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: November 9, 2020
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Daniel Sullivan, Esq.
[redacted], Subject
Lawrence Schaefer, 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: Elizabeth M. Devane
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
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: Daniel Sullivan, 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 (deliberate inappropriate use of restraints). The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted] of abuse (deliberate inappropriate use of restraints) 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 or about [redacted], while at [redacted], located at [redacted], you committed Deliberate Inappropriate Restraint against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 3 Deliberate Inappropriate Restraint pursuant to Social Services Law § 493(4)(c).

The investigation revealed the Subject conducted a restraint with excessive force and improper technique on the Service Recipient, which included placing the Service Recipient in a choke hold and/or placing his knee into the Service Recipient's back.

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

4. The facility, the [redacted], located at [redacted] provides, in pertinent part, inpatient mental health treatment for incarcerated adults. The [redacted] 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 [redacted] (Investigator))

5. Ward [redacted] of [redacted] is an inpatient acute care ward for male patients who need to be separated from the general population on other wards of [redacted] for various reasons including mental health and behavioral issues. (Hearing testimonies of the Investigator, the Subject and Secure Hospital Treatment Assistant (SHTA) [redacted] (SHTA [redacted]); Justice Center Exhibit 39)

6. At the time of the alleged abuse (deliberate inappropriate use of restraints), the 34 year old male Service Recipient was a resident of Ward [redacted] and had been at [redacted] for about three weeks. He had been admitted to [redacted] on numerous previous occasions. The Service Recipient had diagnoses including Antisocial Personality Disorder. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 17, 18, 25, 27, 29, 31, 34, 37 and 39).

7. The Service Recipient had a history of being assaultive, particularly toward Corrections Officers and staff, being impulsive, having suicidal ideations and being self-harming, including lacerating himself and swallowing objects such as an inhaler, metal and plastic pieces. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 27, 31, 34, 37 and 39).

8. At the time of the alleged abuse (deliberate inappropriate use of restraints), the Subject had been employed by the OMH for 6 years as a Secure Hospital Treatment Aide (SHTA) and previously worked at OCFS for 11 years as a Youth Division Aide. His duties included caring

for service recipients and providing safety and supervision for service recipients. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16 and 39) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

9. [redacted] utilized, and the Subject was trained in, Preventing and Managing Crisis Situations (PMCS), the purpose of which included enhancing safety for service recipients and staff. The PMCS training provided staff with appropriate responses to prevent crisis situations and direction on how to manage such situations when they occur. PMCS training identified behavioral warning signs, provided verbal and nonverbal intervention strategies and de-escalation techniques, such as distraction and redirection, to prevent and defuse situations, and reviewed how to perform appropriate physical interventions. PMCS training dictated that a restraint was to be used only as a measure of last resort to avoid imminent injury to a service recipient or others and, in such event, the least restrictive method approved was to be utilized. PMCS instructed that safety concerns were elevated when someone threatened bodily harm to themselves or others, used a weapon, or displayed violent conduct and, as a result, a service recipient or other person was placed in imminent danger of physical injury. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibit 35)

10. From [redacted] at 10:00 a.m. to [redacted] at 10:00 a.m., a Constant Observation Order was prescribed for the Service Recipient. The Order required 1:1 staffing for the Service Recipient with observation of "Assaultive" and "Impulsive" behaviors noted. The Service Recipient's progress notes indicated the Service Recipient's restrictions including, "No sharps/Razor/Pen". (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 24, 30, 31, 34, 37 and 39)

11. At the time of the alleged abuse (deliberate inappropriate use of restraints), the Service Recipient was located in, what was referred to as, a "side room" on Ward [redacted]. A SHTA (SHTA [redacted]) was assigned 1:1 of the Service Recipient and posted outside the room. The room contained a mattress with linens, a chair and paperwork. The room had a window on the wall facing outside and a window on the door facing into the hallway. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 17, 18, 19, 24, 25, 27, 30, 31, 34, 37, 38 and 39)

12. On [redacted], the Subject was assigned to Ward [redacted] for the [redacted] shift. A SHTA (SHTA [redacted]), was assigned supervision of the Service Recipient. At approximately 3:35 p.m., the Subject provided supervision to the Service Recipient while SHTA [redacted] took a break to use the lavatory. At the same time, SHTA [redacted] was assigned to supervise a service recipient who was located in a side room next to the Service Recipient's side room. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 18, 24, 30, 31, 38 and 39)

13. The Subject was supervising the Service Recipient for approximately two minutes when he saw the Service Recipient, who was standing on the chair with his back to the door, get on his tiptoes and reach up toward the side room ceiling vent. The Subject called to the Service Recipient and directed him to get down. The Service Recipient refused to comply with the request. The Subject called to the Service Recipient again and when he did not comply, the Subject entered the side room, grabbed the Service Recipient's left arm and pulled him off the chair. When the Subject did this, he and the Service Recipient veered toward a wall, the Service Recipient swung his arm at the Subject and an altercation ensued. SHTA [redacted] entered the room, attempted to restrain the Service Recipient and he and the Service Recipient fell to the floor. The Subject briefly got

on top of the Service Recipient and held him down. The Red Dot emergency telephone system was used at approximately 3:39p.m. to request additional assistance and a number of staff responded. The Service Recipient was held on the floor for approximately 75 seconds until a restraint bed was brought into the room. The Service Recipient was then secured in a five-point restraint in a supine position on a rolling restraint bed in the side room. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 16, 17, 18, 20, 23, 24, 29, 30, 31, 33, 34, 37, 38 and 39)

14. The physical examination of the Service Recipient performed at 3:50 p.m., and subsequent physical examinations completed on [redacted] and [redacted], found multiple older scars predating the restraint and no recent injuries or bruising to the Service Recipient. (Justice Center Exhibits 17, 22, 23, 26, 31, 34, 36 and 37)

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 report of abuse (deliberate inappropriate use of restraints) 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…" (14 NYCRR § 700.3(f))

The abuse (deliberate inappropriate use of restraints) of a person in a facility or provider agency is defined by SSL § 488(1)(d) as follows:

> (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

Substantiated reports of abuse (deliberate inappropriate use of restraints) shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subjects committed the acts of abuse (deliberate inappropriate use of restraints) alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report. (14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse (deliberate inappropriate use of restraints), the report will not be amended and sealed. Pursuant to SSL § 493(4) and 14 NYCRR § 700.10(d), it must then be determined whether the acts of abuse (deliberate inappropriate use of restraints)

cited in the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) as set forth in the substantiated report.

If the Justice Center did not prove the abuse (deliberate inappropriate use of restraints) by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the abuse (deliberate inappropriate use of restraints) described in "Allegation 1" 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 through 37) The Justice Center also provided a video recording of the side room during the time of the alleged abuse as well as audio recordings of the Investigator's interviews of the Subject, SHTA [redacted] and the Service Recipient. (Justice Center Exhibits 38 and 39) The investigation underlying the substantiated report was conducted by the Investigator who testified at the hearing on behalf of the Justice Center. The Subject testified in his own behalf and SHTA [redacted] also testified at the hearing. No additional documentary evidence was provided.

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

legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL § 488(1)(d))

The Justice Center contends that the methodologies used by the Subject were not proper restraint techniques and were performed by the Subject with excessive force during a physical intervention with the Service Recipient on [redacted]. The Justice Center also argued that there was no basis for an emergency intervention.

The Investigator testified that the restraint techniques used by the Subject, including pulling him, landing on him and putting his knee into the Service Recipient's back were not approved restraint techniques and that, based upon his knowledge of PCMS restraint techniques, his review of the video and his experience, the Subject participated in a restraint with improper technique and excessive force. (Hearing testimony of the Investigator))

PMCS is a multistep process in dealing with an agitated person. According to the PMCS Manual, de-escalation techniques, such as calming the person, moving them to a different location or having other staff intercede, are to be used first. (Justice Center Exhibit 35) Restraints are to only be used as only as a measure of last resort to avoid imminent injury to a service recipient or others and, when an intervention becomes necessary, the least restrictive method is to be utilized. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibit 35) When a restraint becomes necessary, the least restrictive intervention is to be utilized. PMCS states that safety concerns are elevated when someone threatens bodily harm to themselves or others, uses a weapon, or displays violent actions and notes that imminent danger may occur in that stage. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibit 35)

The Subject conceded that the restraint was not performed as trained under PMCS, but that the restraint technique that he used was a reasonable emergency intervention to prevent imminent harm to the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibit 39) The Subject stated and testified that he had observed the Service Recipient multiple times in the past during other [redacted] stays and was aware that the Service Recipient engaged in self-injurious behaviors, including swallowing objects. (Hearing testimony of the Subject; Justice Center Exhibit 39) When the Subject supervised the Service Recipient while SHTA [redacted] took a break, he was initially not concerned that the Service Recipient was standing on the chair as most of the side rooms had new vents, or covers placed on the vents, to prevent service recipients from hiding objects in the vents. However, when the Subject dipped his head down to get a better look at what the Service Recipient was doing, the Subject saw that the grate in that side room did not have a new cover or vent, and that the Service Recipient had his fingers in the grate and was pulling down on it. The Service Recipient's failure to respond when the Subject twice said his name was further cause for alarm. (Hearing testimony of the Subject; Justice Center Exhibit 39)

The Subject stated and testified that he did not know if the Service Recipient had pulled something out of the vent or had something in his hand and did not want the Service Recipient to cut himself or swallow anything so he ran in, grabbed the Service Recipient and pulled him off of chair. The Service Recipient began to struggle and, as the Subject attempted to secure his arms, the Service Recipient punched him. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 35 and 39) The Subject stated that he attempted to get ahold of and maintain control of the Service Recipient the best he could but that it "was not an ideal situation". (Hearing testimonies of the Subject and SHTA [redacted]; Justice Center Exhibits 35 and 39) The Subject testified that he thought that the intervention was a reasonable emergency intervention

necessary to prevent imminent risk to the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibit 39)

The credible evidence in the record establishes that the Subject was fully and currently trained in PMCS techniques and that he was familiar with the Service Recipient's treatment plans at the time of the incident. (Justice Center Exhibit 35 and 39; Hearing testimony of the Subject) The Service Recipient was on 1:1 constant observation due to his recent history of assaultive and impulsive behavior. (Hearing testimonies of the Investigator, the Subject and SHTA [redacted]; Justice Center Exhibits 23, 24, 30 and 39) When the Subject noticed the Service Recipient grabbing at the vent, he did not employ appropriate de-escalation techniques by attempting to speak with or calm the Service Recipient, by first attempting a less restrictive restraint technique, and generally by reacting too abruptly to the situation at hand. (Hearing testimony of the Investigator; Justice Center Exhibit 39) Instead, when the Service Recipient did not immediately reply to the Subject's commands, the Subject ran into the room, grabbed the Service Recipient, forcefully pulled him from the chair and then attempted to perform a restraint with admitted improper technique. The Subject admitted that the technique he used was intentional and not proper technique under PMCS or the Service Recipient's plans, but said it was used as an emergency intervention. Consequently, the technique used by the Subject was deliberately inconsistent with the Service Recipient's plans and with the PMCS physical intervention policy. (Hearing testimonies of the Investigator and the Subject; Justice Center Exhibit 38) The Service Recipient's assaultive and impulsive behavior quickly escalated when the Subject pulled him off of the chair.

While the Subject was aware of the Service Recipient's history of self-injurious behavior and stated that he was afraid that the Service Recipient may have an object in his hand, the Service Recipient did not successfully pull the vent from the ceiling and nothing was found in his hand

and there was no evidence that was occurring. Being in constant eye view of and in close proximity to the Service Recipient, the Subject was in a position to first monitor the Service Recipient to determine what he had obtained from the vent, if anything, and use verbal calming techniques to talk the Service Recipient down from the chair and continue to assess the situation. At the time the Subject grabbed the Service Recipient, the Subject could not have made a determination that the Service Recipient posed a threat to himself or anyone else. The video shows insufficient evidence of an emergency situation and, as the Investigator testified, he "did not see an emergency situation until [the Subject] entered the room and then the struggle between him and the Service Recipient ensued." The altercation that ensued involved the Subject performing another restraint that was not performed as trained under PMCS and a situation which eventually involved a number of staff and the Service Recipient in a five point mechanical restraint bed.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse (deliberate inappropriate use of restraints) alleged and when the Subject initially restrained the Service Recipient, the situation did not rise to the level of a reasonable emergency intervention. The substantiated report will not be amended or sealed.

The next question to be decided is whether the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

Substantiated Category 3 findings of abuse (deliberate inappropriate use of restraints) will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to

make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed, is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: October 20, 2020
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge