

**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
AND ORDER
AFTER HEARING**

Adjudication Case #:

[REDACTED]

Held at:

New York State Office Building
333 East Washington St.
Syracuse, New York
On: [REDACTED]

Parties:

Justice Center for the Protection of People with
Special Needs

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

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

[REDACTED]

By: Margaret J. Fowler, Esq.
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject), for neglect 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 neglect 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 (YC2), you committed neglect when you failed to properly supervise a service recipient by failing to prevent him from entering a residential unit where he attacked another service recipient.

This offense has been SUBSTANTIATED as Category 3 neglect, 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). That Recommended Decision is rejected by the Executive Director pursuant to 14 NYCRR 700.13 and the following constitutes the Final Determination of the Executive Director under 14 NYCRR 700.13.

FINDINGS OF FACT

██████████ (the Facility), located at ██████████, is a medium secure residential treatment facility for male service recipients, 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.

At the time of the alleged neglect, the Subject was employed by the Facility as a Youth Counselor 2, and had been employed by the Facility for four years prior to the date of the incident.

At the time of the alleged neglect, the Service Recipient was 16 years of age and was adjudicated a juvenile delinquent and placed in the custody of the Commissioner of the New York State Office of Children and Family Services.

The area of the Facility relevant to this matter is described as follows: There are two residence units (Unit █ and Unit █) and a cafeteria that connect to each other by a common hallway referred to as the "Spine." Ingress and egress between the cafeteria and the two residence units via the Spine is controlled by individual locked doorways. Upon entering the Spine through the doorway from the cafeteria, the doorway to Unit █ is located around a corner approximately ten feet from the cafeteria doorway and is only visible after passing the corner. The Spiritual Room is located off of the cafeteria and is secured by a locked door that enters into the cafeteria. Hearing testimony of ██████████ and Hearing testimony of the Subject.

On or about ██████████, Service Recipient A was in the cafeteria with other Service Recipients when Service Recipient A hit Service Recipient B. Service Recipients A and B were residents of Unit █ and no residents of Unit █ were involved in the assault. In response to Service Recipient A's conduct, the Facility issued an "all available" code call for help in the

cafeteria. The Subject and several other Facility staff responded to the code call and went to the cafeteria. Upon entering the cafeteria, the Subject observed that Service Recipients A and B had each been restrained by other staff members. The Subject then proceeded to assist another staff member, who had Service Recipient C, also a resident of Unit ■, in a standing restraint. Service Recipient C was not involved in the initial assault of Service Recipient B by Service Recipient A, but had become agitated and attempted to involve himself in same. Justice Center Exhibit 9: Hearing testimony of ■ and Hearing testimony of the Subject.

The other staff member, accompanied by the Subject then took Service Recipient C to the Spiritual Room, located off of the cafeteria, to de-escalate Service Recipient C, as he was upset. Upon entering the Spiritual Room, Service Recipient C was released from the restraint and allowed to de-escalate inside the room. After approximately nine minutes, the Subject called "central" control via her radio and obtained permission to move Service Recipient C back to his room in Unit ■. At this time both Service Recipients A and B had been removed from the cafeteria area. Justice Center Exhibit 8: Interrogation of the Subject, Justice Center Exhibit 9: Hearing testimony of ■ and Hearing testimony of the Subject.

The Subject then left the Spiritual Room with Service Recipient C unrestrained walking in front of her. Leaving the Spiritual Room, the Subject and Service Recipient C entered the cafeteria and walked toward the door of the cafeteria which led into to the Spine. As Service Recipient C approached the door to the Spine, another resident, Service Recipient D accompanied by a staff member were being allowed through the door by Staff ■. After Staff ■ allowed Service Recipient D and the staff member through the door, Staff ■ put her arm across the doorway intending to block Service Recipient C from going through the door. Staff ■ asked the Subject if she had clearance from central control to move Service Recipient C and she

indicated that she did have clearance. Hearing testimony of the Subject. Simultaneously, Service Recipient C then grabbed Staff [REDACTED] and pushed Staff [REDACTED] arm out of the way and forced himself through the door opening and proceeded through the doorway followed by the Subject. Justice Center Exhibit 9, Hearing testimony of [REDACTED] and Hearing testimony of the Subject. The Subject failed to respond in any way, as Service Recipient C grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way, forced himself through the door opening and proceeded through the doorway. Justice Center Exhibit 9.

The Subject stated during her interrogation that no youth, including Service Recipient C should have grabbed a staff member and pushed her arm out of the way to get through a doorway. Justice Center Exhibit 8: Interrogation of the Subject.

As Service Recipient C entered the Spine, and after completing a head count and realizing that one of the Unit [REDACTED] residents had not returned to Unit [REDACTED], a staff member opened the door of Unit [REDACTED] which led into the Spine. Justice Center Exhibit 9. This door was normally secured. Service Recipient C noticed that the Unit [REDACTED] doorway was open and took advantage of the open door, ran past a staff member, another service recipient, and other staff members into Unit [REDACTED]. The Subject and another staff ran after the Service Recipient C inside Unit [REDACTED] and seconds later they found Service Recipient C hitting and attacking the Service Recipient. Upon reaching Service Recipient C and the Service Recipient, the Subject and the other staff isolated the Service Recipient and Service Recipient C was put in a standing restraint by another staff. Justice Center Exhibit 2, Justice Center Exhibit 9, Hearing testimony of [REDACTED] and Hearing testimony of the Subject.

The following facts precipitated the actions of the Service Recipient C against the Service Recipient: Service Recipient A had learned that Service Recipient B was going to punch him as

part of a gang initiation ritual and with that information he (Service Recipient A) decided to preemptively assault Service Recipient B, which he did in the cafeteria. Service Recipient C, being in the same gang as Service Recipient B, believed that Service Recipient A had been “tipped off,” by the Service Recipient that Service Recipient B was going to hit him. With that information, Service Recipient C opted to retaliate against the Service Recipient by attacking him when presented the opportunity. Justice Center Exhibit 8: Interview of Service Recipient C and the Service Recipient and Hearing testimony of [REDACTED]

The Subject had no knowledge of Service Recipient C’s plans or of any of the background that led to the incident in the cafeteria, until after the incident was over. There is no evidence in the record that any Facility staff had any such knowledge. Justice Center Exhibit 8: Interrogation of the Subject and Hearing testimony of the Subject.

It was the normal and regular practice of the Facility to disallow a Service Recipient’s entrance into any residence Unit other than his own residence Unit. Hearing testimony of the Subject.

The Subject stated during her interrogation and testified at the Hearing that as Service Recipient C grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way, forced himself through the door opening and proceeded through the doorway, she should have either performed a type of restraint on him (hook up) or put out an code yellow alarm. Justice Center Exhibit 8: Interrogation of the Subject and Hearing testimony of the Subject.

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 neglect.

- Pursuant to Social Services Law § 493(4), the category level that the neglect 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 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 ...” (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 constitutes neglect; and pursuant to Social Services Law § 493(4), the category level that the neglect abuse constitutes.

Neglect is defined by Social Services Law § 488 (1)(h) as:

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical

treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of neglect alleged in the substantiated report and that such act or acts constitute the category level of neglect 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 act, 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 neglect, 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 neglect cited in the substantiated report constitutes a Category 3 act as set forth in the substantiated report.

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

THE HEARING

The Justice Center called one witness, [REDACTED], the Justice Center investigator who conducted the investigation into the subject incident, and offered nine exhibits which were admitted into evidence. Justice Center Exhibit 8 is a CD which contains a recorded statement of the Subject (which was played during the Hearing) and other witnesses obtained during the course of the investigation. Justice Center Exhibit 9 is a CD which contains video footage of the relevant areas of the Facility during the events of [REDACTED]. The Subject testified and offered two exhibits which were admitted into evidence Subject Exhibits 1 and 2.

[REDACTED] testified in relevant part as follows:

On the date of the incident there was an altercation in the cafeteria among service recipients and the Subject responded to the cafeteria to assist. When the Subject arrived in the cafeteria she assisted in controlling Service Recipient C who was upset and ultimately taken into the spiritual Room to calm him down. The Subject then transported Service Recipient C from the Spiritual Room back to Unit [REDACTED]. When the Subject and Service Recipient C arrived at the doorway between the cafeteria and the residential units, Staff [REDACTED] put her arm out to stop Service Recipient C from passing through the doorway. Service Recipient C then grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way, forced himself through the door opening and proceeded through the doorway.

[REDACTED] testified that it was at this point that the Subject should have restrained Service Recipient C, as the youth are not allowed to push the arm of staff and push by staff. [REDACTED] testified that under the OCFS restraint policy, a restraint at the point where Service Recipient C grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way and forced himself through the door opening, was required under Section III C (i) and (ii), which provides that restraints shall only be used to protect the safety of any person or where a youth is attempting to AWOL/escape the boundary of the Facility. Justice Center Exhibit 5.

[REDACTED] further testified that the Subject had a responsibility to supervise Service Recipient C and she was aware that: there was a prior fight in the cafeteria; that Service Recipient C had been taken to the Spiritual room and that he was escalated and that based on her knowledge of what had happened just before Service Recipient C grabbed Staff [REDACTED] pushed Staff [REDACTED] arm out of the way and forced himself through the door opening, provided the Subject with situated awareness that Service Recipient was up to no good when he pushed by Staff [REDACTED]. Finally, [REDACTED] testified that he asked the Subject during her interrogation what she should have

done when Service Recipient C physically pushed past Staff [REDACTED], and she replied that she should have performed a restraint or made a code yellow call, and that there was no such call until Service Recipient C was already into Unit [REDACTED] on his way to attacking the Service Recipient.

Hearing testimony of [REDACTED]

The Subject testified at the Hearing, in relevant part, as follows:

She responded to a call in the cafeteria. When she arrived in the cafeteria she observed several youths in restraints. She then went to assist a staff member restraining Service Recipient C. The Subject's general understanding, at this time, was that there had been a fight in the cafeteria. The Subject and the other staff restraining Service Recipient C then took Service Recipient C into the Spiritual Room for around ten minutes to calm him down and make sure he was safe.

The Subject then obtained clearance to bring Service Recipient C from the cafeteria to the Spine and then into Unit [REDACTED]. The Subject walked behind Service Recipient C as they reached the door between the cafeteria and the Spine. Staff [REDACTED] opened the door and put her arm between the Subject, Service Recipient C and the door and asked the Subject if they were cleared to move. At this point Service Recipient C ducked under Staff [REDACTED] arm, went through the door, noticed the door to Unit [REDACTED] was opened and went into Unit [REDACTED]. The Subject acknowledged that when asked by Investigator [REDACTED], at her interrogation, what should have been done when Service Recipient C grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way, forced himself through the door opening and proceeded through the doorway, she replied either a hook up restraint should have been employed or a code yellow should have been called. However, during her Hearing testimony, she explained that a hook up should not have been performed in the first instance, before utilizing less intrusive methods such as talking to Service Recipient C. Finally,

the Subject testified that she did not know that Service Recipient was going to rush into Unit [REDACTED].

Hearing testimony of the Subject.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h) for failure to provide proper supervision to Service Recipient C which was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient, and did in fact result in the attack of the Service Recipient by Service Recipient C. Furthermore the Justice Center has established that the neglect is properly categorized as a Category 3 act under Social Services Law § 493(4)(c).

Neglect

The Subject has been shown by a preponderance of the evidence to have committed neglect for failure to provide proper supervision to Service Recipient C which was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient, and did in fact result in the attack of the Service Recipient by Service Recipient C.

The Subject and several other Facility staff responded to the code call and went to the cafeteria. Upon entering the cafeteria, the Subject observed that Service Recipients A and B had each been restrained by other staff members. The Subject then proceeded to assist another staff member, who had Service Recipient C, also a resident of Unit [REDACTED], in a standing restraint. Service Recipient C was not involved in the initial assault of Service Recipient B by Service Recipient A, but had become agitated and attempted to involve himself in same. Justice Center Exhibit 9; Hearing testimony of [REDACTED] and Hearing testimony of the Subject.

The other staff member, accompanied by the Subject then took Service Recipient C to the Spiritual Room, located off of the cafeteria, to de-escalate as he was upset. Upon entering the Spiritual Room, Service Recipient C was released from the restraint and allowed to de-escalate inside the room. Justice Center Exhibit 8: Interrogation of the Subject, Justice Center Exhibit 9: Hearing testimony of [REDACTED]; and Hearing testimony of the Subject.

The Subject then left the Spiritual Room with Service Recipient C unrestrained walking in front of her. Leaving the Spiritual Room, the Subject and Service Recipient C entered the cafeteria and walked toward the door of the cafeteria which led into to the Spine. As Service Recipient C approached the door to the Spine, another resident, Service Recipient D accompanied by a staff member were being allowed through the door by Staff [REDACTED]. After Staff [REDACTED] allowed Service Recipient D and the staff member through the door, Staff [REDACTED] put her arm across the doorway intending to block Service Recipient C from going through the door. Staff [REDACTED] asked the Subject if she had clearance from central control to move Service Recipient C and she indicated that she did have clearance. Hearing testimony of the Subject. Simultaneously, Service Recipient C then grabbed Staff [REDACTED] and pushed Staff [REDACTED] arm out of the way and forced himself through the door opening and proceeded through the doorway followed by the Subject. Justice Center Exhibit 9, Hearing testimony of [REDACTED] and Hearing testimony of the Subject. The Subject failed to respond in any way, as Service Recipient C grabbed Staff [REDACTED], pushed Staff [REDACTED] arm out of the way, forced himself through the door opening and proceeded through the doorway. Justice Center Exhibit 9.

The Subject stated during her interrogation no youth, including Service Recipient C should have grabbed a staff member and pushed her arm out of the way to get through a doorway. Justice Center Exhibit 8: Interrogation of the Subject.

The Subject stated during her interrogation and testified at the Hearing that as Service Recipient C grabbed Staff ■, pushed Staff ■ arm out of the way, forced himself through the door opening and proceeded through the doorway, she should have either performed a type of restraint on him (hook up) or put out an code yellow alarm. Justice Center Exhibit 8: Interrogation of the Subject and Hearing testimony of the Subject.

Neglect is defined in Social Services Law § 488(1)(h), in relevant part 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”. Clearly, in this matter the Subject was aware that Service Recipient C was upset and needed to de-escalate as there had been a fight in the cafeteria.

Within a very short period of time after the fight in the cafeteria, while walking behind Service Recipient C and supervising his movement back to his Unit, the Subject witnessed Service Recipient C grab Staff ■ and push Staff ■ arm out of the way and force himself through the door opening, proceed through the doorway, and the Subject did nothing, despite her acknowledgment that she should have either performed a type of restraint on him (hook up) or put out an code yellow alarm. Justice Center Exhibit 8: Interrogation of the Subject and Hearing testimony of the Subject.

Despite the Subject's acknowledgment that she should have responded in some manner, and failed to do so, the video of the incident, not only clearly establishes the Subject's complete inaction or lack of attention, at this critical point in time, but also refutes her Hearing testimony that a hook up should not have been performed in the first instance, before utilizing less intrusive methods such as talking to Service Recipient C. Justice Center Exhibit 9.

Clearly, no less intrusive measure would have prevented Service Recipient C from causing physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or likely causing such physical injury or impairment, once he grabbed Staff ■, pushed Staff ■ arm out of the way, forced himself through the door opening and proceeded through the doorway. In fact, the Subject's complete inaction or lack of attention, at this critical point in time, breached her duty as a custodian and allowed Service Recipient C to run into Unit ■ and seconds later attack the Service Recipient. That the Subject did not know the exact negative consequences of her breach is not a defense. The fact is that the Subject's complete inaction or lack of attention, at this critical point in time, breached her duty to provide proper supervision to Service Recipient C which was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient, and did in fact result in the attack of the Service Recipient by Service Recipient C.

Accordingly, the Justice Center has established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h) against the Service Recipient. Finally, given the above, not only has the Justice Center established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h), against the Service Recipient, but it has also established that the neglect is properly categorized as a Category 3 act under Social Services law § 493(4)(c).

The Administrative Law Judge in the Recommended Decision, recommended that this case be unsubstantiated as to the allegation of neglect, essentially based on two grounds: 1) the Justice Center did not establish by a preponderance of evidence that the Subject committed neglect, against the Service Recipient or any service recipient, because the Subject did not violate the OCFS restraint policy, specifically, Section III C (i) and (ii), which provided that

restraints shall only be used to protect the safety of any person or where a youth is attempting to AWOL/escape the boundary of the Facility. Justice Center Exhibit 5. The ALJ ruled that the AWOL provision in the restraint policy only applied to AWOL attempts outside the Facility boundaries, and no such AWOL attempt was made here and; 2) that, under the OCFS restraint policy, the Subject's failure to perform a restraint at the point where Service Recipient C pushed Staff [REDACTED] arm out of the way and forced himself through the door opening, proceeded through the doorway, was not negligent, because a restraint was not necessary to protect the safety of any person, under Section III C (i). Justice Center Exhibit 5. The ALJ based this conclusion largely on the proposition that the Subject had no prior knowledge of Service Recipient C's plan to attack the Service Recipient or anyone else and that the Subject did not know that the door to Unit [REDACTED] was open, which gave Service Recipient C the opportunity to attack the Service Recipient.

Initially, as a threshold matter, substantiation for neglect under Social Services Law § 488(1)(h), is in no way conditioned on a violation of or non-compliance with any facility or provider agency rule or policy. While a violation of a facility or provider agency rule or policy, could constitute evidence of negligence, such violation is not a condition precedent to a substantiated finding under Social Services Law § 488(1)(h).

Here, however, it is held that the Subject, by her own acknowledgment, as set for above, should have attempted a restraint at the point when Service Recipient C pushed Staff [REDACTED] arm out of the way and forced himself through the door opening, proceeded through the doorway, to protect the safety of any person, including, but not limited to the Service Recipient, under the OCFS restraint policy, Section III C (i). Justice Center Exhibit 5. Moreover, quite apart from the restraint policy, at the same point in time, the Subject, again by her own acknowledgement, should have put out an code yellow alarm, to obtain assistance of other staff, which again could

have reduced the likelihood of Service Recipient C attacking the Service Recipient or other persons.

Rather, the Subject herein, within a very short period of time after the fight in the cafeteria, while walking behind Service Recipient C and supervising his movement back to his Unit, witnessed Service Recipient C grab Staff [REDACTED] and push Staff [REDACTED] arm out of the way and force himself through the door opening, proceed through the doorway and did nothing, despite her acknowledgment that she should have either performed a type of restraint on him (hook up) or put out an code yellow alarm. Justice Center Exhibit 8: Interrogation of the Subject, Justice Center Exhibit 9 and Hearing testimony of the Subject. The Subject's complete inaction or lack of attention, at this critical point in time, breached her duty as a custodian and allowed Service Recipient C to run into Unit [REDACTED] and seconds later attack the Service Recipient.

The second basis for recommending unsubstantiating this allegation, specifically that the Subject had no prior knowledge of Service Recipient C's plan to attack the Service Recipient or anyone else and had no prior knowledge that the door to Unit [REDACTED] was open, which gave Service Recipient C the opportunity to do so, is equally lacking in merit. As set forth above, the fact that the Subject did not know the exact negative consequences of her breach, or the precise ill intent of a service recipient she is supervising, is not a defense. The Subject's complete inaction or lack of attention, at this critical point in time, breached her duty to provide proper supervision to Service Recipient C which was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient, and did in fact result in the attack of the Service Recipient by Service Recipient C.

Accordingly, the Justice Center has established by a preponderance of evidence that the Subject committed neglect, as defined in Social Services Law § 488(1)(h) against the Service Recipient.

Accordingly, based on the foregoing it is hereby:

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

The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report for neglect is properly categorized as Category 3 neglect.

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 4, 2016
Delmar, New York


Davin Robinson
Chief of Staff

**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, Room 115
Syracuse, New York 13202
On: [REDACTED] [REDACTED]

Parties:

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

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

[REDACTED]
[REDACTED]

By: Margaret J. Fowler, Esq.
Levene, Gouldin & Thompson, LLP
P.O. Box F1706
Binghamton, New York 13902

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for 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], received and dated [REDACTED] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject on [REDACTED]. The report was also substantiated against another individual who is not a party to this proceeding. The Justice Center concluded that:

Offense 1

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian (YC2), you committed neglect when you failed to properly supervise a service recipient by failing to prevent him from entering a residential unit where he attacked another service recipient.

This offense has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

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

4. [REDACTED] (the Facility), located at [REDACTED]

██████████, is a medium secure residential treatment facility for male Service Recipients, 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.

5. At the time of the alleged neglect, the Subject was employed by the Facility as a Counselor 2, and had been employed by the Facility for four years prior to the date of the incident.

6. At the time of the alleged neglect, the Service Recipient was 16 years of age and was adjudicated a juvenile delinquent placed in the custody of the Commissioner of the New York State Office of Children and Family Services.

7. The area of the Facility relevant to this matter is described as follows: There are two residence units (Unit █ and Unit █) and a cafeteria that connect to each other by a common hallway referred to as the "Spine." Ingress and egress between the cafeteria and the two residence units via the Spine is controlled by individual locked doorways. Upon entering the Spine through the doorway from the cafeteria, the doorway to Unit █ is located around a corner approximately ten feet from the cafeteria doorway and is only visible after passing the corner. The Spiritual Room is located off of the cafeteria and is secured by a locked door that enters into the cafeteria. The location of the Unit █ doorway is not reflected in the record. (Hearing testimony of ██████████ and hearing testimony of the Subject)

8. On or about ██████████, Service Recipient A was in the cafeteria with other Service Recipients when Service Recipient A hit Service Recipient B. Service Recipients A and B were residents of Unit █ and no residents of Unit █ were involved in the assault. In response to Service Recipient A's conduct, the Facility issued an "all available" code call for help in the

cafeteria. The Subject and several other Facility staff responded to the code call and went to the cafeteria. Upon entering the cafeteria, the Subject observed that Service Recipients A and B had each been restrained by other staff members. The Subject then proceeded to assist another staff member, who had Service Recipient C, also a resident of Unit [REDACTED], in a standing restraint. Service Recipient C¹ was not involved in the initial assault of Service Recipient B by Service Recipient A, but had become agitated and attempted to involve himself in same. (Justice Center Exhibit 9; hearing testimony of [REDACTED] and hearing testimony of the Subject)

9. The other staff member, accompanied by the Subject then took Service Recipient C to the Spiritual Room, located off of the cafeteria. Upon entering the Spiritual Room, Service Recipient C was released from the restraint and allowed to de-escalate inside the room. After approximately nine minutes, the Subject called "central" control via her radio and obtained permission to move Service Recipient C back to his room in Unit [REDACTED]. At this time both Service Recipients A and B had been removed from the cafeteria area. (Justice Center Exhibit 8: audio interview with Subject, Justice Center Exhibit 9; hearing testimony of [REDACTED]; and hearing testimony of the Subject)

10. The Subject then left the Spiritual Room with Service Recipient C unrestrained walking in front of her. Leaving the Spiritual Room, the Subject and Service Recipient C entered the cafeteria and walked toward the door of the cafeteria which led into to the Spine. As Service Recipient C approached the door to the Spine, another resident, Service Recipient D and Staff [REDACTED], were being allowed through the door by Staff [REDACTED]. After Staff [REDACTED] allowed Service Recipient D and [REDACTED] through the door, Staff [REDACTED] put her arm across the doorway intending to block Service Recipient C from going through the door. Staff [REDACTED] asked the Subject if

¹ Service Recipients B and C were members of the same gang and were both residents of Unit [REDACTED]. Service Recipient A was not a member of this gang, but was a resident of Unit [REDACTED].

she had clearance from central control to move Service Recipient C and she indicated that she did have clearance. (Hearing testimony of the Subject) Simultaneously, Service Recipient C then pushed Staff [REDACTED] arm out of the way and proceeded to walk through the doorway followed by the Subject who told Staff [REDACTED] that she had been given permission by central to transport the Service Recipient C to his room in Unit [REDACTED]. (Justice Center Exhibit 8: audio interview with Subject, Staff Z and Service Recipient C; Justice Center Exhibit 9; hearing testimony of [REDACTED] and hearing testimony of the Subject)

11. As Service Recipient C entered the Spine, and after completing a head count and realizing that one of the Unit [REDACTED] residents had not returned to Unit [REDACTED], Staff [REDACTED] opened the door of Unit [REDACTED] which led into the Spine. (Justice Center Exhibit 8: audio interview with [REDACTED] and Justice Center Exhibit 9) This door was normally secured. Service Recipient C noticed that the Unit [REDACTED] doorway was open and took advantage of the open door and ran past Staff A, another Service Recipient, a second staff standing in the Spine, and [REDACTED], who was standing just inside the Unit [REDACTED] doorway. The Subject and another staff ran after the Service Recipient C inside Unit [REDACTED] and seconds later they found Service Recipient C hitting the Service Recipient. Upon reaching the Service Recipients, the Subject and the other staff isolated the Service Recipients and Service Recipient C was put in a standing restraint by another staff. (Justice Center Exhibit 8: audio recorded of interviews of Subject, [REDACTED] and Service Recipient C; Justice Center Exhibit 9; testimony of [REDACTED] and hearing testimony of the Subject)

12. The following facts precipitated the actions of the Service Recipient C against the Service Recipient: Service Recipient A had learned that Service Recipient B was going to punch him as part of a gang initiation ritual and with that information he (Service Recipient A) decided

to preemptively assault Service Recipient B, which he did in the cafeteria. Service Recipient C, being in the same gang as Service Recipient B, believed that Service Recipient A had been "tipped off," by the Service Recipient that Service Recipient B was going to hit him. With that information, Service Recipient C opted to retaliate against the Service Recipient by attacking him when presented the opportunity. (Justice Center Exhibit 8: audio recording interview with Service Recipient C and the Service Recipient and hearing testimony of [REDACTED]).

13. The Subject had no knowledge of Service Recipient C's plans or of any of the background that led to the incident in the cafeteria, until after the incident was over. There is no evidence in the record that any Facility staff had any such knowledge. (Justice Center Exhibit 8: audio interview with Subject and hearing testimony of the Subject).

14. It was the normal and regular practice of the Facility to have Unit [REDACTED] and Unit [REDACTED] Service Recipients eat together in the cafeteria, go to the gym together and go outside together. (Justice Center Exhibit 8: audio recorded interview with [REDACTED] and Staff [REDACTED]) It was also the normal and regular practice of the Facility to disallow a Service Recipient's entrance into any residence Unit other than his own residence Unit. (Hearing testimony of the Subject)

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

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

- 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
 - (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
 - (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct

or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

- (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.
- (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.
- (e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

- (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
- (g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.
- (h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse 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).

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 one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

- (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.
- (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.
- (d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse 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 not established by a preponderance of evidence that the Subject [REDACTED] has committed Category 3 neglect as is alleged in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-7) and audio recordings

of the Justice Center investigator interviews (Justice Center Exhibit 8). The investigation underlying the substantiated report was conducted by Justice Center investigator [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified on her own behalf and presented two exhibits (Subject Exhibits 1 and 2). The Justice Center submitted a visual only video of the incident, which was a significant tool in the analysis of the substantiated allegation. (Justice Center Exhibit 9)

The Justice Center contends that the Subject should have restrained Service Recipient C at the point in time when he pushed past Staff [REDACTED]. In support of its contention, the Justice Center cites OCFS Policy and Procedural Manuals: Supervision of Service Recipient (PPM 3247.03) and Crisis Prevention and Management (PPM 3247.12), which the Justice Center argues, required the Subject to restrain Service Recipient C or, at the least, authorized the restraint.

Addressing the issue of whether a restraint or physical intervention was authorized, first, the Justice Center investigator testified that under OCFS policies and procedure once Service Recipient C pushed past Staff [REDACTED], a restraint or some type of physical intervention was warranted because Service Recipient C was "AWOL."

The Justice Center relies upon NY OCFS PPM 3247.12 (effective February 6, 2012), citing the "Circumstances Under Which Physical Restraint May be Used" provision, and contends that the provision required the Subject to restrain Service Recipient C. There are three relevant circumstances delineated in the PPM namely: 1) "Where emergency physical intervention is necessary to protect the safety of any person;" 2) "Where a Service Recipient is physically attempting to AWOL/escape the boundary of a facility;" and 3) "Where a Service Recipient is physically attempting to AWOL/escape from custody while off-grounds." (Justice

Center Exhibit 5 page 8)

Previous prescribed guidelines which dictated when a restraint could be used, and which are now superseded by OCFS restraint provisions cited above, were not so narrow as to limit an AWOL to “an escape outside of the boundaries of the facility.” In fact, under previous policies a Service Recipient who failed to follow a command to move to another location, or to remain in a specified location within the facility boundaries, was considered to be AWOL and physical intervention was permitted under those circumstances. (See NYS OCFS PPM 3247.13: effective February 27, 2007)²

However, the term AWOL as used in the policy in effect at the time of this report, is narrowly defined to mean an escape beyond the facility boundary. This narrowly tailored definition came about as a result of a revision to the NYS OCFS *Crisis Prevention and Management* (PPM 3247.12): which became effective on February 6, 2012. The narrowly tailored definition of AWOL resulted directly from Federal Civil Rights litigation and the subsequent Federal Court settlement agreement entered into between the New York State Office

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The former New York State OCFS Crisis Prevention and PPM 3247.13: effective February 27, 2007 until February 6, 2012 stated in pertinent part that physical interventions were justified:

1. To prevent a Service Recipient from harming him or herself, staff members, or others.
2. To prevent an escape or AWOL by a Service Recipient: A Service Recipient is attempting to escape and fails to respond when ordered to stop or a Service Recipient is AWOL and refuses to return when located.
3. To escort a Service Recipient who is causing or threatening to cause an immediate serious disruption that threatens the safety of others by refusing to leave a place after being asked to leave because:
 - the Service Recipient is inciting other Service Recipient to hurt themselves or others; or
 - the Service Recipient's behavior is escalating to the point that further de-escalation techniques need to take place in another location.

of Children and Family Service and the United States Justice Department of Justice on July 14, 2010.³

There is no evidence in the record, nor is it contended that Service Recipient C was outside the facility boundaries. Therefore, a physical intervention was not warranted under the applicable OCFS policy authorizing same for an AWOL Service Recipient.

Alternatively, the Justice Center contends that an emergency intervention was necessary to protect the safety of the Service Recipient and others. However, the evidence in record does not support a finding that an emergency intervention was necessary at the point in time that Service Recipient C pushed his way past Staff [REDACTED]. The Subject testified credibly that she had no knowledge of the dynamics that led Service Recipient C to decide to attack the Service Recipient, or that any such attack was imminent or even forthcoming. (Hearing testimony of the Subject) The Counsel for the Justice Center argued that the Subject was aware of the fight in the cafeteria and that this knowledge should have made her situationally aware enough to react to Service Recipient C's push past Staff [REDACTED] by restraining him.

There is absolutely no evidence in the record that the Subject had any knowledge of, or

³ The Settlement agreement between New York State OCFS and the United States Justice Department (<http://www.justice.gov/sites/default/files/opa/legacy/2010/07/14/agreement-07142010.pdf>) which became effective on July 14, 2010 reads in pertinent part that:

41. Use of restraints. The State shall require that Service Recipient must not be subjected to undue restraints. The State shall create or modify policies, procedures, and practices to require that the use of restraints be limited to exceptional circumstances, as set forth below, where all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a Service Recipient poses a danger to himself/herself or others. Restraints shall never be used to punish Service Recipient. Accordingly, restraints shall be used only in the following circumstances:

- i. where emergency physical intervention is necessary to protect the safety of any person;
- ii. where a Service Recipient is physically attempting to escape the boundary of a Facility ...

reason to suspect that Service Recipient C intended to assault the Service Recipient or anyone else after pushing past Staff [REDACTED]. There is no evidence that any staff had such knowledge. Given the information which the Subject had at the relevant time, if the Subject had restrained Service Recipient C, she risked being charged with violating the OCFS restraint policy and a potential finding of a deliberate inappropriate use of restraints.

Initiating a restraint based upon speculation, or in an “abundance of caution” about what might occur without some reasonable basis to conclude that harm is afoot, is greatly discouraged. Stated another way, the presumption is not in favor of, but against restraints and physical interventions in OCFS facilities.

Furthermore, because of the layout of the Facility, it was not possible for the Subject to see the open door to Unit [REDACTED] from the point where Service Recipient C pushed past Staff [REDACTED] and, in fact, Service Recipient C could not have known about the open door to Unit [REDACTED] when he pushed past Staff [REDACTED]. Finally, Service Recipient C’s gate and demeanor did not vary until the point he reached the corner and noticed the open Unit [REDACTED] doorway, giving the Subject no reason to act. Service Recipient C saw the open door, a door which was not normally open and sprinted through the door pushing past the staff who was standing in the doorway. The Subject was not in a position to see the open door and had absolutely no basis to suspect that Service Recipient C would sprint through the door.

The Justice Center further contended that the Subject admitted in her interview that Service Recipient C should have been “hooked-up” as a result of him pushing past Staff [REDACTED]. (Justice Center Exhibit 8: audio interview with Staff [REDACTED]) However, the Subject’s response to the Justice Center investigator’s question: “What should be happening right here?” was: “Probably a Code Yellow? Maybe even hook him up?” The Subject’s response was in the form of a

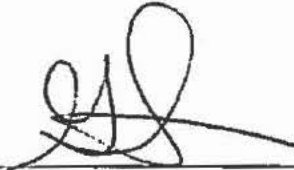
question, as opposed to statement of fact, and appears to have been a function of the Subject thinking out loud of what actions she could or might have taken. Later in the interview the Subject explained that calling a "Code Yellow" was not necessary because a "Code Yellow" had already been called and all available staff had already responded. The Subject further explained that she had no reason to restrain Service Recipient C because, although he pushed past Staff ■, he was moving in the direction she was transporting him, she observed nothing unusual about the manner in which he was comporting himself, and she had no knowledge of his intention to seek an opportunity to attack the Service Recipient. (Justice Center Exhibit 8: audio interview with Subject)

After considering all of the evidence, it is concluded that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in the substantiated report.

DECISION: The request of ■ that the report "substantiated" on ■
■; dated and received on ■
■ be amended and sealed is granted. The Subject has not been shown
by a preponderance of the evidence to have committed neglect.

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

DATED: April 20, 2015
Schenectady, New York


Gerard Serlin, ALJ