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

Adjud. Case #: [redacted]

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: Theresa Wells, Esq.

[redacted]

By: Charles DeAngelo, Esq.
Fessenden Laumer & DeAngelo, PLLC
81 Forest Avenue, P.O. Box 0590
Jamestown, New York 14702-0590

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

ORDERED: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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

DATED: March 6, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that she is not the subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted] of neglect by the Subject of two Service Recipients.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 3[1]

> It was alleged that on [redacted], while on the agency van on an outing from the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to two service recipients by not following their transportation plans, during which time one service recipient had sexual contact with another service recipient.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The [redacted] (the facility), located at [redacted]

[1] Allegations 1 and 2 of the said report were unsubstantiated against the Subject at some point prior to the hearing.

[redacted] provides day habilitation services for disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. The facility also oversees the [redacted] work program that provides jobs for disabled individuals.

5. At the time of the alleged neglect, the Subject was employed as a Direct Support Assistant (DSA) at the [redacted] and also functioned as a shared support staff member at the [redacted] work program. When the Subject worked at [redacted], her direct supervisor was Staff 1, a Habilitation Specialist 1. During work day mornings, the Subject drove to the facility along with the [redacted] service recipients who were residents of the [redacted]. Once at the facility, they met with other participating [redacted] service recipients from various group homes. The Subject's [redacted] job responsibilities involved assisting and supervising service recipients regarding their work program responsibilities and ensuring that they understood their specific work assignments. Due to her employment, the Subject was a custodian as that term is so defined in SSL §488 (2). (Hearing testimonies of the Subject and Staff 1; Justice Center Exhibits 6 and 14)

6. At the [redacted] work program, the service recipients performed various job duties, such as facility landscaping services, piece work for companies in the community as well as some vending tasks. There were times during the work day when [redacted] service recipients traveled by van into the community in order to retrieve or deliver completed piece work under the supervision of Staff 1 and the Subject. At the end of their work day, the service recipients were transported to their respective group homes. (Hearing testimonies of the Subject, Staff 1 and former OPWDD Office of Investigations and Internal Affairs (OIIA) Investigator [redacted]; Justice Center Exhibit 6 and Justice Center Exhibit 14: an audio recording of the Subject's interrogation)

7. At the time of the alleged neglect, Service Recipient 1 was a twenty-three year old male who resided at the [redacted], located at [redacted], since [redacted] 2009. During [redacted] work day mornings, Service Recipient 1 was transported by van from the [redacted] to the facility. Service Recipient 1 had diagnoses of moderate intellectual disability, attention deficit hyperactive disorder (ADHD), impulse control disorder, bipolar disorder and other medical conditions. (Justice Center Exhibits 6 and 11-13)

8. Service Recipient 1's [redacted] Plan Of Protective Oversight (POPO) outlined specific required levels of supervision designed to protect him from sexual exploitation. It is noted in the POPO that Service Recipient 1 is not capable of consenting to sexual relationships. Service Recipient 1's POPO mandated that, during transport, staff was to maintain "range of scan" supervision of him through the use of "strategic seating," which required staff to be seated in the center row seats of the van when more than one service recipient was riding in the van with him. Additionally, Service Recipient 1's POPO stated that he had a history of inappropriate sexual conduct and that he should have limited contact with children when on supervised family visits. He also was prohibited from having access to media that is child-centered, violent or contains inappropriate sexual material. (Hearing testimony of former OPWDD Office of Investigations and Internal Affairs (OIIA) Investigator [redacted]; Justice Center Exhibits 6 and 11-13)

9. At the time of the alleged neglect, Service Recipient 2 was a twenty-four year old male who resided at the [redacted] since 2005 and worked at [redacted] along with Service Recipient 1. Service Recipient 2 had diagnoses of moderate intellectual disability, seizure disorder and other medical conditions. (Justice Center Exhibits 6 and 8-9)

10. According to Service Recipient 2's Behavior Support Plan and

Psychiatric/Behavioral Guidelines revised on [redacted] and Risk Management Plan dated [redacted], Service Recipient 2 had a history of engaging in inappropriate sexual deviant behaviors, which included allegations of sexual abuse. (Justice Center Exhibits 8 and 10)

11. Service Recipient 2's POPO dated [redacted], noted that he is capable of independently fastening and unfastening his seat belt. The POPO also prescribed a "range of scan" supervisory level when other service recipients were riding in the back of the van and directed staff to be "strategically seated" based upon the number of other individuals present and their respective particular behaviors. (Hearing testimonies of OPWDD OIIA Investigator [redacted], Staff 1 and the Subject; Justice Center Exhibits 6 and 9)

12. Sometime between 9:00 a.m. and 2:00 p.m. on [redacted], the Subject and Staff 1 were riding in the van with Service Recipient 1, Service Recipient 2 and two other service recipients during an [redacted] work assignment. The van that was used to transport service recipients during [redacted] work days belonged to the [redacted]. It was a twelve passenger van that had two captain seats in the front for the driver and a passenger. Behind the front seats were three rows of bus-style bench seats that could accommodate two persons on each bench. The Subject was sitting in the front driver's side captain seat driving the van and Staff 1 was sitting in the front passenger side captain seat. Service Recipient 1 was seated in the far back bench seat of the van and Service Recipient 2 was seated in the middle bench seat directly in front of Service Recipient 1's seat. The two other service recipients were seated in the first row bench seats directly behind the two front captain seats. (Hearing testimonies of the Subject and Staff 1; Justice Center Exhibit 6; Justice Center Exhibit: 14, an audio CD of the interrogations of the Subject and Staff 1; and Justice Center Exhibit 19)

13. At some point during the van ride, Service Recipient 2 reached his arm around the

side of his seat and, with his hand, he touched Service Recipient 1's "privates" (penis and testicles) over his pants. Service Recipient 1 and Service Recipient 2 were the only witnesses to the incident. (Hearing testimony of former OPWDD OIIA Investigator [redacted]; Justice Center Exhibit 6; Justice Center Exhibit 14: an audio CD of interviews and interrogations; and Justice Center Exhibits 19 and 26)

14. On [redacted], Service Recipient 1 reported the incident to his psychologist during his psychological interview and assessment. The psychologist found no actual diminution of Service Recipient 1's condition due to staff's actions, and he was unable to determine if the alleged incident caused the likelihood of a diminution of his emotional, social or behavioral development or condition. (Justice Center Exhibits 26 and 29)

15. The day after the incident, Service Recipient 1's body check was performed by the [redacted] nurse and no physical injuries were found. (Justice Center Exhibit 18)

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 of 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 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), which states as follows:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4)(c) 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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed the act of neglect, described as "Allegation 3" in her substantiated report. At the time of the incident, the Subject could not have been responsible for providing continual range of scan supervision for both Service Recipients using strategic seating because she was in the driver's seat focused on driving the van.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-13; Justice Center Exhibit 14: an audio CD of interviews and interrogations; and Justice Center Exhibits 15-31) The investigation underlying the substantiated report was conducted by former OPWDD OIIA Investigator [redacted] who is presently employed as a Justice Center Investigator. [redacted] was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and Staff 1 also testified.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject breached her custodian's duty to the Service Recipients.

The Subject's testimony was similar to Staff 1's testimony. The Subject testified that she was driving the van the entire time that day and that she never heard or saw anything happen. She also testified that Service Recipient 1 never reported an incident to her. The Subject testified that there were occasions when Staff 1 sat in the front passenger seat when she (the Subject) was

driving, but that occurred when there was only one service recipient riding in the van. The Subject testified further that, when Service Recipient 2 was in the van with other service recipients (particularly Service Recipient 1), Staff 1 practiced "strategic seating" because the two Service Recipients fought often. The Subject testified that she does not have a full and independent recollection of riding in the van on the date of the alleged incident, but that Service Recipient 1 usually sat in the far back bench seat of the van. The Subject also testified that she does not recall if both she and Staff 1 were sitting in the front of the van that day, but that about ninety percent of the time Staff 1 sat in the back seats in order to maintain the proper level of supervision of all of the service recipients riding in the van. (Hearing testimonies of the Subject and Staff 1)

For the most part, the testimony of the Subject and Staff 1 was consistent with what they told the investigator during their interrogations. (Justice Center Exhibits 6 and 14)

Additionally, investigatory interviews were conducted with all four service recipients who rode in the van during [redacted] on the day in question. Service Recipient 1 stated in his interview that, while the Subject was driving the van and Staff 1 was in the front passenger seat, Service Recipient 2 inappropriately touched him. Service Recipient 1's statement was consistent with his initial report to [redacted] staff and his psychologist. However, Service Recipient 1's interview was inconsistent with his initial report concerning where he sat in the van and his newly raised allegation that Service Recipient 2 had exposed his genitals to him. These inconsistencies are addressed in more detail later.

Service Recipient 2's interview corroborated Service Recipient 1's version of events insofar as Service Recipient 2 admitted that during a recent [redacted] transportation, he reached behind his center bench seat and inappropriately touched Service Recipient 1 who was sitting behind him in the rear bench seat. Although Service Recipient 2 could not recall the exact date that he did

this, he did recall that the Subject was driving and that Staff 1 was sitting up front next to the Subject. Also, Service Recipient 1's psychological report noted that [redacted] staff, who was present during Service Recipient 1's psychological interview and assessment, reported that Service Recipient 2 apologized to Service Recipient 1 for inappropriately touching him during the van ride.

The third [redacted] service recipient, who was in the van at the time of the incident, told the investigator that he did not witness the incident, that he thought but was not certain that the Subject was driving and that there have been times when he saw both the Subject and Staff 1 sitting in the front seats during the [redacted] van ride.

The fourth service recipient, who was also in the van at the time of the incident, stated that Service Recipient 1 usually sits on the most rear bench seat and that Service Recipient 2 usually sits on the middle bench seat during the van ride. He did not recall anything remarkable that happened on the date of the incident. (Justice Center Exhibits 6, 14 and 26)

The Subject denied the allegations and raised various assertions at the hearing. Because the Subject has raised a complete and meritorious defense to the allegations, all of the other assertions raised by her will not be discussed in detail. The Subject argues that she cannot be found to have committed neglect because she was driving the van at the time the incident occurred and could not have practiced the "strategic seating," as required in the Service Recipients' plans.

Most of the witnesses riding in the van that day, including Service Recipient 1 and Service Recipient 2, stated during their interviews that the Subject was driving the van that day, thereby corroborating the Subject's testimony that she was driving the van the entire time that day. In her hearing testimony, Staff 1 more or less corroborated the Subject's testimony that she (the Subject) was driving the van.

Based upon the credible evidence in the record, it is determined that the Subject was driving the van on the day of the incident and, as a result, she was not able to nor required to provide "range of scan" supervision of the service recipients who were riding in the van. Staff 1 was present for that purpose, and it is determined that Staff 1 had the duty to maintain proper "range of scan" supervision of all of the service recipients, including the two Service Recipients, by utilizing "strategic seating," as mandated by the Service Recipients' transportation plans. The Subject could not have driven the van while simultaneously providing continual "range of scan" supervision of all of the service recipients without jeopardizing the safety of all of the van occupants. Therefore, it is further determined that the Subject did not have a duty to provide "range of scan" supervision of the Service Recipients.

Accordingly, the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. Therefore, the substantiated report against the Subject will be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] 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 Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: February 28, 2017
West Seneca, New York