recipient, and at the moment he entered, two of the staff were attempting to restrain the Service Recipient. The Subject testified that he entered the room to assist Staff [REDACTED] and Staff [REDACTED] who were struggling with the restraint. However, a careful review of the surveillance video reveals that the Subject entered the visiting room immediately upon the Service Recipient's behavior escalation and, instead of helping Staff [REDACTED] and Staff [REDACTED], he pushed past Staff [REDACTED] to get to the Service Recipient

██████████ and became involved in the restraint. Furthermore, the Subject's act of pushing by Staff ██████████ contributed to the upending of the table which placed every person in the room at further risk of harm.

Later on in the incident while the Subject was in front of the Service Recipient, the Subject put his right hand around the back of the Service Recipient's neck and pulled it down to his chest. A short while later the Subject put his right arm around the Service Recipient's right arm and pushed him into Staff ██████████ who was against the wall. (See Justice Center Exhibit 15, V1) According to ██████████ ██████████ neither technique (pulling a service recipient's head down by the neck or hooking a service recipient's arm from the front) is taught or permitted under OCFS CPM policy. (See testimony of ██████████)

Finally, the Subject testified that after getting bitten by the Service Recipient, he decided to perform a single person restraint and communicated this decision to the other staff in the room. The Subject testified that the reason for his decision was that it was necessary to remove the Service Recipient from the room due to the small amount of space and the safety hazard posed by the overturned broken table. He further testified that the narrow door opening prevented the possibility of escorting the Service Recipient while in a two person restraint. (See testimony of the Subject)

The OCFS CPM Policies and Procedure Manual provides that "The team approach is the preferred method to be used in all physical restraints", and that "The single person physical restraint may only be used when no other alternative is available." (See Justice Center Exhibit 8 page 9)

While it appears to be true that only a single person escort would have functioned to remove the Service Recipient from the room, the Subject did not establish that at the time he

attempted to perform a single person restraint, there was no alternative to a single person restraint, and there is otherwise insufficient evidence in the record evidence to support such a finding.

Therefore, the Justice Center has sufficiently established that the Subject deliberately became unnecessarily and improperly involved in a physical restraint, and attempted to perform a single person restraint and escort in contradiction to OCFS policy.

### **Offense 2**

The Justice Center contends that the Subject physically abused the Service Recipient when he struck a Service Recipient in the face during a restraint, and that the Subject's actions caused physical injury, serious or protracted impairment of the service recipient's physical, mental or emotional condition or the likelihood of such injury or impairment. The record reflects that, although the Service Recipient sustained abrasions on his head and knee, and complained of a "jammed thumb," he did not sustain these injuries as a result of the Subject's conduct alleged in Offense 2. Furthermore, there's no evidence in the record that would support a finding that the Service Recipient sustained serious or protracted impairment of his physical, mental or emotional condition. Consequently, the Justice Center's remaining theory must be based on the likelihood of physical injury or impairment as a result of the Subject's alleged actions.

The Subject contends that he was following OCFS policy and training which provides that when staff is bitten by a Service Recipient, staff: "must fight your natural reaction" to pull away from the bite and: "push into the bite with the body part being bitten" which: "forces the resident to open his/her mouth wider." (See Subject Exhibit 8 pages 15 and 16)

A careful review of the surveillance video reveals that the Subject initially reacted to the Service Recipient's bite by pulling back from the bite, and then by pushing into the bite. However, by the time the Subject pushed into the bite, the Service Recipient had already released

██████████

the bite and had started to pull his head away from the Subject's arm. As a result, the Subject's arm contacted the Service Recipient's head but was retracted immediately by the Subject. The amount of time, from the time the Service Recipient started biting the Subject's arm until the time the Subject retracted his arm, was less than one second. (See Justice Center Exhibit 15 V1)

It is clear from the video that the Subject's initial reaction, pulling away from the bite, was performed by the Subject at the command of his natural instincts, and that the Subject's secondary action, pushing into the bite, was a deliberative action taken in accordance with the Subject's training. It is also clear that contact between the Subject's arm and the Service Recipient's face was nominal as it lasted for a split second and was done with minimal force. Thus, it is determined that there was very little likelihood that the contact between the Subject's arm and the Service Recipient's face would cause physical injury or serious or protracted impairment of the Service Recipient's physical condition.

Consequently, it is determined that the Subject acted in accordance with OCFS policy and training, and any contact he made with the Service Recipient was a result of that policy and training and that such contact was minimal in time and force, and resulted in no physical injury, physical impairment, or likelihood of either. Therefore, the Justice Center has not sufficiently established that the Subject physically abused the Service Recipient when he struck a Service Recipient in the face during a restraint.

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 physical abuse as alleged in Offense 1. Having determined that the Justice Center has sufficiently proven abuse in Offense 1, the substantiated report will not be amended or sealed. It is further determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse as alleged in Offense 2.

██████████

Although Offense 1 of the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse set forth in the substantiated report. Based upon the totality of the circumstances, the evidence, the testimony presented and the governing legislation, it is determined that the category of the affirmed substantiated abuse described as Offense 1 in the substantiated report was properly substantiated as a Category 3 act.

A substantiated Category 3 finding of abuse or neglect will not result in the Subject 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 ██████████  
██████████ as it pertains to Offense 1 be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse alleged in Offense 1.

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

The request of ██████████ that the report substantiated on ██████████  
██████████; dated and received on ██████████  
██████████ as it pertains to Offense 2 be amended and sealed is granted.

The Subject has not been shown by a preponderance of the evidence to have committed the abuse alleged in Offense 2.

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

**DATED:** August 5, 2015  
Schenectady, New York



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John T. Nasci, ALJ