

**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]

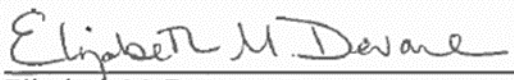
The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

This decision is ordered by Elizabeth M. Devane, ALJ, Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: September 24, 2018
Schenectady, New York


Elizabeth M. Devane
Administrative Law Judge

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[REDACTED], Subject
Michael Diederich, Jr., Esq.

**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 B. Rocco
Administrative Law Judge

Held at:

New York State Justice Center for the Protection
of People with Special Needs
Eleanor Roosevelt State Office Building
4 Burnett Blvd., 2nd Floor
Poughkeepsie, New York 12601
On: [REDACTED]

Parties:

New York State Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Alliah Rozan, Esq.

[REDACTED]

By: Michael Diederich, Jr., Esq.
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361 Route 210
Stony Point, New York 10980

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 "substantiated" report dated [REDACTED] of neglect by the Subject of a Service Recipient.

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

Allegation 2¹

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to provide proper supervision to a 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 in-patient adolescent psychiatric unit [REDACTED] at the facility, [REDACTED], located at [REDACTED], provides inpatient psychiatric treatment to adolescents with varying psychiatric diagnoses, and as such, is licensed by the New York State

¹ Allegation 1 was unsubstantiated.

Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by the facility as a Patient Care Technician (PCT) for approximately 3 years and worked a regular [REDACTED] shift four days a week. The Subject's duties as a PCT included the care, support and safety of the service recipients. (Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a sixteen-year old male with relevant diagnoses of unspecified psychotic disorder, unspecified anxiety disorder, major depressive disorder with a history of self-injurious behavior and suicidal ideations. At the time of the alleged neglect, the Subject was assigned 1:1 constant observation of the Service Recipient due to the risk of self-mutilation and verbalized suicidal ideation. (Justice Center Exhibits 8, 9 and 10)

7. [REDACTED] policy regarding constant observation provided for continual oversight to ensure the safety and security of the facility's vulnerable service recipients. The facility policy dictated that staff assigned to constant observation were required to maintain an "eyes on at all times" unobstructed view of the assigned service recipient. Additionally, the policy prohibited a staff member from relinquishing a constant observation assignment unless relieved by another staff member. (Justice Center Exhibit 11)

8. At approximately 7:30 p.m. on the date of the alleged neglect, approaching the end of his shift, the Subject was walking down the hallway towards the nurse's station with the Service Recipient following a few feet behind him. As the Subject passed Service Recipient [REDACTED] bedroom, Service Recipient [REDACTED] requested the Subject enter his room for a discussion. The Subject reluctantly stepped into the room in response to Service Recipient [REDACTED] pleading, wherein a physical

altercation ensued. The Service Recipient remained alone in the hallway until other staff responded to the commotion coming from Service Recipient [REDACTED] bedroom. (Justice Center Exhibits 6, 23, 24 and 30; Hearing testimony of the Subject)

9. The [REDACTED] Police Department investigated an allegation of assault regarding the altercation inside Service Recipient [REDACTED] room, which resulted in no criminal charges being pursued; however, the instant neglect allegation followed. (Justice Center Exhibit 31)

ISSUES

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

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of 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) as follows:

- (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.

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

(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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act of neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 established by a preponderance of the evidence that the Subject

committed an act, described as “Allegation 2” in the substantiated report.

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that he breached that duty and that his breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-31) 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 in his own behalf and provided no other evidence.

On the day of the alleged neglect, the Subject was employed by the facility as a PCT and was therefore acting as a custodian as that term is defined in Social Services Law § 488(2).

The facts are not in dispute. The record established, and the Subject admitted in his police interview and in his testimony, that while assigned 1:1 constant observation of the Service Recipient, the Subject momentarily left the Service Recipient unsupervised in the hallway to address Service Recipient [REDACTED]. The Subject testified that, as he walked down the unit hallway with the Service Recipient in tow, he was briefly diverted, responding to Service Recipient [REDACTED] request to enter his room to converse. (Justice Center Exhibits 6, 7, 13, 17, 23, 24 and 30; Hearing testimony of the Subject)

Counsel for the Subject argued that there was no evidence from “any medical authority” to prove an allegation of neglect. Counsel for the Subject argued that the Subject was in the presence and proximity of the Service Recipient at all times and did not expect to get assaulted by Service

Recipient [REDACTED]. Counsel for the Subject asserted that the Subject was lured into Service Recipient [REDACTED] bedroom where he was violently attacked. Counsel for the Subject argued that the Subject did not abandon the Service Recipient but rather attended to his other duties as a PCT by responding to Service Recipient [REDACTED] request to talk. Counsel for the Subject further argued that the facility policy regarding levels of observation was merely guidance and that it would have been ridiculous to strictly construe the terms in practice. Counsel for the Subject insisted that 1:1 observation was implausible here because once the Subject was assaulted by Service Recipient [REDACTED], the Subject's duty to maintain eyes on visual supervision of the Service Recipient was superseded by his need to defend himself. Counsel's arguments were not convincing, as each conspicuously overlooked the uncontroverted facts in this matter as well as the fundamental elements of neglect as defined by SSL § 488(1)(h).

The principal objective of the facility's observation policy is to provide the necessary level of supervision required by the service recipient's condition with the safety and well-being of the service recipient being paramount. The facility policy is precise in its definition of constant observation as maintaining an unobstructed, eyes on at all times visual observation of the service recipient. Additionally, the policy unambiguously dictates that a staff member assigned to constant observation should not attend to anything other than their assigned service recipient at all times. (Justice Center Exhibit 11)

The evidence clearly established that the Service Recipient required 1:1 constant observation at all times because of his proclivity to self-mutilate, as well as his history of suicidal ideation. The Service Recipient's Comprehensive Treatment Plan specifically addressed his concerning behaviors by requiring staff to maintain constant visual supervision for his welfare. (Justice Center Exhibit 10) Additionally, Inpatient Progress Notes and the Discharge Summary

similarly emphasized the nature of the Service Recipient's dangerous behaviors and the requirement for constant visual supervision as a proactive safety measure. (Justice Center Exhibits 8 and 9) Furthermore, the Subject testified that he was familiar with the Service Recipient's history of self-injurious behavior and suicidal ideation, and acknowledged the need for and understanding of the Service Recipient's required supervision level. (Hearing testimony of the Subject)

The Subject testified that, as a PCT, he owed a duty to all of the service recipients on the unit and that he was attempting to assist Service Recipient ■ by engaging in a conversation initiated by him. The Subject explained that the unit's service recipients were vulnerable adolescents and, as a PCT, his duty was to support each of them, regardless if he was assigned 1:1 with another service recipient. The Subject testified that Service Recipient ■ had experienced some difficulties earlier that day and the Subject believed that he was aiding in the therapeutic support of Service Recipient ■ when he responded to his request to talk. (Hearing testimony of the Subject) Conversely, the Subject admitted during his testimony that he was warned earlier in the day that Service Recipient ■ was exhibiting aggressive behavior targeted towards the Subject and that the Subject was instructed by a supervisor to avoid interaction with Service Recipient ■. (Justice Center Exhibits 6, 20, 21 and 30; Hearing testimony of the Subject)

Although the Subject's testimony regarding his dedication to and concern for each individual service recipient was credible and commendable, it did not abrogate the duty he owed to the Service Recipient to maintain constant, unobstructed visual supervision, which he admittedly did not do. Not only did the Subject breach his duty by failing to maintain eyes on supervision of the Service Recipient when he walked down the hallway as the Service Recipient followed behind him, (Justice Center Exhibits 17 and 28 at page 073; Hearing testimony of the Subject) but the Subject further breached his duty when he left the Service Recipient in the hallway

unsupervised upon entering Service Recipient [REDACTED] room. (Justice Center Exhibit 28 at pages 075 – 077; Hearing testimony of the Subject) Moreover, the Subject acknowledged during testimony, that once inside Service Recipient [REDACTED] room, his focus was exclusively on Service Recipient [REDACTED] not the Service Recipient. (Hearing testimony of the Subject)

It is not necessary for the Justice Center to prove that the Subject's conduct caused actual physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients, if a preponderance of the evidence supports a conclusion that such injury or impairment was likely. (SSL § 488(1)(h)) The fact that the Service Recipient was placed on a 1:1 supervision level for self-injurious behavior and suicidal ideations emphatically underscores the significant likelihood of potential harm or death to the Service Recipient if left unsupervised.

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 neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act. A substantiated Category 3 finding of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496(2). This report will be sealed after five years.

DECISION:

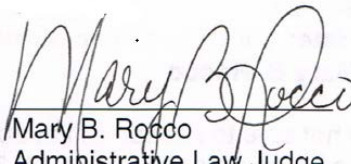
The request of [REDACTED] that the substantiated report dated [REDACTED]
[REDACTED] be amended and sealed is denied.

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

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Mary B. Rocco, Administrative Hearings Unit.

DATED: September 7, 2018
Plainview, New York



Mary B. Rocco
Administrative Law Judge