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]

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

[redacted]
[redacted]
[redacted]
By: Lawrence H. Schaefer, Esq.
Lippes, Mathias, Wexler, Friedman, LLP
54 State Street, Suite 1001
Albany, New York 12207

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

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

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

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

DATED: June 27, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: New York State Office Building
207 Genesee Street, Room 103D
Utica, New York 13501
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: Kristin Kopach, Esq.

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JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [REDACTED] [REDACTED], of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [REDACTED], at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you conducted an unwarranted restraint with excessive force and improper technique, which included deflecting and/or pushing a service recipient's wheelchair onto him and causing him to fall to the floor.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect[1] pursuant to Social Services Law § 493(4)(c).

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

4. The facility, the [REDACTED], located at [REDACTED]

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[1] Although the report alleged abuse (deliberate inappropriate use of restraints), it was substantiated as neglect. (Justice Center Exhibit 1)

, is a psychiatric treatment hospital that provides, among other services, psychiatric treatment for inmates who are incarcerated in New York State correctional facilities. The facility is operated by the New York State Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of , Justice Center Investigator, hereinafter referred to as "the Investigator")

5. At the time of the report, the Subject was employed by the as a Secure Hospital Treatment Assistant (SHTA) and had been employed by the facility for approximately eleven years. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the report, the Service Recipient was an adult male approximately sixty years old, and had been a resident of the facility for approximately three weeks. The Service Recipient was incarcerated at and had been transferred to the facility this time and four previous times during his incarceration. The Service Recipient had mental health diagnoses of schizophrenia and antisocial personality disorder. While at the facility, the Service Recipient was given the use of a wheelchair although not by physician order. (Justice Center Exhibits 25, 43, and 46; and Hearing testimonies of the Investigator, – Senior SHTA , hereinafter referred to as "Sr. SHTA" and the Subject)

7. At the time of the report, the facility used an emergency procedure which involved dropping a telephone receiver to the floor ("dropping the phone"). By dropping the phone, other wards were notified of the emergency, and staff from the other wards (the "red dot team") were instructed to proceed to the ward where the emergency was occurring. Several of the "red dot phones" were located in various positions throughout ward . In the event of an emergency, staff were instructed to drop the phone, signifying that they needed help. (Hearing testimony of the Subject)

8. On [redacted], at approximately 6:45 p.m., the Subject, the Sr. SHTA, [redacted] (SHTA 1) and [redacted] (SHTA 2) were monitoring twenty-five service recipients, including the Service Recipient, in the dayroom of ward [redacted] of the facility. The service recipients were sitting in several rows of lounge chairs all facing toward the front of the dayroom, watching television. The Subject, SHTA 1 and SHTA 2s were sitting at desks located directly behind the service recipients' chairs, and were facing the service recipients. The Sr. SHTA was sitting to the side of the other staff at a separate desk which contained a computer. The door to enter and exit the dayroom was located to the other side of the room and a few feet forward of where the Subject and other staff were sitting. (Justice Center Exhibits 9, 11, 23, 27 and 58; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA, the Subject and SHTA 1; Justice Center Exhibit 60: audio recording of Justice Center Interrogations of the Sr. SHTA and the Subject; and Hearing testimonies of the Sr. SHTA and the Subject)

9. While the Subject and other staff were sitting at the staff desk, the Service Recipient came to the staff desk in his wheelchair and stared at the staff. SHTA 1 asked the Service Recipient what he wanted and, after a short while of more staring, the Service Recipient told SHTA 1 that he wanted to go lay down in his bedroom in the dormitory area of ward [redacted]. SHTA 1 responded to the Service Recipient by telling him that the dormitory was locked until 9:00 p.m. and to go back to watching television. (Justice Center Exhibits 9, 11, 23 and 27; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA, the Subject and SHTA 1; Justice Center Exhibit 60: audio recording of Justice Center Interrogations of the Sr. SHTA and the Subject; and Hearing testimonies of the Sr. SHTA and the Subject)

10. The Service Recipient then became extremely agitated and started yelling, swearing and calling staff vulgar names, which did not arouse any urgency in staff because such conduct was normal behavior for the Service Recipient. The Service Recipient then stood up from his

wheelchair and, in the process, he pushed or knocked the wheelchair over on its side on the floor. The Sr. SHTA then directed staff sitting at the desk to remove the Service Recipient from the dayroom and put him in the side room. The Service Recipient then picked up the wheelchair with both hands, held it at approximately eye level and came toward staff and the staff desk with an unsteady gait. (Justice Center Exhibits 9, 11, 23 and 27; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA, the Subject and SHTA 1; Justice Center Exhibit 60: audio recording of Justice Center Interrogations of the Sr. SHTA and the Subject; and Hearing testimonies of the Sr. SHTA and the Subject)

11. The Subject, who was seated closest to the Service Recipient, rose from his seat at the staff desk and approached the Service Recipient who was coming toward the desk with the wheelchair in the air. The Subject raised his arms to eye level, put his hands together in front of him and blocked the wheelchair's forward momentum. As a result of the Subject's block and the Service Recipient's unsteady gait, the Service Recipient fell backward to the floor and the wheelchair fell backward on him, hitting him in his face and head, and then falling to his side. (Justice Center Exhibits 9, 11, 23 and 27; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA, the Subject and SHTA 1; Justice Center Exhibit 60: audio recording of Justice Center Interrogations of the Sr. SHTA and the Subject; and Hearing testimonies of the Sr. SHTA and the Subject)

12. The Subject assisted the Service Recipient with getting up from the floor and the Subject and the Sr. SHTA each took an arm of the Service Recipient and escorted him out of the dayroom, across the hallway and into a side room located approximately across the hallway from the dayroom. Once in the side room, the Subject and the Sr. SHTA released the Service Recipient's arms and told him to be seated. The Service Recipient took a few steps, then turned around and charged the Subject and the Sr. SHTA. As a result, the Service Recipient, the Subject and the Sr.

SHTA all fell to the floor where the Subject and the Sr. SHTA restrained him and held him on the floor. At the same time, a red dot team arrived in response to red dot phones having been dropped by various staff during the preceding minutes. The red dot team relieved the Subject and the Sr. SHTA, put the Service Recipient in a bed in the side room and placed him in a five-point mechanical restraint. (Justice Center Exhibits 9, 11, 23 and 27; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA, the Subject and SHTA 1; Justice Center Exhibit 60: audio recording of Justice Center Interrogations of the Sr. SHTA and the Subject; and Hearing testimonies of the Sr. SHTA and the Subject)

13. While in the side room shortly after the Service Recipient was put in the five-point restraint, he was assessed by , Nurse 2 (Nurse A). Nurse A found that the Service Recipient had abrasions to the right and left temple area of his head, a bruise under his left eye, swelling above his left eye, and no other injuries. (Justice Center Exhibit 15)

14. Approximately ten to twenty minutes after the incident, , (Doctor A) assessed the Service Recipient. Doctor A observed the Service Recipient pounding his head against the hard plastic of the restraint bed. Doctor A also noted swelling to the Service Recipient's left eye, a slight abrasion to his right face with no remarkable hemorrhage, edema and contusion around his left orbit, and no broken bones or dislocated joints. Doctor A further noted that the Service Recipient was able to open both eyes and determined that no emergency medical treatment was necessary. (Justice Center Exhibit 17)

15. The following day, , the Service Recipient was taken to a local hospital after (Nurse 1) noticed that his injuries had worsened to the point where he had a severe contusion to his left eye which was swollen shut. (Justice Center Exhibits 7 and 28)

16. At the local hospital, the Service Recipient was diagnosed with a "C7 fracture with

bilateral subarachnoid hemorrhage." The local hospital transferred the Service Recipient the same day to [REDACTED] for further treatment. (Justice Center Exhibit 41)

17. At [REDACTED], the Service Recipient had "scans of his chest and abdomen/pelvis, which were negative." The [REDACTED] spine team took cervical films which "did not show clear evidence of fracture or change in alignment." On [REDACTED], the Service Recipient was discharged from [REDACTED] with several dietary recommendations and the use of a walker. (Justice Center Exhibit 43)

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 (substantiated as 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 (3), which is defined as follows:

> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

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

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

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and photographs obtained during the investigation. (Justice Center Exhibits 1 through 59) The Justice Center also presented a CD containing audio and video recordings of New York State Police (NYSP) interviews of the Subject and several other witnesses, and audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 60) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented one witness, the Sr. SHTA, who testified on his behalf.

The Justice Center contends that, when the Subject confronted the Service Recipient while he was wielding his wheelchair, the Subject pushed or shoved the wheelchair and/or the Service Recipient with excess force, causing the Service Recipient to fall to the floor and sustain injuries to his face when the wheelchair fell upon him. The Justice Center further contends that the Subject should have "deflected" the wheelchair instead of "shove" the wheelchair. (Hearing testimony of the Investigator)

The Subject argued that the Service Recipient was coming toward him with the intent to hit him with the wheelchair and that he blocked or deflected the wheelchair as a defensive maneuver in order to avoid being hit and injured by the wheelchair. (Hearing testimony of the Subject)

The majority of the evidence in the record supports the Subject's contention. The Subject stated, in his NYSP depositions, NYSP interview, JC interrogation and hearing testimony, that he deflected the wheelchair in a defensive maneuver. (Justice Center Exhibit 9, Justice Center Exhibit 60: audio recording of New York State Police interviews of the Subject; Justice Center Exhibit 60: audio recording of Justice Center Interrogation of the Subject; and Hearing testimony of the

Subject) The Sr. SHTA stated, in the OMH Incident report, the Progress Notes, NYSP depositions, his NYSP interview, his JC interrogation and hearing testimony, that the Subject blocked or deflected the wheelchair. (Justice Center Exhibits 11, 27 and 37; Justice Center Exhibit 60: audio recording of New York State Police interviews of the Sr. SHTA; Justice Center Exhibit 60: audio recording of Justice Center Interrogation of the Sr. SHTA; and Hearing testimony of the Sr. SHTA) SHTA 2 stated, in his Justice Center interview that the Subject deflected the wheelchair. (Justice Center Exhibit 60: audio recording of Justice Center Interview of SHTA 2)

The only evidence that supports the Justice Center's contention, that the Subject used excessive force by pushing the Service Recipient, is found in the NYSP deposition of an unnamed service recipient (service recipient 1). (Justice Center Exhibit 12) However, the only other statement from a service recipient (also unnamed), who provided a NYSP deposition, agreed with the Subject that the Subject "deflected" the wheelchair. (Justice Center Exhibit 13)

Consequently, the NYSP deposition of service recipient 1 is not credited evidence. Conversely, the Subject's testimony and statements, along with those of the Sr. SHTA and SHTA 2, are credited evidence.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty and that the Subject's breach of duty 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 Justice Center contends that the Subject had a duty to not use excessive force, when he was confronted with the Service Recipient who was wielding a wheelchair at him. The Justice Center further contends that the Subject breached his duty by shoving the wheelchair, and that his actions caused the Service Recipient's injuries. As stated above, the Justice Center has not proved that the Subject used excessive force. Conversely, the credible evidence in the record establishes

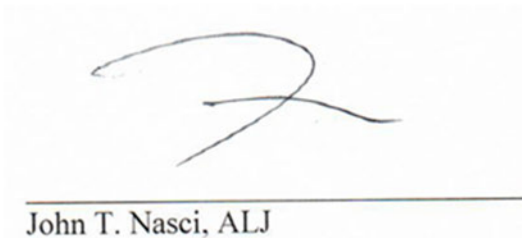
that the Subject blocked or deflected the wheelchair in a defensive maneuver. Consequently, the Justice Center has not established that the Subject breached his duty to not use excessive force.

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

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

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: June 21, 2017
Schenectady, New York



John T. Nasci, ALJ