

**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  
David Friedman, 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: David Friedman, Esq.  
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## **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse (obstruction of reports of reportable incidents) 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 a "substantiated" report dated [REDACTED], [REDACTED] of abuse (obstruction of reports or 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 2<sup>1</sup>**

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 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.

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<sup>1</sup> This recommended decision only addresses those allegations contained in Allegation 2. Subject [REDACTED] attorney submitted a Motion to Dismiss Allegation 1 based upon the doctrine of collateral estoppel arising from the Subject's employee disciplinary arbitration decision and to dismiss Allegation 2 based upon the Justice Center failing to comply with CPLR § 214. The Justice Center conceded that collateral estoppel applied to Allegation 1 and opposed dismissal of Allegation 2. The Motion to Dismiss was granted as to dismissing Allegation 1 but denied as to dismissing Allegation 2. Refer to the audio recording at the beginning of the [REDACTED] hearing. The Motion to Dismiss papers are included in the record.

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

3. An Administrative Review was conducted and as a result the 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 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 [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>2</sup>; Justice Center Exhibits 66 A at page 664, 67, 72 and 75 - 77)

5. At the time of the alleged neglect, the Subject<sup>3</sup> had been employed at the facility for about fifteen years 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>4</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

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<sup>2</sup> [REDACTED] is hereinafter referred to as Justice Center Investigator 1.

<sup>3</sup> Prior to this hearing, the county court dismissed the criminal charges brought against the Subject with regard to this incident. (Subject's Hearing testimony; Justice Center Exhibits 32, 55 and 67 - Subject's audio interview)

<sup>4</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.

(known as the recovery position) to prevent aspiration when a seizing service recipient foams at the mouth. (Hearing testimonies of the Subject, the former Mental Hygiene Developmental Specialist Trainer (MHDST)<sup>5</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 so defined in Social Services Law § 488(2).

6. On [REDACTED], the date of the alleged incident, the Subject had worked his regular day shift from [REDACTED] and then stayed at the facility to work overtime during the evening shift from [REDACTED] in House [REDACTED]. (Justice Center Exhibit 54) During the overtime shift, the Subject was assigned to provide one to one (1:1) supervision of Service Recipient H who resided in House [REDACTED]. The Subject was working along with Staff 1<sup>6</sup>, Staff 2<sup>7</sup>, Staff 3<sup>8</sup>, Staff 4<sup>9</sup>, Staff 5<sup>10</sup>, Staff 6<sup>11</sup> and Staff 7<sup>12</sup> who were also working the evening shift from [REDACTED] shift. Staff 8<sup>13</sup> and the facility Registered Nurse (RN 1)<sup>14</sup> were also working the evening shift. (Hearing testimonies of the Subject, Staff 1, Staff 3 and Justice Center Investigator 1; Justice Center Exhibits 32, 54, 67, 72 and 75 - 77)

7. At the time of the alleged neglect, the Service Recipient was an eighteen-year-old male who had been a resident 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

<sup>5</sup> [REDACTED] is hereinafter referred to as **MHDST**.

<sup>6</sup> [REDACTED] is hereinafter referred to as **Staff 1**.

<sup>7</sup> [REDACTED] is hereinafter referred to as **Staff 2**.

<sup>8</sup> [REDACTED] is hereinafter referred to as **Staff 3**.

<sup>9</sup> [REDACTED] is hereinafter referred to as **Staff 4**.

<sup>10</sup> [REDACTED] is hereinafter referred to as **Staff 5**.

<sup>11</sup> [REDACTED] is hereinafter referred to as **Staff 6**.

<sup>12</sup> [REDACTED] is hereinafter referred to as **Staff 7**.

<sup>13</sup> [REDACTED] is hereinafter referred to as **Staff 8**.

<sup>14</sup> [REDACTED] hereinafter referred to as Registered Nurse (**RN 1**).

medication indicated. (Justice Center Exhibits 21, 64, 72, 75 - 77)

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]." 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 staffs' 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 Therapist<sup>15</sup> and were held in the gymnasium located in the ██████████ 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 1 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 ██████████, there were two recreational periods scheduled: service recipients who lived in Houses ██████████ and ██████████ attended the first recreational period that began at 2:15

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<sup>15</sup> ██████████ is the facility's Recreational Therapist or Habilitation Specialist (**Hab Spec**) 1.

██████████ p.m. and ended at 3:00 p.m. and service recipients who lived in Houses ██████ and ██████ attended the second recreational session from 3:00 p.m. to 3:45 p.m. Since the Service Recipient lived in House ██████, he attended the first recreational period along with his housemates. However, on that day, the Hab Spec 1 allowed the Service Recipient and Service Recipient B, who lived in House ██████, 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 residence at House ██████. Service Recipient B was to report to House ██████ homeroom and then be escorted to his residence at House ██████. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 47 - 49, 51, 67 - audio interviews of Hab Spec 1, Service Recipient D and Staff 8’s second 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 while he was still in the gym, the Service Recipient called Staff 3 a “bitch” or “whore.” Other service recipients were present in the gym and overheard the Service Recipient’s demeaning comment about Staff 3. (Justice Center Exhibits 66 A at pages 258 – 278; 66 B, and 67 - audio interviews of the Staff 2, Staff 8, Hab Spec 1 and Service Recipients A, C, F, G and H) Staff 1, who was also present in the gymnasium, either heard the Service Recipient make the derogatory comment to Staff 3 or somehow became aware that the comment was made. 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 2, 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. Staff 2 was in his homeroom located across and down the hall from the Computer Room. Staff 2 could hear the Service Recipient coming down the hallway and yelling “I didn’t do it” at Staff 1. As they walked down the hallway, Staff 1 agitated 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) Staff 2 and Staff 3 were also in the Computer Room at the time. The Service Recipient then got upset and tried to leave the Computer Room. Staff 1 ran out into the hallway after the Service Recipient and told the Service Recipient to get back in “the fucking class” but the Service Recipient refused. Staff 1 then went into the hallway and 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. The Subject was standing in the doorway of the Computer Room at this time. (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. Staff 8 observed the Service Recipient and Staff 1 standing face to face and arguing in the back of the

room. At some point, Staff 2 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 8 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 2, 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., while the Subject, Staff 1, Staff 2, Staff 3 and Staff 8 were in the room, 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 and rammed his shoulder into the left side of the Service Recipient's mid-section. Staff 1 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 2, Staff 8, Service Recipients A, C and G)

17. As the Service Recipient laid on his back, Staff 1 re-positioned himself and grabbed the Service Recipient's right arm to hold him down. The Subject grabbed the Service Recipient's left arm and Staff 2 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 re-

positioned 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 the Subject, Staff 1 and Staff 2 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 a seizure while staff continued to hold him down. (Justice Center Exhibit 67 - audio interviews of Staff 8 and 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 were the Subject, Staff 1, Staff 2, Staff 3 and Staff 8. The Service Recipient's seizure continued. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - audio interviews of Staff 2 and Staff 8, 72 and 75 - 77)

20. Finally, Staff 3 pressed her [REDACTED] at about 3:45 p.m. which registered on the Safety Officer's computer at 3:47 p.m. and Staff 4, the hall monitor, immediately responded and entered the room. (Justice Center Exhibits 66 A at pages 110 - 115 and at pages 393 - 408) Staff 3 told Staff 4 to call the Code [REDACTED]. Staff 4 mistakenly called Safety Officer 1 at extension [REDACTED] and told him that there was 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 the Subject, Staff 3, 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] had been activated, Staff 5 and Staff 6 responded from the Head

of Shift's Office and entered the Computer Room. When Staff 5 entered the Computer Room, Staff 4 was on the Code [REDACTED] call reporting a medical emergency, the Service Recipient was having seizure like activity and the Subject, Staff 1, Staff 2 and Staff 3 were kneeling around the Service Recipient. Staff 6 assisted with holding down the Service Recipient. Staff 5 briefly left the room and returned with head pads that were placed either next to or underneath the Service Recipient's head. Staff 5 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 5 and Staff 6; Justice Center Exhibits 67, 72 and 75 - 77)

22. In response to the [REDACTED] and/or Code [REDACTED], Safety Officer 2<sup>16</sup> was the first officer to arrive at the scene. Shortly thereafter, Safety Officer 3<sup>17</sup> entered the room and saw the Service Recipient lying on his back during his seizure event with some of the staff kneeling around him. (Justice Center Exhibit 67)

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

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<sup>16</sup> [REDACTED] is hereinafter referred to as **Safety Officer 2**.

<sup>17</sup> [REDACTED] is hereinafter referred to as **Safety Officer 3**.

that “while [the Service Recipient] was on floor lying on R side<sup>18</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.” (Justice Center Exhibit 26) 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.

24. The facility physician<sup>19</sup> and other nursing staff, RN 2<sup>20</sup> and RN 3<sup>21</sup>, 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 and returned to the Computer Room and assisted medical staff 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 1<sup>22</sup> and EMT 2<sup>23</sup>, 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 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

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<sup>18</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>19</sup> [REDACTED] is hereinafter referred to as the **facility physician**.

<sup>20</sup> [REDACTED] is hereinafter referred to as **RN 2**.

<sup>21</sup> [REDACTED] is hereinafter referred to as **RN 3**.

<sup>22</sup> [REDACTED] is hereinafter referred to as Emergency Medical Technician (**EMT**) 1.

<sup>23</sup> [REDACTED] is hereinafter referred to as **EMT 2**.

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 2, Staff 8, the facility physician, RN 2, RN 3, EMT 2 and Safety Officer 3; 72 and 75 - 77)

26. 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 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)

27. At approximately 7:15 p.m. that same evening, the Subject was notified by an unidentified supervisor that he was being placed on administrative leave and thereafter, the Subject

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

left the facility. (Hearing testimony of the Subject; Justice Center Exhibits 13, 67 - audio interviews of the Subject and AOD)

28. 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, 72 and 75 - 77)

29. At approximately 11:50 p.m., another staff nurse<sup>25</sup> 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 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)

30. 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)

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<sup>25</sup> Facility RN [REDACTED] is referred to as another staff nurse.

### **ISSUES**

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

### **APPLICABLE LAW**

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

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

"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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 1 which is respectively defined under SSL §§ 493(4)(a)(ii) 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;

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

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

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

### **DISCUSSION**

The Justice Center has established by a preponderance of the evidence that portion of Allegation 2 stating that the Subject breached his duty owed 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.

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 report was conducted by Justice Center Investigators 1 and 2<sup>26</sup>.

Justice Center Investigator 1 and MHDST also 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 in his own behalf. Staff 1, Staff 3, Staff 4, Staff 5, Staff 6 and Staff 7 also testified during the consolidated hearing. Staff 2 waived his appearance and did not testify at the consolidated 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 Subject denied the allegations contained in the substantiated report.

The Justice Center contended that after the Service Recipient hit his head on the floor triggering a seizure that lasted at least fifteen minutes, the Subject failed to follow facility procedures when he did not immediately notify the nurse to seek medical attention for the head injury/seizure, that he failed to properly position him onto his right recovery side during his seizure and that he failed to immediately release the Subject's hold of the Service Recipient when EMTs requested that staff release him.

The record is replete with differing versions of the material facts regarding the incident.

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<sup>26</sup> [REDACTED] is hereinafter referred to as Justice Center Investigator 2.

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 room and pushed tables/chairs while walking toward the back of his homeroom. The Subject and some of the Co-Subjects also claim that the Service Recipient punched Staff 1 in the face after Staff 1 and the Subject had tried to verbally de-escalate the Service Recipient. As a result, Staff 1 and the Subject properly utilized a two-person physical restraint to take the Service Recipient down to the floor, then Staff 2 came to assist in the restraint. The Subject, Staff 1, Staff 2 and Staff 3 initially 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 swung his right hand to initiate multiple blows that struck the left side of Staff 1's head/face. (Hearing testimony of the Subject; Justice Center Exhibits 32 and 67) Staff 1 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." (Hearing testimony of Staff 1; Justice Center Exhibits 33 and 67). Staff 2 alleged that the Service Recipient's punch landed on the left side of the Subject's face. (Justice Center Exhibits 34 and 67) Staff 3 alleged that the Service Recipient punched the Subject on the side of his face but did not specify which side. (Hearing testimony of Staff 3; Justice Center Exhibits 29, 35 and 67) Staff 3 also alleged that the Service Recipient punched the Subject with a swinging "closed fist" that "connected with" the Subject and staff was unable to deflect it. (Hearing testimonies of the Subject, Staff 1 and Staff 3; Justice Center Exhibits 32 - 41, 43 - 44 and 67)

The accounts of the Service Recipient and Staff 8 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 trials. The Service Recipient testified that the Subject, by himself, 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 Staff 1 did not utilize a two-person physical intervention because the Subject and Staff 2 did not assist until after Staff 1 had already brought the Service Recipient down 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 Staff 1. (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, staff rolled him onto his recovery side to prevent aspiration. Yet, staff was inconsistent as to whether it was the left or right side that 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 Staff 1) However, Staff 1 did not mention this during his investigatory audio 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 initially momentarily entered the room that 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. 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 Computer Room, he observed the Service Recipient lying on his back with the Subject, Staff 1 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 the Subject 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 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 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 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 stated he saw the Service Recipient lying on his back (not his side) in a grand mal seizure. (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 room immediately before the incident and that he saw the entire incident. 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, Staff 1 expressed no remorse for what had happened to the Service Recipient. (Justice Center Exhibit 67)

Staff 8 further stated during his second interview that he entered the Computer Room after he heard the commotion, which was before the [REDACTED] was activated. Staff 8 stated that when he entered the Computer Room, he was standing about ten feet away and observed the Service Recipient vocalizing at Staff 1 as they stood facing each other in the back of the room by the window. There were other service recipients and staff present in the room. Staff 8 stated that he saw Staff 1, by himself, engage in a football-style 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 Staff 1 also fall to the floor. Staff 8 recalled that Staff 1 then re-positioned himself, 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 Staff 1 applied pressure underneath the Service Recipient’s neck.

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 Staff 1 attacked the Service Recipient, throughout the incident, during the Service Recipient's hospital stay and after he left the hospital to return to the facility and finish working the rest of his shift. Overall, Staff 8's version of the incident was corroborated by other witnesses' accounts. In addition, the Service Recipient, during his trial testimonies, presented consistent and credible accounts when describing the Subject'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. (Justice Center Exhibits 66 A and 67)

### ***Allegation 2***

#### ***Category 1 Neglect***

The Justice Center proved by a preponderance of the evidence that the Subject committed

neglect when he failed to provide adequate medical care to the Service Recipient, which included not immediately seeking medical attention and/or making appropriate notifications while the Service Recipient experienced a grand mal seizure, not appropriately positioning him during a seizure. The Justice Center did not prove 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 he 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))

The Subject denied the allegations. The Subject testified that after recreation had ended, the Service Recipient came into the Computer Room having a behavioral episode. The Subject testified that when he and Staff 1 tried to verbally de-escalate the Service Recipient, the Service Recipient punched Staff 1, at which time they performed a two-person take down of the Service Recipient. The Subject stated on their way down to the floor that he was against the wall, fell sideways and hit his own head against the radiator but that he was not injured and did not receive any medical attention. The Subject testified that once they were on the floor, the Service Recipient had been placed into a supine position and that Staff 2 assisted by holding down the Service Recipient's legs. The Subject testified that after the Service Recipient began to seize, staff released their hold of him and began to move tables away from him. The Subject testified that Staff 4 called Code █ to notify medical staff and that when the Service Recipient began to foam at the mouth, staff rolled him onto his right side, facing the doorway with his arm above his head and the other hand under his head. The Subject said that he bent the Service Recipient's left leg at the knee to



keep him from rolling onto his stomach then supervisors Staff 5 and Staff 6 arrived. The Subject stated that he was not in the room when medical responders came because he had escorted service recipients out of the room. The Subject also testified that he was not aware of and had no independent knowledge that the Service Recipient hit his head during the take down and that the Subject never saw Staff 8 in the facility at any time that day. (Hearing testimony of the Subject) The Subject's testimony is found to be inconsistent and unsupported.

After analyzing the credible evidence, it is found that, as a trained custodian, the Subject had a duty to ensure that either he or available staff 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. However, the Subject breached his duty by failing to follow the facility's suspected head injury policy and seizure protocol. (Justice Center Exhibit 62)

The Subject's claim that he was not aware that the Service Recipient hit his head is not credible. The credible evidence showed that the Subject was in the room at the time of the incident and knew or should have suspected that the Service Recipient sustained a head injury when his head hit the hard floor. The credible facts reveal that in using excessive force Staff 1 football-style tackled the Service Recipient who fell back, hit his head on the floor and suffered a seizure. Staff 8, who was in the room standing about ten feet away from the commotion, heard a loud "puck" sound when the Service Recipient hit his head. During Staff 8's conversation with Staff 1 at the hospital, Staff 1 confirmed that he too heard a loud sound when the Service Recipient's head hit the floor. Staff 2 also told investigators that he heard the Service Recipient's head hit the floor as did other service recipients who were also present in the room. (Justice Center Exhibit - 67 audio

interviews) Furthermore, assuming arguendo, it was plausible that the Subject was unaware that the Service Recipient hit his head; under these circumstances, the facility's suspected head injury procedures should still have been followed since it was possible that the Service Recipient could have hit his head and the seizure event itself triggered the Subject's responsibility under the policy to respond "prudently and cautiously" and notify the nurse of any seizure activity. (Justice Center Exhibit 62)

Here, the Subject had a duty to act in the spirit of the facility's suspected head injury protocol and immediately call the nurse to report the seizure or even ask other staff to do so after the Service Recipient fell, hit his head and began to convulse. The record shows that the incident occurred sometime between 3:15 p.m. and 3:30 p.m., but that Staff 4 did not notify the nurse/medical staff by calling Code [REDACTED] until approximately 3:45 p.m. about the same time that Staff 3 had activated the [REDACTED]. The delay of at least fifteen minutes or more is unacceptable and unjustifiable. The record shows that if the Subject was unable to timely notify the nurse himself there were other staff members in the room to which he could have requested to get help. (Justice Center Exhibit 16 and 67)

The evidence also established 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 aspiration. (Hearing testimony of MHDST; Justice Center Exhibit 8)

Given the circumstances in this case, 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 specifically instituted to prevent the risk of aspiration when foam emitted from the Service Recipient's mouth. 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 seizure, 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, post traumatic seizure and loss of consciousness, 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..."

In light of the above, it is determined that Category 1 neglect is the appropriate category level for Allegation 2 of the substantiated report. 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 sustained 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 immediate and critical medical attention and his failure to follow the facility's suspected head injury policy and seizure protocol. The symptoms of the Service Recipient without receiving medical attention for fifteen minutes put him in a grave and substantial risk of death and created a serious impairment of health, and clearly, given the above, was likely to result in both. (SSL § 493(4)(a)(ii))

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.

**DECISION:** The request of the Subject [REDACTED] that Allegation 1 of the substantiated report dated [REDACTED], be amended and sealed is granted. The Subject's Motion to Dismiss Allegation 1 based upon collateral estoppel was granted.

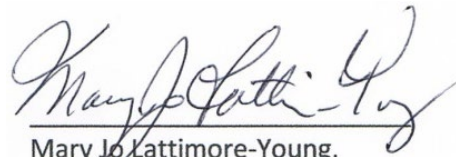
The request of the Subject that Allegation 2 of the substantiated report be amended and sealed is denied. The Subject has been shown by a

preponderance of the evidence to have committed neglect as alleged in Allegation 2.

The substantiated report is properly categorized as Category 1 act.

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

**DATED:** December 4, 2019



Mary Jo Lattimore-Young,  
Administrative Law Judge