

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

In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

**FINAL
DETERMINATION
AND ORDER
AFTER HEARING**
Adjud. Case #: [REDACTED]

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

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

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

This decision is ordered by Elizabeth M. Devane, ALJ, 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
David Friedman, Esq.

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

In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

[REDACTED]

Before:

Mary Jo Lattimore-Young
Administrative Law Judge

Held at:

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

[REDACTED]

On:

[REDACTED]

Parties:

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

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By: Rachael Dunn, Esq. and
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[REDACTED]

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED]¹ (the Subject) for abuse (obstruction of reports of reportable incidents) and neglect. The Subject requested that the VPCR amend their report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [REDACTED], [REDACTED] of abuse (obstruction of reports of reportable incidents) and neglect by the Subject of the 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], at the [REDACTED] located at [REDACTED], while a custodian, you committed abuse (obstruction of reports of reportable incidents) when you provided a false account of events in your Preliminary Witness Statement.

This allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Service Law § 493(4)(b).

Allegation 2

It was alleged that on [REDACTED], concerning a report of a reportable incident that occurred at the [REDACTED], located at [REDACTED]

¹ [REDACTED] marital name at the time of the hearing was [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 Service Law § 493(4)(a)(xiii).

Allegation 3

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

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

4. ██████████, the facility, located at ██████████, 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 age from approximately eighteen to over fifty years old. Most, if not all, of the service recipients had been 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 ██████████ houses: House ██████████, House ██████████, House ██████████ and House ██████████. Staff involved in the instant matter were assigned to work in

these four houses. (Hearing testimony of Justice Center Investigator 1²; Justice Center Exhibits 66 A at page 664, 67, 72 and 75 - 77)

5. At the time of the alleged abuse (obstruction of reports of reportable incidents) and neglect, the Subject had been employed at the facility overall for approximately twenty-five years, but for about the last thirteen years she had worked in a supervisory capacity as a Developmental Disabilities Secure Care Treatment Aid (DDSCTA) 2. The Subject usually worked the evening shift from [REDACTED] and she worked out of the Head of Shift's office located in the [REDACTED] program area. The Subject had been trained in Strategies in Crisis Intervention - Revised (SCIP-R)³ 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 foams at the mouth. On the date of the incident, the Subject was working as a supervisor along with Staff 6⁴. (Hearing testimonies of the Subject, the former Mental Hygiene Developmental Specialist Trainer (MHDST)⁵ and Justice Center Investigator 1; Justice Center Exhibits 8, 21, 67, 72 and 75 - 77) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. On [REDACTED], the date of the alleged incident, the Subject, Staff 1⁶, Staff 2⁷, Staff 3⁸, Staff 4⁹, Staff 5¹⁰, Staff 6, and Staff 7¹¹ worked the same [REDACTED] shift.

² [REDACTED] is hereinafter referred to as Justice Center Investigator 1.

³ 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.

⁴ [REDACTED] is hereinafter referred to as Staff 6.

⁵ [REDACTED] is hereinafter referred to as MHDST.

⁶ [REDACTED] is hereinafter referred to as Staff 1.

⁷ [REDACTED] is hereinafter referred to as Staff 2.

⁸ [REDACTED] is hereinafter referred to as Staff 3.

⁹ [REDACTED] is hereinafter referred to as Staff 4.

¹⁰ [REDACTED] is hereinafter referred to as Staff 5.

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

Staff 4 (Staff 1's girlfriend), Staff 8¹² and the facility Registered Nurse (RN 1)¹³ were also present during the shift. (Hearing testimonies of the Subject, Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff 7 and Justice Center Investigator 1; Justice Center Exhibits 33, 54, 67, 72 and 75 - 77)

7. At the time of the alleged abuse (obstruction of reports of reportable incidents) and neglect, the Service Recipient was an eighteen-year-old male who had been a resident in House [REDACTED] for approximately [REDACTED] placed there pursuant to a court mandate. 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 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 was 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]."

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

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

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 was 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's responsibilities on campus were: 1.) to assess if a service recipient is "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 Therapist¹⁴ 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

¹⁴ [REDACTED] is the facility's Recreational Therapist (or Habilitation Specialist (**Hab Spec**) 1.

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 interviews of Hab Spec 1 and Staff 8; 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 Houses [REDACTED] and [REDACTED] 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 Spec allowed the Service Recipient and Service Recipient B, who lived in House [REDACTED] 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; 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 4 a “bitch” or “whore.” Other service recipients were present in the gym and overheard the Service Recipient’s

[REDACTED]

demeaning comment about Staff 4. (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 4 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, Staff 1 walked down the hallway behind the Service Recipient who was headed towards the Computer Room agitating the Service Recipient by pushing him while the Service Recipient kept telling Staff 1 to stop it. After the Service Recipient entered the Computer Room, Staff 1 followed. Staff 1 at some point stated out loud, and within earshot of Service Recipient C, that Staff 1 was going to teach the Service Recipient a lesson. (Justice Center Exhibit 67 - audio interviews of Service Recipients A and C) The Service Recipient then got upset and tried to leave the room. Staff 1 and Staff 2 ran out into the hallway after the Service Recipient. Staff 2 stood in the doorway. Staff 1 told the Service Recipient to get back in "the fucking class", but the Service Recipient refused. Staff 1 then tried to grab or push the Service Recipient to direct him back into the Computer Room. The Service Recipient told Staff 1 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) Staff 1 re-entered

the Computer Room, approached the Service Recipient and, as they stood face to face, the Service Recipient began to yell at Staff 1. Upon hearing the commotion at approximately 3:15 p.m., Staff 8 left House [REDACTED] homeroom, headed down the hall towards the Computer Room and entered the Computer Room. Staff 8 observed the Service Recipient and Staff 1 standing face to face and arguing in the back of the Computer Room. At some point, Staff 3 also heard the commotion and entered the Computer Room. Service Recipients A, C, E and G, as well as Staff 2, Staff 3 and Staff 4, were present in the room but were not near Staff 1 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 3, 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 Staff 1 at which point Staff 1 engaged in a football-style tackle of the Service Recipient. Staff 1 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. Staff 1 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 room. (Justice Center Exhibit 67 - audio interviews of Staff 3, Staff 8 and Service Recipients A, C and G)

17. As the Service Recipient laid on his back, Staff 1 repositioned 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 room and was about ten feet away from where the Service Recipient was

laying, observed Staff 1 placing his forearm tightly across the Service Recipient's neck, and then began swearing and yelling at the Service Recipient that he better respect females. The Service Recipient struggled to breathe because of Staff 1's chokehold and his facial coloring had changed to a reddish-grey. Thereafter, Staff 1 released his chokehold of the Service Recipient and repositioned his hold by grabbing the Service Recipient's right arm. (Justice Center Exhibit 67 - audio interviews of Staff 8 and Service Recipient G)

18. While Staff 1, 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 seize then staff released him to move tables out of his way. (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 as he laid on his back on the floor and at some point, foam began to expel from his mouth. Present in the room was Staff 1, Staff 2, Staff 3, Staff 4 and Staff 8. The Service Recipient's seizure continued. At this time, the Subject and Staff 6 were both working in the Head of Shift's Office located in the program area. (Hearing testimonies of the Subject and Justice Center Investigator 1; Justice Center Exhibits 67 - Staff 3's audio interview and Staff 8's second audio interview; 72 and 75 - 77)

20. Finally, Staff 4 pressed her [REDACTED] which registered on the Safety Officer's computer at 3:47 p.m. and Staff 5, the hall monitor, immediately responded and entered the room. (Justice Center Exhibit 66 A at pages 110 - 115 and at pages 393 - 408) Staff 4 told Staff 5 to call the Code [REDACTED]. Staff 5 mistakenly called Safety Officer 1 at extension [REDACTED] and told him that there was a medical emergency. Safety Officer 1 instructed Staff 5 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 4, Staff 5 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] had been activated, the Subject and Staff 6 responded from the Head of Shift's Office and entered the Computer Room. When the Subject entered the Computer Room, Staff 5 was on the Code [REDACTED] call reporting a medical emergency that the Service Recipient was having seizure like activity. The Subject briefly left the room and returned with head pads that were placed either next to or underneath the Service Recipient's head. The Subject was supervising staff in the room and at times momentarily left the room to arrange for the arrival of the EMTs and 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 6 and Staff 7; Justice Center Exhibits 67, 72 and 75 - 77)

22. In response to the [REDACTED] and/or Code [REDACTED], Safety Officer 2¹⁵ was the first officer to arrive at the scene. Shortly thereafter, Safety Officer 3¹⁶ entered the 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 event, Staff 1 and the other staff in the room continued their conversations about the story they were planning to collectively tell about

¹⁵ [REDACTED] is hereinafter referred to as **Safety Officer 2.**

¹⁶ [REDACTED] is hereinafter referred to as **Safety Officer 3.**

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. During that group conversation, Staff 1, Staff 2, Staff 3, Staff 4 and Staff 8 were all in the Computer Room. Having arrived after the Service Recipient was already on the floor, the Subject and Staff 6 were present during staff's group discussion. (Hearing testimonies of the Subject and 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 having a seizure, lying on his back, and saw that foam was 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 side¹⁷ 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." (Justice Center Exhibit 26) RN 1's Body Check Form also did not list any injuries, lacerations, redness or bruising seen on either of the Service Recipient's knuckles or the backside of his hands.

24. The facility physician¹⁸ and other nursing staff, RN 2¹⁹ and RN 3²⁰, then arrived and they had all observed that the Service Recipient was lying on his back, exhibiting seizure-like symptoms with foam coming from his mouth. (Justice Center Exhibit 67) By then Staff 7 had

¹⁷ 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)

¹⁸ [REDACTED] is hereinafter referred to as the **facility physician**.

¹⁹ [REDACTED] is hereinafter referred to as **RN 2**.

²⁰ [REDACTED] is hereinafter referred to as **RN 3**.

come back into the Computer Room, at which time she and other staff assisted medical staff 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 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 1²¹ and EMT 2²², arrived at the scene wherein 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, Safety Officer 1 and supervisors had instructed 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)

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

²² [REDACTED] is hereinafter referred to as EMT 2.

26. At approximately 4:35 p.m. that evening, the Subject telephoned the Administrator on Duty (AOD)²³ to report the incident and thereafter completed, signed and filed both the Restrictive Intervention Application Data Form (RIA) and the OPWDD 147 Incident Form that included the falsehood that the Service Recipient was engaged in a behavioral episode where he became physically assaultive by punching staff and SCIP-R was initiated in the form of a "...two person takedown into 2 - 3 person supine control.." by Staff 1 and Staff 2. (Justice Center Exhibits 13 and 24 at pages 1 - 4)

27. After arriving at the hospital, the Service Recipient complained to the hospital physician²⁴ 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 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)

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

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

29. 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)

30. 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 the Subject, Staff 4, and Staff 6 were already present, along with an unidentified staff person. At that time, Staff 4 instructed Staff 8 what to document as a part of the agreed upon false narrative 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 Staff 1, which warranted the SCIP-R two-person take down that was properly performed by Staff 1 and Staff 2. Also included in the falsehood was that the Service Recipient was lying properly on the floor on his “right side” (the recovery side). (Hearing testimonies of the Subject and Justice Center Investigator 1; Justice Center Exhibits 31 at page 4, 64 and 67 - audio interviews of the Subject, Staff 3, Staff 8 and Service Recipient A)

31. At approximately 11:50 p.m., another staff nurse²⁵ performed a visual body check 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

²⁵ Facility RN [REDACTED] is referred to as another staff nurse.

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)

32. On [REDACTED], the Subject wrote in her Preliminary Witness Statement that she headed towards the Computer Room in response to the [REDACTED] that was activated at approximately 3:45 p.m. The Subject further wrote that, after she entered the room, the Service Recipient was on the floor experiencing a seizure, Staff 5 was on the telephone calling in a medical emergency and that the Service Recipient appeared to have foam in his mouth. She then added the falsehood to her Preliminary Witness Statement by writing that the Service Recipient was "rolled onto his [R] side with his [R] arm under his head to hold this position..." (Justice Center Exhibit 36)

33. 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 2-1/2" x 2-1/2" 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 the Justice Center Investigator; Justice Center Exhibits 18 - 19, 66 A at pages 635 - 636, 67 - RN 1's audio interview; 72 and 75 - 77)

34. On [REDACTED], during her investigatory interview, the Subject's account of the incident was consistent for the most part with what she had written in her Preliminary Witness Statement. The Subject told investigators that she did not see the take down, but that staff had

reported to her that they did not know why, but that the Service Recipient had punched one of the staff members and Staff 1 and Staff 2 took the Service Recipient down to the floor. The Subject also told investigators that staff had released the seizing Service Recipient when she had walked in the room. The Subject then reiterated to investigators the falsehood that staff had rolled the Service Recipient onto his side, when the truth was that staff had left the Service Recipient lying on his back when foam came from his mouth during his seizure. The Subject told investigators that on the day of the incident that she had completed the OPWDD 147 - Incident Report Form based upon what staff had reported to her and that she also had to obtain authorization from AOD for the Service Recipient to go to the hospital. (Justice Center Exhibits 13 and 67)

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 (obstruction of reports of reportable incidents) 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 (obstruction of reports of reportable incidents) and/or neglect of a person in a facility or provider agency is defined respectively by SSL §§ 488(1)(f) and (h) as:

"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 and 2, which are respectively defined under SSL § 493(4)(a)(ii) and (xiii), SSL § 493(4)(b) as follows:

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

(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; and

(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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse (obstruction of reports of reportable incidents) and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse (obstruction of reports of reportable incidents) and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the acts of abuse and/or neglect cited in the substantiated report constitutes the category of abuse (obstruction of reports of reportable incidents) and neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse (obstruction of reports of reportable incidents) and neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts described as Allegation 1, Allegation 2 and Allegation 3 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 - 10 and 13 - 78) The investigation underlying the substantiated report was conducted by Justice Center Investigator 1 and Justice Center Investigator 2²⁶. Justice Center Investigator 1 and MHDST testified at the hearing 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 in her own behalf. Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff 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 - E were received into evidence.

The Subject denied the allegations contained in the substantiated report and argued at the hearing that the report should be unsubstantiated against her.

The Justice Center contended that the Subject intentionally withheld material information and made materially false statements in her Preliminary Witness Statement and during her investigatory interview with the intent to impede and obstruct the investigation. (Justice Center Exhibit 36) During the investigation, the Subject used these falsities to conceal the treatment of the Service Recipient, that the Subject did not ensure that the nurse was contacted immediately to provide medical attention to the Service Recipient who fell, injured his head suffered a post

²⁶ [REDACTED] is hereinafter referred to as Justice Center Investigator 2.

traumatic seizure and that the Subject did not ensure that the Service Recipient was rolled onto his side during his seizure when foam came from his mouth to prevent aspiration.

There were differing accounts as to how the Service Recipient was lying on the floor at the time of his seizure. 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, staff rolled him onto his recovery side to prevent aspiration. Yet, staff was inconsistent as to whether it was the left or right side, they had turned the Service Recipient onto, and some staff did not even specify which side. Interestingly, during the hearing, Staff 1 testified that he actually was the one who turned the Service Recipient onto his recovery side during the seizure. (Hearing testimony of the Subject) 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) The Subject and Staff 6, the other supervisor who was present at the time, had reported to investigators that staff had rolled the Service Recipient on his side. Staff 7 also reported to investigators that while she momentarily stood at the doorway of the Computer Room before staff told her to leave and go across the hall to assist the other service recipients, 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, 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. Prior to the EMTs responding, the facility physician and other nursing staff, RN2 and RN 3, had all observed that the Service Recipient was lying on his back while seizing and foam was coming from his mouth. 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 Staff 1, 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 Staff 1 told him that the Service Recipient came from the gym and entered the 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 room after he heard a commotion and before the [REDACTED] was activated. Staff 8 told investigators that he entered the room before the take down and that he saw the Service Recipient vocalizing at Staff 1 then, Staff 1 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 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 he had reported to the Head of Shift's Office, at which time, Staff 4 told him what to write to cover up the incident and that the Subject and Staff 6 were present at the time. The Subject

denies that she was present when staff wrote their Preliminary Witness Statements. (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 truth was finally revealed to investigators. Staff 8 remorsefully admitted that he indeed was present in the 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 5) 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 Staff 1 in a store, that Staff 1 expressed no remorse for what had happened to the Service Recipient. (Justice Center Exhibit 67)

Staff 8 told investigators that, 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 4 told Staff 8 what to write as the false narrative in his Preliminary Statement. During that time, the Subject, Staff 6 and another unidentified staff person were also present in the Head of Shift's Office. Staff 8 said that both supervisors, the Subject 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 4, 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 4 was and remained at the time of the hearing Staff 1's girlfriend, Staff 3 was dating Staff 7, who is now his wife, and RN 1 had known Staff 4 most of her life since Staff 4 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 staff's 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 Staff 1 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, during his trial testimonies, presented consistent and credible accounts when describing Staff 1's solo football-style tackle of him at

which time he fell onto the floor, hit the back of his head triggering a seizure and 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 then he began 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 with foam expelling from his mouth. Moreover, Staff 8's version of the incident provides a compelling, truthful and rational motive as to why the Subject and Co-Subjects (excluding Staff 5) perpetuated the false narrative 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 he was aware of and was involved in staffs' cover up of material facts about the incident, and 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 5) 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 overheard 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 staff's 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 2 Abuse (Obstruction of Reports of Reportable Incidents)

The Justice Center has proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when she provided a false account of events in her Preliminary Witness Statement.

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," and by "... intentionally withholding material information during an investigation into such a report ..." (SSL § 488(1)(f))

SSL § 488(16) defers to the definition of the term "intentionally" as it is stated in New York's Penal Law. Pursuant to New York Penal Law § 15.05(1) "...[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))

The credible evidence established that in her Preliminary Witness Statement, the Subject intentionally made a false statement and withheld material information during the investigation of the treatment of the Service Recipient to conceal the truth and impede the investigation. (Justice Center Exhibits 29 and 35) The Subject used the false facts in her signed Preliminary Witness Statement, dated [REDACTED], in order to conceal the wrongful treatment of the Service Recipient. The Subject stated in her Preliminary Witness Statement that after she entered the room, the Service Recipient "...appeared to have foam in his mouth..." then the Subject incorporated into her statement part of staff's contrived false narrative when she wrote that the Service Recipient

“... was rolled onto his [right] side with his [right] arm under his head to hold this position...” (Justice Center Exhibit 36) As discussed in detail above, the credible proof established that the Subject and staff failed to follow seizure protocol by properly turning the Service Recipient onto his recovery side during his seizure when foam emitted from his mouth, and instead left him lying on his back exposing him to the risk of aspiration while they strategized a cover story. The Subject saw or should have seen the Service Recipient lying on his back with foam in his mouth because she was present in the room at the time of his seizure.

The Subject’s actions delayed and impeded the investigation because it took over six months from the date of the incident, [REDACTED] until Staff 8’s last interview on [REDACTED] [REDACTED] for the full truth to be finally disclosed. The record shows that the Subject’s conscious objective or motive in undertaking such wrongful conduct was to protect her job, as well as to protect staff directly involved in the incident.

Moreover, the credible evidence in the record established that, at the time of the Service Recipient’s seizure, staff present in the room began to talk amongst themselves as to what to write in their notes. Afterwards, Staff 4 reiterated and relayed further the agreed to false narrative to be reported to staff involved in the incident at various times and locations on the day of the incident. The Subject was involved in the perpetuation of the false narrative as she was present in the Head of Shift’s Office with Staff 4 and Staff 8 that same evening after Staff 8 had returned from the hospital. At that time, Staff 4 told Staff 8 what falsities he was to write in his Preliminary Witness Statement. Likewise, the Subject wrote the falsehood in her Preliminary Witness Statement that during the seizure when the Service Recipient appeared to have foam in his mouth, “...rolled onto his [R] side with his [R] arm under his head to hold this position...” (Justice Center Exhibit 36) Additionally, the record showed that the Subject also conferred with other staff about what

falsehood to report and write in their notes. The record established that the Subject provided a false account of the events in her Preliminary Witness Statement and thus impeded the investigation by intentionally withholding material information and intentionally making false statements during an investigation into a report of the treatment of the Service Recipient. (SSL § 488(1)(f)) The Subject and the Co-Subjects (excluding Staff 5) undertook such action to protect themselves and each other. (Justice Center Exhibit 67)

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. 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 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)) The issue then becomes whether the Subject's actions of intentionally making such false statements or intentionally withholding material information during an investigation into the report seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b))

After reviewing the record, it is further found that Allegation 1 abuse (obstruction of reports of reportable incidents) of the substantiated report is properly categorized as a Category 2 level act under SSL § 493(4)(b). Given the credible evidence in this case, the Subject's conduct in hiding the material facts about the incident that involved the safety, treatment and supervision of the Service Recipient seriously endangered the Service Recipient's health, safety and welfare. Being that the Service Recipient's medical treatment and care was undeniably and implausibly delayed, the extent of the Service Recipient's injuries could have been overlooked and could have been

seriously adversely impacted by the inaccurate description of the incident. (Justice Center Exhibit 64)

A substantiated Category 2 finding of abuse (obstruction of reports of reportable incidents) 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 2 - Category 1 Abuse (Obstruction of Reports of Reportable Incidents)

The Justice Center has proved by a preponderance of the evidence that the Subject 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, she intentionally made materially false statements with the intent to obstruct said investigation.

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," and by "... intentionally withholding material information during an investigation into such a report ..." (SSL § 488(1)(f))

The credible evidence established that the Subject and Co-Subjects (excluding Staff 5) 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 showed that staff acted together in order to coordinate and perpetuate the false story before the incident had to be reported by the Subject to the AOD, by which time some of the facility documents were filed, and 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 5) 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 record established that on the date of the incident Staff 4 had created the false narrative in her Progress Notes which she and other staff used as a guide to unify their stories. Later that evening, when Staff 8 returned from the hospital, he went into the Head of Shift's Office where the Subject, Staff 4, Staff 6 and another unidentified staff person were present. At that time, Staff 4 told Staff 8 part of the false narrative to write in his Preliminary Witness Statement. Thereafter, the Subject then incorporated part of the false narrative into her own Preliminary Witness Statement signed and dated [REDACTED]. During the course of her investigatory interview on [REDACTED], the Subject intentionally withheld material facts and intentionally made false statements by reiterating the same falsities to investigators that she had included in her Preliminary Witness Statement about the treatment of the Service Recipient. The Subject told investigators that she responded to the [REDACTED] and entered the Computer Room, at which time the Service Recipient was already down on the floor. The Subject further explained that when she walked in the Computer Room someone had said that the Service Recipient was having a seizure. At that time, the Subject stated that she saw staff release the Service Recipient, roll him onto his side and Code [REDACTED] was being called by Staff 5 to notify the nurse. The Subject stated that she had left the

room to get head pads for the Service Recipient and tried to talk to him, but that he was incoherent. The Subject told investigators that when EMTs arrived she assisted by holding his legs as they were trying to get an IV in his arm and that she called for staff to bring him dry clothes because he had urinated on himself. The Subject told investigators that staff reported to her that the Service Recipient punched one of the staff members and staff took him down and then released him when he began to seize, and staff rolled him onto his side. The Subject also told investigators that staff was using Staff 4's Progress Notes to assist them in filling out facility documentation. (Justice Center Exhibits 13, 29, 36, 67 - Subject's audio interview; 72 and 75 - 77) The Subject intentionally impeded and obstructed the investigation by withholding material information and providing false statements during the investigation.

Given the above, it is determined that the Subject committed abuse (obstruction of reports of reportable incidents) under 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 her 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 **her** own conduct.

In this case, the Subject’s knowing, and reckless conduct deprived the Service Recipient of immediate and critical medical attention. Despite the Subject not being an eyewitness to the physical abuse by Staff 1 of the Service Recipient, the Subject, as a supervisor was present in the Computer Room thereafter as well as in the Head of Shift’s office later that evening. The Subject allowed the staff to conspire, fabricate, concoct and perpetuate the false story without any reprimand or consequence, and participated in the false story by alleging that the Service Recipient was turned on his recovery side although he was laying on his back. The Subject facilitated what Service Recipient C described as a history of staff conferring with each other about what to write in their incident reports and statements. The Subject, herself, despite her years of employment at

the same facility, did not use her training and neglected the Service Recipient by not ensuring that facility protocols were followed. Instead of supervising and directing staff, the Subject allowed staff to contrive a false scenario that was reported to medical professionals, facility superiors and Justice Center investigators.

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 her desire to protect her employment. The record established that the Subject, during the incident, immediately following the incident, and throughout the investigation, colluded and conspired with Co-Subjects (excluding Staff 5) in the perpetuation and continuation of a false narrative to impede the investigation and conceal their conduct.

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 3 - Category 1 Neglect

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect when she failed to ensure that she or staff appropriately positioned the Service Recipient during a seizure event and foam emitted from his mouth. The Justice Center did not prove by a preponderance of the evidence the remainder of Allegation 3.

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 she 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))

At the hearing, the Subject testified consistently with her investigatory interview. The Subject testified that she and Staff 6 were in the Head of Shift's Office when they heard the [REDACTED] and then responded to the scene. After the Subject entered the Computer Room, she heard Staff 5 on the telephone calling the Code [REDACTED] for emergency medical assistance for the Service Recipient's seizure. The Subject testified that she saw the Service Recipient lying on the floor towards the back of the room. The Subject testified that when she entered the room that she saw staff roll the Service Recipient onto his side and that she noticed that he had a whitish foam coming from his mouth. The Subject stated that the Service Recipient appeared scared and although she tried to talk to him, he was not coherent. She said that she did not notice any head injuries on the

Service Recipient. The Subject further testified that she went to other classrooms to find head pads, brought the pads back to the room and placed one next to or underneath the seizing Service Recipient's head. When the facility's medical team arrived, the facility physician tried to put an IV in his arm, but the seizure had stopped before that could be done. She testified that Safety Officer 2 informed everyone to vacate the room and walk across the hallway since there were too many people in the room. However, Staff 1, Staff 2, Staff 3 and Staff 4 had remained in the room. In the meantime, the Subject testified that she had been in and out of the room to make arrangement for the arrival of the EMTs. She testified that she observed Staff 8 holding down the Service Recipient when the medical team was there. (Hearing testimony of the Subject)

After analyzing the credible evidence, it is found that when the Subject entered the Computer Room the Service Recipient was already on the floor and that she did not see or hear the Service Recipient being taken down to the floor and hit his head. The credible evidence further showed that when she entered the room the Service Recipient was lying on his back during his seizure with foam coming from his mouth, and not on his side as the Subject had falsely reported. During the course of the investigation, Staff 8, Safety Officer 3, facility medical responders and EMTs all told investigators that when they arrived at the scene the Service Recipient was lying on his back. RN 1 had initially reported that the Service Recipient was on his side when she arrived, but during her trial testimony indicated that the Service Recipient was actually lying on his back. (Justice Center Exhibit 67)

The Subject had a duty to ensure that either she or available staff follow facility seizure protocol requiring staff during a seizure event to turn the Service Recipient onto his recovery side when foam emits from his mouth to prevent aspiration. The Subject breached her duty when she failed to follow the seizure protocol by placing or ensuring that staff placed the Service Recipient

onto his side to prevent the risk of aspiration. (Hearing testimony of MHDST; Justice Center Exhibit 67)

During the hearing, MHDST credibly testified that during the Subject's basic first aid and CPR training, she 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 aspiration. (Hearing testimony of MHDST; Justice Center Exhibit 8)

Given the circumstances in this case, the Subject failed to follow the required protocol during the seizure specifically to be instituted to prevent the risk of aspiration when foam emitted from the Service Recipient's mouth. The Subject's conduct clearly 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 Service Recipient's prolongation of suffering a post traumatic seizure and loss of consciousness, without an immediate medical evaluation and attention, constitutes a serious or protracted impairment of his physical condition.

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 Subject's neglectful conduct resulted in and was likely to result in a physical injury that created a substantial risk of death and a serious impairment of the Service Recipient's health. After the Service Recipient hit his head and experienced a seizure, he was gasping for air,

struggling to breathe and was at risk of aspirating because of the Subject's knowing and reckless failure to provide and/or seek immediate and critical medical attention as well as her failure to follow facility protocols. The symptoms suffered by the Service Recipient without receiving medical attention for upwards of fifteen minutes put him in grave and substantial risk of death. (SSL § 493(4)(a)(ii))

Accordingly, 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 ensure that she or staff appropriately positioned the Service Recipient on his side during his seizure to prevent aspiration when foam came from his mouth.

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.

DECISION: The request of [REDACTED] that the 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 2 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

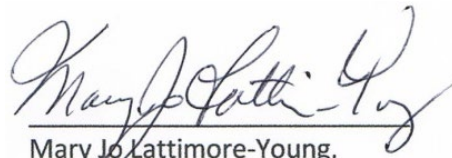
of the evidence to have committed Category 1 serious conduct of abuse (obstruction of reports of reportable incidents);

As to Allegation 3, the Subject's request for amendment is granted in part and denied in part. The Subject has been shown by a preponderance of the evidence to have committed a Category 1 level neglect act by failing to seek immediate medical attention for the Service Recipient and for failing to ensure that she or staff appropriately positioned the Service Recipient during a seizure. That portion of the allegation shall not be amended. However, since the remainder of the allegation regarding failing to comply with emergency responder's request was not proven by a preponderance of the evidence, that portion of the allegation shall be amended and sealed.

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

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

DATED: December 4, 2019


Mary Jo Lattimore-Young,
Administrative Law Judge