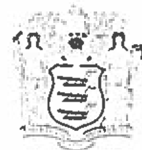

STATE OF NEW JERSEY

In the Matter of D.M. Ann Klein Forensic Center, Department of Health CSC DKT. NO. 2018-3796 OAL DKT. NO. CSV 10026-18 and HSL 05669-18 **(Consolidated)**	:	**FINAL ADMINISTRATIVE ACTION OF THE CIVIL SERVICE COMMISSION**

ISSUED: JULY 31, 2019 BW

The appeal of D.M., Human Services Assistant, Ann Klein Forensic Center, Department of Health, removal effective March 5, 2018, on charges, was heard by Administrative Law Judge Tama B. Hughes, who rendered her initial decision on March 21, 2019. Exceptions were filed on behalf of the appointing authority and a reply to exceptions was filed on behalf of the appellant.

Having considered the record and the Administrative Law Judge's (ALJ) initial decision including the finding of abuse sustained by the Office of Program Integrity and Accountability in this joint case, and having made an independent evaluation of the record, the Commission, at its meeting of July 31, 2019, rejected the recommendation to reverse the removal as contained in the attached Administrative Law Judge's initial decision. Rather, the Commission upheld the removal.

ORDER

The Civil Service Commission rejections the ALJ's recommendation to reverse the removal. Rather the Commission, pursuant to the Office of Program Integrity and Accountability, finds that the action of the appointing authority in removing the appellant was justified. The Commission therefore affirms that action and dismisses the appeal of D.M.

This is the final administrative determination in this matter. Any further review should be pursued in a judicial forum.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
THE 31ST DAY OF JULY, 2019

Deirdré L. Webster Cobb
Chairperson
Civil Service Commission

Inquiries
and
Correspondence

Christopher S. Myers
Director
Division of Appeals and Regulatory Affairs
Civil Service Commission
P. O. Box 312
Trenton, New Jersey 08625-0312

Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. HSL 05669-18

AGENCY DKT. NO. DRA # 18-005

RECORD SEALED

D.M.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES, OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY,

Respondent.

IN THE MATTER OF D.M., DEPARTMENT OF HEALTH, ANNE KLEIN FORENSIC CENTER.

OAL DKT. NO. CSV 10026-18

AGENCY DKT. NO. 2018-3796

(CONSOLIDATED)

Christopher Gray, Esq., for petitioner/appellant D.M. (Sciarra and Catrambone, LLC, attorneys)

Stephen Slocum, Deputy Attorney General, for respondent Department of Human Services, Office of Program Integrity and Accountability (Gurbir S. Grewal, Attorney General of New Jersey, attorney)

New Jersey is an Equal Opportunity Employer

Daniel Pierre, Deputy Attorney General, for respondent Department of Health, Anne Klein Forensic Center (Gurbir S. Grewal, Attorney General of New Jersey, attorney)

Record Closed: February 2, 2019 Decided: March 21, 2019

BEFORE **TAMA B. HUGHES,** ALJ:

STATEMENT OF THE CASE

In the matter docketed HSL 05669-18, petitioner, D.M. (petitioner or D.M.) appeals the finding of respondent, the Department of Human Services (DHS), that he committed an act of physical abuse, as defined in N.J.A.C. 10:44D-1.2, against a service recipient of the Division of Developmental Disabilities (Division), and the decision of DHS to place his name on the Central Registry of Offenders (Central Registry) against Individuals with Development Disabilities.

In the matter docketed CSV 10026-18, petitioner appeals the Anne Klein Forensic Center (AKFC), Department of Health findings and sustained charges of N.J.A.C. 4A:2-2.3(a)(6) (Conduct unbecoming of public employee), and Section A.O. 4:08(C)3 (Physical or mental abuse of a patient, client, resident or employee), and Section A.O. 4:08(C)5 (Inappropriate physical contact or mistreatment of a patient, client, resident or employee) of the Department of Human Services Disciplinary Action Program (Policy). Additionally, petitioner challenges the severity of the recommended disciplinary action of removal.

PROCEDURAL HISTORY

Upon filing the appeals captioned above (HSL 05669-18 and CSV 10026-18), both matters were transmitted to the Office of Administrative Law (OAL) for a hearing as contested cases pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13.

By Order dated August 16, 2018, the matters were consolidated, and predominant interest was determined to be with the DHS.

Thereafter, several case management conferences were held with respect to outstanding discovery issues and proffered witness testimony. By Letter Order dated October 4, 2018, the issues were addressed.

The hearing in this matter took place on October 12, 2018, October 19, 2018 and November 2, 2018. Upon receipt of summation briefs and supplemental documentation, the record closed on February 5, 2019.[1]

FACTUAL DISCUSSION AND FINDINGS

Edward Tobin (Tobin), the Director of the Office of Investigations for the Department of Health, testified that his office conducts investigations into allegations of abuse, neglect or exploitation at the four State psychiatric hospitals, which would include the Anne Klein Forensic Center.

When an Unusual Incident Report (UIR) is filed and assigned to his office, the matter is investigated and an Investigation Report (IR) generated. As part of his responsibilities, Tobin reviews all matters where the findings are "substantiated."

A UIR was filed regarding an incident (Incident) which occurred on April 26, 2017 wherein A.C., a resident at AKFC, alleged that he was injured by a Medical Security Officer (MSO) during a restraint procedure. The matter was forwarded to Tobin's office for investigation, at which time interviews were conducted and surveillance films were reviewed. At the end of the investigation, the investigator filed an IR which he reviewed and approved. (R-1 and R-2.)

[1] Counsel for petitioner attached to his summation brief a Complaint-Summons and Certification of Disposition. These documents were not introduced at the hearing or entered into evidence and were therefore not taken into consideration by the Tribunal.

Tobin testified that he reviewed the surveillance films in this incident. At no time did he observe A.C. pick up a chair or attempt to fight D.M. He further noted that in the two written statements which D.M. provided, there were discrepancies in reporting. More specifically, the things which D.M. claimed to have occurred could not have occurred from the time the Incident started to when A.C. was removed from the stage. According to Tobin, to substantiate abuse, physical injury is not required.

On cross examination, Tobin agreed that aside from an abrasion on his nose, A.C. had no other injuries as a result of the Incident. He also acknowledged that he did not personally conduct the investigation into the Incident, and that the referral for investigation did not come in until June 5, 2017 – well over a month after the Incident. While it is not his unit's responsibility to investigate the delay in reporting, the concern was brought to AKFC's attention as part of the report. In describing the patients at AKFC, Tobin stated that they are not as stable as patients in the other facilities, likening AKFC to a correctional facility given the type of patients and security personnel required to secure the facility.

As part of an investigation into abuse or neglect, both the patient's and the target's behavioral history is reviewed in the Unusual Incident Report Management Systems (UIRMS) to see if there is any type of pattern either between the parties or the individual which would aid in the investigation. There were no substantiated instances of abuse or neglect in D.M.'s history despite having been named as the alleged perpetrator in multiple incidents. A.C. had multiple UIR's in the system, a majority of which were assaults of patient to patient and two of the incidents involving assaults by A.C. on staff members.

According to Tobin, the Incident occurred at approximately 10:21 a.m. He was unaware that an incident had occurred earlier wherein A.C. was documented to have had behavioral control and assaultive behavior issues. After the Incident, at 11:00 a.m., A.C. was examined by Dr. Sandhu and Dr.

Smith. Both doctors' reports were reviewed as part of the investigation and noted that A.C. did not have any noticeable injuries nor did he complain of any. The reports also indicated that A.C. was in chair restraints, spitting at staff, banging his head and attempting to assault the officers. (P-21 and P-23.)

Also reviewed as part of the investigation was a mental health examination which was performed on June 8, 2017 by Dr. Roth. In his report, Dr. Roth quoted A.C. as stating that ". . . [I] was going to hit him with a chair. I picked it up, then put it down. I wanted to play spades. I punched like I was going to hit an MSO . . . ." (P-22.)

When questioned about witness interviews, Tobin acknowledged that at least fifteen individuals were interviewed as part of the investigation. Typically, the interviews are not taped. Rather, the witnesses are asked to provide a written statement. If a witness has difficulty writing, their comments will be written down and read back to them for their approval.

A.C. was interviewed on June 7, 2017, and a written statement was prepared on his behalf. (P-13.) In this statement, A.C. indicated that his head was not slammed into the table. Rather, he was thrown onto the table. He also stated that he was body-checked face first onto the ground.

E.C. was interviewed on June 13, 2017. He informed the investigator that A.C. came in and attempted to and did in fact spit on D.M. (P-12 and R-1, page 14.) He also stated that A.C. started fighting D.M. At one point, D.M. slipped and they fell on the table. (P-12 and R-1, page 14.)

MSO Prince Smith **(Smith)** was interviewed three times as part of the investigation and provided a written statement after each interview. (P-8 and R-1, page 30.) The first interview occurred on June 7, 2017 wherein he stated that when A.C. came into gym area and onto the stage, he was already agitated and using profanity. At one point, A.C. stood up, grabbed his crotch and told

D.M. in explicit terms what sexual act he wanted from him. He was also attempting to spit on D.M. The second interview occurred on June 8, 2017 and the third was on July 12, 2017.

MSO Gregory Bell **(Bell)** was interviewed on June 8, 2017 and provided two statements. (P-9 and R-1, page 37.) According to Bell, when A.C. came onto the stage area, he got upset when he was told he could not play cards. D.M. attempted to verbally redirect A.C.; however, it did not work as A.C. made a move as though he was going to pick up a chair and hit D.M. Bell saw D.M. grab A.C.'s hand and shoulder to restrain him; however, he turned his attention to other residents in the gym and did not see what occurred subsequently.

D.M. was also interviewed as part of the investigation on June 15, 2017 and again on July 5, 2017. He provided handwritten statements after each interview. (P-7 and R-1, pages 46 – 48.) Additionally, his training record was also reviewed. (P-15.)

In questioning Tobin about his observations on the surveillance films, he admitted that his view of A.C.'s actions was obstructed at certain points and that some of his comments regarding what occurred during the Incident were based on conjecture. He additionally acknowledged that there was no indication that A.C. was pushed to the floor, punched or kicked by D.M. He also admitted that he does not know whether A.C. was attempting to bite D.M.

Regarding the training manuals, Tobin testified that he did not personally review the Therapeutic Options Manual or the Advanced Emergency Hold Training Manual. Additionally, while he is aware that MSO's receive training, he does not know the content or extent of the training. When he reviewed the investigative report, he also reviewed the relevant sections of the Therapeutic Options Manual that were deemed pertinent to the allegations. He is unfamiliar with Advanced Emergency Holds techniques including the five "Advantage Holds." He is also unfamiliar with the levels of force that an MSO may use if a

situation arises. Therefore, he could not say whether D.M.'s actions were consistent with his training. Along these same lines, Tobin admitted that he was unsure what type of training the investigators who conducted the investigation had received.

Tobin acknowledged that in Sandy Ferguson's (Ferguson) statement to the investigators, she stated that D.M. could use Advanced Emergency Holds as needed. (P-1, page 53.) Ferguson is the AKFC Training Technician 4. When questioned, Tobin agreed that if D.M.'s actions were consistent with his training, then no patient abuse would have been substantiated.

Sandi Ferguson (Ferguson) testified that she has been employed by AKFC for the past thirty years and has held the position of Director of Staff Training since 1989. As the Director of Staff Training, it is her responsibility to train and educate all facility staff members as well as write policies and evaluate and develop training curriculums. Some of the training courses provided are Therapeutic Options, Advanced Emergency Holds, abuse and neglect, seclusion and restraint classes. In describing Therapeutic Options, Ferguson stated that it is a program made up of several components among which includes verbal redirection, de-escalation (CALM's model) as well as defensive techniques and holds. (R-4.) In describing the defensive techniques and holds, Ferguson provided a demonstration of the two holds promoted under the program.

According to Ferguson, there are other known therapeutic holds, one of which is the Advanced Emergency Holds. These holds, of which there are five (Mach 1 - Mach 5), may be used by employees when a patient is a danger to themselves or others. Ferguson provided a description and demonstration of all five holds. (R-5.) All five holds required the staff to be standing. On four of the holds, staff are required to hold at least one of the patient's hands. According to Ferguson, the employee would be unable to bend a patient over if executing a Mach 3 or Mach 5 hold if there was an object in front of them for fear of injury. This is not a written rule, rather one of judgment on the employee's part.

Upon viewing the surveillance films, Ferguson was questioned whether it was acceptable to grab a patient's shirt, shove a patient's head on a table or pin a patient down on the floor. In response, she stated at no time, even if a patient was attempting to bite the staff member, were such maneuvers allowed. Ferguson added that D.M.'s actions were not consistent with Therapeutic Option Holds or Advanced Emergency Holds, the seven holds permissible at AKFC.

On cross examination, Ferguson acknowledged that for an employee to implement any of the holds, the patient would have to be standing. She went on to state that if a patient is seated, the officer could stand the patient up by using an escort hold with Therapeutic Options and then move into a Mach One hold under Advanced Emergency Holds. In review of the surveillance film, which she saw the day before the hearing, she could not definitively say whether or not D.M. was using a Mach 1 hold.

When questioned about transitioning from a Mach 1 into a Mach 2 or Mach 3 hold, Ferguson stated that Mach 2 and Mach 3 holds could not be safely implemented if there were obstructions in the way. If the space is tight, the employee should stand back and wait for a supervisor, even if the patient is assaultive and/or spitting on staff. Depending on the situation, an employee could go from a Mach 1 hold to a Mach 4, skipping the two holds in between. Ferguson went on to state that all officers are trained on situational awareness, and how to deal with patients who have a history of violent or assaultive behavior. She acquiesced that there is nothing that anybody can teach that would address every situation that arises with a patient.

Regarding her observations on the surveillance films, Ferguson agreed that she did not see D.M., who trains employees at the facility for Advanced Emergency Holds, choke, punch or kick A.C. However, she felt that D.M. improperly "dragged" A.C. from the stage area to the gym floor. When questioned further, she acknowledged that from the angle of the surveillance films, she could not see how close the stage stairs were to where A.C. was

situated; where D.M.'s hands were in relation to A.C.'s head; and if D.M. was protecting A.C.'s head which was paramount; or how D.M. navigated the steps. She also acknowledged that D.M. received little to no assistance from the other MSO's who were present and that A.C. had a history of violence and spitting.

In discussing training, Ferguson stated that AKFC has a policy in place regarding the use of defense and control techniques (Policy). (R-6.) All patients are treated the same, regardless of whether or not they are DD patients. If the staff members follow the holds as trained, then the employee cannot be deemed to have abused a patient under the Policy. Under the Policy, after an incident occurs where the employee is required to use personal defense and/or controls, the supervisor is required to review the circumstances and techniques used as well as their physical and emotional reaction. She did not know if a debriefing occurred after the Incident nor was she called in as part of the investigation.

Prince Smith (Smith), an MSO at AKFC, testified that he has been an employee of the center for the past twenty years. Over the course of his career he has attended various training courses, which include training in Therapeutic Options and Advanced Emergency Holds. He was working on April 26, 2017 and vividly recalled the Incident. He also provided a written statement to the investigators. (P-8.) The first time he saw the surveillance film was at the hearing.

In relaying the events of that day, he stated that he and other MSO's were playing cards on the stage with a few of the residents. Interacting with residents by playing cards, throwing a football or playing basketball is one of their job responsibilities as it is comforting to the residents and keeps them focused. While playing cards, A.C. came onto the stage and wanted to play cards. He appeared to be angry and was cursing. He and his colleagues tried to talk to him; however, his behavior escalated and he started to threaten D.M., stating that he was going to punch him, spit on him, and perform sexually and anatomically explicit acts.

At one point, A.C. came up behind D.M., sat down and grabbed his groin area telling him (D.M.) that he was going to urinate and/or spit on him, moving towards D.M. as though he was going to do just that. When A.C. started to move, he (Smith) got up and continued to try to de-escalate him, telling him to stop. At the same time D.M. stood up to stop A.C. from taking any further action. A.C. was kicking and spitting when D.M. had A.C. by a table. When the table started to slide, A.C. went to the floor and was subsequently moved to the gym floor. A supervisor was called in at that time. Throughout this, A.C. continued to spit, bite, and kick the officers with D.M. on the floor holding him so that A.C. would not get hurt. At no time did A.C. complain that he was in pain or get hurt, nor was he having difficulty breathing.

It was Smith's testimony that D.M. appropriately applied the hold techniques that they had been trained to perform and authorized to use. At no time did D.M. slam A.C.'s face into a table. In fact, D.M. had A.C.'s wrist and properly lowered him to the ground.

Irshan Ware (Ware), an MSO with AKFC, testified that he has been an employee of the center for the past sixteen years. Over his years of service, the center has offered several different training techniques for handling residents. Among them was PERT, then MANDT with the most recent training programs comprising of Therapeutic Options and Advanced Emergency Holds.

He was working on April 26, 2017 and stationed at the entrance to the gym or "rehab yard door." His attention was split between the gym and the hallway. From this vantage point he could see the stage in the gym. He recalled seeing A.C. approach D.M. on the stage. The stage area is one of the MSO's assigned posts. Due to the acoustics in the gym, he could not clearly hear what was being said. While he did not see the Incident, he could hear loud cursing but did not know who was cursing.

Ware became involved in the Incident after A.C. was placed on the floor of the gym. He recalls that A.C. was cursing and trying to spit on the officers. Ware went over to A.C., knelt, and attempted to calm him down by talking to him. At no time was A.C. kicked, punched or choked by any of the officers present. After a supervisor showed up, A.C. was brought to his feet and escorted to the Quiet Room.

Gregory Bell (Bell), an MSO with AKFC, testified that he has been with the center for the past twenty-one years. Over his years of service, the center has offered several different training techniques for handling residents with the most recent training programs comprising of Therapeutic Options and Advanced Emergency Holds.

He was working on April 26, 2017 and recalls giving a couple of written statements regarding the Incident. (P-9). Prior to A.C. coming onto the stage, he, D.M., and Smith were playing cards with some of the residents at one of the tables. A.C. approached the table and demanded to play cards. When he was told that he had to wait, A.C. started "spewing" epithets, which continued even after he was told that he could play in a few minutes. At one point, A.C. gestured like he was going to knock the cards off the table. Throughout this encounter, D.M. attempted to calm A.C. down and deescalate the situation given A.C.'s known behavior. When A.C. gestured as though he was going to pick up a chair, D.M. stood up and restrained A.C. in a proper hold. Smith also got up to assist. Bell stated that he remained seated and did not assist D.M., as the space was tight. D.M. was a trainer and handling the situation, and he was attempting to keep other residents clear of the area.

Bell went on to testify that he could not see everything from his vantage point; however, could see D.M. resting A.C.'s head on the table. He also saw A.C. dropping his weight/legs as D.M. was attempting to move him. At no time did he see A.C.'s head hit or get slammed on the table, nor did he hear any noise to that effect. A.C. did not appear to be injured as a result of the Incident.

D.M. testified that he is a Senior MSO with the AKFC and has worked at the center since 2002. Over his years of service, he has received several different training techniques for handling residents with the most recent training programs comprising of Therapeutic Options and Advanced Emergency Holds. He is a certified trainer at the center for Advanced Emergency Holds.

D.M. is familiar with A.C. and his treatment plan in AKFC. He is also familiar with A.C.'s aggressiveness having been punched in the mouth by A.C. two weeks prior while placing him in a restraint chair. He also advised that on multiple occasions, A.C. has spit on him and his verbal diatribe is a constant. D.M. stated that when any resident spits on you, there is always a concern about HIV or hepatitis, therefore, it is taken seriously.

On April 26, 2017, while stationed in the gym, he was playing cards with other residents on the stage area when A.C. approached. As he approached, he was using vulgar language and demanding to play cards. At one point, A.C. stated that he should punch D.M. in the mouth again, spit on him, and hit him with a chair, and made to stand up as he was making the threats. While he heard Smith testify that A.C. made other threats in addition to the ones previously noted, he did not recall hearing those specific ones. All of the officers were trying to redirect A.C.; however, A.C. continued to threaten him.

According to D.M., after being told he had to wait to play cards, A.C. swiped the empty card box off the table, all the while continuing with his barrage of vulgar language and threats. When A.C. swiped the box off the table, it was his belief that A.C. was gearing up to hit him with a chair. Having been assaulted by A.C. two weeks prior, he was concerned that A.C.'s conduct would continue to escalate. For the safety of himself and the others present, he stood up to restrain A.C., get him out of the area, and into the Quiet Room. He placed A.C. in an "Escort Hold," which is a hold used to pick a patient up from a sitting position.

After standing A.C. up, he used an Advanced Emergency Hold, Mach 1, which then transitioned into a Mach 2 hold as A.C. was struggling and attempting to spit.[2] As he was transitioning into the Mach 2 hold and realizing that the table was in the way, he attempted to bring A.C. closer to him and away from the table and not bang his head. As this was occurring, the table started to move and A.C. dropped his weight causing him to lose his footing. He could not safely complete the restraint on stage due to the obstacles. He guided A.C. to the ground, holding on to him and placing his head on the stage floor. Due to the proximity of the stage stairs and the hardness of the stage floor, he let go of A.C., walked around him, and grabbed him from behind, and with A.C.'s head in his lap he brought A.C. down to the gym floor, which was softer/spongier.

Once on the gym floor, D.M. stated that he rolled A.C. over, in accordance with his training, so that he could not spit on anyone. While on the floor, he employed PRT, a restraint technique which he had been trained to use years prior which was very similar to Therapeutic Options. Throughout this, A.C. was cursing, kicking, punching, and attempting to bite D.M. At no time did he kick, knee or punch A.C.

When the supervisor showed up, A.C. was still on the gym floor and he was kneeling next to him securing his arms.[3] He had not called in a code nor did he have a radio that day. He is not sure if one of the other MSO's called in a code. After a few minutes, other officers picked A.C. up and transported him to the Quiet Room. According to D.M., when a resident is taken to the Quiet Room after an incident, they are evaluated by a nurse or a doctor and an MSO supervisor.

In June 2017, he was questioned by Investigator Trespeses from the Office of Investigations and wrote a statement. (P-7.) In explaining why he wrote that A.C. had grabbed the chair and gestured as though he was going to use it to hit him, D.M. stated that when he wrote the statement he had not seen

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[2] D.M. demonstrated the holds as he was testifying.

the surveillance films. Given the fact that A.C. had threatened him several times during the Incident to hit him with the chair, and the way the investigator was leading him, he thought that A.C. had grabbed the chair. In his second statement he clarified that A.C. had threatened to hit him with the chair. D.M. reiterated that the actions he took to restrain A.C. were in accordance with his training.

While in hindsight D.M. stated he may have done things differently in restraining A.C., given the confined space on the stage area, the obstacles present (table and chairs), and the rapidity of events, that was not possible at the time.

On cross examination, D.M. was questioned if he had a bad relationship with A.C. In response, he stated that he does not have any type of relationship with A.C., nor does he dislike A.C. He went on to state A.C. will pick on whoever he wants to on a given day. It is his job to handle the patients as they are. As it relates to A.C., A.C. "gives him a reason to watch my back a lot more".

When questioned about his version of events when compared to the surveillance film, D.M. reiterated that A.C.'s head did not hit the table; however, his body connected with the table. D.M. agreed that even a body hitting the table could cause injury. When questioned about his testimony that A.C. was continuously kicking while on the gymnasium floor, D.M. conceded that A.C.'s attempts to kick were sporadic.

When questioned why he did not call a code, he stated that you cannot call a code if you are in the middle of a restraint technique. Regarding the discrepancy in his written statement, D.M. stated that after he wrote the first statement, he viewed the surveillance film and realized that he was mistaken about A.C. grabbing a chair, so he clarified it in the second statement.

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[3] Throughout his testimony, D.M. demonstrated his hand placement on A.C.

D.M. was also questioned about the use of the PRT restraint when A.C. was on the gym floor. He acknowledged that this was not a currently approved hold at AKFC.

For testimony to be believed, it must not only come from the mouth of a credible witness, but it also has to be credible in itself. It must elicit evidence that is from such common experience and observation that it can be approved as proper under the circumstances. See Spagnuolo v. Bonnet, 16 N.J. 546 (1954); Gallo v. Gallo, 66 N.J. Super. 1 (App. Div. 1961). A credibility determination requires an overall assessment of the witness's story in light of its rationality, internal consistency, and the manner in which it "hangs together" with the other evidence. Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963). Also, "'[t]he interest, motive, bias, or prejudice of a witness may affect his credibility and justify the [trier of fact], whose province it is to pass upon the credibility of an interested witness, in disbelieving his testimony.'" State v. Salimone, 19 N.J. Super. 600, 608 (App. Div.), certif. denied, 10 N.J. 316 (1952) (citation omitted).

A trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958).

After hearing the testimony and reviewing the evidence, I **FIND** as **FACT** that on April 26, 2017, A.C., a patient known to be difficult, unpredictable, aggressive, and assaultive, approached the stage area where several MSO's, including D.M., were playing cards with patients. The testimony of D.M. and Smith was consistent and credible that A.C. was already agitated when he came up to the stage area and demanded to play cards. I **FIND** that when A.C. was told that he had to wait, his behavior escalated both verbally and physically, the verbal diatribe and physical threats all directed at D.M.

I **FIND** that consistent with the surveillance film and the testimony of D.M., Bell, and Smith, all three MSO's were focused on A.C.—attempting to redirect and deescalate his behavior—however, they were unsuccessful. D.M. and Smith's testimony was credible that when A.C. stood, it was unclear what he intended to do. This was based upon A.C.'s body language and barrage of threats. When A.C. swept the card box onto the floor, both Smith and D.M. were already moving towards A.C. who continued to physically threaten D.M.

I **FIND** that the stage area is raised approximately three feet from the gymnasium floor and is narrow in width. I further **FIND** that D.M. and Smith's testimony is credible that D.M. executed the proper hold (Escort Hold) in standing A.C. up and thereafter transitioned into a Mach 1 hold. I **FIND** that respondent's witnesses Ferguson and Tobin could not say for certain that D.M. did not implement a Mach 1 hold, and in Tobin's case, he was unfamiliar with any of the authorized holds.

I **FIND** that as D.M. was transitioning into a Mach 2 hold, realizing that the table was in the way, he pulled A.C. closer to him and away from the table. As this occurred, the table started moving, he lost his footing, and A.C. simultaneously dropped his weight. I further **FIND** that A.C. did not slam his head on the table; however, his torso did come into contact with the table. Thereafter, D.M. guided A.C. to the floor of the stage. I **FIND** that D.M. did not body-check A.C. face first onto the floor.

I **FIND** D.M.'s uncontroverted testimony was credible and consistent with the surveillance film, that given the proximity of the stairs and hardness of the stage floor, he properly brought A.C. to the gym floor for his safety, protecting his head throughout the process.

I **FIND** that D.M. did not use a currently authorized restraint procedure while D.M. was on the gym floor; however, used a previously approved

technique. Once on the floor, A.C. continued to attempt to spit, bite, and kick the officers present.

I **FIND** that at no time did D.M. kick, punch, slap, hit or push A.C. I further **FIND** that while D.M. pulled A.C. down to the gym floor, he did not drag him down the steps.

LAW AND ANALYSIS

It is the policy of this State to provide for the protection of individuals with developmental disabilities. N.J.S.A. 30:6D-73(a). The Central Registry is intended to prevent caregivers who become offenders against individuals with developmental disabilities from working with individuals with developmental disabilities. N.J.S.A. 30:6D-73(d). A caregiver may be placed on the Central Registry in cases of substantiated abuse, neglect or exploitation. N.J.S.A. 30:6D-77(b).

A "Caregiver" is defined in N.J.A.C. 10:44D-1.2 as "a person who receives State funding, directly or indirectly, in whole or in part, or who volunteers to provide services or supports, or both, to an individual with a developmental disability."

Central Registry Action

It is undisputed that petitioner was a caregiver for A.C. and that A.C. is a service recipient with the Division of Developmental Disabilities (DDD).

The issue here is two-fold. First, did petitioner commit an act of abuse against A.C. on April 26, 2017. Second, were petitioner's actions intentional, reckless or with careless disregard to the well-being of A.C. which resulted in injury to him or potentially exposed him to an injurious situation.

"Abuse," defined in N.J.A.C. 10:44D-1.2, means "wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability."

"Physical Abuse," defined in N.J.A.C. 10:44D-1.2, means "a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering. Such acts include, but are not limited to, the individual with developmental disability being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged or stuck with a thrown or held object."

For inclusion on the Central Registry, in the case of a substantiated incident of abuse, the investigating unit shall determine whether the caregiver acted with intent, recklessness, or careless disregard to cause or potentially cause injury to an individual with a developmental disability. N.J.S.A. 30:6D-77(b)(1), N.J.A.C. 10:44D-4.1(b).

Petitioner contends that he justifiably restrained A.C. due to his threatening conduct. Additionally, all of the restraint procedures utilized were in accordance with his training and acceptable practices and were effectuated with care. Given the level of perceived threat, the restraint of A.C. was proper and, as a result of his actions, no one, including A.C., other patients or the officers which included himself, the target of A.C.'s aggressions, were injured.

Respondent contends that the video speaks for itself and that petitioner's actions caused A.C. pain, injury, and suffering, specifically, a nose abrasion and torso impact on the table. Such actions were reckless and/or in careless disregard of A.C.'s well-being. As such, not only did petitioner's actions result in injury to A.C., he potentially exposed A.C. to a greater injurious situation.

It is undisputed that the patients at the AKFC are more volatile than patients residing in some of the other State facilities. Due to this fact, to secure the facility, the AKFC requires an increased level of security. According to respondent's witness Tobin, the facility could be likened to a correctional facility.

All witnesses were consistent in their testimony that MSO's are trained on client abuse prevention, which includes training on services and supports. One of the main responsibilities of an MSO is to provide for the safety of the patients entrusted to their care and to ensure their own safety. As stated in the Therapeutic Options training manual, "it is never ok for a staff person to be injured at work." (R-4, page 2.)

As part of their training and job responsibilities, MSO's need to understand each patient's needs and behavior. In situations where a patient is known for violent and aggressive behavior and starts acting out, it is the MSO's responsibility to try to deescalate the situation. This could include talking to the patient or attempting to redirect them, among other techniques. If this is unsuccessful, physical intervention may be required, with the goal being to keep everyone safe and unharmed. Hence, the training on various "hold" techniques when physical restraint is necessary. At all times an MSO must be ready to make split second decisions as a situation unfolds, relying upon their training and experience in reading the situation and responding accordingly. However, as even Ferguson acknowledged, there is nothing that can be taught that can address every situation that arises with a patient.

Respondent relies heavily upon the surveillance film, asserting that it speaks for itself. There is no question that the surveillance film of the incident, if viewed in a vacuum, is inflammatory. However, this is not a case where a "picture is worth a thousand words" and therefore dispositive of the charges. Rather, the totality of the situation must be looked at, which includes the surveillance films and the credible testimony of petitioner and the eye witnesses to the incident. In so doing, a different conclusion can also be reached.

In this regard, it is undisputed that A.C. was a patient known to be difficult, unpredictable, aggressive, and assaultive. When he went up onto the stage area, he was already worked up. When he sat down, the MSO's attempted to talk him down and redirect him. These efforts were unsuccessful. One patient seated on the outer edge of the stage is seen on the surveillance film standing up and moving his chair back, clearly sensing an escalating situation. Within seconds of coming onto the stage area, A.C. swept the card box onto the floor because he was not allowed to play cards. While the surveillance films show that A.C. sat back down after sweeping the cards off the table, his body posture and position of his hands is telling, particularly in light of the testimony provided that A.C. was threatening to urinate on and/or punch petitioner.

From the start and throughout the Incident, A.C. was continuously barraging petitioner with insults and physical threats. Given A.C.'s history of escalating aggressive behavior and after he swept the card box off the table, petitioner and Smith moved towards A.C. to restrain him. Not only was this testified to but also seen on the surveillance film. It was petitioner who reached A.C. first and placed him in an escort hold, attempting to transition A.C. into a Mach 1 hold. Given the lack of space and obstacles present, compounded by A.C.'s action in dropping his weight, petitioner lost his footing as the tables and chairs started moving towards the edge of the stage. While A.C. was pushed up against the table as a result of the momentum, at no time was his head slammed onto the table. Thereafter he was safely lowered to the floor and carefully removed, not dragged, from the stage area onto the gymnasium floor. At no time was he slapped, punched, kicked or dragged.

The unfolding of events happened in a matter of seconds and could not have been predicted or averted. It was not unreasonable for petitioner to expect further aggression from A.C. based upon his prior and current behavior, threats, and body language. It was petitioner's goal to remove A.C. from the location and get him to a Quiet Room. Given the confined space, the patients, and obstacles that were present, petitioner's actions were not reckless or careless. His actions

were quick thinking and prudent under the circumstances and implemented to protect all that were present - including A.C. While petitioner's restraint technique did not end in a text book fashion, as previously noted, one cannot predict every situation that arises, nor can one train for every scenario that could conceivably happen. This is one such scenario. But for the intervening factors (i.e. losing his footing, petitioner dropping his weight and tables/chairs sliding), petitioner may have been able to properly complete the restraint process which he had begun. The fact that he could not does not make his actions reckless or with careless disregard of A.C.'s well-being. Rather, it shows that in a fluid situation, petitioner adapted his actions to ensure the safety of A.C.

For the foregoing reasons, I **CONCLUDE** that petitioner did not commit an act of abuse on A.C. I further **CONCLUDE** that petitioner's actions were not reckless or with careless disregard to A.C.'s well-being.

Civil Service Action

Petitioner's rights and duties are also governed by the Civil Service Act and accompanying regulations. A civil service employee who commits a wrongful act related to his or her employment may be subject to discipline, and that discipline, depending upon the incident complained of, may include a suspension or removal. N.J.S.A. 11A:1-2, 11A:2-6, 11A:2-20; N.J.A.C. 4A2-2.

The appointing authority shoulders the burden of establishing the truth of the allegations by a preponderance of the credible evidence. Atkinson v. Parsekian, 37 N.J. 143, 149 (1962). Evidence is said to preponderate "if it establishes the reasonable probability of the fact." Jaeger v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). Stated differently, the evidence must "be such as to lead a reasonably cautious mind to a given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958); see also Loew v. Union Beach, 56 N.J. Super. 93, 104 (App. Div. 1959).

Here, on June 18, 2018, respondent sustained the following charges against petitioner: Conduct Unbecoming a Public Employee (N.J.A.C. 4A:2-2.3(a)(6); Physical or mental abuse of a patient, client or resident (Administrative Order 4:08 C3); and Inappropriate physical contact or mistreatment of a patient, client, resident or employee (Administrative Order 4:08 C5).

The incidents giving rise to the charges state:

> Based on a recently completed investigation and video review it has been determined that on April 2, 2017, while assigned to the Gym you grabbed Patient A.C. by his shirt, lifting him to a standing position. You then held A.C. by the front of his shirt in the area of his shoulder and pushed A.C. onto a table. You then forcefully push A.C.'s face down onto the table, near the edge of the table; resulting in the left side of A.C.'s jaw forcibly striking the table.

Under the DHS guidelines, physical abuse is defined as:

> [A] physical act directed at a service recipient by a DHS employee, volunteer, intern, or consultant/contractor of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include but are not limited to the service recipient being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object." (R-7, page 4.)

"Physical Abuse," defined in N.J.A.C. 10:44D-1.2, states in pertinent part: "a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering." The requisite "physical act" required to substantiate physical abuse under N.J.A.C. 10:44D-1.2 mirrors the DHS guidelines.

Conduct Unbecoming a Public Employee is an elastic phrase, which encompasses conduct that adversely affects the morale or efficiency of a governmental unit or that has a tendency to destroy public respect in the delivery

of governmental services. Karins v. City of Atlantic City, 152 N.J. 532, 554 (1988); see also In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960). It is sufficient that the complained-of conduct and its attending circumstances "be such as to offend publicly accepted standards of decency." Karins, 152 N.J. at 555 (quoting In re Zeber, 156, A.2d 821, 825 (1959)). Such misconduct need not necessarily "be predicated upon the violation of any particular rule or regulation, but may be based merely upon the violation of the implicit standard of good behavior which devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct." Hartmann v. Police Dep't of Ridgewood, 258 N.J. Super. 32, 40 (App. Div.) (1992) (quoting Asbury Park v. Dep't of Civil Serv., 17 N.J. 419, 429 (1955)). Suspension or removal may be justified where the misconduct occurred while the employee was off duty. Emmons, 63 N.J. Super. at 140.

There is no question that when an MSO is required to implement one of the approved holds to restrain a patient, there is going to be physical contact. It is also undisputed that there is nothing that anybody can train for that would address every situation that may arise with a patient. This incident falls within that category. Given A.C.'s conduct, known propensities, location, and presence of other patients, the petitioner properly moved to restrain A.C. Unfortunately, the follow-through on the hold technique could not occur because of A.C.'s actions and the table and chairs starting to move causing petitioner to lose his footing and grip. As noted above, not every situation can be anticipated or trained for. At no time did petitioner kick, pinch, bite, punch, slap, hit, push, drag, and/or strike A.C. with a thrown or held object.

For the foregoing reasons, I **CONCLUDE** that respondent has failed to meet its burden with respect to the charge of Conduct Unbecoming a Public Employee.

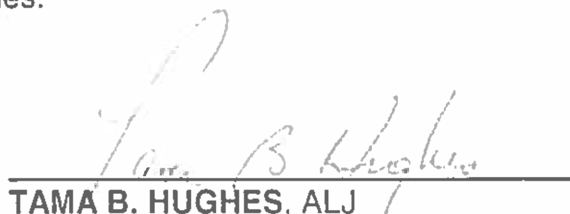
As it relates to the charges of violation of Administrative Order 4:08 C3 (Physical or mental abuse of a patient, client or resident) and Administrative

Order 4:08 C5 (Inappropriate physical contact or mistreatment of a patient, client, resident or employee), for the reasons previously cited above, I **CONCLUDE** that respondent has failed to meet its burden that petitioner physically abused A.C.

I hereby **FILE** this Initial Decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY.**

This recommended decision may be adopted, modified or rejected by the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY**, who by law is authorized to make the final decision on all issues within the scope of its predominant interest. If the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision on all of the issues within the scope of predominant interest shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.



March 21, 2019
DATE

TAMA B. HUGHES, ALJ

Date Received at the Office of Program Integrity and Accountability: __________

Date Mailed to Parties: __________

cmo

APPENDIX

WITNESS LIST

For Petitioner:

Prince Smith

Irshan Ware

Gregory Bell

D.M.

For Respondent:

Edward Tobin

Sandi Ferguson

EXHIBIT LIST

Joint Exhibits:

J-1 (formerly P-1) - DHS – Office of Program Integrity and Accountability Letter Dated January 17, 2018 (2 pages)

J-2 Final Notice of Disciplinary Action (2 pages)

For Petitioner:

P-1 In evidence as J-1

P-2 In evidence as J-2

P-3 In evidence as R-1

P-4 Not in evidence

P-5 Photographs of AKFC gym/stage (4 pages)

P-6 Not in evidence

P-7 D.M. written statements (3 pages)

P-8 Prince Smith written statements (4 pages)
P-9 Gregory Bell written statements (5 pages)
P-10 Not in evidence
P-11 Not in evidence
P-12 E.E. written statement (1 page)
P-13 A.C. written statement (2 pages)
P-14 Not in evidence
P-15 D.M. Learning Transcript (3 pages)
P-16 Not in evidence
P-17 Advanced emergency Holds Training (5 pages)
P-18 Therapeutic Options – Participant Training Handout (21 pages)
P-19 D.M Therapeutic Options – Knowledge and concepts Assessment -A (4 pages)
P-20 Not in evidence
P-21 Physician Order/Progress Note dated April 26, 2017 (2 pages)
P-22 Confidential Mental Status Examination/Evaluation Post Incident Evaluation Report dated June 8, 2017 (1 page)
P-23 Progress Note (1 page)

Respondent:

R-1 DHS – Unusual Incident Report (86 pages)
R-2 Video Recording
R-3 Came in as P-15
R-4 Participant Training Handout (15 pages)
R-5 Description of Advanced Emergency Holds (3 pages)
R-6 Personal Defensive and Control Techniques in Aggressive Patient Situations and Emergencies (4 pages)
R-7 Not in evidence
R-8 DHS Disciplinary Action Program (12 pages)
R-9 AKFC Inter-Office Communication Dated December 10, 2001 (1 page)

State of New Jersey

PHILIP D. MURPHY
GOVERNOR

SHEILA Y. OLIVER
LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY
PO BOX 700
TRENTON, NJ 08625-0700

CAROLE JOHNSON
COMMISSIONER

LAURI WOODWARD
DIRECTOR

FINAL AGENCY DECISION
OAL DKT. NO. HSL 05669-18

AGENCY DKT. NO. DRA # 18-005

D.M.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,
OFFICE OF PROGRAM INTEGRITY
AND ACCOUNTABILITY,

Respondent.

IN THE MATTER OF D.M., OAL DKT. NO. CSV 10026-18
DEPARTMENT OF HEALTH, AGENCY DKT. NO. 2018-3796
ANN KLEIN FORENSIC CENTER. **(CONSOLIDATED)**

In the matter docketed HSL 05669-18, D.M. appealed the finding of the Department of Human Services (Department or DHS) that he committed an act of physical abuse, as defined in N.J.S.A. 30:6D-73 et seq., against a service recipient of the Division of Developmental Disabilities (Division), and the decision of the Department to place his name on the Central Registry of Offenders against Individuals with Developmental Disabilities (Central Registry), pursuant to N.J.S.A. 30:6D-77. D.M. also appealed the disciplinary actions taken against him by the Ann Klein Forensic Center.

In the matter docketed CSV 10026-18, D.M. appealed the Ann Klein Forensic Center (AKFC), Department of Health findings and sustained charges of N.J.A.C. 4A:2-2.3(a)(6)

(Conduct unbecoming of public employee), and Section A.O. 4:08(C)3 (Physical or mental abuse of a patient, client, resident or employee), and Section A.O. 4:08(C)5 (Inappropriate physical contact or mistreatment of a patient, client, resident or employee) of the Department of Human Services Disciplinary Action Program (Policy). Additionally, petitioner challenges the severity of the recommended disciplinary action of removal.

PROCEDURAL HISTORY:

Upon filing the appeals captioned above (HSL 05669-18 and CSV 10026-18), both matters were transmitted to the Office of Administrative Law (OAL) for a hearing as contested cases. By order dated August 16, 2018, the matters were consolidated, and predominant interest was determined to be with the DHS. Thereafter, several case management conferences were held with respect to outstanding discovery issues and proffered witness testimony. By Letter Order dated October 4, 2018, the issues were addressed.

The hearing in this matter took place on October 12, 2018, October 19, 2018 and November 2, 2018. Upon receipt of summation briefs and supplemental documentation, the record closed on February 5, 2019. The Administrative Law Judge's Initial Decision was issued to the parties on March 21, 2019, with Exceptions to be filed by April 4, 2019. An extension to file the Final Agency Decision was granted, extending the deadline until June 19, 2019.

EXCEPTIONS:

Respondent submitted exceptions asking that the Director reject the ALJ's legal conclusions and application of agency policy which directly conflict with the controlling regulation and the testimony. The court's credibility finding was thought inconsistent with the video recording. The ALJ's findings were deemed to be unsupportable on the record and used an incorrect standard for placement upon the Central Registry.

The petitioner, in his exceptions, requested that the Initial Decision be affirmed in its entirety. He found the factual findings were supported by the record; the oral testimony corroborated the video. Further petitioner agreed that the ALJ's credibility findings were supported by the record and that the correct standard for evaluating the incident was used.

INITIAL DECISION:

Testimony and Evidence

The factual issues in this case are whether D.M. abused A.C., an individual with developmental disabilities, causing or potentially causing injury; whether D.M.'s alleged actions demonstrated recklessness or a careless disregard for the health, safety and well-being of A.C.; and whether D.M.'s alleged actions placed A.C. at risk of harm. Respondent presented two witnesses; D.M. testified on his own behalf and presented three other witnesses.

ALJ'S FACTUAL DISCUSSION AND FINDINGS

Edward Tobin (Tobin), the Director of the Office of Investigations for the Department of Health, testified that his office conducts investigations into allegations of abuse, neglect or exploitation at the four State psychiatric hospitals, including the Ann Klein Forensic Center.

Tobin reviews all investigation reports where the findings are "substantiated." The investigation report that Tobin reviewed was entered into evidence.

Medical Security Officer (MSO) Prince Smith was interviewed three times as part of the investigation and provided a written statement after each interview (P-8 and R-1, page 30.). MSO Gregory Bell was interviewed on June 8, 2017 and provided two statements. (P-9 and R-1, page 37.) D.M. was also interviewed as part of the investigation on June 15, 2017 and again on July 5, 2017, providing written statements after each interview (P-7 and R-1, pages 46 – 48.). Additionally, D.M.'s training record was also reviewed. (P-15.)

Tobin testified that he reviewed the surveillance films in this incident. In questioning Tobin about his observations on the surveillance films, he admitted that his view of A.C.'s actions was obstructed at certain points and that some of his comments regarding what occurred during the incident were based on conjecture; there was no indication that A.C. was pushed to the floor, punched or kicked by D.M. He did not know whether A.C. was attempting to bite D.M. At no time did he observe A.C. pick up a chair or attempt to fight D.M. He further noted that in the two written statements which D.M. provided, there were discrepancies in reporting. More specifically, the things which D.M. claimed to have occurred could not have occurred from the time the incident started to when A.C. was removed from the stage. According to Tobin, to substantiate abuse, physical injury is not required.

When he reviewed the investigative report, he also reviewed the relevant sections of the Therapeutic Options Manual. In Sandy Ferguson's (AKFC Training Technician 4) statement to investigators, she stated that D.M. could use Advanced Emergency Holds as needed. (P-1, page 53). When questioned, Tobin agreed that if D.M.'s actions were consistent with his training, then no patient abuse would have been substantiated.

Sandi Ferguson (Ferguson) testified that she has been employed by AKFC for the past thirty years and has held the position of Director of Staff Training since 1989. As the Director of Staff Training, it is her responsibility to train and educate all facility staff members, as well as write policies and evaluate and develop training curriculums. Some of the training courses provided are Therapeutic Options, Advanced Emergency Holds, abuse and neglect, seclusion and restraint classes. In describing Therapeutic Options, Ferguson stated that it is a program made up of several components which include verbal redirection, de-escalation (CALM's model), as well as defensive techniques and holds. (R-4.) In describing the defensive techniques and holds, Ferguson provided a demonstration of the two holds promoted under the program.

There are other therapeutic holds, the Advanced Emergency Holds. These holds may be used by employees when a patient is a danger to themselves or others. Ferguson provided a description and demonstration of all five holds. All five holds required the staff to be standing. On four of the holds, staff are required to hold at least one of the patient's hands. According to Ferguson, the employee would be unable to bend a patient over if executing a Mach 3 or Mach 5 hold if there was an object in front of them for fear of injury.

Ferguson was shown the surveillance films and questioned whether it was acceptable to grab a patient's shirt, shove a patient's head on a table or pin a patient down on the floor. She stated at no time, even if a patient was attempting to bite the staff member, were such maneuvers allowed. Ferguson added that D.M.'s actions were not consistent with Therapeutic Option Holds or Advanced Emergency Holds, the seven holds permissible at AKFC.

Ferguson testified that for an employee to implement any of the holds, the patient would have to be standing. She stated that if a patient is seated, the officer could wait for the patient to calm down and stand up on his own, or an officer could stand the patient up by using the approved escort hold and then move into the approved Mach 1 hold. In reviewing the surveillance film, she was unable to say whether or not D.M. was using a Mach 1 hold. When questioned about transitioning from a Mach 1 into a Mach 2 or Mach 3 hold, Ferguson stated that Mach 2 and Mach 3 holds could not be safely implemented if there were obstructions in the way. If the space is tight, the employee should stand back and wait for a supervisor, even if the patient is assaultive and/or spitting on staff. Depending on the situation, an employee could go from a Mach 1 hold to a Mach 4, skipping the two holds in between. Ferguson went on to state that all officers are trained on situational awareness and how to deal with patients who have a history of violent or assaultive behavior. She acquiesced that there is nothing that anybody can teach that would address every situation that arises with a patient.

Ferguson agreed that she did not see D.M. choke, punch or kick A.C. However, she felt that D.M. improperly "dragged" A.C. from the stage area to the gym floor, acknowledging that there were details not viewable from the angle of the surveillance films. She also acknowledged that D.M. received little to no assistance from the other MSOs who were present and that A.C. had a history of violence and spitting.

Ferguson stated that AKFC has a policy in place detailing the proper use of defense and control techniques (Policy) (R-6.) All patients are treated the same, regardless of whether or not they are individuals with developmental disabilities.

Prince Smith (Smith), an MSO at AKFC, testified that he has been an employee of the center for the past twenty years. He has attended various training courses, including Therapeutic Options and Advanced Emergency Holds. He was working on April 26, 2017 and vividly recalled the incident. The first time he saw the surveillance film was at the hearing.

He stated that he and other MSOs were playing cards on the stage with a few of the residents. Interacting with residents by playing cards, throwing a football or playing basketball is one of their job responsibilities as it is comforting to the residents and keeps them focused. While playing cards, A.C. came onto the stage and wanted to play cards. He appeared to be angry and was cursing. Smith and his colleagues tried to talk to A.C.; however, A.C.'s behavior escalated toward D.M. A.C. stated that he was going to punch D.M., spit on D.M, and perform explicit acts against D.M.

At one point, A.C. came up behind D.M., and sat down. A.C. grabbed his groin and told D.M. that he was going to urinate and/or spit on him, moving towards D.M. When A.C. started to move, Smith got up and continued to try to de-escalate him, telling him to stop. At the same time D.M. stood up, too. D.M. attempted to place A.C in a hold. D.M. had A.C. in a clasp by a table, when the table started to slide. A.C. went to the floor and was subsequently moved from the stage floor to the gym floor by D.M. A supervisor was called in at that time. Smith testified that A.C. continued to spit, bite, and kick the officers while D.M. was on the floor holding A.C. Smith stated that A.C. did not complain that he was in pain or having difficulty breathing. Smith testified that

D.M. appropriately applied the hold techniques that they had been trained to perform and authorized to use.

Irshan Ware (Ware), an MSO with AKFC, testified that he has been an employee of the center for the past sixteen years. Among the trainings that he had received were PERT, then MANDT, and the most recent training programs comprising of Therapeutic Options and Advanced Emergency Holds.

He was working on April 26, 2017 and stationed at the entrance to the gym or "rehab yard door." His attention was split between the gym and the hallway; he could see the stage in the gym. He recalled seeing A.C. approach D.M. on the stage. Due to the acoustics in the gym, he could not clearly hear what was being said. He did not see the incident; he could hear loud cursing but did not know who was cursing. Ware became involved in the incident after A.C. was placed on the floor of the gym. He recalls that A.C. was cursing and trying to spit on the officers. Ware went over to A.C., knelt, and attempted to calm him down by talking to him.

Gregory Bell (Bell), an MSO with AKFC, testified that he has been with the center for the past twenty-one years; his most recent training programs were Therapeutic Options and Advanced Emergency Holds.

He was working on April 26, 2017. Prior to A.C. coming onto the stage, Bell, D.M., and Smith were playing cards with some of the residents at a table. A.C. approached the table and demanded to play cards. When he was told that he had to wait, A.C. started "spewing" epithets, which continued after he was told that he could play in a few minutes. A.C. gestured like he was going to knock the cards off the table. Throughout this encounter, D.M. attempted to calm A.C. down and deescalate the situation. When A.C. gestured as though he was going to pick up a chair, D.M. stood up and restrained A.C. in what Bell characterized as a proper hold. Smith also got up to assist. Bell stated that he remained seated and did not assist D.M., as the space was tight and D.M. was a trainer handling the situation.

Bell testified that he could not see everything from his vantage point; however, could see D.M. "resting" A.C.'s head on the table. He also saw A.C. dropping his weight/legs as D.M. was attempting to move him. Bell stated that A.C. did not appear to be injured as a result of the incident.

D.M. testified that he is a Senior MSO with the AKFC and has worked at the center since 2002. He has received several different training techniques for handling residents with the most recent training being Therapeutic Options and Advanced Emergency Holds. He is a certified trainer at the center for Advanced Emergency Holds.

D.M. is familiar with A.C. and his treatment plan in AKFC. He is also familiar with A.C.'s aggressiveness, having been punched in the mouth by A.C. two weeks prior while placing him in a restraint chair. He also advised that on multiple occasions, A.C. has spit on him and his verbal diatribe is a constant.

On April 26, 2017, he was playing cards with residents on the stage area when A.C. approached. A.C. was using vulgar language and demanding to play cards. A.C. stated that he should punch D.M. in the mouth again, spit on him, and hit him with a chair, D.M. testified that the officers were trying to redirect A.C.; however, A.C. continued to threaten him.

After being told he had to wait to play cards, A.C. swiped the empty card box off the table, while continuing his barrage of vulgar language and threats. When A.C. swiped the box off the table, D.M. believed that A.C. was gearing up to hit him with a chair. He was concerned that A.C.'s conduct would continue to escalate. Citing the safety of himself and the others present, he stood up to restrain A.C., get him out of the area, and into the Quiet Room. He detailed placing A.C. in an "Escort Hold" - a hold to pick a patient up from a sitting position.

After standing A.C. up, D.M. identified (and demonstrated to the tribunal) using an Advanced Emergency Hold, Mach 1, then transitioning into a Mach 2 hold as A.C. was struggling and attempting to spit. As he was transitioned into the Mach 2 hold and D.M. said that he realized that the table was in the way, he attempted to bring A.C. closer to him and away from the table so as to not bang A.C.'s head. The table started to move and A.C. dropped his weight causing D.M. to lose his footing. He could not safely complete the restraint on stage due to the obstacles. He guided A.C. to the ground, holding on to him and placing his head on the stage floor. Due to the proximity of the stage stairs and the hardness of the stage floor, he let go of A.C., walked around him, and grabbed him from behind, and with A.C.'s head in his lap he "brought" A.C. down to the gym floor, which was softer/spongier.

Once on the gym floor, D.M. stated that he rolled A.C. over, in accordance with his training, so that he could not spit on anyone. While on the floor, M.D. detailed using PRT, a restraint technique on which he had been trained years earlier. PRT, however, is not one of the seven permissible holds.

When the supervisor showed up, A.C. was still on the gym floor with D.M. kneeling next to him. D.M. had not called in a code and is not sure who might have. After a few minutes, other officers picked A.C. up and transported him to the Quiet Room. According to D.M., when a resident is taken to the Quiet Room after an incident, they are evaluated by a nurse or a doctor and an MSO supervisor.

In June 2017, D.M. was questioned by an Investigator from the Office of Investigations and wrote a statement (P-7.), without having seen the surveillance films. In explaining why, he had written that A.C. had grabbed the chair and gestured as though he was going to use it to hit him, D.M. stated A.C. had threatened him several times during the incident to hit him with the chair, and the way the investigator was leading him, he thought that A.C. had grabbed the chair. In his second statement, he clarified that A.C. had threatened to hit him with the chair. D.M. reiterated that the actions he took to restrain A.C. were in accordance with his training. D.M. stated that, in hindsight, he may have done things differently in restraining A.C., specifying the confined space on the stage area, the obstacles present (table and chairs), and the rapidity of events.

On cross examination, D.M. was questioned if he had a bad relationship with A.C. In response, he stated that he does not have any type of relationship with A.C., nor does he dislike A.C. He went on to state A.C. will pick on whoever he wants to on a given day. It is his job to handle the patients as they are. As it relates to A.C., A.C. "gives him a reason to watch my back a lot more." When questioned about his version of events when compared to the surveillance film, D.M. reiterated that A.C.'s head did not hit the table; however, his body connected with the table. D.M. agreed that even a body hitting the table could cause injury. When questioned about his testimony that A.C. was continuously kicking while on the gymnasium floor, D.M. conceded that A.C.'s attempts to kick were only one leg movement in the last minute. He did not call a code because he was in the middle of a restraint technique. Regarding the discrepancy in his first written statement, D.M. stated that after he wrote it, he viewed the surveillance film and realized that he was mistaken about A.C. grabbing a chair, so he clarified it in the second statement. D.M. was

asked about the PRT restraint that he used while A.C. was on the gym floor. He acknowledged that this was not a currently approved hold at AKFC.

The ALJ cited the Central Registry's legislative purpose to protect individuals with developmental disabilities from N.J.S.A. 30:6D-73, as well as the definition of a caregiver in N.J.A.C. 10:44D-1.2., finding the petitioner was a caregiver for A.C. and that A.C. is a service recipient with the Division of Developmental Disabilities (DDD) specifically protected by the legislation.

ALJ's Findings

After hearing the testimony and reviewing the evidence, The ALJ **FOUND** as **FACT** that on April 26, 2017:

1. A.C., a patient known to be difficult, unpredictable, aggressive, and assaultive, approached the stage area where several MSOs, including D.M., were playing cards with patients. A.C. was already agitated when he came up to the stage area and demanded to play cards.
2. When A.C. was told that he had to wait, his behavior escalated both verbally and physically, the verbal diatribe and physical threats all directed at D.M.
3. All three MSOs were focused on A.C.—attempting to redirect and deescalate his behavior—however, they were unsuccessful.
4. When A.C. swept the card box onto the floor, both Smith and D.M. were already moving towards A.C. who continued to physically threaten D.M.
5. The stage area is raised approximately three feet from the gymnasium floor and is narrow in width.
6. D.M. executed the proper hold (Escort Hold) in standing A.C. up and thereafter transitioned into a Mach 1 hold
7. As D.M. was transitioning into a Mach 2 hold, realizing that the table was in the way, he pulled A.C. closer to him and away from the table. As this occurred, the table started moving, he lost his footing, and A.C. simultaneously dropped his weight.
8. A.C. did not slam his head on the table; however, his torso did come into contact with the table. D.M. guided A.C. to the floor of the stage. D.M. did not body-check A.C. face first onto the floor.
9. D.M. properly brought A.C. to the gym floor for his safety, protecting his head throughout the process
10. D.M. did not use a currently authorized restraint procedure while D.M. was on the gym floor; however, used a previously approved technique. Once on the floor, A.C. continued to attempt to spit, bite, and kick the officers present.
11. At no time did D.M. kick, punch, slap, hit or push A.C.
12. While D.M. pulled A.C. down to the gym floor, he did not drag him down the steps.

The Initial Decision's credibility assessment was minimal. Items 1, 3, and 6 were mentioned as being supported by the MSOs. The Decision noted that in viewing the video concerning number 6, Ferguson could not be certain that D.M. did not implement a Mach 1 hold.

The Initial Decision **CONCLUDED** that petitioner did not commit an act of abuse on A.C. and further that petitioner's actions were not reckless or with careless disregard to A.C.'s well-being. The ALJ went on to deliver conclusions in the Civil Service matter.

OPIA's REVIEW OF THE INITIAL DECISION

Placement on the Central Registry is a two-step inquiry. First, it must be determined if petitioner committed an act of abuse against A.C. Second, it must be determined if petitioner's actions were intentional, reckless, or done with careless disregard to the well-being of A.C.

The Initial Decision never gave any attention or consideration as to whether or not an individual with disabilities had been the object of a physical act which could cause him pain, injury, anguish, or suffering. A.C., the victim, an individual with developmental disabilities, is portrayed as difficult, unpredictable, aggressive, and assaultive. Despite testimony that no showing of any actual physical injury is necessary to substantiate an allegation of abuse, the presence of abuse toward A.C. was never deliberated. There are repeated recantations in the document that A.C. was "not kicked, punched, slapped, or pushed" – four of the ten examples in the Administrative Code's definition of abuse - but not the only varieties of abuse that could be substantiated. Despite testimony from Ann Klein's Director of Staff Training that none of the techniques shown in the video were proper or warranted, the Initial Decision incorrectly describes items 6 and 9 (above) as "proper holds." D.M., in his testimony, described A.C. as being on the ground, on the stage with his head near the stairwell, when D.M. grabbed A.C. from behind, underneath A.C.'s armpits. With A.C.'s head in D.M.'s lap, D.M. then brought A.C. down to the gym floor. (3T p.28, 25 – p29, 8). The Initial Decision's description of item 12 of a person being "pulled" backwards down steps as not being "dragged" (another of the non-exclusive examples of abuse) down the steps is so contorted of its common usage as to be incredible.

The Initial Decision never addressed the matter of the physical abuse of an individual with developmental disabilities. The Initial Decision ignored the non-physical intervention techniques that are to be afforded and exhausted before an individual who is assigned to a communal, therapeutic environment before any physical action is taken against the individual. The Initial Decision fixates on the use of holds, restraints, and take downs while glossing over the Department's policies of verbal de-escalation. The Initial Decision stated "the surveillance film of the incident, if viewed in a vacuum, is inflammatory." The Initial Decision stated that the facts of the films needed testimony to dispositive, yet the testimony concerning verbal redirection was not mentioned. The Initial Decision never contemplated that physical interaction should never have been used. By assuming that confrontation was inevitable, the Initial Decision justifies it as somehow protecting MSOs and clients and excuses it as series of unfortunate accidents that went awry.

The Initial Decision describes actions by D.M. to remove A.C., utilizing unapproved physical techniques, hampered by lack of space and obstacles present, compounded by A.C.'s action in dropping his weight, while D.M. lost his footing as the tables and chairs started moving towards the edge of the stage. A.C. was pushed up against the table, as a result of the momentum; A.C. was lowered to the floor and taken from the stage area onto the gymnasium floor. The

Petitioner's actions and the "intervening factors (i.e., losing his footing, petitioner dropping his weight and tables/chairs sliding)" – all things testimony had shown to proscribe against the use of physical holds - were not seen as examples of recklessness and careless disregard for safety, but somehow exhibited a lack thereof. Citing a list of calamities and assuming that "but for" those events, all would have gone well does not excuse careless disregard for safety or recklessness, it pretty much defines it.

Failure to consider and apply the appropriate statutes and regulations is an error of law; that mandates the REJECTION of the Initial Decision. Further, the Initial Decision ignored testimony that although there are seven permitted holds, their use is not without restrictions, nor are they situationally preferred techniques. Failure of the Initial Decision to address all of the testimony concerning the applicability of holds is an error of fact that mandates the REJECTION of the Initial Decision.

The Legislative purpose of the Central Registry was mentioned, but ignored. The statute declares, "It is the intent of this legislation to assure that the lives of innocent individuals with developmental disabilities are immediately safeguarded from further injury and possible death and that the legal rights of such individuals are fully protected." (N.J.S.A. 30:6D-73 c.). Since 2010, the Department of Human Services has been tasked with enforcing the Central Registry for the protection of the individuals it serves. The Legislature has defined offenses against these individuals that, if proven by a preponderance of the evidence, would prevent the perpetrators of those offenses from working with this vulnerable population.

The Department decided a case similar to this present case, involving unwarranted and improper holds (J.B. v. DHS, OAL DKT. NO. HSL 07840-18). It involved an obstreperous individual acting out, who was not de-escalated through verbal prompts, but involuntarily carried to her bedroom. After an Office of Administrative Law hearing, The ALJ found that grabbing and carrying a developmentally disabled woman from the living room, then through the kitchen, the hallway, and into her bedroom caused her "pain, injury, anguish, or suffering" by an act of force and violence what was unnecessary to prevent harm to her or anyone else, nor damage to property. The individual had previously flipped over a table and been crawling around, being loud. She was prostrate and weeping when J.B., the supervisor, entered the scene. J.B. and the staff did not employ proper de-escalation techniques. No one spoke to her calmly. The ALJ found that rather than attempting to avoid force, J.B. and her staff chose to use unnecessary force, most likely because they were frustrated by what were the victim's somewhat typical behaviors. The ALJ stated that it was unnecessary to decide whether there was dragging at any point during the conveyance. J.B., while not exclusively to blame, bore the heaviest share of it; she was the supervisor and should have known better than the others what ought to have been done and what ought not to have been done. J.B. acted in careless disregard of the victim's plan of care, by imprudently directing unnecessary force against this individual.

In the J.B. v. DHS Initial Decision, the ALJ concluded that the Department had sustained its burden of proving, by a preponderance of the credible evidence, that J.B.'s actions constituted physical abuse by acting "with careless disregard to cause or potentially cause injury" to the client. Therefore, the ALJ concluded, that the Department's placement of J.B.'s name on the Central Registry of Offenders for physical abuse was within the parameters of the statute. The ALJ ordered

that this finding of physical abuse of a resident by J.B. was sufficient to place her on Central Registry. The Director of the Office of Program Integrity and Accountability affirmed the ALJ's decision and ordered the supervisor's name placed on the Central Registry.

The definition of abuse is not limited to one or more of the ten examples cited in the regulations but encompasses the Statutory definition. "'Abuse' means wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse, or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability." (N.J.S.A. 30:6D-74). The regulations define physical abuse as "a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering. Such acts include, but are not limited to, the individual with a developmental disability being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged or struck with a thrown or held object." (N.J.A.C. 10:44D-1.2). As the Final Agency Decision above illustrates, pain, anguish, or suffering can be caused by a failure to follow a de-escalation protocol and an unwarranted physical transport. No showing of actual physical injury is necessary.

A more thorough review of the testimony concerning de-escalation and the sequencing of techniques is necessary, especially the testimony of Sandi Ferguson and the three other MSOs who had no motivation to dissemble.

Sandi Ferguson has been the Director of Staff Development at Ann Klein Forensic Center since 1989. She is responsible for orientation, training, policies, and curriculum evaluation and development for the facility. She teaches a wide variety of classes. She testified (2T pages 9-17) that she trains staff in Therapeutic Options. She explained the CALM model of de-escalation, which includes verbal redirection, de-escalation, that is to be used any time a patient is acting up or appearing anxious – in need of de-escalation. She physically demonstrated the two Therapeutics Option holds and the five Advanced Emergency holds. The seven holds that Ferguson demonstrated are the only holds that Ann Klein staff may use. She testified that the holds may be used "any time the person is presenting a danger to themselves and others." (2Tp16,7-8).

During direct examination, Ferguson was shown the video of the incident and questioned about what she had seen. After viewing the video, Ferguson testified that D.M. did not use any of the authorized holds of Ann Klein – neither the Advanced Emergency holds nor the Therapeutic Option holds – despite having had the opportunity to do so (2Tp18, 6-21). Ferguson stated that none of the approved holds permit a staff member to grab a patient from the front (2Tp17, 5-6). She stated that a staff member should not shove a patient's head onto a table, even if the patient was attempting to bite (2Tp17, 8-13). Ferguson testified that staff are not allowed to pin a patient down on the floor, as was shown in the video (2Tp17, 14 -18). A staff member cannot grab a patient by their shirt, as depicted in the video (2Tp17, 24 - p18,5).

Under cross examination, Ferguson testified that the holds should only be used when it was safe to do so (2Tp31, 2-3; p32, 3, 14-15; including the classroom training of the holds p33,21-23). Ferguson was asked if training had alternatives for areas where there was not enough room to do the techniques (2Tp33, 23-25). Ferguson testified that one "would get them into the standing position or talk to them until they were ready to cooperate." (2Tp34, 1-3) When pressed on alternatives for what to do "if the person wasn't ready to agree or cooperate and was still

threatening to spit and/or assault patients" while in a confined space (2Tp34, 4-8), Ferguson replied, "You would step back and wait for a supervisor and talk them through it, and when you were able to, we would put them into an escort position." (2Tp34, 9-11) When questioned, again, whether she "would stand back and let the patient to continue to assault and/or spit on staff until more people showed up;" Ferguson affirmed that one would step back out of the range of the spitting and wait (2Tp34, 12-16).

Also, during cross examination Ferguson was shown the part of the video where A.C. was on his back on the gym floor. Asked if "he is either saying (sic) or attempting to bite the officer, what should the officer then do?" (2Tp39, 19-20); Ferguson replied that "if you weren't able to get him into a hold, you would have to step back." (2Tp39, 21-22) Ferguson repeatedly identified that no proper hold was possible or that what was being done to A.C. was improper during his time on the gym floor (2Tp39 – p41). Ferguson specified that with the patient already on the floor and unavailable to receive an approved hold, "You step back and give yourself space, and when they go to get themselves up, then, you can get them into an escort position (2Tp41, 15-17)." At one point in the video (2Tp42 – 43), where four MSOs were visible, Ferguson was asked if the three MSOs seen straddling or holding A.C. were all wrong. Ferguson indicated that the proper techniques were not being used and the MSOs were not doing as they had been trained. When a fifth MSO joined the group, Ferguson, again maintained when asked, that there was only one proper hold for a person on the floor. Later in the video, a supervisor and more MSOs had gathered around A.C., who was still on the ground; by the attorney's count there, then, were "nine medical security officers" present in the scene. Ferguson was again asked, "Now, during a process like this would be the policy (sic) that they should be talking to this patient to see if the patient's going to start complying and following directions?" Ferguson replied, "Yes, throughout the whole process." (2Tp43, 18-22).

On re-direct, Ferguson was asked to read from the Ann Klein Policy and Procedure concerning Personal Defensive and Control Techniques in Aggressive Patient Situations and Emergencies, which had been introduced by the Respondent as R-6. It states, on page 3, "Personal control techniques may be used only when other, less intrusive or more therapeutic techniques (such as verbal interventions and other crisis management techniques) have been exhausted and cannot ensure the safety of the person or others."

In their testimony, MSO Smith, MSO Ware, and MSO Bell spoke of approaching A.C. while he is acting out and trying to verbally de-escalate the situation--trying to calm him down by speaking to him (2T p96, 2-6; p130, 17-18; and p150, 18-24). MSO Smith noted in his testimony that it was when D.M. grabbed A.C.'s arm that "it escalated where the patient get (sic) really combative, so I was just trying to subdue him or stop him at a (sic) patient from getting hurt or the officer from getting hurt." (2T p96, 19 – 23)

The only comment that the ALJ made concerning the credibility of Ferguson's testimony was that from viewing the video, she could not say for certain that D.M. did not implement a Mach 1 hold when D.M. grabbed A.C. out of his chair. The ALJ accepted the testimony of the Petitioner and another MSO who were involved in the incident; however, no other portions of Ferguson's testimony were questioned or mentioned in the findings. Ferguson's testimony came from thirty years of experience of writing policies, evaluating and developing training curriculums.

She is responsible for the training of all of the Ann Klein staff. Ferguson's testimony was forthright and consistent with the documentary evidence, such as the training presentations, tests, and procedures entered in the case, that are related to her testimony. Problems with minute details not being clear during some brief parts of the video were noted throughout the hearings; it is reasonable to deem the rest of Ferguson's testimony as credible, given the Initial Decision's paucity of credibility determinations.

Ferguson's testimony showed that the staff at Ann Klein were taught the CALM technique, a program developed for staff to engage with agitated individuals and to de-escalate their behaviors with verbal redirection to calm the person down. Ferguson physically demonstrated the seven acceptable holds to the court. Ferguson stated that these were the only holds that could be used by the staff and that they should only be used only after all other less intrusive techniques had been exhausted – those more therapeutic methods being verbal redirection or verbal intervention. Ferguson stressed repeatedly that holds should only be attempted when it is safe to do so. Ferguson testified that the use of holds is permissible, but only when there is a danger to the patient or others. If the use of a hold might be unsafe, a difficult client can be left in place to calm down on his own. There is no need to physically intervene immediately if the danger, that a patient poses, can be avoided by merely stepping away, clearing others out of his way, or by removing obstacles.

When shown the video, Ferguson did not identify any properly executed holds - from A.C. being pulled out of his chair to his being held on the gym floor. Asked repeatedly what should be done in a space too tight to execute a hold properly, Ferguson testified that the proper procedure would be to step back and wait for a supervisor, talk to the person, and give yourself space. When confronted with a person spitting, an MSO can step back from that person and allow the person to calm down, until a proper hold can be performed safely. A person on the floor can be permitted time and space to get themselves up and, when safe, an escort hold can be administered. Ferguson testified that the policy was to keep talking to a difficult patient in order to encourage him to comply and follow directions throughout an incident. MSO Smith, MSO Ware, and MSO Bell testified that they were actively engaged in verbally de-escalating A.C.'s behaviors, during each of their interactions with A.C. In fact, MSO Smith testified that A.C.'s behaviors increased when D.M. attempted his maneuver. Placing a patient in a physical hold is not the first move to de-escalate an agitated patient; it should be the last resort.

The Initial Decision called the video "inflammatory," saying it could only be understood through additional testimony. The testimony that was not considered in the Initial Decision involved the appropriate actions that should have been taken before the incident got out of hand. The premature use of extreme measures, and the laser like focus on justifying those measures may have clouded the proper examination of Central Registry placement process.

An agitated individual with developmental disabilities, whose "treatment plan in AKFC" was known to the Petitioner, was sent to a recreational area with MSOs and other clients to relax and interact. In all of the testimony, A.C. was uniformly described as verbally abusive and confrontational toward D.M. While on a small stage above gym floor, two MSOs testified that they attempted to de-escalate and redirect A.C. using the verbal techniques they had been taught. One stood up near A.C. The other remained seated, focusing on a card game while A.C. raged by his shoulder. After knocking a card box off of the table, A.C. sat down in a chair against the wall

at the back of the stage. Despite testimony that no approved hold should be attempted upon a seated person, who cannot be approached from the back, as well as testimony that stepping away from an individual and allowing him to calm down by himself was safe, A.C. was snatched up out of his chair, held, pushed into a table, put on the floor, held by the shoulders and "pulled" down stairs while his legs flailed to the gym floor, where he was restrained using an unapproved hold until a total of nine MSOs and supervisors surrounded him. Only by ignoring that physical holds are potentially dangerous to both the holder and the person being held, disregarding that two MSOs immediately proximate to A.C. were actively engaged in verbal redirection of A.C. and not feeling any danger, and discounting the extensive training and retraining that the 300 to 350 MSOs of Ann Klein receive, could this incident be considered justified or excusable. Rather than reducing the danger to A.C., the other patients, and the MSOs present, D.M.'s failure to follow proper procedures (by joining the other two MSOs in verbal de-escalation techniques), actually increased the risks to everyone in the gym. When one of the seven approved holds is properly applied in a safe environment and after all non-physical attempts to calm and verbally de-escalate a patient's dangerous behavior have been exhausted unsuccessfully, the use of an appropriate hold is not per se abuse. An unwarranted and improperly executed hold attempt, which is made during ongoing verbal de-escalation techniques, under obviously hazardous conditions, falls within the definition of physical abuse, as defined by the Central Registry statute and regulations.

As to the preliminary question in a Central Registry inquiry, **I FIND** that D.M. physically abused A.C. D.M. disregarded his training to use verbal de-escalation in the face of a belligerent patient. D.M. went directly to an attempt at physically placing A.C. in a restraint hold. D.M.'s attempts to gain a correct hold led him to cause A.C.'s body to come in contact with a table, the stage floor, the steps, and the floor of the gym. D.M., as a caretaker to A.C., an individual with a developmental disability, performed a physical act of a type that causes one or more of the following: pain, injury, anguish or suffering. By a preponderance of the evidence, D.M.'s repeated attempts to place A.C. in an unnecessary physical restraint met the regulatory and statutory definitions of physical abuse.

D.M. did not assess or recognize the danger of attempting a hold on the narrow stage. D.M. disregarded his training that there were no approved holds for a seated person whose back was inaccessible. D.M. did not consider, until once he had hold of A.C., there was a table in the space into which he was trying to bend A.C. D.M. did not account for the possibility that A.C. might not fully cooperate by standing erect during his machinations. D.M. did not properly assign the danger inherent in the distances relating to the table and the three foot drop from the stage. D.M. did not contemplate having to place A.C. onto the table and then escort him to the floor of the stage. At each of these inflection points (and all the others, until A.C. is escorted off the gym floor by one of the nine assembled MSOs), D.M. could and should have taken his hands off of A.C., stepped back from A.C., cleared a safe space for A.C. to calm down in, and waited for the arrival of a supervisor. Instead, a series of pratfalls and attempts at holds wound up with A.C. on the floor of the gym, in an unapproved hold.

As to the second question in a Central Registry inquiry, **I FIND** that D.M.'s actions showed not only intention, but recklessness and a careless disregard for the safety of A.C. D.M. made a conscious decision to physically restrain A.C., without earnestly joining the other two MSOs already attempting to verbally de-escalate A.C.; D.M. made a mindful and calculated decision to

remove A.C. from his chair and testified to doing so. He persisted in his attempts to place A.C. in a restraint, even as the attempts failed to work correctly. At a few junctures, where he might have stopped his inappropriate behavior, D.M. continued. D.M. did not exhibit any situational awareness of his actions or his environment. He disregarded the tight space in which he initiated and continued his conducts. D.M. did not show any consideration for the others on the stage – patients or fellow MSOs. In his testimony, D.M. justified launching his emergency hold attempt as preventing danger to A.C. and others; however, his actions were ill-considered, unsafe and potentially injurious to A.C. He acted hastily and thoughtlessly in trying an improvised technique and persisted irresponsibly on, despite never having control of the situation he was escalating.

FINAL AGENCY DECISION:

Pursuant to N.J.A.C. 1:1-18.1(f) and based upon a review of the ALJ's Initial Decision and the entirety of the OAL file, **I REJECT and MODIFY** the Administrative Law Judge's findings and conclusions, due to the noted errors of fact and of law. Although the ALJ had the opportunity to assess the credibility and veracity of the witnesses, there is only the scantest reference to any issues of veracity or credibility. The video, where unobstructed, was used as a benchmark. All of the incidents described in the testimony about the events were based upon concurrent viewing of the video. The video's authenticity and veracity was never questioned. I defer to the ALJ's observations of the events described in the Initial Decision, but not the conclusions concerning the motivations, particularly after having excluded such speculation at the hearing, it was included in the Initial Decision. The testimony of the Ann Klein Director of Staff Training was never applied to the proper use of de-escalation techniques or the safety involving the initiation of emergency holds. The Central Registry statute and regulations was mentioned but not properly applied. Because of the Department's expertise and experience, it was necessary to bring forward this testimony from the hearing and assign it the credibility due, as previously explained. **I CONCLUDE and AFFIRM** that the Department has met its burden of proving sufficiently that D.M. committed an act of physical abuse against an individual with developmental disabilities. **I CONCLUDE and AFFIRM** that D.M. acted intentionally, recklessly or with careless disregard to the well-being of that individual, and that D.M.'s placement on the Central Registry is appropriate.

Therefore, pursuant to N.J.A.C 1:1-18.6(d), it is the Final Decision of the Department of Human Services that **I ORDER** the placement of D.M.'s name on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Having affirmed the Final Agency Decision to place D.M.'s name on the Central Registry of Offenders against Individuals with Developmental Disabilities, I submit this decision to the Civil Service Commission for their deliberation of whatever matters, within their purview, may be left unresolved.

Date: June 19, 2019

Lauri Woodward, Director
Office of Program Integrity and Accountability