STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. N-12/19-851
	)	
Appeal of	)	
	)	
	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Disabilities, Aging and Independent Living (DAIL or Department) substantiating a report that he physically abused C.W., a disabled adult in his care.

Multiple status conferences were held in this case and petitioner filed pre-trial motions which were ruled on by the hearing officer[1]. A video hearing was held on June 25, 2021. The parties filed post-hearing memoranda on August 20, 2021. The following findings of fact are based on the evidence submitted by the parties at hearing.

[1] Petitioner filed the following pre-hearing motions/memoranda: 2/4/20 Appellant's Motion and Memo for Discovery; 2/7/20 Appellant's Pre-status conference Memorandum including Questions and Discovery Issues; 4/2/20 Appellant's Motion for Discovery Orders; 4/3/20 Appellant's Supplemental Memorandum; 5/7/20 Appellant's Second Supplemental Motion and Memorandum; 11/25/20 Appellant's Motion in Regard to Status Conference on 11/30/20; 1/5/21 Petitioner's Motion to Reverse Substantiation Decision and for Summary Judgment; 1/5/21 Petitioner's Motion in Limine; 3/9/21 Motion to Delay Hearing Date Until Subpoena Issues are Resolved. The Department filed responses dated 5/4/20 and 1/11/21 (response to Summary Judgement Motion and Motion in Limine). The hearing officer's rulings on the pre-hearing motions are incorporated herein.

FINDINGS OF FACT

1. In 2019, petitioner served as a respite care provider for C.W., and one other individual, and would care for C.W. at his (petitioner's) home in Orleans, Vermont. On July 26th, after a verbal exchange between petitioner and C.W., both outside and inside petitioner's house, petitioner placed C.W. in a physical restraint and brought C.W. to the floor. After investigation and a commissioner's review hearing, the Department substantiated petitioner for physical abuse of C.W. based on his failure to follow C.W.'s Behavior Support Plan including his use of a physical restraint. Petitioner appeals.

2. At the time of the underlying incident, C.W. was 38 years old (petitioner estimated that C.W. was between 30-32) and petitioner was age 42 (age 44 at time of hearing). According to petitioner, he is 5 feet 9 inches tall and C.W. is shorter and weighs less than petitioner.

3. C.W. has a traumatic brain injury (TBI), developmental disabilities, and diagnoses of seizure disorder, Attention Deficit Hyperactivity Disorder, Major Depression, and Post Traumatic Stress Disorder, all conditions sustained when he was in a car accident with his father, who was killed, when petitioner was six (6) years

old. It is undisputed that C.W. is a "vulnerable adult" as defined by statute and policy. C.W. receives Developmental Disability Services from Green Mountain Support Services (GMSS) which provides C.W. with housing and services.

4. In 2019, C.W.'s longtime residential placement had ended, and he was living in a transitional home while GMSS looked for another permanent home. GMSS contracted with petitioner to provide a certain number of respite days per week to care for C.W. at petitioner's home. Petitioner had cared for C.W. at his home prior to the incident in July 2019. And petitioner had also previously provided care to C.W. in his capacity as the GMSS crisis house manager when C.W. had been placed at the crisis house.

5. GMSS provides a service coordinator to each client. Part of the service coordinator's job is to have appropriate documentation in place outlining the client's care needs. In order to meet federal requirements (authorizing Medicaid payment) and comply with Department regulations (*Regulations Implementing the Developmental disabilities Act of 1996)* and its Behavior Support Guidelines, each client has an Individual Service Agreement (ISA) and a Shared Support/Behavior Plan (BSP or Behavior Support Plan). When, as here, a client is going to a provider's home for respite

care, the service coordinator creates a packet that includes the Behavior Support Plan, an information sheet regarding medications, a sheet outlining emergency procedures and phone numbers (to include 911, and phone numbers for the service coordinator during the day and an on-call number for nighttime hours), and a "Peggy's Law" disclosure sheet. A "Peggy's Law" disclosure form is a form required by Vermont law that is given to providers caring for individuals served by the Department to ensure that the provider has all the relevant information about the individual and can make an informed decision about whether to agree to provide care. C.W.'s packet containing all this information was provided to petitioner when he provided care to C.W.

6. As required by the Behavior Support Guidelines, C.W.'s Behavior Support Plan was prepared using a team approach. The Behavior Support Plan in use for C.W. at the time of the incident was developed in December 2017 by the service coordinator, C.W.'s prior longtime living provider, his guardian and with input from C.W. The Behavior Support Plan had a stated end date of December 25, 2018. However, as testified to by C.W.'s service coordinator and the GMSS Quality Management Review Team staff person, there is no policy requirement for an annual update, and as such the

Behavior Support Plan remained in effect unless and until a new Behavior Support Plan was drafted. The purpose of the Support Plan is to describe C.W.'s known behaviors and outline the positive Behavior supports that providers should use to address those behaviors. Periodic *Therapeutic Options* trainings are provided by the Department to GMSS providers regarding how to use positive supports from the Behavior Support Plan to address a client's behaviors.

In pertinent part, C.W.'s Behavior Support Plan provides as follows:

> . . .
>
> Due to his developmental delays in combination with the TBI, [C.W.] struggles to understand people, situations and interactions. He also struggles to regulate his emotions on a daily basis. As a result, [C.W.] will at times use a challenging behavior in order to express his feeling, wants and needs. Through the implantation of a behavior support plan the team hopes to intervene with these behaviors. A consistent, positive and supportive approach is required in all settings. The behavior support plan will assist those involved with [C.W.'s] in helping him in developing pro-social skills to be able to handle similar situations in the future.
> . . .
>
> Description of Challenging Behaviors:
>
> (1) Verbal outbursts. . . . [C.W.] becoming argumentative with whomever or whatever he believes has "made" him escalate. He will also be non-compliant with directions and following the expectations that have been communicated to him. . .
> (2) Eloping. . . . [C.W.] leaving the setting he is in and walking down the road. Typically he would also be

making statements about running away and not coming back . . .

. . .
However, as long as those supporting [C.W.] are able to stay calm [C.W.] is usually able to get things off his chest and then he takes some space in order to be alone for a bit and then he can come back to the situation and look at it much more functionally.

. . .

Describe the characteristics/approaches of others this person best responds to:

[C.W.] responds best to those who remain, cool calm and collective despite his increasing escalation. He also does best with those who present as being nonjudgmental and those who are able to actively listen to what he is saying. . . .

Describe what others should do when the person is showing signs of being upset:

Allow [C.W.] some time and space to blow off steam before attempting to discuss issues with him. It is important that those supporting [C.W.] do not get into a power struggle with him. Despite his increasing escalation, it is important for his staff to not take it personally and to remain clam. Cueing [C.W.] to take some space can be helpful in preventing further escalation.

Describe what others should do when the challenging behavior occurs:

When [C.W.] presents with challenging behaviors, those around him should remain calm and non-judgmental. If those around him become dysregulated, then [C.W.'s] behavior will intensify. Those supporting him should speak to him in a cool, calm and collective voice using limited words. They should validate [his] feeling and set the limit by saying something like "[C.W.], I see that your [sic] angry about somethings and I'd like to help you with that but first I need you to calm your

> body and relax. Take some space if you need to I'll wait for you." Once this limit has been set do not engage any further until he has calmed down or taken space. . .

7. In the area of the Behavior Support Plan that addresses "Restrictive Measures," the question "[D]oes support require restraint?" is asked and there are boxes for "yes" and "no" and the "No" box is checked. On the form, its states "[I]f no restraint is required, you can skip page 6 and proceed to page 7." The Plan skips the remainder of page 6. As noted in the Behavior Support Plan, and testified to by C.W.'s service coordinator, the potential that C.W. could "elope" was a known behavior but the service coordinator testified that C.W. has never been stopped from eloping; rather, the strategy has been to allow him freedom and follow him, typically in a car, to ensure his safety. The service coordinator also testified that the use of a physical restraint is not a part of C.W.'s Plan and that is why she reported petitioner's use of a physical restraint to APS.

8. The facts of the incident are largely undisputed. Petitioner's account, taken from his written narrative in the critical incident report, in his oral account to the APS investigator, and at hearing, was largely consistent and was as follows: On July 26, 2019, between 1:30 p.m. and 2:15

p.m., petitioner was caring for C.W. and another male vulnerable adult at his home. The group was sitting outside talking and C.W. told a story about being in World War II. Petitioner told C.W. that it was not possible that he was in World War II because of his age. C.W. told petitioner to call his aunt to confirm his story and petitioner said that he would. C.W. became increasing upset about petitioner not believing his story and got up and said he was going to get his belongings and leave petitioner's house. C.W. then entered the house and went up to the second floor and into his room and began packing his things. Petitioner immediately followed C.W. upstairs and stood in the doorway of C.W.'s room (which was described as small) and tried to tell C.W. that he could not leave because it would not be safe. Petitioner stood in the doorway and continued to talk to C.W. to try to persuade him to stay in the home (where it was air conditioned; C.W. does not like hot temperatures) and calm down. However, C.W. continued to want to leave. While petitioner was standing in the doorway C.W. tried to move past him with his packed belongings and petitioner stated that he "redirected him" to stay in the room. Petitioner continued to try to talk to C.W. but C.W. became more agitated. Petitioner stated that he did not feel that it was

safe for C.W. to carry his duffle bag(s) down the stairs and leave so he stopped him when C.W. tried to get past him. Petitioner reported that C.W. started to "attack him" by scratching and attempting to hit petitioner (two punches that petitioner avoided). Petitioner then "brought him to the floor" in the hallway because the stairway was about six feet away and petitioner did not feel that it was safe for C.W. to go down the stairs; it was about eight feet from petitioner's doorway to the stairs. While holding C.W. on the floor, petitioner's chest was against C.W.'s shoulder and petitioner's arms were wrapped around C.W. Petitioner held C.W. on the floor until petitioner felt C.W. was calm. Petitioner estimated that he held C.W. on the floor for approximately 12-15 minutes.

9. After petitioner let C.W. up, C.W. remained with petitioner for that night, which they spent at petitioner's parents' cottage, and then one additional night at his home. Petitioner argues that after the incident, C.W. was fine with him and they got along for the remainder of that evening and the next day, suggesting that C.W. was not "harmed" by the petitioner's conduct. While it is true that C.W. remained with petitioner for some period after the incident, that was really outside of C.W.'s control. While C.W. may have indeed

calmed down and may have gotten along with petitioner after the incident, C.W. is an individual with significant developmental disabilities who was held on the ground for up to 15 minutes; petitioner's suggestion that C.W. did not suffer trauma because of the restraint is rejected. In total, petitioner's rationale for his responses to C.W.'s behaviors are entirely self-serving and lacks credibility. And petitioner's argument that C.W. was not adversely impacted by the incident conflicts with C.W.'s bruises and his visibly upset demeanor when he later described the incident to the service coordinator and the APS investigator.

10. Petitioner reported his use of the restraint to C.W.'s GMSS service coordinator the day after the incident. The service coordinator testified at hearing that petitioner should have immediately reported the incident rather than waiting until the next day. Petitioner's explanation for that delay was that after the incident, he, C.W., and the other person in his care left his home and went to his parents' cottage, as noted above, and spent the night there. Because there was no landline at his parents' cottage and his cell phone was dead, he therefore called the next day. In any event, the service coordinator took the report from petitioner, had him fill out a critical incident statement,

and then reported the incident to Adult Protective Services (APS). The service coordinator also arranged for C.W. to be picked up from petitioner's house. The service coordinator met with C.W., along with C.W.'s guardian (his aunt), on the afternoon of July 27th or July 28th at C.W.'s doctor's office. At that time, she noted that C.W. had quite a few bruises on his face, arms and knees and that the bruises on his face were quite red. She also noted that he was visibly upset and anxious to tell her about the incident. Photos of the bruises were taken at the doctor's office and were admitted in evidence. Later, C.W. was also interviewed by an Adult Protective Services (APS) investigator about the incident and she noted that C.W. was visibly upset when he described the incident to her. Petitioner does not dispute that C.W. was bruised in multiple places because of his use of the restraint and offered that he had put bacitracin and Band-Aids on C.W. after the incident. However, petitioner also asserts that some of the bruises were pre-existing from a different event on June 2nd that is discussed below.

11. Petitioner has provided care to vulnerable adults for many years. He testified that he has had multiple trainings about providing care to individuals with developmental disabilities. He has also had a training in

how to administer a standing restraint technique. He has never received training on administering a restraint to place someone on the floor.

12. Petitioner asserts that it was appropriate for him to use the physical restraint under the circumstances presented because (1) he was being attacked by C.W., and (2) the Behavior Support Plan did not clearly limit the use of a physical restraint, and (3) the Behavior Support Guidelines and the Peggy's Law form do not prohibit the use of a physical restraint and (4) it was unsafe for C.W. to go down the stairs from 2nd floor given C.W.'s prior problems with balance earlier in June 2019 (explained below, when his medications needed adjustment), and (5) and unsafe for him to leave the property given the physical siting of the house. Petitioner presented a significant number of photos of the inside of his home (to show the proximity of the stairs to C.W.'s room in the upstairs hallway) and the outside of the home. Petitioner argued that outside the home there was a steep embankment on one side of his property, a steep driveway to the road, and there was extensive road construction going on between his road and the town such that it would have been very dangerous, in his opinion, for C.W. to try to walk down the road to town.

13. Petitioner also testified about the high quality of his prior care of C.W. Petitioner offered that on June 2nd, he was called to provide care to C.W. at the crisis house, as he had before, and that C.W. was having significant difficulty walking and keeping his balance, and that C.W. fell a few times and hurt himself, resulting in bruising to his face, hand and body. Petitioner determined that C.W.'s medications were likely causing the problem and he initiated getting petitioner to the hospital to be cared for and have his medication levels corrected. However, there was no evidence introduced that C.W. was having any problems with his balance on July 26th.

14. A member of the Department's Developmental Disabilities Services Division Quality Management Review Team (QMRT staff member) also testified at hearing. He has worked for the Department in the area of developmental disabilities since 1999 in various capacities. Prior to 1999, he worked for an area mental health agency, managed a group home, and worked in an institutional setting as well as being a home provider for seven (7) years for an individual with autism. In summary, the QMRT staff member has extensive experience working in special needs individuals, particularly those with developmental disabilities. His current responsibilities

include providing technical support, including interpretations of policies and regulations for the designated agencies to include GMSS, as well as training for the designated agencies. The Review Team also performs quality review assessment of the designated agencies, to include GMSS. The QMRP staff member had also previously served as the training coordinator for the Department for many years. He testified that the basis for an individual's Behavior Support Plan is to provide a therapeutic approach and that the Department provides Support Plan templates to the designated agencies to provide that direction. All care for an individual is guided by a "positive support strategy" which is a defined approach to responding to a behavior that the individual may have. The positive support strategies are intended to assist the client to regulate their behavior and calm down if they have become agitated. For example, if an individual has become emotional, the positive support strategy would be explained as steps to take and language to use to help the person de-escalate that emotion or behavior. He testified that the Department has Behavior Support Guidelines in place which only support the use of any physical restraint of an individual if the individual is actively unsafe and hurting themselves or others. Further,

he testified that a prone restraint, such as was used in this case, is absolutely prohibited in the Department's Behavior Support Guidelines both because it is traumatizing and because it can result in asphyxiation. Therefore, the Department does not train any providers in the use of a prone physical restraint, instead it provides "Therapeutic Options" trainings to teach positive support strategies.

15. The Department has not disputed petitioner's testimony that he provided competent care to C.W. on many occasions prior to June 26, 2019. However, the evidence also demonstrates that petitioner's actions on the date in question - by continuing to challenge C.W.'s statements about being in World War II, his decision to immediately follow C.W. into the house and up the stairs and stand in the doorway, and continuing to talk to C.W. after he had become upset - were all inconsistent with the "positive Behavior supports" described in the Support Plan, and that those actions appear to have escalated C.W.'s behavior.

16. Once C.W.'s behavior had escalated as described above, petitioner then took the action of using a prone physical restraint on C.W. Based on the preponderance of evidence standard, petitioner's actions listed above, and then including the use of a prone physical restraint that

resulting in him holding petitioner on the ground for 12-15 minutes, were not authorized by C.W.'s Support Plan. The prone restraint was in fact an act prohibited by the Department's Behavior Support Guidelines. Petitioner's actions on June 26th, in their totality, constituted abuse of C.W. because his actions were "conduct committed with . . . reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain, or unnecessary suffering to a vulnerable adult." 33 V.S.A 6902(1)(B). C.W.'s Support Plan provided a clear alternative to continuing to challenge C.W. and placing him in a restraint. Petitioner's argument that he had no other alternative but to physically restrain C.W. to prevent him from leaving because the physical site was not safe is rejected; the team that put together the Support Plan specifically detailed that C.W. should be given space, should not be challenged, and that he should be left alone to cool down. The Plan also recognized that C.W. might leave the premises. Petitioner could have followed him, taking the other client in the car with him (as he did later when he took both individuals to his parents' cottage) and/or called for assistance. Petitioner's approach of challenging C.W. and using a prone physical restraint to stop C.W. was anticipated and rejected by the Behavior Support Plan (which

provided for not challenging C.W., giving him space, and even allowing him to leave the premises). Thus, petitioner's actions were unwarranted and meet the definition of abuse.

ORDER

The Department's decision substantiating petitioner for physical abuse is affirmed.

REASONS

The hearing before the Board is *de novo* and the burden is on DAIL to establish by a preponderance of the evidence that the facts they relied upon occurred and that those facts constitute abuse as set forth in the statute at 33 V.S.A. § 6902.

Legal Framework for Protection of Individuals with Developmental Disabilities

Developmental disabilities services are paid for with federal Medicaid funds pursuant to the *Global Commitment to Health" Medicaid waiver.* ***https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver***. To remain eligible for these funds Vermont must assure the federal government that necessary safeguards have been taken to protect the health and welfare of the beneficiaries to

include as assurance that "adequate standards for all types of providers" are in place. 42 CFR § 441.302 (a)(1). It must further ensure that any home or community-based setting for the individual "ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint (defined as a physical restraint)." 42 CFR § 441.301 (c)(4).

Vermont law establishes that:

> It is the policy of the State of Vermont that each citizen with a developmental disability shall have the following opportunities:
>
> (1) Live in a safe environment with respect and dignity.
>
> . . .

18 V.S.A. § 8721 [Vermont Developmental Disabilities Act].

Vermont law further provides that a person with developmental disabilities receiving services provides by the State has the right to "[B]e free from aversive procedures, devices, and treatments. 18 V.S.A. § 8728(a)(1).

To implement these federal and state statutory requirements, the Department has implemented regulations and guidelines. See Regulations *Implementing the Developmental Disabilities Act of 1996 (Regulations) and Behavior Support Guidelines for Support Workers Paid with Developmental Services Funds* (Behavior Support Guidelines or Guidelines).

The Guidelines outline "positive support strategies and represent a commitment to work continuously to end coercion." Guidelines, p. 5. The Guidelines provide generally that any type of restraint is permitted "only in extraordinary circumstances where personal safety is at risk and where positive behavior support have not yet succeeded." Guidelines, page 13. If it is anticipated that a restraint may be necessary, it would be included in the individual's Behavior Support plan. Id. Further if a restraint is used, it may be done only as follows:

> [o]n a time-limited basis in rare instance for the purpose of protecting the safety of an individual or other; and,
>
> in the presence of documented evidence that less intrusive attempts to address behavior have not yet succeeded; and
>
> when the Procedural Requirements described in Part 2 have been followed; and
>
> when workers who will be using the restraints are trained in their proper use.

BS Guidelines p. 13.

The Guidelines further provide as follows:

> When physical restraint is necessary to prevent serious harm, the minimum amount of force necessary shall be used. Excessive use of physical restraining may be considered abuse. Workers who may be using physical restraints must be trained in:
>
> - Emotional self-regulation (e.g., Strategic Self-Regulation

- Positive behavior supports and de-escalation techniques (E.G. Vermont Safety Awareness Training), and
- The restraint specific to the person (e.g. Safety Mechanics).

Restraints Prohibited

The following types of restraint are prohibited under any circumstances:

- o Restraints in which the individual lies face down;
- o Restraints that have the individual lying on the ground or in a bed with a worker on top of the individual;
- o Restraints that restrict breathing;
- o Restraints that hyper-extend a joint;
- o Restraints that rely on pain for control; and
- o Restraints that rely on a takedown technique in which the individual is not supported and allows for free fall as he or she goes to the floor.

BS Guidelines, pps. 15-16.

As noted by C.W.'s service coordinator, GMSS is required to develop a Behavior Support Plan for each individual based on these Guidelines. *See* Guidelines [Part 2 Procedural Requirements for Behavior Supports]. And, as noted by the QRMT staff member, the Department provides template Behavior Support Plans to the designated agencies to aid in the development of the plans. The purpose of that Behavior Support Plan is to identify known behaviors and inform the

providers how to address those behaviors. Further, the Department provides a periodic Therapeutic Options Training to all GMCS providers on how to apply the Guidelines and the Behavior Support Plans. Petitioner acknowledged that he had received training from the Department, including a training on using a "standing restraint", but acknowledged that he has never received training for performing a prone restraint.

Abuse Standard

DAIL is required by statute to investigate reports of abuse of vulnerable adults 33 V.S.A. 6906(a)(1). If, upon completion of the investigation, a recommendation is made to place a substantiation in the registry, the person substantiated has a right to request a review before the Commissioner of DAIL within fifteen days and thereby stays any placement of their name in the registry. If the Commissioner affirms the decision to place the name in the registry, the affected person may appeal to the Human Services Board within 30 days of that decision and a fair hearing is held pursuant to 3 VSA § 3091(a). 33 V.S.A. § 6906(d).

33 V.S.A. § 6901 *et seq*. protect "vulnerable adults" from abuse, exploitation and neglect. It is undisputed that

C.W. is a "vulnerable adult" as defined in the statute and in DAIL regulations.

DAIL substantiated the petitioner as the caretaker of C.W., finding that his actions met the following definitions of "abuse" found in the statute:

> (1) "Abuse" means:
>
> > (B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain, or unnecessary suffering to a vulnerable adult.
> >
> > . . .

33 V.S.A. § 6902 (1)(B).

While the DAIL statute does not define reckless disregard, the Vermont Supreme Court has noted that:

> reckless disregard is more than negligence – a person acts recklessly if he acts with the knowledge that there is a high risk of physical harm to another but deliberately proceeds to act . . . in conscious disregard of that risk.

Fly Fish Vermont, Inc. v. Chapin Hill Estates, Inc., 2010 Vt 33, ¶ 24 (internal quotations omitted). *See* also Fair Hearing No. 18,698 (A person acts recklessly when he consciously disregards a substantial and unjustifiable risk from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct, and the circumstances known to him, its disregard involves a gross deviation from the standard of

conduct that a law-abiding person would observe in the actor's situation.)

By failing to follow the positive behavioral supports described in the Behavior Support Plan, petitioner's actions were a precipitating factor resulting in C.W.'s escalating behaviors and showed a reckless disregard for what might follow. Petitioner's subsequent act of using a prone physical restraint was also in contradiction of C.W.'s Behavior Support Plan, as well as prohibited by the Behavior Support Guidelines. This evidence establishes that petitioner's conduct was in reckless disregard of the likely risk of causing C.W. physical pain and injury[2]. And, even if the use of a restraint was not addressed in the Behavior Support Plan, petitioner's failure to use de-escalation techniques and subsequent use of a physical restraint were consistent with the definition of abuse. See Fair Hearing No. 18,719 (use by a paid caretaker of a physical restraint and taking adult individual with developmental disabilities to the floor after the individual's use of challenging verbal behavior held to be abuse under 33 V.S.A § 3606); Fair Hearing No. 12,871 (caregiver's use of physical force against

[2] Even absent petitioner's role in escalating C.W.'s distress, holding C.W. in a prone restraint for 12-15 minutes was a drastic measure that was not justified under the circumstances presented.

individuals with developmental disabilities whose well-being he knew required that they not be subject to rough coercive and intimidating handling by their caregivers meets the definition of abuse); Fair Hearing No. 9716 (caregiver's manhandling of client endangered the client's welfare and breached trust and security to which client was entitled); Cf. Fair Hearing No. T-11/17-640 (use of a physical restraint by a therapeutic caregiver in violation of Department for Children and Families' standards for behavior intervention constituted abuse).

While petitioner suggested that C.W. was fine after the incident, C.W.'s service worker expressly countered that testimony in her later observations and conversation with C.W. as did the APS investigator. And the evidence of bruising to C.W. due to the petitioner's use of the restraint was undisputed.

As the Department's decision to substantiate petitioner for abuse is consistent with the relevant statutes and regulations, the decision must be affirmed by the Board. 3 V.S.A. § 3091(d), Fair Hearing Rule 1000.4.D.

# # #