State of New Jersey

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FINAL AGENCY DECISION
OAL DKT. NO. HSL 05737-20
AGENCY DKT. DRA 20-005

E.O.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent.

Joel C. Seltzer, Esq., for petitioners

Jessica A. Sampoli, Deputy Attorney General (Andrew J. Bruck, Acting Attorney General of New Jersey, attorneys) for respondent

STATEMENT OF THE CASE and PROCEDURAL HISTORY

This matter was transmitted to the Office of Administrative Law (OAL) where it was filed on June 23, 2020, as a contested case. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to-13.

E.O. (E.O. or petitioner) appealed the decision of the respondent, the Department of Human Services (Agency/DHS) to place E.O. on the Registry of Offenders Against Individuals with Developmental Disabilities. Placement on the Central Registry prohibits the listed offenders from working for or volunteering in DHS-funded programs, including employment in developmental centers, community agencies, and other programs licensed, contracted, or regulated by DHS.

The essence of the decision is founded on the agency's determination that on November 23, 2019, E.O. "grabbed an individual by his upper arms, pushed him backward and struggled with him, resulting in scratches to his chin, neck and arms." The individual was N.C. (Patient or N.C.) who was a long-term care resident at Greystone Park Psychiatric Hospital.

Respondent filed a motion for summary decision, which was denied by Order dated February 18, 2021. A hearing was held April 22, 2021. The record was left open to June 15, 2021, for submission of post hearing briefs, at which time the record closed. An extension of time for the Initial Decision was entered owing to a backlog of matters that arose during the COVID-19 pandemic health emergency, disrupted accessibility to work resources, disruption of work conditions and voluminous case load.

EXCEPTIONS TO INITIAL DECISION

The attorney representing the Petitioner, E.O., filed exceptions to the Administrative Law Judge's Initial Decision on November 1, 2021. No exceptions were submitted by the Respondent. A discussion of the Petitioner's Exceptions is included here.

The exceptions filed by the Petitioner are wanting. In claiming that it was impossible for E.O. to escape once N.C. had grabbed her, the video evidence is being ignored. The ALJ stated, "As shown in the video, once E.O. stood up, she moved toward N.C. and both of them raised their hands to each other and clutched at each other. This clutching and tugging resulted in E.O. pushing N.C. to the wall where the entrance/exit door was located." (ID p.5) The witness that testified that staff are trained to "create space [in] that they move away from the patient if the patient is being aggressive" (ID p.5) described the video – "when N.C. 'moved toward her and made kicking actions, and at that point, E.O. stood up and moved to within an arm's reach, so she actually moved closer to him rather than further away from him.'" (ID p.6) There is ample evidence that E.O. moved toward N.C. rather than away. Speculating that E.O. would have been followed by N.C. had she walked away and, thus, in more danger never happened and is not at issue in this proceeding. The ALJ, having heard all of the testimony and considered the video, found as fact, that: "E.O. did not attempt to retreat; while her chair was positioned against a wall, the space between her and the patient and the space within the room was sufficient to at least attempt to safely retreat and/or distance herself from him." (ID p.7)

The exceptions aver that: "The testimony of Ms. Murphy rested on hearsay statements which should not have been relied on by the court." Hearsay is admissible in Administrative Hearings. The Petitioner raised the issue of hearsay several times during the hearing, and in its post hearing summary. At the end of the hearing, the ALJ ruled to allow the answers already given, as they were basically part of the previously admitted investigation report. The ALJ ruled, "The weight of the evidence does not depend on the individual opinions of the people who observe the incident, but the people who are bringing forth evidence to [the] trier [of] fact. So, the fact that there may be hearsay within hearsay is not … the reason why I might not give any weight at all to the testimony on those points, it's a matter of weight not a matter of admissibility." Trans p.67 5-13 Citing the residuum rule, the investigation report was allowed into evidence and the witness

was allowed to state that it was used as part of the reasoning she employed to reach her conclusions. In the Petitioner's exceptions, no finding of fact or conclusion of law is specified as having been affected by a statement known to be impermissible hearsay.

The exceptions correctly state the text of N.J.A.C. 10:44D-4.1 (b) - "the caregiver must have acted with intent, recklessness or careless disregard to cause or potentially cause injury," and decries the lack of citations to "back up this definition of 'careless disregard'." However, the Petitioner does not include that intent, recklessness, and careless disregard are each separately defined in the regulations – consistent with Black's Law Dictionary - in (b) 1 through 3:

> "**1.** Acting intentionally is the mental resolution or determination to commit an act.
>
> **2.** Acting recklessly is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk.
>
> **3.** Acting with careless disregard is the lack of reasonableness and prudence in doing what a person ought not to do or not doing what ought to be done."

Citing two federal criminal cases, the exceptions attempt to use the term "willfulness" – which appears nowhere in the Statute or Regulations (although, 'willfully' appears once in the definition of Neglect, but is not at issue in this case) - to equate to the term "careless disregard." The first criminal case (involving an insurance company and whether willfully failing to comply with federal credit rating requirements were reckless violations, not just knowing violations) robustly defines willfulness and reckless, while mentioning "careless disregard." (Safeco Ins. Co. v. Burr., 551 U.S. 47 (2007) The definitions in Safeco refer to and quote the second, cited federal criminal case (involving whether a tax filer 'willfully' refused to give testimony and supply information as to certain income tax deductions). The mention of careless disregard in the Safeco case is taken directly from the second case, and also includes a detailed definition of "willful":

> "[Willfully] often denotes an act which is intentional, or knowing, or voluntary, as distinguished from accidental. But when used in a criminal statute it generally means an act done with a bad purpose; without justifiable excuse; stubbornly, obstinately, perversely. The word is also employed to characterize a thing done without ground for believing it is lawful, or conduct marked by careless disregard whether or not one has the right so to act." U.S. v. Murdock, 290 U.S. 389,394-395 (1933)

Federal criminal law's use of the term "willful" in federal statutes is not at issue in this Administrative Law hearing. The citations, listed in the exceptions, are of no merit or relevance to this case. The term "careless disregard," as used in Central Registry cases, is sufficiently defined in the regulations.

The exceptions accuse the court of "a blame the victim jurisprudence." E.O. is at bar because she is a caretaker. She has been employed for 16 years to take care of and protect patients in State-run psychiatric hospitals. She has been trained how to protect herself from aggressive patients. The Central Registry statute was passed to protect individuals with developmental disabilities. It was E.O.'s failure to adhere to her training, in how to avoid confrontations and escalations of aggressive behaviors by patients, that created the danger to N.C. As a caretaker,

E.O. failed to prevent or deescalate the incident to protect N.C., as required by law. The court was presented evidence of the content of the training given to the Petitioner and documentation that it was completed by the Petitioner. The exceptions ask for an expert "to establish a standard of care in this circumstance." Petitioner raised this issue at the hearing, questioning the ability of "an investigator" to know "what a nurse or patient care person is supposed to do." Trans p.62 3-5 The ALJ commented that, "I don't see how an investigator could investigate anything like this without having knowledge of what the nurse is supposed to do." Trans p.62 8-10 The investigator was then questioned by the Respondent's DAG; the investigator detailed the training that all hospital staff receive; the various hospital rules, regulations, policies and procedures consulted; patient and staff records available. The witness also described her own investigative certification program. As noted above (re: the hearsay exception) The ALJ admitted the investigative report into evidence, with the hearsay portions to be given their due weight under the residuum rule.

INITIAL DECISION'S FACTUAL DISCUSSION AND FINDINGS

Respondent relied on a 27-page investigative report, as testified to by Margaret Murphy (Investigator Murphy), a Quality Assurance Specialist for the Agency and a video of the incident that occurred involving E.O. and a patient N.C (patient) in the Socialization room at the Greystone Park Psychiatric Hospital (GPPH) on November 23, 2019, at approximately 2:40 p.m. Petitioner relies on her own eyewitness testimony and that of Bilikuso Alhassan (Nurse Alhassan), nurse, who witnessed a portion of the relevant interaction between E.O. and the patient, and who is also familiar with some of the behaviors of the patient. However, much of the relevant evidence is not in dispute.

On Saturday, November 23, 2019, E.O. was a Human Service Technician (HST) and N.C. a patient at GPPH. Ms. Murphy testified as follows: She is responsible for conducting investigations into allegations of Abuse and Neglect of individuals receiving services from the Division of Developmental Disabilities, such as occur in facilities regulated or operated by the Agency. In this case, her investigation began with a review of the Unusual Incident Reporting System, concerning the incident that occurred at the GPPH between the Patient and E.O. In the course of her investigation for the Agency spoke with the Patient, with E.O., with the witness Ms. Alhassan, and with staff on duty that day. She also reviewed the patient's medical history, his behaviors and the prescribed treatment for him while at GPPH.

The patient has suffered with mental illness for 13 years. He "carries a mental/behavioral diagnosis of unspecified intellectual disabilities." He "has no insight into his mental illness." A Psychosocial Assessment of June 3, 2019, noted that he "instigates peers and staff to fight," exhibits "'verbal abuse' toward both staff and peers threatening violence and yelling racial slurs." His Psychological Assessment of November 11, 2019, states that the patient, exhibits a "pattern of destructive, verbally abusive, non-compliant aggressive, assaultive, withdrawn unpredictable, labile and impulsive behavior." He had a history of "intrusive and verbal and physical aggression with peers and staff," and has "difficulty with impulse control, frustration tolerance, emotion regulation and delayed gratification." The patient "at times," instigates peers and staff to fight and

requires extensive redirection to remain appropriate, and had in the past had multiple injections, been placed in restraints and put in locked seclusion for his own safety and the safety of others. On November 23, 2019, the patient was on "intermittent Observation for his unpredictable behavior." (R-1 pages, 10-11).

The patient, N.C., was having a "bad day," as described by Ms. Murphy's testimony. The Investigation Report, Ms. Alhassan's testimony and E.O.s testimony described how on the day of the incident, at approximately 2:15 p.m., the patient engaged in attention seeking behaviors, including trying to climb the Patient Information Center (PIC), which is a separate area for patients and staff to talk. Because of the patient's behaviors, Ms. Alhassan had to give the patient several redirections that day. Redirections were described by Ms. Alhassan as "interventions" to deal with difficult, aggressive or non-compliant patients without force. She saw the patient call E.O. "monkey" (she added he calls everyone that), and trying to provoke her. E.O. reported to Ms. Alhassan that the patient spat at her.

E.O. had been conducting "face checks," which she described as: going around to make a head count every 15 minutes. E.O. testified that while doing these checks that day, the patient had called her a "bitch," "whore," "monkey," that her "generation was a monkey" and said he would make sure she got fired.[1] She also told Investigator Murphy that between the hours of noon and 1:00 p.m. that day, N.C., followed her within the unit, cursed at her, called her names like "monkey" and spat at her. A Psychotropic Emergency Certification Form, dated November 23, 2019, at 2:50 p.m., ten minutes after the incident occurred, described the patient as meeting the "emergency certification definition" and also described the patient's behavior as "threatening cursing hitting spitting at and attacking as well as climbing PIC." (R-1, page 9). Further, a nursing note penned at 3:55 p.m. stated that it had been "reported" (although by whom is unclear) that the patient spat at "the Check staff, [and] was verbally redirected."

At approximately 2:40 p.m., E.O. entered the Socialization Room, which is apparently a separate room for staff and patients to talk and interact. What followed was captured by a video camera. Undoubtedly E.O. was alone in the room and sat down on a chair with a desk next to her with her Face check clipboard in her hand. Soon thereafter, the patient entered the room. **THE ALJ FOUND** the above narrative to be the uncontroverted **FACTS** of the case.

Although the events were recorded by a short silent video, (R-2) what actually occurred in a little over a minute between the patient and E.O. in the Socialization room is contested. E.O. testified that when N.C. entered the room, she asked him if he wanted some milk, and he replied "No, shut up bitch, go, I'll give it to your mama." Then, she said he "kicked her in the leg" and she stood up to tell the Charge Nurse in the nearby dining room that N.C. was attacking her and that she wanted her to "change her assignment." E.O. also testified that, as soon as she stood up, N.C. punched her, and grabbed onto her. Although the patient is 5'2'' and E. O. is 5' 0' tall, she described the patient as "very strong" and that she could not break his grasp.[2] As shown in the video, once E.O. stood up she moved toward N.C. and both of them raised their hands to each

[1] The patient's name calling, and threats made E.O. wonder, "what did I do to this man."
[2] She added that sometimes when the patient needs to be put in the seclusion room "five healthy men" would not be able to put him in the room.

other and clutched at each other. This clutching and tugging resulted in E.O. pushing N.C. to the wall where the entrance/exit door was located. During this time. E.O. testified she was yelling "help, help, help" and Nurse Alhassan responded and quickly got in between the two. E.O. testified that during the struggle, she never punched at N.C. and that she was trained not to scratch patients and didn't have nails to scratch anyway. E.O. said she was hurt by N.C. Her eye, or both eyes were red and swollen from being punched and she was also scratched. She was told to go to the "Morristown Medical Memorial Hospital" and went there that Saturday, but "to [my] surprise and they did different kinds of tests" and told her to return in four days for a follow up. However, a staff member, Mr. Frank from GPPH, told her not to return to the Hospital that Tuesday, and instead E.O. went to "Urgent Care," where a doctor "tested her" and gave her Motrin for a headache.

E.O. testified that she was surprised she was told not to return to GPPH where she had worked since 2003 and that she had never abused any patient.

Under cross examination, and in response to questions by the Court, E.O. testified that she had been trained at GPPH how to defend herself when patients attack. She agreed that when dealing with attacks by patients she was trained to try and retreat but that in this instance it was not possible because N.C. had grabbed her in the "twinkle of an eye." She also added that two of the kicks by N.C. landed on her leg.

Investigator Murphy testified that when dealing with a patient, "[T]he training at the hospital is that they (the staff) create space [in] that they move away from the patient if the patient is being aggressive toward them." The "main problem" and the reason why E.O. was fired and placed on the Registry was that E.O. "didn't follow the training, she didn't make space between them." Referring to her own view of the video, when N.C. "moved toward her and made kicking actions, and at that point, E.O. stood up and moved to within an arm's reach, so she actually moved closer to him rather than further away from him."

Investigator Murphy also detailed portions of her report including her talk with N.C. about the incident. N.C. admitted to her that he grabbed E.O. and "shouldn't have," and that E.O. had "scarred up his arms." She also discussed with another staff member, Milton Rosado, who had seen the patient with fresh scratches on his chin, neck and arms and when asked, N.C. told him that E.O. had caused them. N.C. received medication to address his being upset by the incident. Dr. Walter Bakun, documented "minor" injury to N.C. from "multiple scratches on both forearms and right shoulder, with no swelling or neurovascular deficit." A mental exam by Dr. Baliga, Clinical Psychiatrist, found that N.C. had the mental capacity to relate events of the incident. N.C. related that "staff had" attacked him. N.C. was sent to the Morristown Medical Center Emergency room for the scratches on both forearms and right shoulder. (R-1, pages 11-13, and page 18).

Investigator Murphy's testimony and report also detailed relevant training E.O. had received while at GPPH among them being one called "Legal Responsibilities, Abuse and Professional Misconduct, completed and passed on 1/12/15". (Ibid, page 15)

Regarding the facts of what occurred in the Socialization room, based on the testimony of E.O., Investigator Murphy and Nurse Alhassan, and its immediate aftermath, The ALJ made the following additional **FINDINGS** of **FACTS**:

A. E.O. was trained in distancing herself and retreating in order to avoid conflicts with a patient who is attacking her.

B. A review of the video is not helpful in determining with any degree of certainty whether or not the patient actually kicked E.O. or tried to do so but failed, or whether the kicks were even intended to land on E.O.

C. Likewise, nothing in the video supports E.O.'s claim that N.C. punched her, as no punch is clearly discernible on it. No medical or other witness account was given to support E.O.'s claim that she had redness and/or swelling around her eye or eyes.

D. The video shows that once N.C. made kicking motions directed at E.O.'s legs as she was sitting in a chair, E.O. reacted by getting up and immediately bringing her body closer to N.C., resulting in the two of them grabbing each other almost simultaneously.

E. E.O. did not attempt to retreat; while her chair was positioned against a wall, the space between her and the patient and the space within the room was sufficient to at least attempt to safely retreat and/or distance herself from him.

F. E.O.'s explanation that when she stood up after the attempted or actual kicks, it was to register a complaint about N.C. to the Charge Nurse, is an unintended admission that she did not feel she was in immediate danger.

G. Nurse Alhassan did not see enough of the struggle to give probative evidence on the relevant issues.

H. E.O. was not credible and was somewhat evasive on the issue of causing scratches to N.C.'s arms and neck. In her testimony she didn't deny scratching him but rather said she doesn't "fix nails" and is a professional so she wouldn't abuse a client.

I. The evidence is overwhelming that N.C. received multiple scratches as a result of the altercation and the most reasonable explanation is that E.O., who pushed and shoved N.C. across the room, without great difficulty, exclusively caused the scratches.

INITIAL DECISION'S LEGAL ANALYSIS AND CONCLUSIONS

Under the Central Registry Act, N.J.S.A. 30:6D-73 (b):

> The safety of individuals with developmental disabilities receiving care from State operated facilities or programs . . . licensed contracted or regulated by the Department of Human Services or from State-funded community-based services shall be of paramount concern.

The Act is designed to prevent, neglect, abuse, and exploitation of developmentally disabled individuals by prohibiting employment of those responsible for such conduct in the Division of Developmental Disabilities, its facilities, and programs. N.J.A.C. 10:44D.

Under the Act, physical abuse is defined 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, being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, or struck with a thrown or held object." N.J.S.A. 30:6D-74. The caregiver must have "acted with intent, recklessness or careless disregard to cause or potentially cause injury . .. ." N.J.S.A. 30:6D-77(b)(1). Acting with careless disregard "is the lack of reasonableness and prudence in doing what a person ought not to do, or not doing what ought to be done." N.J.A.C. 10:44D-4.1(b).

The burden of proof falls on the agency in enforcement proceedings to prove a violation. Cumberland Farms v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). In this matter the Department bears the burden of establishing the proof 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). 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). Precisely what is needed to satisfy this burden necessarily must be judged on a case-by-case basis.

While one can sympathize deeply with E.O.'s predicament, which was, as must often be the case, initiated by an irrational developmentally disabled patient who sought to fight with his caregiver, E.O.'s actions of lunging toward the patient to confront his aggression constituted "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." N.J.S.A. 30:6D-74. See also N.J.A.C. 10:44D-1.2. As E.O. clearly did not attempt to avoid confronting the patient's aggression by retreating or creating space between herself and him, her actions, which clearly caused pain, injury and suffering to the patient cannot be justified.

Further, E.O. clearly was not only trained to avoid such confrontations but was or should have been hyper-aware of the patient's aggression towards her as he had been following and provoking her beginning two hours before the incident. There is nothing in the record, however, to indicate that E.O. intentionally caused the abusive action and little evidence that she recklessly created a substantial risk of harm to N.C. by a conscious disregard of the risk. While it was not stated by anyone, that the patient had ever physically attacked E.O. before, his behavior was well known to be or should have been known by E.O. to be "unpredictable" and, at times, aggressive against fellow patients and staff. She was trained in how to avoid confrontations and escalations of aggressive behaviors by patients.

Even N.C., with his multiple developmental disabilities, having had time to reflect admitted to the investigator that he should not have grabbed E.O. As a caregiver, E.O. was charged with having at least the same common sense N.C. showed in admitting he initiated the altercation. Straining credibility, E.O. takes no responsibility for her actions while failing to follow her training

in the face of what amounted to threat gestures by a hapless and futile attention-seeking disabled and irrational patient. This lapse in judgement and her inappropriate and unnecessary engaging with the aggressor clearly shows E.O. acted with "careless disregard to the service recipient resulting in injury to an individual with a developmental disability" N.J.A.C. 10:44D-4.1(b). Accordingly, the placement of E.O. on the Central Registry was permitted.

Accordingly, **THE ALJ CONCLUDED** that the DHS has sustained its burden of proving, by a preponderance of the credible evidence, that petitioner's actions rise to the level of abuse as defined in N.J.A.C. 10:44D-1.2. Further, **THE ALJ CONCLUDED** that E.O. acted with careless disregard for the well-being of N.C., resulting in injury to an individual with a developmental disability, justifying that her name be entered onto the Central Registry.

INITIAL DECISION'S ORDER

Consistent with the above findings and conclusions, the Initial Decision **ORDERED** that the determination of abuse by respondent Department of Human Services against petitioner E.O. was **AFFIRMED.** It was further **ORDERED** that E.O.'s name be placed on the New Jersey Central Registry of Offenders Against Individuals with Developmental Disabilities.

The ALJ **FILED** the initial decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** for consideration, which 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 in this matter.

Within thirteen days from the date on which the recommended decision was mailed to the parties, any party may file written exceptions with the **ADMINISTRATIVE HEARINGS COORDINATOR, OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY.** Only the Petitioner filed written exceptions.

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 - including the entire transcripts of all testimony, the post hearing submissions of the petitioner and the respondent, the documents entered into the record, and the Petitioner's exceptions – I concur with the Administrative Law Judge's findings and conclusions. The ALJ had the opportunity to assess the credibility and veracity of the witnesses; I defer to his opinions concerning these matters, based upon his observations described in the initial decision. **I CONCLUDE and AFFIRM** that the Department has met its burden of proving sufficiently that E.O. committed an act of physical abuse against an individual with developmental disabilities. I **CONCLUDE and AFFIRM** that E.O. acted with careless disregard to the well-being of that individual, causing injury, and that E.O.'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 E.O.'s name on the Central Registry of Offenders Against Individuals with Developmental Disabilities.

Date: 11/29/21 Lauri Woodward

Lauri Woodward, Director

Office of Program Integrity and Accountability