

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**  
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, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: December 27, 2019  
Schenectady, New York



Elizabeth M. Devane, Esq.  
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register  
Rachel Dunn, Esq.  
[REDACTED], Subject  
Brian Barrett, Esq.

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Mary Jo Lattimore-Young  
Administrative Law Judge

Held at:

New York State Justice Center for the Protection  
of People with Special Needs at

[REDACTED]

-and-

[REDACTED]

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: Rachel Dunn, Esq. and

Thomas Parisi, Esq.

[REDACTED]

By: Brian Barrett, Esq.

5676 Cascade Road

Lake Placid, New York 12946-4139

### **JURISDICTION**

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

### **FINDINGS OF FACT**

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

1. The VPCR contains an amended "substantiated" report dated [REDACTED], [REDACTED] of abuse and neglect by the Subject of a Service Recipient.
2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

#### **Allegation 1**

It was alleged that on [REDACTED], concerning a report of a reportable incident that occurred at the [REDACTED], located at [REDACTED], while a custodian, you committed abuse (obstruction of reports of reportable incidents) when, while being interviewed and/or interrogated during the course of an investigation of Category 1 conduct, you intentionally made materially false statements with the intent to obstruct said investigation.

This allegation has been SUBSTANTIATED as Category 1 serious conduct pursuant to Social Services Law § 493(4)(a)(xiii).

#### **Allegation 2**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to provide adequate medical care to a service recipient, which included not immediately seeking medical attention and/or making appropriate notifications for him while he experienced a grand mal seizure,

not appropriately positioning him during his seizure episode, and/or not immediately complying with requests made by Emergency Medical Technicians.

This allegation has been SUBSTANTIATED as Category 1 neglect pursuant to Social Services Law § 493(4)(a)(ii)

### **Allegation 3**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed serious physical abuse when you intentionally or recklessly caused physical injury, or serious impairment of health, or loss or impairment of the function of any bodily organ or part, or consciously disregarded a substantial and unjustifiable risk that such physical injury, impairment, or loss would occur when you used excessive force to take down a service recipient, during which time his head struck the floor, and/or you used your forearm to apply pressure to the service recipient's throat.

This allegation has been SUBSTANTIATED as Category 1 serious physical abuse pursuant to Social Services Law §493(4)(a)(i).

### **Allegation 4**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed abuse (deliberate inappropriate use of restraints) when you conducted an unwarranted restraint with excessive force and improper technique, which included tackling or utilizing a similar unapproved technique to take down a service recipient.

This allegation has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) pursuant to Social Services Law § 493(4)(b).

### **Allegation 5**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to utilize appropriate de-escalation techniques with a service recipient, and instead pushed or bumped into him, spoke to him in an inappropriate manner, and/or escalated or otherwise provoked a behavior.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. [REDACTED], the facility, located at [REDACTED], is a facility for disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. The service recipients who reside at the facility range in ages from approximately eighteen to over fifty years old. Most, if not all, of the service recipients were placed at the facility as a result of a family court and/or criminal court proceeding. The facility was comprised of three different units with security levels ranging from most secure to least secure. The service recipients involved in the instant matter resided in the four moderately secure residential houses collectively referred to as the [REDACTED] houses: House [REDACTED], House [REDACTED], House [REDACTED] and House [REDACTED]. Staff involved in the instant matter were assigned to work in these four houses. (Hearing testimony of Justice Center Investigator 1<sup>1</sup>; Justice Center Exhibits 66 A at page 664, 67, 72 and 75 - 77)

5. At the time of the alleged abuse and neglect, the Subject<sup>2</sup> had been employed at the facility since 2009 as a Developmental Disabilities Secure Care Treatment Aid (DDSCTA) 1 and was responsible for the direct care of the service recipients. The Subject had been trained in Strategies in Crisis Intervention - Revised (SCIP-R)<sup>3</sup> as well as first aid and CPR trainings, which included the facility's seizure protocol requiring staff to place a service recipient on his side (known as the recovery position) to prevent aspiration when a seizing service recipient foamed at

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<sup>1</sup> [REDACTED] is hereinafter referred to as Justice Center Investigator 1.

<sup>2</sup> It should be noted that, prior to the hearing, the Subject was arrested and charged with the felony of falsifying business records along with multiple misdemeanor charges. Following a jury trial, the Subject was acquitted on all charges. Documents relating to his criminal prosecution are a part of the Justice Center's records. (Justice Center Exhibits 33, 56, 59, 67, 72, 75 - 77 and Subject Exhibit C)

<sup>3</sup> SCIP-R refers to facility authorized physical restraint interventions that are maneuvers taught to staff to use to address a service recipient's behavioral episodes if SCIP-R is allowed by their treatment plans.

the mouth. (Hearing testimonies of the Subject, the former facility Mental Hygiene Developmental Specialist Trainer (MHDST)<sup>4</sup> and Justice Center Investigator 1; Justice Center Exhibits 8, 21, 67, 72 and 75 - 77) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. On [REDACTED], the date of the alleged incident, the Subject, Staff 1<sup>5</sup>, Staff 2<sup>6</sup>, Staff 3<sup>7</sup>, Staff 4<sup>8</sup>, Staff 5<sup>9</sup>, Staff 6<sup>10</sup>, and Staff 7<sup>11</sup> worked the same [REDACTED] shift. The Subject was assigned to work in House [REDACTED]. Staff 1, the Subject's girlfriend and a DDSCTA 1, worked in House [REDACTED]. Staff 8<sup>12</sup> and the facility Registered Nurse (RN 1)<sup>13</sup> were also present during the shift. (Hearing testimonies of the Subject, Staff and Justice Center Investigator 1; Justice Center Exhibits 33, 54, 67, 72 and 75 - 77)

7. At the time of the alleged abuse and neglect, the Service Recipient was an eighteen-year-old male who had resided in House [REDACTED] for approximately [REDACTED] and was placed there pursuant to a court mandate. (Justice Center Exhibit 21 at page 2) The Service Recipient had a diagnosis of a moderate intellectual disability with no psychiatric diagnoses and no psychotropic medication indicated. (Justice Center Exhibit 21)

8. The Service Recipient's [REDACTED] Intake and Interim Behavioral Intervention Plan (IBIP) required staff to follow the IBIP for the Service Recipient's supervision and care. The IBIP listed punching, hitting and theft as the Service Recipient's target behaviors

4 [REDACTED] is hereinafter referred to as **MHDST**.

5 [REDACTED] is hereinafter referred to as **Staff 1**.

6 [REDACTED] is hereinafter referred to as **Staff 2**.

7 [REDACTED] is hereinafter referred to as **Staff 3**.

8 [REDACTED] is hereinafter referred to as **Staff 4**.

9 [REDACTED] is hereinafter referred to as **Staff 5**.

10 [REDACTED] is hereinafter referred to as **Staff 6**.

11 [REDACTED] is hereinafter referred to as **Staff 7**.

12 [REDACTED] is hereinafter referred to as **Staff 8**.

13 [REDACTED] hereinafter referred to as Registered Nurse (**RN 1**).

and noted that the focus of his treatment should include social/personal adaptive skills training and anger management. Most importantly, the IBIP specified that staff were allowed to use physical restraint interventions under SCIP-R for behavioral management of the Service Recipient in the event of an “EMERGENCY only, after 1 verbal prompt” and that staff should attempt to re-direct the Service Recipient by pointing or gesturing to an adjacent area for him to remove himself from the situation and “...*Chill* and sit down.” In the alternative, the IBIP allowed staff to “use 1 or 2 - person escorts/removals” of the Service Recipient under SCIP-R if it was needed to safely remove the Service Recipient to an “adjacent area” to allow him to calm down. (Hearing testimonies of MHDST and Justice Center Investigator 1; Justice Center Exhibits 21, 72 and 75 - 77)

9. In handling emergencies at the facility, all direct care staff members were required to carry on their person a key chain or hand-held fob, commonly referred to as the “[REDACTED].” Staff were required to push the [REDACTED] if they needed immediate assistance and, once activated, the facility safety officer was notified as to which staff member needed assistance as well as their exact location within the facility. The safety officer then dispatched this information over the facility’s intercom system to alert available staff to immediately report to the scene for assistance. In the event of a potential medical emergency, staff were required to call a special recorded telephone line known as Code [REDACTED] which was connected to the facility’s internal telephone line and directly piped into the facility’s safety office. Thereafter, the safety officer would summon emergency services and broadcast an alert throughout the facility for staff to immediately respond. (Justice Center Exhibits 66 A, 67, 72 and 75 - 77)

10. The facility’s “Policy and Procedure for Suspected Head Injury,” dated March 23, 1999 (Head Injury Policy), stated that staff were to “respond prudently and cautiously to suspected head injuries” involving service recipients. The Head Injury Policy, however, did not state a

specific time frame as to when nursing was required to be contacted in the event of a suspected head injury. The first four items of the Head Injury Policy specifically noted that direct care staff responsibilities on campus were: 1.) to assess if a service recipient was “conscious or unconscious;” 2.) “not” to “move” a service recipient (“consumer”) and stabilize their “cervical spine if spinal injury suspected”; 3.) to “stop any bleeding”; and 4.) to notify the “nurse.” (Justice Center Exhibit 62)

11. Sports activities for the service recipients were scheduled by the facility’s Recreational Therapist<sup>14</sup> and were held in the gymnasium located in the [REDACTED] program area of the facility. Typically, two different houses were permitted to attend one recreational period in the gymnasium at the same time. When the recreational period ended, the service recipients walked down the hallway into their assigned homerooms to gather (or “hub up”) for a head count before staff escorted them to their assigned residential houses. There were times when the facility’s Hab Spec or other staff would authorize a service recipient to attend more than one recreational period, thereby allowing a service recipient to participate in activities that involved residents from different houses. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 51, 67 - audio interview of Hab Spec 1 with transcript and Staff 8’s audio interviews with transcripts, 72 and 75 - 77)

12. On [REDACTED], there were two recreational periods scheduled: service recipients who lived in Houses [REDACTED] and [REDACTED] attended the first recreational period that began at 2:15 p.m. and ended at 3:00 p.m. and service recipients who lived in Houses [REDACTED] and [REDACTED] attended the recreational period from 3:00 p.m. to 3:45 p.m. Since the Service Recipient lived in House [REDACTED], he attended the first recreational period along with his housemates. However, on that day, the Hab

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<sup>14</sup> [REDACTED] is the facility’s Recreational Therapist (or Habilitation Specialist (**Hab Spec**) 1.



Spec 1 allowed the Service Recipient and Service Recipient B to stay over at the end of the first recreation period and attend the second recreational period. At the end of the second recreation period, the Service Recipient was to report to the Computer Room in order to “hub up” and then be escorted by staff to his own residence at House [REDACTED]. Service Recipient B was to report to House [REDACTED] homeroom and then be escorted to his own House [REDACTED]. (Hearing testimony of Justice Center Investigator 1 and Justice Center Exhibits 47 - 49, 51, 67 - audio interviews of Hab Spec 1, Service Recipient D, Staff 8’s second audio interview, 72 and 75 - 77)

13. The second recreational period, however, abruptly ended (sometime between 3:00 p.m. and 3:15 p.m.) because the Service Recipient became upset with regard to a sporting activity. The Service Recipient then became further agitated because the recreation period had prematurely ended. At some point, the Service Recipient, while still in the gym, called Staff 1 a “bitch” or “whore.” Other service recipients were present in the gym and overheard the Service Recipient’s demeaning comment about Staff 1. (Justice Center Exhibits 66 A at pages 258 - 278, 66 B, and 67 - audio interviews of Staff 3, Staff 8, Hab Spec 1 and Service Recipients A, C, F, G and H) The Subject, who was also still present in the gymnasium, either heard the Service Recipient make the derogatory comment to Staff 1 or somehow became aware that the comment was made from other staff or service recipients. The service recipients then began to transition, exiting the gymnasium with staff and walking down the corridor toward their respective homerooms. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 51, 67 - audio interviews of Hab Spec 1, Staff 3 and Staff 8 and Service Recipients A and B; 72 and 75 - 77)

14. While the service recipients were still transitioning into their assigned homerooms, the Subject walked down the hallway behind the Service Recipient who was headed towards the Computer Room. Staff 3 was in his homeroom located across and down the hall from the

Computer Room. Staff 3 could hear the Service Recipient coming down the hallway and yelling “I didn’t do it” at the Subject. As they walked down the hallway, the Subject agitated the Service Recipient by pushing him while the Service Recipient kept telling the Subject to stop it. After the Service Recipient entered the Computer Room, the Subject followed. The Subject at some point stated out loud, and within earshot of Service Recipient C, that the Subject was going to teach the Service Recipient a lesson. (Justice Center Exhibit 67 - audio interviews of Service Recipients A and C) The Service Recipient was upset and tried to leave the Computer Room. The Subject and Staff 2 ran out into the hallway after the Service Recipient. Staff 2 stood in the doorway. The Subject told the Service Recipient to get back in “the fucking class” but the Service Recipient refused. The Subject then tried to grab or push the Service Recipient to direct him back into the Computer Room. The Service Recipient told the Subject not to touch him. (Justice Center Exhibit 67 - audio interviews of Service Recipients C and G)

15. When the Service Recipient eventually entered the Computer Room, he was upset and kicked an object (either a garbage can or fan) toward the back of the Room where there were no other service recipients. (Justice Center Exhibit 20 - photographs at page 5) The Subject re-entered the Computer Room, approached the Service Recipient and, as they stood face to face, the Service Recipient began to yell at the Subject. Upon hearing the commotion at approximately 3:15 p.m., Staff 8 left House [REDACTED] homeroom, headed down the hall and entered the Computer Room. Staff 8 observed the Service Recipient and Subject standing face to face and arguing in the back of the room. At some point, Staff 3 also heard the commotion and entered the Computer Room. Service Recipients A, C, E and G, along with a number of other service recipients, as well as Staff 1 and Staff 2, were present in the Computer Room but were not near the Subject and the Service Recipient at that time. (Hearing testimony of Justice Center Investigator 1; Justice Center

Exhibits 66 A at pages 352 - 373 and 67 - audio interviews of Staff 4, Staff 8 and Service Recipients A, C and G, 72 and 75 - 77)

16. Sometime between 3:15 p.m. and 3:30 p.m., the Service Recipient continued to vocalize at the Subject at which point the Subject engaged in a football-style tackle of the Service Recipient. The Subject bent over, rammed his shoulder into the left side of the Service Recipient's mid-section and then grabbed the outside of the Service Recipient's knees, causing the Service Recipient to lift upwards, fall backwards and hit the back-crown portion of his head on the hard floor. The Subject then fell on top of the Service Recipient. When the Service Recipient fell, the impact of the back of his head slamming onto the floor emitted a loud noise that could be heard by staff and service recipients in the Computer Room. (Justice Center Exhibit 67 - audio interviews of Staff 3 and Staff 8, Service Recipients A, C and G)

17. As the Service Recipient laid on his back, the Subject re-positioned himself and grabbed the Service Recipient's right arm to hold him down. Staff 2 grabbed the Service Recipient's left arm and Staff 3 grabbed onto the struggling Service Recipient's legs to hold them down. Staff 8, who remained in the Computer Room and was about ten feet away from where the Service Recipient was lying, observed the Subject placing his forearm tightly across the Service Recipient's neck, swearing and yelling at the Service Recipient that he better respect females. The Service Recipient struggled to breathe because of the Subject's chokehold and his facial coloring had changed to a reddish-grey. Thereafter, the Subject released his chokehold of the Service Recipient and re-positioned his hold by grabbing the Service Recipient's right arm. (Justice Center Exhibit 67 - audio interviews of Staff 8's second interview and Service Recipient G)

18. While the Subject, Staff 2 and Staff 3 continued to maintain their hold, the struggling Service Recipient remained lying on his back on the floor. At some point, the yelling

and kicking Service Recipient began to black out and experience seizure-like symptoms while staff continued to hold him down. (Justice Center Exhibit 67 - audio interviews of Staff 8, Service Recipients A and G)

19. At approximately 3:30 p.m., while the Service Recipient's seizure continued, staff maintained their hold of him as he laid on his back on the floor, at which point foam began to expel from his mouth. Present in the Computer Room with the Subject was Staff 1, Staff 2, Staff 3 and Staff 8. While the Subject, Staff 2 and Staff 3 continued to maintain their hold of the Service Recipient and the Service Recipient's seizure continued, the Subject and the staff in the room focused their discussions on what they were going to say and do to cover up what had happened to the Service Recipient. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibit, 67 - Staff 3's audio interview and Staff 8's second audio interview; 72 and 75 - 77)

20. Finally, Staff 1 pressed her [REDACTED] which registered on the Safety Officer's computer at 3:47 p.m. and Staff 4, the hall monitor, immediately responded and entered the Computer Room. (Justice Center Exhibits 66 A at pages 110 - 115 and at pages 393 - 408) Staff 1 told Staff 4 to call the Code [REDACTED]. Staff 4 mistakenly called Safety Officer 1 at extension [REDACTED] and told him that there may be a medical emergency. Safety Officer 1 instructed Staff 4 to hang up and call back on the special Code [REDACTED] line required for medical emergencies. (Justice Center Exhibit 66 A at page 403) 911 emergency was called at approximately 3:48 p.m., Safety Officer 1 radioed and paged medical staff to immediately report to the scene. (Hearing testimonies of Staff 1, Staff 4 and Justice Center Investigator 1; Justice Center Exhibits 16, 66 A at pages 98 - 114 and at pages 388 - 409, 67 - Safety Officer 1's audio interview, 72 and 75 - 77)

21. After the [REDACTED] was activated, but before the Code [REDACTED] was called, Staff 5 and Staff 6, who were both in the Head of Shift office, responded and entered the Computer Room.

Staff 6 assisted in holding down the Service Recipient. Staff 5 briefly left the Computer Room and returned with head pads that were placed either next to or underneath the Service Recipient's head. Staff 5 also supervised staff in the Computer Room and at times momentarily left the room to arrange for the Service Recipient's transport to the hospital. Staff 7 had stepped into the room momentarily to ask if assistance was needed but staff told her to go across the hall to assist with the other service recipients removed from the room. Staff 7 complied. (Hearing testimonies of the Subject, Staff 5, Staff 6 and Staff 7; Justice Center Exhibits 67, 72 and 75 - 77)

22. In response to the [REDACTED] and/or Code [REDACTED], Safety Officer 2<sup>15</sup> was the first officer to arrive at the scene. Shortly thereafter, Safety Officer 3<sup>16</sup> entered the Computer Room and saw the Service Recipient was lying on his back during his seizure event with some of the staff kneeling around him. At some point, during the Service Recipient's seizure, Staff 3 yelled out to everyone "we're fired, we're done!" While waiting for medical responders to arrive and as the Service Recipient remained lying on his back during the seizure, the Subject and the other staff in the Computer Room continued their conversations about the story they were planning to collectively tell about what happened to the Service Recipient. (Justice Center Exhibit 67 - audio interviews of Staff 3, Service Recipient A and Staff 8's second audio interview) Some of the staff took notes about the false narrative they had begun to develop. To assist in restraining the Service Recipient, Staff 8 took hold of the Service Recipient's arm from Staff 2, during which time Staff 8 overheard the other staff's conversations evincing their panic and concerns about being fired from their jobs due to the Service Recipient's seizure. During that group conversation, the Subject, Staff 1, Staff 2, Staff 3 and Staff 8 were all in the Computer room. Staff 5 and Staff 6 were also

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<sup>15</sup> [REDACTED] is hereinafter referred to as **Safety Officer 2**.

<sup>16</sup> [REDACTED] is hereinafter referred to as **Safety Officer 3**.

in the Computer Room during the group conversation, having arrived after the Service Recipient was taken to the floor. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - audio interviews of Staff 3, Staff 8, Safety Officer 3; 72 and 75 - 77)

23. RN 1, the first medical staff person to arrive at the scene, observed the Service Recipient lying on his back having a seizure with foam coming from his mouth. RN 1 performed a cursory assessment of the Service Recipient and completed the [REDACTED] Body Check Form which she and Staff 6 had signed. (Justice Center Exhibit 26 at pages 1 - 2) On said Body Check Form, RN 1 had documented a "Medical Emergency Grand mal Seizure" and that "while [the Service Recipient] was on floor lying on R side<sup>17</sup> did a quick check of...head... Ø lumps noted, Ø blood noted unable to visualize injury to head" and further stated that "asked staff if he hit his head and they stated he did not." RN 1's Body Check Form also did not list any injuries, lacerations, redness or bruising seen on the either of the Service Recipient's knuckles or the backside of his hands. (Justice Center Exhibit 26)

24. When the facility physician<sup>18</sup> and other nursing staff, RN 2<sup>19</sup> and RN 3<sup>20</sup>, subsequently arrived, they all observed that the Service Recipient was lying on his back and having a seizure with foam coming from his mouth. (Justice Center Exhibit 67) By then, Staff 7 had returned to the Computer Room and, together with other staff, assisted medical responders by holding the Service Recipient down as the facility doctor attempted to administer an IV of anti-seizure medication in the Service Recipient's right arm. At some point, an unidentified female staff person asked RN 1 to explain the proper procedure for staff to undertake in the event of a

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<sup>17</sup> During RN 1's investigatory interview and testimony in her criminal trial, RN 1 admitted that although she documented that the Service Recipient was lying on his right side the Service Recipient was actually lying on his back when she first arrived on the scene. (Justice Center Exhibits 66 A at page 641 and 661 - and 67)

<sup>18</sup> [REDACTED] is hereinafter referred to as the **facility physician**.

<sup>19</sup> [REDACTED] is hereinafter referred to as **RN 2**.

<sup>20</sup> [REDACTED] is hereinafter referred to as **RN 3**.

seizure and RN 1 did so. (Justice Center Exhibits 26 at page 5, 66 A at pages 646 - 665; 67, 72 and 75 - 77)

25. At approximately 4:01 p.m., the emergency response services, EMT 1<sup>21</sup> and EMT 2<sup>22</sup>, arrived at the scene. The Service Recipient was still lying on his back on the floor with staff holding him down. EMT 1 directed staff to release the Service Recipient and an unknown female staff told the EMTs that the Service Recipient may have hit his head when he fell. At some point, supervisors instructed the Subject and other staff to leave and return to their assigned houses. After treating the Service Recipient, the EMTs placed the Service Recipient on a stretcher and transported him by ambulance to the hospital. Staff 8 rode in the ambulance with the Service Recipient. While in route to the hospital, although the Service Recipient was conscious, he was not coherent until a few minutes before arriving at the hospital. He kept rubbing the back of his head and EMTs noticed a three-inch circular bruise on the back of his head. The Service Recipient reported to the EMTs that he had a behavioral episode and that he hit the back of his head when staff took him down. (Justice Center Exhibit 64 at page 24) At 4:22 p.m., the Service Recipient arrived at the hospital's emergency room and Staff 8 stayed with him at the hospital. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 16, 64, 66 A at pages 551 - 594 and 609 - 683 and 66 B at pages 1 - 40 and 67 - audio interviews of Staff 3, Staff 8, the facility physician, RN 2, RN 3, EMT 2 and Safety Officer 3; 72 and 75 - 77)

26. In Staff 1's handwritten log note dated [REDACTED] at 4:05 p.m., Staff 1 described the Service Recipient as combative and that he punched the Subject necessitating a SCIP-R two person take down into a three-person supine control. (Justice Center Exhibit 29 at pages 2 - 3) At approximately 4:35 p.m. that evening, Staff 5 telephoned the Administrator on

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<sup>21</sup> [REDACTED] is hereinafter referred to as Emergency Medical Technician (EMT) 1.

<sup>22</sup> [REDACTED] is hereinafter referred to as EMT 2.

[REDACTED]

Duty (AOD)<sup>23</sup> to report the incident and thereafter completed, signed and filed both the Restrictive Intervention Application Data Form (RIA) and the OPWDD 147 Incident Form indicating that the Service Recipient became physically abusive requiring a two-person take down into a three-person supine control. (Justice Center Exhibit 24 at pages 1 - 4)

27. After arriving at the hospital, the Service Recipient complained to the hospital physician<sup>24</sup> that he had a headache and was treated for a head injury/seizure with sudden onset. The history provided to the hospital was that the Service Recipient was “being restrained by staff after he was reported to have become aggressive and kicked over fan and punched a staff member. Was taken to the ground and struck head.” A Computed Tomography (CT) scan of the Service Recipient’s head/brain was performed on [REDACTED] and yielded normal (or negative) results for any “acute intracranial pathology” or “skull fracture.” However, the CT scan also showed that the Service Recipient had sustained a hematoma (bruise) on the back of his head with “soft tissue swelling overlying the posterior aspect of the vertex.” The Service Recipient had also sustained lacerations and bruises on his body. (Justice Center Exhibit 64)

28. After staff had returned to their assigned houses to finish their shifts, Service Recipient A and Service Recipient C overheard conversations amongst staff involved in the incident about their facility notes/documentation and observed staff passing notes to each other about the incident for review. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 54, 67 - audio interviews of Staff 3, Staff 8, Service Recipients A and C; 72 and 75 - 77)

29. The Subject was thereafter directed to deliver clothing to the Service Recipient at the hospital. Before departing for the hospital, Staff 3 asked the Subject what he wanted Staff 3 to say regarding the incident. The Subject told Staff 3 to say that the Service Recipient did not hit

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<sup>23</sup> [REDACTED] was the Administrator on Duty (AOD) on the date of the incident.

<sup>24</sup> [REDACTED], M.D. hereinafter referred to as the **hospital physician**.



his head when he fell, even though Staff 3, along with the Subject, Staff 1, Staff 2 and Staff 8 were all fully aware that the Service Recipient had hit his head since a loud “puck” sound was emitted when the Service Recipient’s head hit the hard floor. (Hearing testimonies of the Subject, Staff 1, Staff 2 and Justice Center Investigator 1; Justice Center Exhibits 20, 66 A at pages 262 and 263 and at pages 534 - 538; 66 A at pages 358 - 360, 67 - audio interviews of Staff 3, Staff 8 and Service Recipients A, B, C, H; 72 and 75 - 77)

30. While Staff 8 was at the hospital with the Service Recipient, Staff 8 telephoned the Service Recipient’s father at or about 5:00 p.m. to inform him of Staff 8’s concerns regarding staff’s use of excessive force against the Service Recipient, which caused him to hit his head on the floor and to flop like a “fish out of water.”<sup>25</sup> (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - audio interviews of Staff 8 and the Service Recipient’s Father; 72 and 75 - 77)

31. After the Subject arrived at the hospital with clothes for the Service Recipient, he saw and spoke to the Service Recipient. The Subject also had a conversation with Staff 8. During that conversation, the Subject provided Staff 8 with part of the false narrative to “cover your ass and my ass.” The Subject had instructed Staff 8 to falsely state that the Service Recipient punched the Subject in the face, that the Service Recipient was fine when he was taken down but struck his head during the seizure while convulsing on the floor and that the Service Recipient was rolled onto his right side and into the proper recovery position. While the Subject was still at the hospital, an unidentified supervisor called him to inform him that he was being placed on administrative leave. Staff 2 was also notified that same evening that he was being placed on administrative leave. (Subject’s Hearing testimony; Justice Center Exhibits 13 and 67 - Staff 8’s audio

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<sup>25</sup> Also refer to Justice Center Exhibits 66 A - Service Recipient’s Father’s Trial transcript.

interviews) The Subject left the hospital, returned the vehicle to the facility and left without finishing the remainder of the shift. (Hearing testimonies of the Subject and Justice Center Investigator 1; Justice Center Exhibits 13, 54, 67 - Staff 8's second audio interview, 72 and 75 - 77)

32. Upon discharge from the hospital at approximately 9:42 p.m. that same evening, the Service Recipient had been diagnosed with a "minor head injury" and "post-traumatic seizures" related to the incident. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 64, 66 A at pages 222 -257, 67 - Staff 8's second audio interview; 72 and 75 - 77)

33. Sometime before 10:00 p.m., and upon returning from the hospital to the facility with the Service Recipient, Staff 8 went into the Head of Shift's office where Staff 1, Staff 5 and Staff 6 were already present, along with an unidentified staff person. At that time, Staff 1 instructed Staff 8 what to document as a part of the agreed upon false narrative created by her and the Subject that staff was going to say happened and use in writing facility notes and/or statements to cover up what actually occurred. (Justice Center Exhibits 29 and 41) The agreed upon false story that staff was to advance was that the Service Recipient's behavioral episode in the gymnasium continued even after he entered the Computer Room, at which time the Service Recipient punched the Subject, which warranted the SCIP-R two-person take down that was properly performed by the Subject and Staff 2. Also included in the falsehood was that when Staff 8 entered the Computer Room, the Service Recipient was lying properly on the floor on his "right side" (the recovery side). (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 31 at page 4; 64 and 67 - audio interviews of Staff 3, Staff 8 and Service Recipient A)

34. At approximately 11:50 p.m., another staff nurse<sup>26</sup> performed a visual body check

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<sup>26</sup> Facility RN [REDACTED] is referred to as another staff nurse.

on the Service Recipient and noted the following injuries: six-inch superficial abrasion right side of back, approximately 1 - ½” diameter bruise left elbow, approximately 1 - ½” diameter bruise above left elbow, several red marks antecubital area and an abrasion/reddened area in the back of his head. There were no injuries, lacerations, redness or bruising noted on the Service Recipient’s knuckles or the backside of either hand. (Justice Center Exhibits 26, 31 and 64)

35. The following day [REDACTED], RN 1 conducted a medical body check on the Service Recipient. (Justice Center Exhibit 26 at pages 5 - 8) RN 1 then documented and took photographs of his physical injuries. (Justice Center Exhibit 19) The injuries noted were a 3” x 3” red abrasion to the back of his head, a 2-½” x 2-½” purple/red bruise on the right antecubital (or area in front of elbow from where blood was drawn) that RN 1 noted was due to the insertion of the IV injection/disruption of medication and left antecubital area of his head with bruises/abrasions on his back, his left elbow, back of left arm, right and left shoulder blades and mid-back. No redness, lacerations, bruises or other injuries were noted on the back of the Service Recipient’s hands or knuckles. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 18 - 19, 66 A at pages 635 - 636, 67 - RN 1’s audio interview; 72 and 75 - 77)

36. On or about [REDACTED], the Subject completed and signed a voluntary statement for the New York State Police. The Subject included in his written statement that the Service Recipient punched him in the right ear so hard that it bent his glasses. The Subject wrote in said statement that he then grabbed the Service Recipient’s right arm, and with Staff 2’s assistance they performed a two person take down of the Service Recipient but that the Subject did not recall seeing the Service Recipient’s head strike the floor. The Subject also wrote in said statement that when the Service Recipient began to seize that he released his hold then when the Service Recipient started to foam at the mouth that “we” placed him in a “recovery position” where

his head was propped “to the side in order to prevent aspiration.” (Justice Center Exhibit 33)

### **ISSUES**

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

### **APPLICABLE LAW**

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A “substantiated report” means a report “... wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred...” (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined respectively by SSL §§ 488(1)(a), (d), (f) and (h) as:

"Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

"Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies,

except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

"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.

"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 Categories 1, 2 and 3, which are respectively defined under Social Service Law §§ 493(4)(a)(i), (ii), (xiii) and Social Service Law §§ 493(4)(b) and (c) as:

- (a) Category one conduct is serious physical abuse, neglect 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;

(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;

- (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; and
- (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 acts of abuse (obstruction of reports of reportable incidents), neglect, physical abuse and abuse (deliberate inappropriate use of restraints) alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the

category of such abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse (obstruction of reports of reportable incidents), neglect, physical abuse and/or abuse (deliberate inappropriate use of restraints), 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 acts of abuse (obstruction of reports of reportable incidents), neglect, physical abuse and/or abuse (deliberate inappropriate use of restraints) cited in the substantiated report constitute the categories of such abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse (obstruction of reports of reportable incidents), neglect, physical abuse and/or abuse (deliberate inappropriate use of restraints) 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 the acts described as Allegations 1, 2, 3, 4, and 5 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 - 8 and 13 - 78) The investigation underlying the substantiated reports was conducted by Justice Center Investigators 1 and 2<sup>27</sup>.

Justice Center Investigator 1 and MHDST testified on behalf of the Justice Center at the consolidated hearing for the Subject, Staff 1, Staff 2, Staff 3, Staff 4, Staff 5, Staff 6 and Staff 7 (Co-Subjects).

The Subject testified on his own behalf. Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff

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<sup>27</sup> [REDACTED] is Justice Center Investigator 2.

7 also testified during the consolidated hearing. Staff 3 waived his right to be present and did not testify at the hearing but was represented by legal counsel. Subject Exhibits B through E were received into evidence on behalf of the Subject and Co-Subjects.

The Justice Center contended that the Subject failed to utilize proper de-escalation techniques and that he conducted an unwarranted restraint with excessive force when he tackled the Service Recipient causing him to fall and hit the back of his head on the floor triggering a seizure that lasted at least fifteen minutes and that the Subject failed to appropriately respond to the Service Recipient's head injury. The Justice Center further claimed that the Subject and Co-Subjects, fearing the loss of their jobs, worked together to perpetuate a false narrative to conceal their wrongful conduct.

The Subject denied the allegations contained in the substantiated report.

The record is replete with differing versions of the material facts regarding the incident. According to the Subject's and several Co-Subjects' accounts of the incident, the Service Recipient punched the telephone/wall, kicked a fan across the Computer Room and pushed tables/chairs while walking toward the back of his homeroom. The Subject and some of the Co-Subjects also claimed that the Service Recipient punched the Subject in the face after the Subject and Staff 2 had tried to verbally de-escalate the Service Recipient. As a result, the Subject and Staff 2 properly utilized a two-person physical restraint to take the Service Recipient down to the floor and then Staff 3 came to assist in the restraint. The Subject, Staff 1, Staff 2 and Staff 3 denied that the Service Recipient hit his head during the take down.

While the Subject, Staff 1, Staff 2 and Staff 3 claimed that the Service Recipient punched the Subject in the face, they differed in their descriptions of the encounter. The Subject alleged that the Service Recipient punched him on the right side of his face (near the ear) with his right



hand and with force “hard enough that it bent my glasses.” (Subject’s Hearing testimony; Justice Center Exhibits 33 and 67). Staff 1 alleged that the Service Recipient punched the Subject on the side of his face but did not specify which side. (Staff 1’s Hearing testimony; Justice Center Exhibits 29, 35 and 67) Staff 2 stated that the Service Recipient swung his right-hand landing multiple blows that struck the left side of the Subject’s head/face. (Hearing testimony of Staff 2; Justice Center Exhibits 32 and 67) Staff 3 alleged that the Service Recipient punched the Subject with a swinging “closed fist” that “connected with” the Subject who was unable to deflect it. (Hearing testimonies of the Subject, Staff 1 and Staff 2; Justice Center Exhibits 32 - 41, 43 - 44 and 67)

The Service Recipient’s and Staff 8’s accounts of the take down differed from the Subject’s and several Co-Subjects’ versions of events. The Service Recipient had consistently testified at the ancillary criminal trials. The Service Recipient testified that the Subject football-style tackled him when he bent over, rammed his shoulder into the left side of the Service Recipient’s mid-section and grabbed the outside of the Service Recipient’s knees causing him to be lifted upwards, fall backwards and hit the crown of his head on the floor triggering a seizure. (Justice Center Exhibits 66 A and 66 B) Staff 8 told investigators that he saw the Subject take down the Service Recipient using a football like tackle. Staff 8 further explained that the Subject did not utilize a two-person physical intervention because Staff 2 and Staff 3 did not assist until after the Subject had already brought down the Service Recipient to the floor by himself. Staff 8 also stated that there was no need for the Service Recipient to have been taken down because he was only vocalizing and did not hit the Subject. (Justice Center Exhibit 67 - Staff 8’s audio interviews)

There were also differing accounts as to how the Service Recipient was lying on the floor at the time of his seizure event. The Subject and most of the Co-Subjects reported that, when staff

noticed that foam was coming from the Service Recipient's mouth during the seizure event, staff rolled him onto his recovery side to prevent aspiration. Yet, staff was inconsistent as to what side they had turned the Service Recipient onto, and some staff did not even specify which side. Interestingly, during the hearing, the Subject testified that he was the one who turned the Service Recipient onto his recovery side during the seizure. However, the Subject did not mention this during his investigatory interview or in his Voluntary Statement to police. Additionally, none of the other staff members could specifically recall who had actually turned the Service Recipient onto his side during his seizure event. (Justice Center Exhibits 32 - 40 and 67) Both of the supervisors, Staff 5 and Staff 6, who were present at the time had also reported that staff had rolled the Service Recipient on his side. Staff 7 told investigators that when she had initially momentarily entered the Computer Room she observed the Service Recipient lying on his right side with his arm fully extended. In addition, RN 1 testified at trial that when she first reported to the scene that the Service Recipient was lying on his back, although on the day of the incident she wrote on the Body Check Form that the Service Recipient was on the floor lying on his right (recovery) side. EMT 1 told investigators and also testified at trial that when she first reported to the scene the Service Recipient was lying on his back. Similarly, EMT 2 told investigators that when he came onto the scene, he observed that the Service Recipient was lying on his back. (Hearing testimonies of the Subject, Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff 7; Justice Center Exhibits 26, 29, 32 - 38, 66 A, 66 B and 67)

During his first investigatory interview on [REDACTED], Staff 8 initially told investigators that he responded to the Computer Room after hearing the [REDACTED] being activated and when he entered the room, he observed the Service Recipient lying on his back with the Subject, Staff 2 and other staff holding the Service Recipient down on the floor as he was either

resisting the restraint or having a seizure. Staff 8 stated that he relieved Staff 2 in the restraint and held down the Service Recipient's left arm while Staff 6 held down his legs. Staff 8 had reported that the Subject told him that the Service Recipient came from the gym and entered the Computer Room highly agitated, pushing chairs and that they implemented a two-person take down. Staff 8 also told the investigators that he did not know if the Service Recipient hit his head on the way down, although he had asked staff but could not get a clear answer. However, when further questioned by investigators about not being forthcoming with information, Staff 8 began to recant what he initially told investigators and admitted that he responded to the Computer Room after he heard a commotion and before the [REDACTED] was activated. Staff 8 told investigators that he entered the Computer Room before the take down and that he saw the Service Recipient vocalizing at the Subject and then the Subject took him down. Staff 8 told investigators that as soon as the Service Recipient hit the floor, he began to seize. Staff 8 told investigators that it was at that time that staff knew they were going to lose their jobs and they all tried to cover it up. Staff 8 stated he saw the Service Recipient lying on his back (not his side) in a grand mal seizure. Staff 8 further told investigators that upon returning from the hospital Staff 1 told him what to write to cover up the incident. (Justice Center Exhibits 29, 41 and 67)

During his second interview on [REDACTED], Staff 8 continued to recant the false parts of his initial statement until the full truth was revealed to investigators. Staff 8 remorsefully admitted that he indeed was present in the Computer Room immediately before the incident, that he saw the entire incident and that he actively joined in the Subject's and Co-Subjects' (excluding Staff 4) scheme to protect their jobs by covering up material facts regarding the incident that caused the Service Recipient's head injury and seizure. Staff 8 told investigators that he no longer wanted to be a part of the cover up because he observed what the Service Recipient was going through in

the hospital and stated that sometime later when he saw the Subject in a store, that the Subject expressed no remorse for what had happened to the Service Recipient. (Justice Center Exhibit 67)

During this second interview, Staff 8 stated that he entered the Computer Room prior to the [REDACTED] activation and after he heard a commotion. Staff 8 stated that after he entered the Computer Room, he was standing about ten feet away. He observed the Service Recipient vocalizing at the Subject as they stood facing each other in the back of the Computer Room by the window. There were other service recipients present in the Computer Room. Staff 8 stated that he saw the Subject, by himself, engage in a football-like tackle of the Service Recipient, causing him to fall and hit his head on the floor, which emitted a “puck” sound. Staff 8 stated that he then witnessed the Subject also fall to the floor. Staff 8 recalled that the Subject then re-positioned himself on top of the Service Recipient, placed his forearm under the Service Recipient’s neck and verbally threatened the Service Recipient by yelling at him that he needed to respect females. Staff 8 stated that he saw the Service Recipient’s facial color turn reddish-gray while the Subject applied pressure underneath the Service Recipient’s neck. (Justice Center Exhibit 67)

Staff 8 told investigators that, while he was at the hospital with the Service Recipient, the Subject came and asked Staff 8 to falsely report that the Service Recipient’s verbally aggressive behavior towards women continued from the gymnasium into the homeroom during which time the Service Recipient punched the Subject in the face and then the Subject and Staff 2 performed a proper two-person physical restraint intervention to take down the Service Recipient. After leaving the hospital, Staff 8 returned to the facility and went into the Head of Shift’s office where staff were discussing and writing up the incident. While there, Staff 1 told Staff 8 what to write as the false narrative in his Preliminary Statement which he did. During that time, Staff 5, Staff 6 and another unidentified staff person were also present in the Head of Shift’s Office. Staff 8 said

that both supervisors, Staff 5 and Staff 6, knew about the cover up and went along with it to protect staff. Staff 8 also told investigators that cover ups happened all the time at the facility and that he was afraid to report the incident for fear that he would have a “bull’s eye” on his back as a “rat” and that staff would make his work life “hell.” (Justice Center Exhibit 67 - audio interviews of Staff 8 and Service Recipient A)

The record established that, at the time of the investigation, the Subject, Staff 1, Staff 2, Staff 3, Staff 5, Staff 6, Staff 7, Staff 8 and RN 1 were directly involved in the incident. Many of them had been co-workers for many years. Over time, they developed friendships socially or at work, and some even closer personal or familiar type relationships. At the time of the incident, Staff 1 was and remained at the time of the hearing the Subject’s girlfriend, Staff 3 was dating Staff 7, who is now his wife and RN 1 had known Staff 1 most of her life since Staff 1 had played with RN 1’s daughter when they were children. Most importantly, the Subject, Co-Subjects, Staff 8 and RN 1 all shared a major stake in the investigation’s outcome, along with a common intent, genuine bias to protect themselves, each other, their livelihood and employment status in a rural community.

After a careful review of the record, it is found that by his second interview, Staff 8 had rehabilitated himself, restored his credibility by retracting his prior false statements and recalling the true facts of the incident. Staff 8’s second account was honest, remorseful and genuine, especially when he told the investigators that he no longer wanted to be a part of staffs’ cover-up. By his second interview, Staff 8 had provided a compelling, detailed, reliable and credible account of what actually occurred, as well as a sound rationale as to why it occurred.

Staff 8’s account of the incident during his second interview is found to be reliable because it was a chilling admission of culpability and a detailed statement made against his own interests.

Staff 8 was a direct eyewitness present in the Computer Room immediately before the Subject attacked the Service Recipient, throughout the incident, during the Service Recipient's hospital stay and after he left the hospital he returned to the facility and finished working the rest of his shift. Staff 8 had direct knowledge and actively participated in perpetuating the false narrative. Overall, Staff 8's version of the incident was corroborated by other witnesses' accounts, such as Staff 3 who tacitly admitted to staff's cover up and that he too heard a loud sound when the Service Recipient's head hit the floor. In addition, the Service Recipient presented consistent and credible accounts during his trial testimonies. The Service Recipient consistently described the Subject's solo football-style tackle of him, which caused him to fall on the floor and hit the back of his head, which triggered a seizure. Staff 8's version was further corroborated by the Service Recipient's father, who maintained in his interview and/or trial testimonies that someone (Staff 8) called him to inform him that his son was hospitalized in "bad condition" because staff had slammed his son's head onto the floor causing his son to flop like a "fish out of water." In addition, parts of the credible accounts of Service Recipients A, C and F corroborate Staff 8's account of the incident as well as the accounts of other witnesses, such as, RN 1, RN 2, RN 3, Safety Officer 3, the Facility Physician and EMT 2, who all stated that when they arrived on the scene, they too observed the Service Recipient lying on his back and foam expelling from his mouth. Moreover, Staff 8's version of the incident provides a compelling, truthful and rational motive for the Subject to have improperly engaged and maneuvered the Service Recipient as well as the reason why the Subject and Co-Subjects (excluding Staff 4) perpetuated the false narrative, which was to protect each other and their jobs. (Justice Center Exhibits 66 A and 67)

Additionally, portions of Staff 3's investigatory interview are also found to be detailed, reliable, credible and corroborative of Staff 8's final account of the incident. Staff 3 told

investigators that the Subject took the Service Recipient down to the floor by himself, that he was aware of and was involved in staffs' cover up of material facts about the incident, that the reason for the cover up was due to the concern about the Service Recipient's seizure and staff being able to maintain their jobs.

Moreover, many of the service recipients presented credible and consistent versions of the incident that also corroborated Staff 8's account, especially with regard to the fact that the Subject and Co-Subjects (excluding Staff 4) had many opportunities during their work shift to develop, coordinate and actively participate in perpetuating the false narrative. Service Recipient A told investigators that he heard staff talking about what to write in their notes. Service Recipient C told investigators that staff had asked him if he was interviewed and wanted to know what he told investigators. Service Recipient C also told investigators that he was aware of staffs' history of conferring with each other about what to write in their notes after an incident. (Justice Center Exhibit 67 - audio interviews of Service Recipients A, C and F)

### ***Allegation 1***

#### ***Category 1 Abuse (Obstruction of Reports of Reportable Incidents)***

The Justice Center has proved by a preponderance of the evidence that the Subject's conduct constituted abuse (obstruction of reports of reportable incidents).

In order to prove abuse (obstruction of reports of reportable incidents) as it was alleged in this report, the Justice Center must establish by a preponderance of the evidence that the Subject impeded the "... investigation of the treatment of a service recipient by ... intentionally making a false statement," or "... intentionally withholding material information during an investigation into such a report ..." (SSL § 488(1)(f))

The credible evidence establishes that the Subject and Co-Subjects (excluding Staff 4)

intentionally withheld material information and provided false statements and jointly impeded the discovery, reporting or investigation of staff's wrongful treatment and/or failures with regard to the Service Recipient's care. The record shows that staff (excluding Staff 4) acted together in order to coordinate and perpetuate the false story before the incident had to be reported to the AOD, by which time some of the facility documents had to be filed. Staff also acted together to conceal material facts as to what actually happened to the Service Recipient during and following the incident and during the on-going investigation. The record also demonstrates that the Subject and other staff involved acted with the intent to hide their misdeeds and avoid accountability by conferring with other staff to misreport the incident and use a false narrative to withhold material information during the investigation. The conduct of the Subject and Co-Subjects (excluding Staff 4) caused the truth to be concealed for over a six-month period, from [REDACTED], the date of the incident, to [REDACTED], the date of Staff 8's second interview when he finally came forward and revealed the truth.

The fact that the Subject, Co-Subjects (excluding Staff 4) and other staff had conspired to impede the investigation was evident when, before he left for the hospital, the Subject asked Staff 3 to lie and not to say that the Service Recipient hit his head during the incident. Staff 3 complied and wrote in his statement that the Service Recipient punched the Subject with a swinging "closed fist," and that after experiencing a seizure, the staff rolled him onto his left side. While at the hospital, the Subject also asked Staff 8 to lie and say that the Service Recipient punched the Subject. Also, that Staff 1, the Subject's girlfriend, assisted in the creation and incorporation of the false narrative into her written progress notes about the incident which staff involved could review and utilize to perpetuate the same falsehood in their documentation of the incident. Additionally, Staff 8 and Service Recipient A witnessed staff exchanging and sharing notes about



the incident both during and after the Service Recipient experienced a seizure. (Justice Center Exhibits 29 and 67 - audio interviews of Staff 3, Staff 8 and Service Recipient A)

The Subject and Co-Subjects (excluding Staff 4) obstructed the investigation of the treatment of the Service Recipient by falsely claiming: (1) the Service Recipient was the aggressor when he punched the Subject in the face causing the Subject and Staff 2 to justifiably initiate an authorized SCIP-R two-person physical intervention and take down the Service Recipient to the floor where staff restrained him; (2) the Service Recipient did not hit his head when he fell on the floor; and (3) while the Service Recipient was lying on the floor having a seizure with foam coming from his mouth, staff properly rolled him onto his recovery side instead of leaving him lying on his back.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse (obstruction of reports of reportable incidents) alleged. (SSL § 488(1)(f)) The substantiated report will not be amended or sealed.

Because the Justice Center substantiated the allegation of abuse (obstruction of reports of reportable incidents) as a Category 1 act, which is the most serious category determination, the question becomes whether the elements as set out in SSL § 493(4)(a)(xiii) are also met. In this case, the Justice Center had to establish that the Subject intentionally made a materially false statement during an investigation into a report of a serious conduct of physical abuse and/or neglect of the Service Recipient as described in SSL § 493(4)(a)(i) and § 493(4)(a)(ii), with the intent to obstruct such investigation.

Serious physical abuse under SSL § 493(4)(a)(i) includes “intentionally causing physical injury as defined in “Penal Law § 10.00(9) or “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...” New York Penal Law § 10.00(9) defines physical injury as an “... impairment of physical condition or substantial pain...”

Serious conduct of neglect under SSL § 493(4)(a)(ii) includes a knowing, reckless or criminally negligent failure to perform a duty that resulted in physical injury that created a substantial risk of death or caused death.

In his defense, the Subject argued that the Category 1 level threshold in Allegation 1 of the report cannot be reached because at the time of the investigation the Subject had not yet received the substantiated report and could not have been aware at the time that said investigation involved Category 1 serious conduct. However, the Subject’s argument lacks merit because SSL § 493(4)(a)(xiii) requires only that the intentional, materially false statements be made during an “investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph...” and because the Subject’s argument would require the Subject to be unaware of his own conduct.

In this case, the Subject intentionally caused physical injury to the Service Recipient when he unjustifiably and purposefully tackled the Service Recipient, lifted him up and caused him to fall and injure the back of his head. The Subject held his forearm tightly across the Service Recipient’s neck yelling and cursing at him while other staff held the Service Recipient down on the floor. The Subject’s intentional conduct triggered a post-traumatic grand mal seizure with loss of consciousness for at least fifteen minutes. The Subject subsequently deprived the Service Recipient of immediate and critical medical attention while he strategized a cover story for at least fifteen minutes, evincing his total disregard for the Service Recipient’s life. The Subject’s conduct

resulted in physical injury as defined in subdivision nine of Penal Law § 10 causing substantial pain and serious impairment of the Service Recipient's physical condition when the Service Recipient remained lying on his back for fifteen minutes, struggling to breathe while uncontrollably flopping like a fish out of water and experiencing blackouts.

The ensuing investigation, during which the Subject intentionally made materially false statements, was plainly an investigation into a report of conduct described as serious physical abuse and serious neglect. (SSL § 493(4)(a)(i) and § 493(4)(a)(ii))

As set forth above, the investigation was into the circumstances and potential culpability surrounding the clear traumatic injuries sustained by the Service Recipient which triggered a post-traumatic grand mal seizure with loss of consciousness for at least fifteen minutes, with an accompanying significant time lapse in obtaining vital and necessary medical attention.

Certainly, the investigation was into a report of conduct described as serious physical abuse and serious neglect when the Subject was interviewed as part of the investigation as to how the Service Recipient sustained a post-traumatic seizure and languished without medical attention for far too long. In the context of that investigatory interview, the Subject intentionally made the materially false statements with the intent to obstruct the investigation motivated by his desire to protect his employment. The record established that the Subject, during the incident, immediately following the incident, and throughout the investigation, colluded and conspired with Co-Subjects in the perpetuation and continuation of a false narrative to impede the investigation and conceal their conduct. The Subject told Staff 3 to lie about the Service Recipient hitting his head when he fell, and he told Staff 8 to lie and say that the Service Recipient was the initial aggressor when he punched the Subject.

Accordingly, the Subject's intentional and materially false statements during an investigation into a report of serious conduct of physical abuse and neglect was made with the intention to obstruct such an investigation. A substantiated Category 1 finding of abuse will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

***Allegation 2 - Category 1 Neglect***

The Justice Center has established by a preponderance of the evidence that portion of Allegation 2 stating that the Subject breached his duty to the Service Recipient when he failed to seek immediate medical attention and/or make appropriate medical and emergency notifications while the Service Recipient experienced a grand mal seizure and when the Subject failed to properly turn the Service Recipient onto his side during the seizure event. The Justice Center has not established by a preponderance of the evidence the remainder of Allegation 2.

A finding of neglect requires that a preponderance of the evidence establishes that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that the 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))

At the hearing, the Subject argued that he did not have a duty to provide adequate medical care because it was the responsibility of the trained medical staff or medical responders, and that Staff 4 timely notified the nurse by calling the Code [REDACTED]. The Subject testified that he saw foam coming from the Service Recipient's mouth and followed the facility's seizure protocol when he

properly placed the Service Recipient on his recovery (right) side during his seizure episode. However, as set forth above, the Subject is not found to be credible in his testimony regarding turning the Service Recipient onto his recovery side. (Hearing testimony of the Subject)

After analyzing the credible evidence, it is found that, as a trained custodian, the Subject had a duty to follow facility policy by responding “prudently and cautiously” with respect to suspected head injuries to the Service Recipient and make proper notifications by contacting the facility nurse or facility physician in a timely fashion. The Subject also had a duty to follow the facility’s seizure protocol by placing the Service Recipient on his side to prevent aspiration. (Justice Center Exhibit 62) The Subject breached his duty by failing to follow the facility’s suspected head injury policy and seizure protocol.

The Subject knew or should have known that the Service Recipient injured his head when the Subject tackled him, and the Service Recipient fell backwards onto the floor. During his interview, the Subject stated that he did not remember seeing the Service Recipient’s head strike the floor. At the hearing, the Subject testified that the Service Recipient did not hit his head when he fell from the takedown. Both Staff 3 and Staff 8 admittedly heard a loud sound when the Service Recipient’s head hit the floor. The Subject, who was even closer to the struggling Service Recipient, told Staff 8 during their hospital conversation that he too heard a “puck” sound when verbally describing the impact of the Service Recipient’s head hitting the hard floor. (Justice Center Exhibit 67 - Staff 8’s first audio interview)

Under these circumstances, as soon as the Subject and the Service Recipient fell to the floor and the Subject heard the Service Recipient hit his head, the Subject should have taken immediate reasonable and prudent actions pursuant to the facility’s head injury protocol. The Subject should have but failed to direct nearby staff to immediately contact the nurse to ensure that

the Service Recipient obtained timely and proper medical attention from a medical professional for any potential head injury.

The record shows the Subject attacked the Service Recipient sometime between 3:15 p.m. and 3:30 p.m. However, Staff 4 did not call the medical emergency Code [REDACTED] until about 3:45 p.m. The time lapse of approximately fifteen minutes to call for medical assistance is unacceptable and without justification, especially in light of the circumstances and availability of Staff 1, Staff 2, Staff 3 and Staff 8 who were standing nearby at the time, and the requirement for all direct care staff to carry the [REDACTED]. (Justice Center Exhibits 16 and 67)

The evidence also establishes that the Subject breached his duty to the Service Recipient when he did not follow the facility's seizure protocol and properly position the Service Recipient on his side when the Service Recipient experienced a seizure with foam coming from his mouth. During the hearing, MHDST credibly testified that during the Subject's basic first aid and CPR training, he was taught about the facility's seizure protocol to place an individual having a seizure in the recovery position or on his side to prevent asphyxiation. (Hearing testimony of MHDST; Justice Center Exhibit 8)

The Subject's breach of duty to the Service Recipient resulted in physical injury and serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h)) The Service Recipient sustained physical injuries involving a head injury (hematoma) and post-traumatic seizures, loss of consciousness, bruises and abrasions. In addition, the Subject's failure to seek or direct medical assistance in a timely manner, upon his knowledge and/or observation that the Service Recipient hit his head and experienced a seizure, delayed a medical professional from examining and/or evaluating the Service Recipient. The Service Recipient's prolongation of suffering with a head injury without an immediate medical evaluation

and attention, constituted a serious or protracted impairment of the physical condition of the Service Recipient. (Justice Center Exhibits 18, 19 and 64)

Since the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes Category 1 neglect as set forth in the substantiated report. In this case, serious conduct of neglect under SSL § 493(4)(a)(ii) requires in relevant part “a knowing, reckless or criminally negligent failure [of the Subject] 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... or is likely to result in either...”

The record established that the Subject was the aggressor, that he intentionally football-style tackled the Service Recipient causing him to fall to the floor, hit the back of his head triggering a seizure episode. While the Service Recipient laid on his back on the floor, the Subject re-positioned himself on top of the Service Recipient and used his forearm to apply pressure to the base of the Service Recipient’s neck verbally threatening him as the Service Recipient choked and gasped for air and his face turned colors. The Service Recipient thereafter suffered a post-traumatic seizure with loss of consciousness for at least fifteen minutes. The Subject failed to seek essential and proper medical attention following the Service Recipient’s head injury and the Subject further failed to follow necessary protocol during the seizure when foam emitted from the Subject’s mouth specifically instituted to prevent the risk of aspiration. The Subject’s conduct clearly resulted in physical injury that created a substantial risk of death to the Service Recipient and created a serious impairment of health, and clearly given the above was likely to result in both. (SSL § 493(4)(a)(ii))

Given all of the above, it is determined that Category 1 neglect is the appropriate category

level for Allegation 2 of the substantiated report. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed Category 1 neglect for failing to provide adequate medical care by not immediately seeking medical attention and by not appropriately positioning him during his seizure episode.

A substantiated Category 1 finding of neglect will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

### ***Allegation 3 - Category 1 Serious Physical Abuse***

The Justice Center has proved by a preponderance of the evidence that the Subject's conduct constituted Category 1 serious physical abuse when he intentionally used excessive force to take down the Service Recipient, during which time his head struck the floor, and/or the Subject used his forearm to apply pressure to the Service Recipient's throat.

To sustain an allegation of physical abuse, the Justice Center must show that the Subject had physical contact with the Service Recipient; that such contact was either intentional or reckless; and that such contact caused either physical injury or serious or protracted impairment of a Service Recipient's physical, mental or emotional condition; or caused the likelihood of such injury or impairment. The statute allows, as an exception, the use of physical contact as a reasonable emergency intervention necessary to protect the safety of any person. (SSL § 488(1)(a))

The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York State Penal Law. (SSL § 488(16)) New York State Penal Law states that "[a] person acts intentionally with respect to a result or to conduct ... when



his conscious objective is to cause such result or to engage in such conduct.” (PL §15.05(1)) New York State Penal Law states that “...[a] person acts recklessly with respect to a result or to a circumstance ... when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation ...” (PL §15.05(3))

The credible evidence established that the Subject engaged in physical abuse of the Service Recipient as per SSL § 488(1)(a)). The Subject clearly was angry at the Service Recipient for calling Staff 1 derogatory names earlier while they were in the gym. The Subject wanted to teach the Service Recipient a lesson. Accordingly, the Subject intentionally used excessive force to tackle the Service Recipient causing him to fall and slam the back-crown part of his head onto the hard floor. After the Service Recipient fell and was lying on his back, the Subject re-positioned himself to maintain his hold of the struggling Service Recipient and used his forearm to apply pressure on the Service Recipient’s neck, while verbally threatening him to respect females. The Service Recipient had a difficult time breathing, his face turned “reddish-gray” and he experienced a post-traumatic seizure with loss of consciousness due to his head injury. (Justice Center Exhibit 67 - audio interviews of Staff 8, Hab Spec 1, Service Recipients C, F, G and H)

In addition, during the verbal argument between the Subject and the Service Recipient in the back of the Computer Room near the window, the record revealed that there were no other service recipients nearby and the Subject could have walked away from the Service Recipient. There were a number of staff members within or near the Computer Room that could have assisted in verbally de-escalating the Service Recipient. Instead, the Subject continued his aggression toward the Service Recipient by tackling him and lifting him up; resulting in the Service Recipient

slamming his head on the hard floor. The Subject's intentional conduct resulted in the physical injury of the Service Recipient. The Subject's actions of tackling and choking the Service Recipient were neither justified nor undertaken as a reasonable emergency intervention necessary to protect the safety of any person.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the physical abuse alleged. (SSL § 488(1)(a)) The substantiated report will not be amended or sealed.

Because the Justice Center substantiated this allegation of physical abuse as a Category 1 act, which is the most serious category determination, the question then becomes whether the Justice Center established that the Subject intentionally or recklessly caused physical injury as defined in subdivision nine of Section 10.00 of the Penal Law and that his conduct caused serious impairment of health or loss or impairment of the function of any bodily organ or part, or that the Subject consciously disregarded a substantial and unjustifiable risk that such physical injury or impairment or loss would occur. (SSL § 493(4)(a)(i)) Penal Law § 10(9) defines physical injury as impairment of physical condition or substantial pain.

As discussed above, the Subject's intentional physical contact with the Service Recipient caused physical injury as defined in subdivision nine of Section 10.00 of the Penal Law. The Subject also consciously disregarded the substantial and unjustifiable risk of death and serious impairment of the Service Recipient's health. The Subject's improper and excessively aggressive tackle of the Service Recipient caused him to suffer a head-injury/seizure with a loss consciousness of at least fifteen minutes, a significant period of time. In addition, the Subject's subsequent choking of the Service Recipient denied him oxygen as he gasped for air.

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 1 act of serious physical abuse.

A substantiated Category 1 finding of serious physical abuse will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

***Allegation 4 - Category 2 Abuse (Deliberate Inappropriate Use of Restraints)***

The Justice Center has proved by a preponderance of the evidence that the Subject's conduct constituted abuse (deliberate inappropriate use of restraints).

In order to prove abuse (deliberate inappropriate use of restraints) the Justice Center must establish that the Subject used a restraint on the Service Recipient in which the technique used, the amount of force used or the situation in which the restraint was used, was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. The term "restraint" is defined by statute as any manual, pharmacological or mechanical measure or device used to immobilize or limit the ability of a service recipient to freely move his or her arms, legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL § 488(1)(d))

There is no dispute that the Subject was engaged in a manual physical restraint that immobilized or limited the ability of the Service Recipient to move his arms, legs or body freely. The issue is whether the technique, amount of force or the situation in which the restraint was used

by the Subject, was deliberately inconsistent with the Service Recipient's treatment plan, facility's general policies and/or if so, whether the Subject's conduct was nevertheless allowed under the statutory exception of SSL § 488(1)(d). (Hearing testimony of MHDST)

The Service Recipient's IBIP stated that, in the event of an "emergency" only, staff was authorized to use a proper two-person SCIP-R physical restraint. (Justice Center Exhibit 21) The Subject knew or should have known that the Service Recipient's treatment plan authorized the use of a SCIP- R two-person physical restraint only in the event of an emergency and that facility policy required staff to refrain from the use of a one-person take down unless there was an emergency. Contrary to SCIP-R guidelines, the Subject used an improper technique when he used excessive force and conducted an inappropriate one-person football-style tackle of the Service Recipient and slammed his body on the floor. The Subject was angry at the Service Recipient for calling Staff 1 derogatory names and intentionally tackled the Service Recipient in deliberate breach of the IBIP and SCIP-R. (Justice Center Exhibits 66 A, 66 B, and 67 - audio interviews of Staff 3, Staff 8, Hab Spec 1 and Service Recipients A and C)

Service Recipients A and C, Staff 8 and Staff 3 support the Justice Center's contention that this was not an emergency and the Service Recipient did not physically threaten the Subject. Immediately prior to the Subject's one-person tackle of the Service Recipient, the Service Recipient was only vocalizing face to face with the Subject as they stood in the back of the Computer Room with no other service recipients in their immediate area. The Subject could have walked away but did not. (Justice Center Exhibit 67 - audio interviews of Staff 8, Service Recipients A and F) Therefore, the one-person take down was not a reasonable emergency intervention necessary to prevent imminent harm to the Service Recipient or others and the Subject's conduct does not fall under the statutory exception of SSL § 488(1)(d).

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

Since the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report.

Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b))

Based upon the totality of the circumstances and the credible evidence presented, including witnesses' testimonies, statements and/or interviews, it is determined that Allegation 4 is properly categorized as a Category 2 act. The Subject's deliberate inappropriate use of restraints in singlehandedly tackling the Service Recipient and causing the Service Recipient to hit the back of his head seriously endangered the Service Recipient's health, safety and welfare. The Subject could have sustained a concussion to the back of his head. (SSL § 493(4)(b))

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

#### ***Allegation 5 - Category 2 Neglect***

The Justice Center has established by a preponderance of the evidence that the Subject's conduct constituted neglect when he failed to utilize appropriate de-escalation techniques with the Service Recipient, and instead pushed or bumped into him, spoke to him in an inappropriate

manner, and/or escalated or otherwise provoked a behavior.

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 her 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))

The record established that, as a staff member at the facility, the Subject knew or should have been aware of the Service Recipient's IBIP and as a custodian, the Subject had a duty to follow it. The IBIP specified that in the event the Service Recipient was upset or displayed behaviors, staff was required to slowly point and gesture for the Service Recipient to calm and sit down in an adjacent area away from the perceived stressor or targeted staff. If necessary, after staff attempted one verbal and point away gesture, staff could utilize a one or two-person escort/removal of the Service Recipient to take him to the adjacent area to calm down. (Justice Center Exhibit 21)

The credible evidence showed that the Subject breached his duty to the Service Recipient. While standing in the hallway outside of the Computer Room, the Service Recipient was upset that recreation had ended early, refused to enter the room and kept trying to leave the room once he finally entered. Instead of de-escalating the Service Recipient according to his IBIP, the Subject told the Service Recipient to "get back in the fucking class" and used his hand(s) to inappropriately bump and/or push the Service Recipient from the hallway into the Computer Room. The Subject's conduct caused the Service Recipient's behavior to escalate such that when the Service Recipient did enter the Computer Room, he kicked an object (garbage can or fan) towards the back of the room. Fortunately, there were no other service recipients in that part of the Computer Room.

(Justice Center Exhibit 67 - audio interviews of Service Recipients A and C)

At the time the Service Recipient was refusing to enter the Computer Room, in order to properly de-escalate the situation under his IBIP, the Subject should have slowly pointed/gestured for the Service Recipient to go to an adjacent area to “*Chill & sit down.*” If the Subject was the target of the Service Recipient’s vocalizations, the Subject could have communicated this to nearby staff in the Computer Room. The other staff, including Staff 1, Staff 2, Staff 3 and/or Staff 8 could have interceded to conduct a proper one or two-person escort removal of the Service Recipient to an adjacent area away from the Subject. Instead, the Subject cursed at the Service Recipient and used his hands to push the Service Recipient inside the Computer Room.

The Subject’s failure to properly utilize de-escalation techniques resulted in serious physical injury to the Service Recipient. (SSL § 488 (1)(h)) The Subject pushed, agitated and provoked the Service Recipient which escalated the situation. The Subject physically accosted the Service Recipient by tackling him to the ground, slamming his head on the ground and choking him with a resulting traumatic grand mal seizure and a loss of consciousness.

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. (SSL § 448(1)(h)) The substantiated report will not be amended or sealed.

Since 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.

Category 2 level conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b))

Based upon the totality of the circumstances, the evidence presented and the witnesses’ statements, it is determined that Allegation 5 of the substantiated report is properly categorized as

a Category 2 act under SSL § 493(4)(b). The Service Recipient's IBIP was designed to focus on and address his social growth and developmental problems as well as his history of violence. Under his IBIP, the Service Recipient was to receive anger management as a part of his treatment to address his target behaviors of hitting and punching. The Service Recipient's IBIP also recognized his distrust in staff such that his plan was developed to focus on building skills to help him understand that "...people are not always 'messing with him' because they are trying to be hostile..." (Justice Center Exhibit 21)

Here, the Subject's wrongful actions of bumping and/or pushing the Service Recipient and speaking to him in a derogatory fashion were contrary to the Service Recipient's treatment plan and further supported the Service Recipient's distrust in staff and misguided belief that people were hostile toward him. Under these circumstances, and in light of what actually transpired as a result of the Subject's failure to utilize proper de-escalation techniques, the Subject's breach of duty clearly and seriously endangered the health, safety and welfare of the Service Recipient.

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

**DECISION:** The request of [REDACTED] that the amended substantiated report dated [REDACTED], [REDACTED] be amended and sealed shall be as follows:

As to Allegation 1, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance



of the evidence to have committed Category 1 abuse (obstruction of reports of reportable incidents);

As to Allegation 2, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance of the evidence to have committed Category 1 neglect level acts of failing to seek immediate medical attention for the Service Recipient and not appropriately positioning the Service Recipient during his seizure episode;

As to Allegation 3, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance of the evidence to have committed Category 1 physical abuse;

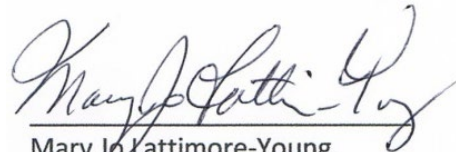
As to Allegation 4, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance of the evidence to have committed Category 2 abuse (deliberate inappropriate use of restraints); and

As to Allegation 5, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance of the evidence to have committed Category 2 neglect.

The substantiated report is properly categorized as Category 1 and 2 level acts.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

**DATED:** December 4, 2019



Mary Jo Lattimore-Young,  
Administrative Law Judge