SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1308-21

E.O.,

Petitioner-Appellant,

v.

NEW JERSEY DEPARTMENT
OF HUMAN SERVICES,

Respondent-Respondent.

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Submitted May 8, 2023 – Decided May 18, 2023

Before Judges DeAlmeida and Mitterhoff.

On appeal from the New Jersey Department of Human Services, Office of Program Integrity and Accountability.

Joel C. Seltzer, attorney for appellant.

Matthew J. Platkin, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney General, of counsel; Jessica A. Sampoli, Deputy Attorney General, on the brief).

PER CURIAM

Petitioner, E.O., appeals from the October 29, 2021 final agency decision of the New Jersey Department of Human Services ("DHS" or the "Agency"), which affirmed the October 22, 2021 initial decision of the Administrative Law Judge ("ALJ") that respondent's decision to place E.O. on the Central Registry of Offenders Against Individuals with Developmental Disabilities ("Central Registry") was appropriate. We affirm.

This matter arises from a November 23, 2019 incident wherein petitioner became involved in a physical altercation with a developmentally disabled male patient, N.C., who was a long-term care resident at Greystone Park Psychiatric Hospital ("GPPH"). We discern the following facts from the record, which includes video footage of the incident.

N.C. has suffered with mental illness for thirteen years, "carrie[s] a mental/behavioral diagnosis of unspecified intellectual disabilities," and "has no insight into his mental illness." N.C. has a history of "verbal and physical aggression with peers and staff," and has "difficulty with impulse control, frustration tolerance, emotion regulation[,] and delayed gratification." At times, N.C. has instigated peers and staff to fight and has required extensive

redirection[1] to remain appropriate; in the past—for his safety and the safety of others—N.C. has received sedative injections, has been placed in restraints, and has been put in locked seclusion.

On November 23, 2019, N.C. was described as having a "bad day," and was placed on "intermittent observation" for his unpredictable behavior.[2] At approximately 2:15 p.m., N.C. began engaging in "attention seeking behaviors," including an attempt to climb the patient information center, which is a separate area for patients and staff to talk. Due to such behaviors, Bilikuso Alhassan—a charge nurse and petitioner's supervisor at GPPH—had to give N.C. several redirections that day.

For over sixteen years, petitioner was employed as a direct care professional at GPPH. On the date in question, petitioner had been conducting "face checks," which she described as going around to make a head count of the patients every fifteen minutes. Petitioner testified that, while doing these checks, N.C. called her a "bitch," "whore," "monkey," and said that he would

[1] Redirections are described as "interventions" to deal with difficult, aggressive, or non-compliant patients without force.

[2] A psychotropic emergency certification form, dated November 23, 2019 at 2:50 p.m.—ten minutes after the incident in question occurred—described N.C. as meeting the "emergency certification definition."

make sure she got fired. Petitioner further claimed that, around the hours of noon and 1:00 p.m. that day, N.C. followed her around the unit and cursed and spat at her.

At approximately 2:40 p.m., petitioner entered the hospital's socialization room where the altercation ultimately occurred. Initially, petitioner was alone but, soon thereafter, N.C. entered the room. Although the events that followed were recorded by a short silent video, what actually occurred between N.C. and petitioner in a little over a minute is contested.

Following the altercation in the socialization room, DHS launched an investigation into the incident, the findings of which "substantiated" the claim that petitioner had "abused an individual receiving services from the Division of Developmental Disabilities ("DDD")." Accordingly, DHS decided to place petitioner on the Central Registry.[3] The "essence" of respondent's decision was founded on the Agency's determination that, on November 23, 2019, petitioner "grabbed an individual by his upper arms, pushed him backward[,] and struggled with him, resulting in scratches to his chin, neck[,] and arms."

[3] Placement on the Central Registry prohibits the listed offender 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.

Petitioner appealed from the decision of respondent and the matter was transmitted to the Office of Administrative Law ("OAL"), where, on June 23, 2020, it was filed as a contested case, pursuant to N.J.S.A. 52:14B-1 to -15. Respondent filed a motion for summary judgment, which was denied by order dated February 18, 2021.

A hearing was conducted in the matter on April 22, 2021. There, the central issue concerned the placement of petitioner on the Central Registry and whether the events of the socialization room on November 23, 2019 warranted such placement. Respondent relied on a twenty-seven-page investigative report, as testified to by investigator Margaret Murphy,[4] a quality assurance specialist for the Agency, and the video of the incident. Petitioner, on the other hand, relied on her own eyewitness testimony and the testimony of Nurse Alhassan, who witnessed a portion of the relevant interaction between petitioner and N.C. and was familiar with the behaviors of N.C.

[4] Investigator Murphy is responsible for conducting investigations into allegations of abuse and neglect of individuals receiving services from DDD, that have occurred 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 at GPPH between the patient and petitioner. In the course of her investigation, Murphy spoke with the patient, petitioner, nurse Alhassan, and other staff on duty that day. She also reviewed the patient's medical history, his behaviors, and the prescribed treatment for him while at GPPH.

Petitioner testified that, when N.C. entered the room, she asked him if he wanted some milk, to which he replied, "[n]o, shut up[,] bitch, go[.] I'll give it to your mama." Then, petitioner said that N.C. "kicked her in the leg," which prompted petitioner to stand up to go tell the charge nurse that N.C. was "attacking her" and to request that the nurse "change her assignment." Petitioner alleges that, as soon as she stood up, N.C. punched her and grabbed onto her.[5]

As shown in the video, petitioner moved toward N.C. immediately upon standing up and both parties raised their hands and began clutching one another. This clutching and tugging resulted in petitioner pushing N.C. against the wall where the entrance/exit door was located. During this time, petitioner testified that she was yelling "help, help, help," and Nurse Alhassan responded by quickly getting between the two. Petitioner further testified that, during the struggle, she never punched at N.C. and was trained not to scratch patients.[6]

Petitioner contends that she was hurt by N.C.: her eye, or both eyes, were allegedly red and swollen from "being punched," and she was also allegedly

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[5] Although the patient is 5'2" and petitioner is 5'0", petitioner described the patient as "very strong" and contended that she could not break his grasp. She further added that, sometimes when the patient needed to be put in the seclusion room, "five healthy men" would not be able to put him in the room.

[6] Petitioner further alleges that she did not have nails to scratch.

scratched. That same day, petitioner asserts that she was told to, and did, go to Morristown Medical Center, where she was advised to return in four days for a follow up. In the interim, a staff member told petitioner not to return to GPPH.

Under cross-examination, and in response to questions by the court, petitioner testified that she had been trained at GPPH on how to defend herself when patients attack. She agreed that, when dealing with attacks by patients, she was trained to try and retreat, but claimed it was not possible under the instant circumstances because N.C. grabbed her in the "twinkle of an eye." She also added that two of N.C.'s kicks landed on her leg.

According to the testimony of Investigator Murphy, when dealing with a patient, "the training at [GPPH] 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 petitioner was fired and placed on the registry, was that petitioner "didn't follow the training, she didn't make space between them." Referring to her own review of the video, when N.C. "moved toward her and made kicking actions, . . . [petitioner] 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 discussion with N.C. about the incident. N.C. admitted to her that he grabbed petitioner and "shouldn't have," and told her that petitioner "scarred up his arms." She also interviewed another staff member, Milton Rosado, who had seen the patient with fresh scratches on his chin, neck and arms; when asked about the scratches, N.C. told him that petitioner caused them.

According to Murphy's report, Dr. Walter Bakun documented "minor" injury to N.C. caused by "multiple scratches on both forearms and right shoulder, with no swelling or neurovascular deficit." A mental exam by Dr. Baliga, a clinical psychiatrist, further found that N.C. had the mental capacity to relate the events of the incident; N.C. related to Murphy that "staff" had attacked him.

Finally, Investigator Murphy's testimony and report also detailed relevant training petitioner had received while at GPPH. Among the relevant training was "Legal Responsibilities, Abuse and Professional Misconduct," which petitioner completed and passed on January 12, 2015.

In an initial decision, dated October 22, 2021, the ALJ—having heard all of the testimony and considered the video—made the following findings of fact:

1. [Petitioner] was trained in distancing herself and retreating in order to avoid conflicts with a patient who is attacking her.

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

3. Likewise, nothing in the video supports [petitioner]'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 [petitioner]'s claim that she had redness and/or swelling around her eye or eyes.

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

5. [Petitioner] 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.

6. [Petitioner]'s explanation that when she stood up after the attempted or actual kicks it was to register a complaint about N.C. to the [c]harge [n]urse is an unintended admission that she did not feel she was in immediate danger.

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

> 8. [Petitioner] 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.
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> 9. The evidence is overwhelming that N.C. received multiple scratches as a result of the altercation and the most reasonable explanation is that [petitioner], who pushed and shoved N.C. across the room, without great difficulty, exclusively caused the scratches.

After establishing the appropriate legal standards, the ALJ ultimately concluded that DHS sustained its burden of proving, by a preponderance of the credible evidence, that petitioner's actions rose to the level of abuse, as defined in N.J.A.C. 10:44D-1.2, and that petitioner 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. The judge provided the following rationale for his decision:

> While one can sympathize deeply with [petitioner]'s predicament, which was, as must often be the case, initiated by an irrational developmentally disabled patient who sought to fight with his caregiver, [petitioner]'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. 30:60-74. See also N.J.A.C. 10:440-1.2. As [petitioner] 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, [petitioner] 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 [petitioner] 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 [petitioner] before, his behavior was well known to be or should have been known by [petitioner] 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 [petitioner]. As a caregiver, [petitioner] was charged with having at least the same common[]sense N.C. showed in admitting he initiated the altercation. Straining credibility, [petitioner] 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 judgment and her inappropriate and unnecessary engaging with the aggressor clearly shows [petitioner] 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 [petitioner] on the Central Registry was permitted.

On November 1, 2021, petitioner filed exceptions to the ALJ's initial decision, raising many of the same issues now before this court. Thereafter, on November 29, 2021, DHS issued a final agency decision. At the outset, the decision addressed, and ultimately rejected, each of petitioner's exceptions, finding that they were "wanting." First, DHS addressed petitioner's claim that it was impossible for her to retreat, as was her training, once N.C. grabbed her:

> In claiming that it was impossible for [petitioner] to escape once N.C. had grabbed her, the video evidence is being ignored. The ALJ stated, "As shown in the video, once [petitioner] 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 [petitioner] pushing N.C. to the wall where the entrance/exit door was located." 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[,]" described the video — "when N.C. 'moved toward her and made kicking actions, and at that point, [petitioner] stood up and moved to within an arm's reach, so she actually moved closer to him rather than further away from him.'" There is ample evidence that [petitioner] moved toward N.C. rather than away. Speculating that [petitioner] 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: "[petitioner] 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."

Second, DHS addressed petitioner's contention that Investigator Murphy's testimony and report rested on inadmissible hearsay and, thus, was improperly relied upon by the ALJ:

> The exceptions aver that: "The testimony of [Investigator] Murphy rested on hearsay statements which should not have been relied on by the court." Hearsay is admissible in Administrative Hearings. The [p]etitioner 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." 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 [p]etitioner's exceptions, no finding of fact or conclusion of law is specified as having been affected by a statement known to be impermissible hearsay.

Next, petitioner took issue with the definition of "careless disregard" employed by the ALJ, which DHS disposed of by resort to the regulatory text:

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 [p]etitioner 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.
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> 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,[7] 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 it is not at issue in this case) – to equate to the term "careless disregard." . . .

. . . .

Federal criminal law's use of the term "willful" in federal statutes is not at issue in this Administrative

[7] Safeco Ins. Co. v. Burr, 551 U.S. 47 (2007) and U.S. Murdock, 290 U.S. 389 (1933).

> 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.

Finally, DHS addressed petitioner's contentions that its decision to place petitioner on the Central Registry was akin to victim-blaming and that an expert witness was required to establish the applicable standard of care:

> The exceptions accuse the court of "a blame the victim jurisprudence." [Petitioner] is at bar because she is a caretaker. She has been employed for [sixteen] years to take care of and protect patients in State-run psychiatric hospitals. She has been trained [on] how to protect herself from aggressive patients. The Central Registry statute was passed to protect individuals with developmental disabilities. It was [petitioner]'s failure to adhere to her training, in how to avoid confrontations and escalations of aggressive behaviors of patients, that created the danger to N.C. As a caretaker, [petitioner] 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 [p]etitioner and documentation that it was completed by the [p]etitioner. 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." 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." The investigator was then questioned by the [r]espondent's [Deputy Attorney General]; 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)[,] [t]he ALJ admitted the investigative report into evidence, with the hearsay portions to be given their due weight under the residuum rule.

Based upon a review of the ALJ's initial decision and the OAL file, including the testimony transcripts, post-hearing submissions, documents entered into the record, and petitioner's exceptions, DHS concurred with the ALJ's findings and conclusions. Because "[t]he ALJ had the opportunity to assess the credibility and veracity of the witnesses," DHS chose to "defer to his opinions concerning these matters." Ultimately, DHS affirmed the decisions of the ALJ: (1) that the Agency met its burden of providing sufficiently that petitioner committed an act of physical abuse against an individual with developmental disabilities; and (2) that petitioner acted with careless disregard to the well-being of N.C., causing injury. Therefore, DHS found that petitioner's placement on the Central Registry was appropriate. This appeal followed.

On appeal, petitioner raises the following arguments:

> POINT I
>
> THE FINAL DECISION OF THE ADMINISTRATIVE LAW JUDGE DATED OCTOBER 22, 2021 AND FINAL DECISION OF THE DHS REVIEW PANEL DATED NOVEMBER 29, 2021 READ TOGETHER WERE AGAINST THE WEIGHT OF THE

EVIDENCE AND WERE ARBITRARY, CAPRICIOUS[,] AND UNREASONABLE.

A. Petitioner Did Not Abuse the Patient and She Did Not Act Recklessly or With Careless Disregard.

POINT II

THE INVESTIGATIVE REPORT INTRODUCED INTO EVIDENCE AND TESTIMONY OF MARGARET MURPHY TO THE EXTENT THAT THIS TESTIMONY RELIED ON THE HEARSAY OBSERVATIONS OF THOMAS SHAFFER, DIRECTOR OF STAFF DEVELOPMENT AND TRAINING MUST BE DISALLOWED AS IT IS PURE HEARSAY AND IS INADMISSIBLE.

POINT III

INVESTIGATOR MURPHY WAS A LAY WITNESS AND NOT QUALIFIED TO OFFER AN EXPERT OPINION AS TO A STANDARD OF CARE. LACKING EXPERTISE HER TESTIMONY MUST BE DISREGARDED AND LIMITED TO HER FINDINGS OF FACT.

The principles governing appellate review of administrative agency determinations are well-recognized. In re Stallworth, 208 N.J. 182, 194 (2011). We have a "limited role" in the review of such decisions. Ibid. "In order to reverse an agency's judgment, [we] must find the agency's decision to be 'arbitrary, capricious, or unreasonable, or [ ] not supported by substantial credible evidence in the record as a whole.'" Ibid. (second alteration in original)

(quoting Henry v. Rahway State Prison, 81 N.J. 571, 579-80 (1980)). In determining whether agency action is arbitrary, capricious, or unreasonable, our role is restricted to three inquiries:

> (1) whether the agency's action violates express or implied legislative policies, that is, did the agency follow the law; (2) whether the record contains substantial evidence to support the findings on which the agency based its action; and (3) whether[,] in applying the legislative policies to the facts, the agency clearly erred by reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
>
> [Ibid. (quoting In re Carter, 191 N.J. 474, 482-83 (2007)).]

The burden of establishing that the agency acted in an arbitrary, capricious, or unreasonable manner rests on the party opposing the administrative action. E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 349 (App. Div. 2010) (citing In re Arenas, 385 N.J. Super. 440, 443-44 (App. Div. 2006)). It is not the function of the reviewing court to substitute its own judgment for that of the administrative agency, "even though the court might have reached a different result." Stallworth, 208 N.J. at 194 (quoting Carter, 191 N.J. at 483).

We must also "'defer to an agency's technical expertise, its superior knowledge of its subject matter area, and its fact-finding role,'" and therefore

are "obliged to accept all factual findings that are supported by sufficient credible evidence." Futterman v. Bd. of Review, Dep't of Labor, 421 N.J. Super. 281, 287 (App. Div. 2011) (quoting Messick v. Bd. of Rev., 420 N.J. Super. 321, 325 (App. Div. 2011)). Although we are not bound by an agency's interpretation of law, we accord a degree of deference when the agency interprets a statute or a regulation that falls "within its implementing and enforcing responsibility . . . ." Wnuck v. N.J. Div. of Motor Vehicles, 337 N.J. Super. 52, 56 (App. Div. 2001) (citation omitted). Thus, our authority to intervene is limited to "those rare circumstances in which an agency action is clearly inconsistent with [the agency's] statutory mission or with other State policy." Futterman, 421 N.J. Super. at 287 (alteration in original) (internal quotation marks omitted).

Applying these principles, we discern no basis for disturbing the Agency's well-reasoned determination that petitioner's placement on the Central Registry was appropriate. Our review of the record, including the videotape of the incident, firmly establishes that petitioner physically abused N.C., as defined by N.J.A.C. 10:44D-1.2, despite her training. Moreover, it is clear that DHS employed the correct definition of "careless disregard," i.e., by reference to the accompanying regulations, when considering petitioner's actions. See N.J.A.C. 10:44D-4.1(b)(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."). Finally, contrary to petitioner's arguments, "proceedings before administrative agencies shall not be governed by" the rules of evidence. N.J.R.E. 101(a)(4). With regard to the admission of alleged hearsay, the ALJ—citing the residuum rule—properly concluded that "it's a matter of weight not a matter of admissibility."

To the extent we have not addressed any argument raised by petitioner, we have deemed such arguments lacking sufficient merit to warrant discussion in a written opinion. Rule 2:11-3(e)(1)(E).

Affirmed.