State of New Jersey
DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY
PO Box 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
LT. GOVERNOR

JENNIFER VELEZ
Commissioner

FINAL DECISION
OAL DKT. No.: HSL 1681-14
Agency Case Nos.: DAR 14-005

C.O.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

A. INTRODUCTION

C.O. appealed the determination of the Department of Human Services to place his name on the Central Registry of Offenders against Individuals with Developmental Disabilities. The placement was deemed appropriate due to an investigation by the Office of Investigation which substantiated that C.O. had neglected and abused an individual with developmental disabilities. The Department determined that C.O. had struck a Service Recipient in the face and had failed to intervene during a serious altercation involving two Service Recipients. C.O. was determined to have acted with recklessness or gross negligence in the incident as it pertains to neglect (as defined at N.J.S.A. 30:6D-73 et seq.).

B. THE INITIAL DECISION

A hearing took place on November 5, 2014, before the Administrative Law Judge (ALJ), Laura Sanders, the Acting Director and Chief ALJ. The Initial Decision, which is attached hereto, was based upon the testimony of four witnesses: The Petitioner, C.O.; his wife P.O., a health care worker: Adam Fishman, the Director of Operations for the agency that operates the group home; and Diana Reinkraut, the Director of Behavioral Services for the agency.

CONCLUSION:

The ALJ concluded that the Department of Human Services had not shown sufficient evidence to prove by a preponderance of the evidence that C.O. had failed to intervene or that C.O. had struck the Service Recipient in the face. The Department did prove, however, that the Service Recipient had sustained significant injuries. C.O. could not have utilized the crisis-intervention techniques that he was required to employ in order to stop or avert a violent attack. C.O.'s failure amounted to gross negligence. "C.O. performed a conscious, voluntary omission that was in reckless disregard to his duty, and to the physical consequences for [the Service Recipient], who, like [the second Service Recipient], was in C.O.'s care and whose safety, and whom he was obligated to protect." The ALJ concluded that the Department's placement of C.O.'s name on the Central Registry was within the parameters of the statute. The ALJ **AFFIRMED** that the placement of C.O.'s name on the Central Registry of Offenders against Individuals with Developmental Disabilities was proper.

C. EXCEPTIONS

No exceptions to the Initial Decision were received.

D. FINAL DECISION

Careful consideration was given to the entirety of the OAL file and the Initial Decision of the Administrative Law Judge. Because the ALJ had the opportunity to listen to the testimony and observe the demeanor of the witnesses, I have considered her findings concerning credibility. The recommended decision of the ALJ is hereby **ADOPTED and AFFIRMED** by the Office of Program Integrity and Accountability.

Therefore, pursuant to N.J.A.C 1:1-18.6(b), it is the Final Decision of the Department of Human Services that the Petitioner's name, C.O., be placed on the Central Registry of Offenders against Individuals with Developmental Disabilities and that he be prohibited from working with individuals with developmental disabilities, as described by N.J.S.A. 30:6D-73 et seq.

Date: 12/8/14

Lauri Woodward, Director
Office of Program Integrity and Accountability
Department of Human Services

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HSL 01681-14
AGENCY DKT. NO. DAR 14-005

C.O.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

C.O., petitioner, pro se

Erick Lucadamo, Deputy Attorney General, for respondent Department of Human Services (John Hoffman, Attorney General of New Jersey, attorney)

Record Closed: November 5, 2014 Decided: November 19, 2014

BEFORE **LAURA SANDERS**, Acting Director and Chief ALJ:

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

C.O. appeals the determination of the Department of Human Services (the Department) to place his name on the Central Registry of Offenders against Individuals with Development Disabilities on grounds of neglecting and abusing a developmentally

disabled individual living in a group home. C.O. contends he complied with all required protocols.

C.O. was notified of the Department's decision on January 14, 2014, and, by letter dated January 29, 2014, requested a fair hearing. The Department transmitted the contested case to the Office of Administrative Law (OAL), where it was filed on February 10, 2014. N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13. The hearing was held on November 5, 2014, and the record closed.

FACTUAL DISCUSSION

Although the parties agree on few facts, the background is not in dispute. On November 14, 2011, C.O. was working at a New Concepts group home in which three disabled men were living. Two of them—T.R. and J.R.—were there when C.O. arrived at around 4 p.m. The third, S.S., arrived about an hour late from the day facility where he goes for training, because for a substantial period of time, he had refused to come home. After the driver dropped S.S. off, C.O. was the only staff member at the facility. At around 4:15 p.m., the group home manager, Jackie Forman, received a call from C.O., who also had called 9-1-1. C.O. advised her that there had been an incident, in which S.S. had struck T.R. By the time she arrived at about 4:30 p.m., the police also were there. She later called Adam Fishman, Director of Operations for New Concepts, who sometime later contacted C.O. by phone at the facility. S.S. had blood on his hands and face, blood on the inside of his nose and mouth, as well as on his outer lips. There also was a bruise and cut under his right eye. S.S. was taken by ambulance to the hospital emergency room, where he was examined and released. The factual question is what happened in the short period between S.S. being dropped off and C.O.'s phone call to Forman.

Forman did not testify. In lieu of testimony, the Department offered the first page of R-1, an initial incident report that Fishman said Forman had prepared. It states that C.O. reported that " . . . S.S. was hitting . . . T.R. and that S.S. was on top of T.R. When he went to pull S. off T., S. lost his balance and hit the wall, face first." Fishman said he prepared the second page of the report, which states that C.O. "said he heard . . . T.R.

yelling. He immediately went to T.'s room and he witnessed . . . S.S. physically aggressing toward T. by hitting him." (Ibid.) When asked how S.S. got hurt, "C.O. stated that S. hit his face on T.'s metal bed. (C.O.) said that he tried to remove T. by pulling him out of the way so T. could be free." When Fishman asked "'[W]hy didn't you use crisis intervention (sic) like you were taught in your training,' (C.O.) did not have a response." (Ibid.)

Diana Reinkraut, whose last name at the time of the incident was Germano, is the Director of Behavioral Services at New Concepts. She testified that since she visits the house almost daily, she knows the three residents well. She also is responsible for writing behavioral plans for them, and providing some therapy and counseling. On the day after the incident, she arrived at the home at around 8 a.m. She first approached T.R., who was watching television. She asked him how he was doing and he immediately began to tell her that the night before S. went into his room and tried to take his medals. He also said S. hit him and pointed toward his face. She checked T.'s face but saw no marks. T. said "the nice staff stopped" S. They went up to T.'s room, where T. pointed to his wall and said, "Staff hit S. and his head hit the wall and S. hit the ground." When she looked where he was pointing, she saw a pattern of what looked to her like a spray of blood droplets on the wall. She took a picture of the pattern. (R-4.) She acknowledged that she does not know for a fact that it was blood, as no one tested it. She also said she did not know how often the walls are washed, and could not say whether the marks were there previously or were fresh.

She then went across the hall to J.'s room. He was very excited to tell her about the police having been there because he loves the police and likes to think he is an officer. Unprompted, he said, "Staff hit S.," and in T.'s room, he pointed at exactly the same spot on the wall that T. had indicated. Then she went to visit S., who was lying in his bed with his arms crossed, looking angry. At first he would not talk to her. She testified that he had extensive bruising on his face, which started above his left eye and circled it. The bruise under the eye was swollen. He had dried blood up his nose, and a cut lip, all on the left side. After perhaps four minutes of refusing to answer questions, he finally responded to a query about whether the bruises on his face hurt with, "They

don't hurt. Nobody hit me." She said she had not said anything about anyone hitting him.

Reinkraut was inclined to believe that S. tried to take T.'s medals, because he likes things like that, and T. has a number of Special Olympics medals hanging on his wall. She also credits T.'s statement that S. was hitting him because S. has a history of both noncompliance with rules and commands, and of aggression towards others. This can range from threats and name-calling to spitting, kicking, and hitting. The negative behaviors are more frequent in the holidays, when they might occur ten times in four months. T. on the other hand, has not displayed any negative behaviors, to her knowledge. He is a "calm, sweet, nice (guy) who goes with the flow." J.R. is also sweet but can get grouchy and agitated if someone disrupts his routines. Generally, however, he settles for threatening to arrest the offender.

Both Fishman and Reinkraut testified to a meeting with C.O. and his union representative on December 7, 2011, a few weeks after the incident. Both characterized C.O.'s demeanor at the meeting as angry and defensive, noting that he said repeatedly that his life was more important than those of the men in the group home, and that he would not put himself in a position to get hurt. Reinkraut testified that she prepared the written report on the meeting. The report states that C.O. told them that he was making dinner in the kitchen when he heard yelling for help. He checked downstairs first, then, finding no one, ran upstairs, where he found S. in T.'s room, striking T. repeatedly. (R-4.) C.O. said

> he grabbed T. (whom was in a fetal position sitting on a chair in his room) by the shoulders and pulled him out of S.'s way. (C.O.) then stated S. followed him downstairs and refused to take a PRN as instructed. C.O. stated he noticed S.'s eye was red, swollen, and he was bleeding from his nose and mouth so he called 911. C.O. stated that R. was red (in) his face where S. was hitting him.
>
> [Ibid.]

The report also states that in the opinion of the reporter, C.O. "changed his story several times," originally stating that S. "tripped and hit his head on the wall. However, he also

stated he does not know how S. received his injuries." The report states that he was inconsistent in telling Forman that he was in the basement administering medication when he heard someone yell and later stated he was in the kitchen." (Ibid.) The report also states that C.O. told them that he was trained that when working alone, it was not appropriate to use a crisis technique, and that, although S. had been exhibited negative behaviors on days previous to the one of the incident, C.O. had not filed any forms reporting this.

Fishman explained that "PRN" is a term for a physician-prescribed drug that can be given to New Concepts consumers in certain situations to calm agitation. He also stated that crisis-management training includes techniques such as a basket hold, bite releases, hair-pulling releases, and blocks for overhand strikes, side punches, and kicks. Although New Concepts held off on its own investigation until the police had completed theirs, no one at hearing offered a copy of a police report.

C.O. testified that on the day in question, S. had been particularly noncompliant in taking so long to agree to return home. C.O. spoke to the person who dropped him off, in hopes that the driver would remain on the shift with him. He sought to suggest that one staff member per three residents was not sufficient. C.O. was in the kitchen on the first floor, making dinner for the residents, who normally eat around 5 p.m., when he heard someone yelling help. He ran to the basement, then seeing no one there, upstairs to the second floor. He saw S. in T.'s room, hitting T. T. was lying on his bed, curled up, and S. was by the foot of the bed, hitting him. He asked S. to stop, and said they could go down and play video games. S. looked at him and then stopped and followed him down the stairs. He retrieved S.'s calming medication and tried to administer it to S., who knocked it from his hand. He then noticed that S. had blood on his left side, and he called Forman and 911, because that is the proper procedure. He said he does not know how S. was injured; he never touched him. He maintained that he never spoke directly to Forman when she arrived. The only conversation he had with her was over the phone when he called to tell her about the incident.

C.O.'s wife, P.O., who said she has been in patient care since 2005, testified that it is her understanding that when one is working alone, one has to weigh the

circumstances in the environment in determining whether anything more than redirection is appropriate. If one is not certain that a restraint can be performed properly in the situation, than it would not be appropriate to use it. She and C.O. both sought to suggest that the approximately three to four feet between T.'s bed and the safety door and wall limited the options for halting the attack.

Much of the evidence is hearsay, and although hearsay is admissible in administrative proceedings, and may be employed to corroborate competent proof, Weston v. State, 60 N.J. 36 (1972), hearsay alone is not enough for a decision. Findings of fact and conclusions must be "based upon sufficient, competent, and credible evidence." N.J.S.A. 52:14B-10(c). Forman's report of what she personally observed might be admissible as a business record, but her account of what C.O. said to her is embedded hearsay. Additionally, even as embedded hearsay, it is very weak because she states that "Due to his accent he was very difficult to understand." (R-1.) Similarly, the account of what the residents said to Reinkraut is hearsay.

However, Fishman's testimony as to C.O. having told him on the phone that when he pulled T.R. away from S., S. hit his head on the metal bed frame, is admissible as an admission because C.O. said it directly to Fishman. The same is true of testimony by Reinkraut and Fishman as to what C.O. said during his December interview. The account that C.O. gave at hearing—that he stopped S. from hitting T.R. with a single attempt at redirection—was simply not credible. C.O. himself had indicated that S. had been in a difficult frame of mind even before he arrived home, and C.O. obviously was well aware that S. did engage in physically aggressive behavior. This is supported by his unhappiness about having been left alone with the three residents. Whether he struck S.S., struggled with him, or simply pulled him off of T.R. with enough force that he accidentally banged into a wall, the bed frame, or something else is not known, but it is clear that S.S. somehow sustained injuries and that C.O. could not have been utilizing the crisis-intervention techniques that he was required to use.

LEGAL ANALYSIS AND CONCLUSION

The Department charged petitioner with failing "to intervene for at least 20 minutes during a serious physical altercation between two service recipients of the Division of Developmental Disabilities" and with striking "one of the service recipients in the face, causing the individual to fall to the ground and sustain injuries." (R-6.) These acts, the Department contends, meet the statutory criteria for physical abuse and neglect under N.J.S.A. 30:6D-73 et seq. With regard to neglect, the statute provides:

> In the case of a substantiated incident of neglect, it shall be determined if the caregiver acted with **gross negligence, recklessness** or evidenced a pattern of behavior that caused harm to an individual with a developmental disability or placed that individual in harm's way.
>
> 1. Acting with gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences to another party.
>
> 2. Acting with recklessness is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk.
>
> 3. A pattern of behavior is a repeated set of similar wrongful acts.
>
> [N.J.A.C. 10:44D-4.1(c) (emphasis added).]

Neglect is defined as follows:

> "Neglect" shall consist of any of the following acts by a caregiver on an individual with a developmental disability: willfully failing to provide proper and sufficient food, clothing, maintenance, medical care, or a clean and proper home; or failure to do or permit to be done any act necessary for the well-being of an individual with a developmental disability.
>
> [N.J.S.A. 30:6D-74.]

"Gross negligence" is defined by Black's Law Dictionary 1134 (9th ed. 2009) as follows:

> 1. A lack of slight diligence or care. 2. A conscious, voluntary act or omission in **reckless** disregard of a legal duty and of the consequences to another party, who may typically recover exemplary damages.—Also termed ***reckless negligence***; *wanton negligence*; *willful negligence*; *willful and wanton negligence*; *hazardous negligence; Magna neglegentia.*
>
> [See also Restatement (Second) of Torts, § 500 (1963-1964).]

"Reckless" is defined by Black's Law Dictionary 1385 (9th ed. 2009) as follows:

> Characterized by the creation of a substantial and unjustifiable risk of harm to others and by a **conscious** (and sometimes deliberate) **disregard** for or **indifference** to that risk; heedless; rash. Reckless conduct is much more than mere negligence: it is a **gross deviation** from what a reasonable person would do.
>
> [Emphasis added.]

The difference between mere negligent conduct and wanton and willful misconduct cannot be described with mathematical precision. "Like many legal characterizations, willful misconduct is not immutably defined but takes its meaning from the context and purpose of its use." Fielder v. Stonack, 141 N.J. 101, 124 (1995). The label turns on an evaluation of the seriousness of the actor's misconduct. McLaughlin v. Rova Farms, 56 N.J. 288, 306 (1970).

With regard to the failure to intervene for at least twenty minutes, no competent evidence relating to that failure was offered, and therefore, I **CONCLUDE** that the Department has not shown a failure to intervene. The Department also produced insufficient competent evidence to prove by a preponderance of the credible evidence that C.O. struck S.S. in the face, causing him to fall and sustain injuries. However, as noted above, the Department did prove that S.S. somehow sustained significant injuries and that C.O. could not have been utilizing the crisis-intervention techniques that he was required to use in stopping the attack. That failure amounts to gross negligence, as C.O. performed a conscious, voluntary omission that was in reckless disregard to his duty, and to the physical consequences for S.S., who, like T.R., was in his care and whose safety, and whom he was obligated to protect.

Therefore, I **CONCLUDE** that the Department's placement of C.O.'s name on the Central Registry of Offenders was within the parameters of the statute.

ORDER

The placement of C.O.'s name on the Central Registry of Offenders is hereby **AFFIRMED**.

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

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 a final decision in this matter. 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 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, **ADMINISTRATIVE HEARINGS COORDINATOR, OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY, 222 South Warren Street, 4th Floor, P.O. Box 700, Trenton, NJ 08625-0700,** marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

November 19, 2014
DATE

Laura Sanders
LAURA SANDERS
Acting Director and Chief
Administrative Law Judge

Date Received at Agency: November 19, 2014

Date Mailed to Parties: 11/19/14

/caa

WITNESSES

For Petitioner, C.O.:

C.O.

P.O.

For Respondent, Department of Human Services:

Adam Fishman

Diana Reinkraut

EXHIBITS

For Petitioner, C.O.:

No exhibits

For Respondent, Department of Human Services:

R-1 Division of Developmental Disabilities, Initial Incident Report dated November 14, 2011

R-2 New Concepts for Living Investigation Report dated November 14, 2011

R-3 Division of Development Disabilities Follow-up Incident Report dated December 7, 2011

R-4 Photograph of T.R.'s medals and the wall in his bedroom

R-5 Department of Human Services Special Response Unit Interviewee Summary Sheet

R-6 Letter to C.O. advising him of Intention to Place on the Central Registry of Offenders against Individuals with Developmental Disabilities, dated April 3, 2013

R-7 Letter to C.O. advising him that decision to place his name on the Central Registry was affirmed, dated January 14, 2014

R-8 Letter from C.O. requesting a fair hearing, dated January 29, 2014

R-9 Certificate of completion of Crisis Management Course dated August 13, 2009

R-10 Certificate of attendance at Crisis Management Recertification Training, dated October 27, 2010

R-11 Individual Habitation Plan for S.S. dated April 28, 2011