State of New Jersey

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FINAL AGENCY DECISION

OAL DKT. NO. HSL 05400-15

AGENCY DKT. NO. DAR # 15-002

C.A.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

C.A. appealed a decision by the Department of Human Services to place his name on the Central Registry of Offenders against Individuals with Developmental Disabilities ("Central Registry") due to a substantiated act of neglect for failing to properly supervise an individual with developmental disabilities and allowing the individual to stuff food in his mouth and choke. C.A. denies that his conduct constituted neglect. Further, C.A. denies that the circumstances warrant placement of his name on the Central Registry.

The Department advised C.A. of its determination by letter dated November 14, 2014, and C.A. requested a fair hearing. As a result, the matter was transmitted to the Office of Administrative Law on April 15, 2015, for determination as a contested case. Initially the case was assigned to Tiffany M. Williams, ALJ and then transferred to the Danielle Pasquale, ALJ. Attorneys changed on both sides and several adjournments were requested and granted with consent to allow new attorneys time to familiarize themselves with the case. Judge Williams signed an Order to Seal

on May 18, 2015. A Protective Order was put in place, at the parties' request. A hearing was conducted on July 1, 2016, and the record closed. At that time, the parties agreed to order the transcripts and submit briefs within thirty days of their receipt. The tribunal never received any post-hearing submissions and called the parties. The briefs were eventually received on September 15, 2017 and the record closed. An Initial Decision was entered November 1, 2017.

EXCEPTIONS

C.A. submitted, pro se, exceptions to the Initial Decision by letter dated November 22. 2017 and later retained new counsel who submitted additional, supplemental exceptions by letter dated January 24, 2018. The pro se exceptions included an allegation that the video shown at the hearing "was edited;" however, C.A.'s attorney admitted into evidence, without objection, a CD with three different videos (cameras 209, 210, and 211)[1] where, during the hearing it was stated that only camera 209 had been shown. The entire CD had been supplied to the petitioner prior to the hearing, as part of discovery. The pro se exceptions allege that a bit of C.A.'s testimony to police "was removed." However, there is no showing that his attorney had introduced such evidence at the hearing and the police testimony was part of the exhibits admitted during the hearing. The pro se exceptions try to offer evidence and arguments that were never raised at the hearing by the petitioner's counsel, including decisions of the petitioner's boss, phone calls, and evidence presented in a separate, trial concerning wholly different charges, held in a municipal court. The pro se exceptions are based on evidence that could have been introduced at the hearing but, for whatever reasons, were not.

> "Evidence not presented at the hearing shall not be submitted as part of an exception, nor shall it be incorporated or referred to within exceptions." N.J.A.C. 1:1-18.4(c)

The pro se exceptions are without merit of consideration.

The exceptions provided by C.A.'s new counsel argued that the testimony of witnesses was improper hearsay, without showing how the Administrative Law Judge (ALJ) misused her discretion under the hearsay evidence residuum rule (N.J.A.C. 1:1-15.5). The new counsel argues that the witnesses were not qualified without showing how the ALJ misused her discretion concerning expert and other opinion testimony (N.J.A.C. 1:1-15.9). Petitioner's attorney, at the time, raised hearsay objections during the hearing, which were considered by the ALJ, but all of the evidence and testimony considered by the ALJ (and now by the agency for its decision) was

[1] Transcript Page 112- 113

allowed in by the ALJ and is to be found in the records of the hearing. Although the only witnesses called were those called by the respondent, no objections were made during the hearing to any of the witnesses. The doctrine of invited error precludes the consideration of evidence or objections that the petitioner now wants included in the record. "Trial errors which were induced, encouraged or acquiesced in or consented to by defense counsel ordinarily are not a basis for reversal on appeal" (State v. Corsara, 107 N.J. 339, 345 found in N.J. Div. of Youth and Family Servs. v. M.C .III, 201 N.J. 328, 341). The counsel cannot now object to witnesses or evidence that were allowed to be introduced unchallenged at the hearing. The new counsel also submitted documents from a municipal court trial that were not introduced in the hearing and which concern a criminal case with different charges and a criminal standard of proof. That evidence, also, cannot be considered under N.J.A.C. 1:1-18.4(c) (quoted above).

None of the submissions show a compelling relevance to the two step inquiry into the administrative process of a caretaker's placement on the Central Registry. There is no discussion about a preponderance of the evidence in the investigation that shows neglect of an individual with developmental disabilities, nor is there a discussion of the level of neglect amounting to gross negligence, recklessness, or being part of a pattern of behavior. Further, none of the exceptions apply an analysis showing an aberration from the rules of Administrative Law hearings. The exceptions, although noted, are not persuasive that the hearing was in any way -- legally or factually -- flawed.

INITIAL DECISION

The ALJ correctly followed the two-step statutory process for determining placement on the Central Registry as set forth in N.J.S.A. 30:6D-73 et seq and the regulations at N.J.A.C. 10:44D.The first issue is whether C.A. committed a substantiated act of neglect for failing to properly supervise an individual with developmental disabilities with known dysphagia and impulse control disorder and allowing the individual to stuff food in his mouth and choke. The second issue is whether C.A. should be placed on the Central Registry due to a showing of gross neglect, recklessness, or a pattern of behavior.

The ALJ heard testimony from three witnesses for the Department: Mr. Robert Brozon, Quality Assurance Specialist for Department of Human Services, Office of Investigation; Officer

Nicholas Riesinger, Branchburg Police Department; and Lieutenant Crisafulli, Branchburg Police Department. The ALJ commented that the witnesses were considered to be fully credible. Represented by counsel during the hearing, C.A. chose not testify to dispute any of the testimony, nor did he present any witnesses on his behalf during the OAL hearing. C.A.'s attorney participated in the cross examination of the witnesses. C.A. did not address his earlier written and videotaped statements; his version of events could only be gleaned by the documentary evidence. The ALJ reviewed and entered into evidence sixteen items, including documents and videos.

The ALJ listed, in the Initial Decision, the following to be found as facts:

1. "As of February 5, 2014, C.A. was employed by Benchmark Human Services ("BHS") as a Senior Direct Support Staff Member and was a caregiver assigned to R.F.
2. BHS operates a state-licensed group home with supervised rooms for individuals with developmental disabilities.
3. C.A. was assigned to the group home located in Branchburg, New Jersey where the residents included R.F., F.S. and J.M., who were all in the ShopRite, in Branchburg on February 5, 2014.
4. R.F.'s Individual Habilitation Plans (IHP) states that R.F. cannot be left alone in a vehicle and that he requires a 1:1 supervision ratio in the community requires "arm's length " supervision when he is eating due to a condition called dysphagia which puts him at risk for choking. BHS has a policy that staff must call 911 in the event of a life-threatening emergency. The IHP for R.F. contains the same provisions.
5. BHS's definition of a "life-threatening emergency" means a situation in which a prudent person could reasonably believe that immediate intervention is necessary to protect the life of a person receiving services at Benchmark or to prevent the lives of other persons at Benchmark. BHS defines life threatening emergencies to include: a) unresponsive to pain or stimuli; b) unconscious, unusually confused, or seems to be losing consciousness; c) having difficulty breathing, is not breathing, or is breathing in a strange way; d) having a weak pulse or no pulse, etc...
6. BHS outlines in detail call procedures if one or two staff members are present during a life-threatening emergency. Once the EMS workers are on the scene then the staff shall report the incident to their on-call supervisor within two hours. That delay is built in to allow the caregiver to administer aid first and work with the EMTs to describe the DDD resident's medical conditions.
7. C.A. reviewed the IHP for R.F. and was familiar with the provisions within.
8. C.A. is trained on Danielle's Law requirements and procedures, abuse and neglect and Adult First Aid and CPR and is aware of the BHS's policy for calling 911 during a life-threatening emergency.
9. On February 5, 2014, C.A. took R.F. with his co-worker Victor Ehizele and two other residents (F.S. and J.M.), to a ShopRite located in Branchburg, New Jersey for toiletries for the male residents.
10. C.A. left the van with two residents including R.F. in violation of the one-to-one ratio required for R.F.'s care in the community as noted in his IHP.

11. R.F. stole a cake in the bakery section of the ShopRite, shoved it in his mouth, circled an area caught by the corresponding video where he is walking in circles, becomes distressed and collapses to the floor.
12. C.A. was not with R.F. when he stole the cake and had to be informed by his junior co-worker Victor Ehizele of the incident.
13. During the investigation, C.A. stated that he was left with too many residents in the van.
14. Regardless, C.A. made the decision to go into the ShopRite with two of them including R.F. against the fears of the more junior caregiver Victor Ehizele.
15. The video clearly shows that C.A. was not with R.F. when R.F. shoved cake in his mouth in the bakery section of the store. The video shows C.A. standing and watching two ShopRite employees assist R.F. after he collapses and cannot drink water, C.A. merely stands there.
16. The video clearly shows that C.A. did not administer any care to R.F. other than to lift up his arm which appeared limp and then to drop it back down. He then paces with his hand to his forehead with an apparent look of dismay at R.F.'s condition and collapse.
17. C.A. did not call 911.
18. C.A. stood over R.F. without rendering any aid to R.F. near the ShopRite employees who are all caring for R.F., not C.A.; who appears to simply be watching nearby.
19. C.A. provided no care for at least four and one-half minutes when the police arrived, nor did he communicate or respond to the officers when they asked who was responsible for R.F. or if anyone knew of his medical issues.
20. R.F. was clearly in distress as shown in the video and corroborated by the officers that responded and administered aid to R.F.
21. C.A. did not tell the officers that R.F. suffered from dysphagia or anything about his medical conditions, and the video shows C.A. is merely acting as a bystander. At one point, leaning casually, on what looks like a column watching the officers, ShopRite employees and EMT's assist R.F.
22. C.A. did not initially take any responsibility for R.F. being in his care after the ShopRite employees started to administer help and inquire about R.F.
23. C.A. did not attempt CPR.
24. C.A. did not state whether R.F. suffered from epilepsy or seizures when asked by the police once they started to administer aid.
25. C.A. did not attempt to sweep anything from R.F.'s mouth.
26. C.A. never described R.F.'s developmental disabilities to anyone at the scene.
27. C.A. called the group home but not 911 and falsely claimed to the officers that he needed to save his cell phone battery and thus that is why he did not call 911.
28. C.A. was aware of R.F.'s condition and his IHP requiring one-to-one supervision in the community especially around food; knew about his food grabbing and knew that he needed to be within arm's reach of R.F. around food.
29. C.A. knew that if R.F. was near food and a caregiver attempted to redirect him with verbal prompts and even physically blocked him, that he may still be non-compliant with redirection.
30. R.F. choked at the store on the cake he stole from the bakery when C.A. was not within arm's reach and days later died in the hospital as a result of the incident at the ShopRite which gave rise to the instant action.
31. R.F. was taken from the ShopRite via ambulance after CPR was unsuccessful and died days later as a result of the February 5, 2014 incident.
32. C.A. did not reveal his status as a caregiver for R.F. until Officer Riesinger took him to the van when Mr. Ehiezele (sic) stated that they both were caregivers. When Mr. Ehizele

> realized that C.A. was denying his role, he correctly identified C.A. as R.F.'s caregiver. Just prior, C.A. had falsely told the officers that he worked at the group home in maintenance and was in the ShopRite to get supplies."

The ALJ analyzed the Central Registry statute's policy and definitions. 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(a). A caregiver may be placed on the Central Registry in cases of substantiated abuse, neglect or exploitation N.J.S.A. 30:6D-73(d). It is undisputed that C.A. was a caregiver for R.F. The first issue is whether C.A. committed an act of neglect against the service recipient with the Division of Developmental Disabilities on February 5, 2014. "Neglect" is defined in N.J.A.C. 10:44D-1.2 as "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." "Inadequate supervision" also constitutes neglect. N.J.A.C. 10:44D-2.1(e)1. In accordance with N.J.A.C. 10:44A-5.7(b)3, individuals receiving services whose IHP has determined that being in the community without one-to-one supervision would present a danger to themselves or others shall be supervised accordingly.

C.A. left the safety of the van with two DDD residents including R.F., despite the fact that the IHP for R.F. contained a provision which stated that he should not be in the community unless closely monitored on a one-to-one ratio because "he does not possess the safety skills to be left in the community at any time." To compound matters, C.A. left with yet another developmentally disabled individual who could have also hurt himself, gotten lost, or any number of negative outcomes. In addition, R.F.'s food grabbing behavior and dysphagia requires his caregiver to be within arm's reach around food in addition to the one-to-one ratio requirement. C.A. was aware of the IHP that noted that R.F. had a one-to-one ratio in the community and required being within arm's reach around food because he had an "impulse control disorder", with "mild dysphagia", including "food grabbing". The IHP goes on to note that he needed to be monitored closely around food.

C.A.'s statement, made during the initial investigation, reveals that he felt that the group home manager, Herb Sheftal, was the major factor in R.F.'s crisis. He indicated that he sent two caregivers with three individuals, thereby creating a ratio that would not be permissible and

contrary to BHS policy. His statement claims that his cellular phone battery was low preventing him from calling 911 even though he was seen on video texting and talking and also witnessed by officers texting and calling Mr. Sheftal, as well. C.A. claims no ill will toward R.F. or any of his residents. C.A.'s statement noted that even though R.F. had a 20-year history of stealing cake even before he entered the group home, "it was a generally accepted idea he was okay." C.A. claims that he was told by the officers to "get back" and that is why he did not respond to the Officers when they asked who R.F. was and what his condition was.

The ALJ noted and considered C.A.'s statements: that two caregivers with three individuals created an impermissible staff-to-client ratio; that his cellular phone battery was low preventing him from calling 911 even though he was seen on video texting and talking; and that even though R.F. had a 20-year history of stealing cake even before he entered the group home, "it was a generally accepted idea he was okay." C.A. claims that he was told by the officers to "get back" and that is why he did not respond to the Officers when they asked who R.F. was and what his condition was. The ALJ found, "C.A.'s arguments are unpersuasive."

The danger to R.F. was readily apparent, and an injurious event could have occurred quickly to any of the other residents. The documents detail R.F.'s food grabbing behavior; C.A. knew this and knew that he needed to be in arm's length around food. C.A. knew that he should never have left the van with R.F. and the other resident. The testimony and supporting documentary evidence goes into extreme detail about what to do to attempt to redirect R.F. and to physically "block" him if possible. In fact, as noted above, if food is in sight, it was well-known that R.F. may still be non-compliant. C.A. could have avoided the danger to R.F. by simply not leaving the van. Under the circumstances, the ALJ concluded that C.A. neglected R.F. by failing to provide adequate supervision in the community on February 5, 2014 -- the first prong of the inquiry.

The second issue is whether C.A. should be placed on the Central Registry. In accordance with N.J.A.C. 10:44D-4.1(a), when an investigation results in substantiation of neglect, an additional determination shall be made whether the incident involves the elements set forth in N.J.A.C. 10:44D-4.1(c), which provides as follows:

> "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."

The junior and newer staff member with C.A. advised C.A. before entering the food store that a more reasonable decision would be for C.A. to stay with the two residents, including R.F., in the van. C.A. alone made the decision to go into the supermarket with two residents, thereby exposing R.F., with a known 20-year problem of food grabbing, R.F.'s need for 1:1 and arm's length supervision, as well as the other resident, to a substantial and unjustifiable risk of harm. The ALJ again found, "C.A.'s arguments … unpersuasive." R.F. required 1:1 ratio in the community especially around food. The above-mentioned dangers were outlined in detail in the IHP. The risk was known, substantial and unjustifiable -- C.A. could have remained in the van. As noted in the investigation documents, the video, and the corroborating witness testimony, C.A. failed to provide safety to R.F. C.A. did not ensure proper supervision in the vicinity of food while in a community grocery store. As a result of that neglect, R.F. sustained major injury after obtaining food and subsequently choking. C.A. did not seek immediate medical attention, nor did he provide immediate medical care for R.F. C.A. did not even evaluate him to determine if his airway was blocked. This lack of care and action eventually resulted in R.F.'s death. The ALJ concluded that these actions and inactions amounted to gross negligence and recklessness on the part of C.A.

C.A. showed extremely poor judgment, which created a substantial and unjustifiable risk of harm to R.F. The tribunal felt that it would be remiss if it did not note that several witnesses and the video make clear that C.A.'s main concern was not about supervising R.F. or helping once he was in distress. His withholding of information to the officers administering care, his standing

over R.F. without doing anything other than attempting to give him water, his failure to call 911 and his poor judgment about going into a supermarket with an intellectually disabled person who may not be responsive to redirection or the blocking maneuvers he was taught compounded the risk and are truly troublesome. After analyzing the circumstances and the applicable law, the ALJ concluded and ordered that C.A.'s name should be placed on the Central Registry.

FINDINGS AND CONCLUSIONS OF LAW

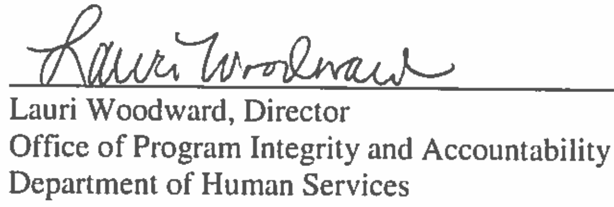
After a careful examination of the entire record generated during the hearing at the Office of Administrative Law – its initial decision, transcripts, exhibits, and exceptions – **I FIND**, by a preponderance of the evidence that the Office of Investigation properly substantiated neglect on the part of C.A. C.A. failed to provide adequate supervision in the community to an individual with a developmental disability, as defined by N.J.A.C. 10:44D.

I FURTHER FIND, by a preponderance of the evidence, that C.A. made the conscious decision to go into the supermarket with two residents, thereby recklessly exposing that individual with a known 20-year, dangerous propensity of food grabbing (and his need for 1:1 and arm's length supervision), to substantial and unjustifiable risks of harm, which in this case led to the individual's unfortunate death. C.A. had been reminded of the dangers of choking in the food filled environment of a supermarket. C.A.'s failure to exercise a minimum of care to provide proper supervision, combined with his recognition of the dangers associated with that failure, represent gross negligence and reckless behavior, as defined by N.J.A.C. 10:44D. C.A. acted recklessly by creating an unjustifiable risk of harm. Due to acting with gross negligence and recklessness, C.A. was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

After a careful consideration of the Initial Decision, a review of all of the evidence, testimony, exceptions, exhibits, and with deference to the ALJ's having the opportunity to hear testimony and observe witnesses' demeanor to evaluate credibility; **I AFFIRM THAT,** C.A. was properly substantiated for neglect by failing to provide proper supervision of R.F. and that C.A. was grossly negligent and reckless in his conscious disregard of the danger in his failure to provide sufficient care to an individual with developmental disabilities. C.A. **IS THEREFORE**

ORDERED to be placed on the Central Registry of Offenders against Individual with Developmental Disabilities.

Date: 3/29/18



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