

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH HEARING OFFICE

February 25, 2010

Michael P. Del Sole, Esq.
Del Sole and Del Sole, LLP
46 South Whittlesey Avenue
Wallingford CT 06492

CMRRR# 91 7108 2133 3932 0692 1143

Leslie Scoville, Staff Attorney
Legal Office - MS#12LEG
Department of Public Health
410 Capitol Avenue
P. O. Box 340308
Hartford CT 06134-0308

Via E-Mail: leslie.scoville@ct.gov

RE: Edwin J. Feraco, LCSW

Petition No. 2005-1027-058-007

Dear Attorney Del Sole and Attorney Scoville:

Enclosed please find a copy of the final Memoranda of Decision rendered by Hearing Officer Donna Buntaine Brewer in the above-referenced case.

Respectfully,

Janice E. Wojick, Hearings Liaison
Public Health Hearing Office, MS#13PHO
Tel. (860) 509-7648 FAX (860) 509-7553

c: J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
Michael J. Purcaro, Management Team Leader, Administrative Branch
Lynn Rioux, Paralegal Specialist, Office of the Attorney General
Wendy H. Furniss, Branch Chief, Healthcare Systems
Jennifer Filippone, Section Chief, Practitioner Licensing and Investigations
Matthew Antonetti, Principal Attorney, Legal Office

Phone:



Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134

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**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH HEARING OFFICE**

In Re: Edwin J. Feraco, LCSW
License No. 004144

Petition No. 2005-1027-058-007
February 25, 2010

FINAL MEMORANDUM OF DECISION

On October 28, 2010, a Proposed Memorandum of Decision was issued in this matter pursuant to §4-179 of the Connecticut General Statutes. On November 9, 2009, Edwin Feraco ("respondent"), by his attorney, Michael Del Sole, requested oral argument and filed exceptions to the Proposed Decision. On November 10, 2009, the Commissioner of the Department of Public Health designated the undersigned to hear oral argument, to determine findings of fact and conclusions of law, and to issue a final decision in this matter. On December 17, 2009, the Department filed a brief; and, on December 28, 2009, respondent filed an additional brief. On January 6, 2010, oral argument was heard. Attorney Del Sole represented respondent; attorney Leslie Scoville represented the Department. On January 14, 2010, an order was issued reopening the record for receipt of additional documentation regarding courses completed by respondent. The additional documentation along with an objection by the Department was filed on January 20, 2010, marked for identification as "Joint Exhibit 1," and entered into the record. The record was then closed on January 20, 2010.

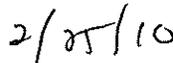
After full consideration of the oral arguments and the complete record, and in accordance with Connecticut General Statutes § 4-180, the undersigned hereby adopts the Proposed Memorandum of Decision issued by Hearing Officer Owens as the Final Memorandum of Decision in this matter, with the following modifications:

1. Page 9 - 10, paragraphs 2 through and including 7 of the Order are hereby deleted.
2. A new paragraph 2 is hereby inserted as follows:
 2. While under the circumstances, an order requiring course work is warranted, in light of the fact that respondent has recently successfully completed the type of course work that would be required, it is not necessary at this time to require any additional course work.
3. Former paragraph 8 is renumbered, paragraph 3; and, former paragraph 9 is renumbered, paragraph 10.

A true copy of the Proposed Memorandum of Decision is attached hereto and incorporated herein by reference as the Final Memorandum of Decision in this matter.



Donna Brewer, Esq.
Hearing Officer



Date

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH HEARING OFFICE**

Edwin J. Feraco, LCSW
License No.: 004144

Petition No.: 2005-1027-058-007
October 28, 2009

PROPOSED MEMORANDUM OF DECISION

Procedural Background

On February 13, 2008, the Department of Public Health (“the Department”) issued a Notice of Hearing (“the Notice”) and a Statement of Charges (“the Charges”) against Edwin J. Feraco, licensed clinical social worker (“respondent”). Rec. Exh. 5. The Charges allege grounds for disciplinary action pursuant to §20-195p of the Connecticut General Statutes (“the Statutes”). In the Notice the Commissioner of the Department appointed the undersigned as Hearing Officer in this matter to preside at the hearing, to rule on all motions, and to recommend findings of fact, conclusions of law, and order. Rec. Exh. 1.

After respondent requested and was granted several continuance the hearing was held on January 7, 13, and 14, 2009 in accordance with Chapter 54 of the Statutes and §19a-9-1, *et seq.* of the Regulations of Connecticut State Agencies (“the Regulations”). Respondent was present and was represented by Attorney Michael Del Sole; Attorney Leslie Scoville represented the Department. Both parties were given the opportunity to present evidence and argument on all issues and to conduct cross-examination.

This Proposed Memorandum of Decision is based entirely on the record and sets forth this Hearing Officer’s recommended findings of fact, conclusions of law and order. To the extent that the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc. v. S & H. Computer Systems, Inc.*, 605 F.Supp. 816 (M.D. Tenn 1985).

Allegations

1. In paragraphs 1 and 5 of the Charges, the Department alleges that respondent is, and has been at all times referenced in the Charges, the holder of Connecticut clinical social worker license number 004144.
2. In paragraphs 2 and 5 of the Charges, the Department alleges that at all relevant times, respondent worked as a clinical social worker in private practice in Mystic, Connecticut.

Count One

3. In paragraph 3 of the Charges, the Department alleges that from approximately March 2003, through June 2004, respondent treated a minor male child, ME. During respondent's treatment of ME, respondent failed to:
 - a. notify ME's mother ("YE") that respondent planned to report YE to the Department of Children and Families ("DCF") for mentally neglecting ME;
 - b. maintain ME's confidentiality when respondent failed to maintain the confidentiality of ME's patient records;
 - c. make adequate arrangements for ME's future treatments before discontinuing his treatment of ME;
 - d. secure YE's consent for release of YE's medical record before accessing YE's medical record; and/or,
 - e. consult with a colleague regarding respondent's disintegrating relationship with YE.

Count Two

4. In paragraph 6 of the Charges, the Department alleges that from approximately June 2005 through August 2005, respondent treated a male patient, GW. From approximately July 2005 through August 2005, respondent sent inappropriate electronic mail ("e-mail") messages to GW.
5. In paragraph 7 of the Charges, the Department alleges that during November 2005, respondent sent facsimiles to GW's employer inappropriately stating that GW was abusing narcotics, was a pedophile, and/or had severe psychiatric issues.
6. In paragraphs 4 and 8 of the Charges, the Department alleges that the above-described facts constitute grounds for disciplinary action pursuant §20-195p of the Statutes.

Findings of Fact

1. Respondent is, and has been at all times referenced in the Charges, the holder of Connecticut clinical social worker license number 004144. Rec. Exh. 2, 4.
2. At all times relevant to the Charges, respondent worked as a licensed clinical social worker in private practice at the Psychiatric Medicine Center, P.C ("PMC") in Mystic, Connecticut as an independent contractor. Tr. 1/14/09, p. 4-9; Dept Exh. 1, pp. 72, 73.

Count One

3. PMC is owned by Dr. Henry Crabbe, M.D., who is licensed as a physician and surgeon in the State of Connecticut. Dr. Crabbe is a Board certified psychiatrist who is also a psychopharmacologist. Dr. Crabbe sees patients during their medication visits and refers them to the independent contractors of PMC for their counseling and psychotherapy needs. Dr. Crabbe provided treatment to ME, a minor male, and YE, ME's mother. Tr. 1/14/09, p. 4, 5, 9, 10.
4. From approximately March 2003 through June 2004, respondent treated ME. Dept. Exh. 1.

5. On May 22, 2004, respondent, Dr. Crabbe, Dr. Arlene Dumais (YE's therapist) and YE met to discuss and devise a plan to address issues with YE and ME. During such meeting, YE was instructed to contact DCF's voluntary services, and was told that if she failed to do so, respondent would report YE to DCF for mentally neglecting ME. Dept. Exh. 1, pp. 11, 12, 34, 50-51 (protective order); Resp. Exh. B; Tr. 1/14/09, p. 19.
6. From March 2003 through June 2004, ME's patient records were kept in a locked file cabinet at PMC in a locked room with other medical records. There was no public access to the room; only administrative staff of PMC had access to the locked room with the medical files. When a patient was scheduled for an appointment, PMC's practice was for administrative staff to put the patient's file in the clinician's mailbox in a locked room. However, respondent's practice was to have patient files personally handed to him. Tr. 1/14/09, pp. 25, 26, 56-66, 72-74; Resp. Exh. B.
7. The evidence is insufficient to establish that respondent violated the standard of care by failing to ensure the confidentiality of ME's patient records. Tr. 1/14/09, pp. 25, 26, 56-66, 72-74; Resp. Exh. B.
8. On numerous occasions between May and June 11, 2004, Dr. Crabbe and respondent discussed the disintegration of respondent's relationship with YE and how respondent could address it. Dept. Exh. 1, pp. 50 (protective order), 72, 112, 72, 73; Tr., 1/7/2009, pp. 140-142; Tr., 1/14/09, pp. 17-23, 37, 38.
9. On June 11, 2004, YE terminated respondent as ME's social worker. Dept. Exh. 1, pp. 2, 11, 12, 33, 72; Resp. Exh. B.
10. After being terminated from providing care to ME, respondent called YE, and on June 15, 2004, respondent wrote to YE, and suggested that she contact United Family Services in Norwich and the City of Norwich for possible referrals. In June 2008, respondent also made arrangements in agreement with Dr. Crabbe, to refer ME to Gary Fox, LCSW, who is also an independent contractor with PMC. ME has been a patient of Mr. Fox's since August 2004. Dept. Exh. 1, pp. 11, 33, 12; Tr. 1/14/09, pp. 67, 68, 72; Resp. Exhs. B, E.
11. There is insufficient evidence to establish that respondent failed to satisfy the standard of care for discharging ME from his care. Dept. Exh. 1, pp. 11, 33, 12; Tr. 1/14/09, pp. 67, 68, 72; Resp. Exhs. B, E.
12. There is insufficient evidence to establish that respondent failed to secure YE's consent for release of YE's medical record before accessing YE's medical record. Dept. Exh. 1, p. 50 (protective order); Resp. Exh. B; Tr. 1/7/09, pp. 134.

Count Two

13. From approximately June 2005, through August 2005, respondent treated a male patient, GW. Dept. Exh. 3; Resp. Exh. A; Tr. 1/13/09, pp. 54-57.

14. From approximately July 2005 through August 2005, respondent sent inappropriate e-mail messages to GW. Dept. Exh. 1, pp. 104, 116; Dept. Exh. 3, pp. 4-6, 16-29, 62; Tr. 1/13/09, pp.35-43, 69-85, 91-114, 116-123.
15. There is insufficient evidence to establish that during November 2005, respondent sent facsimiles to GW's employer stating that GW was abusing narcotics, was a pedophile, and/or had severe psychiatric issues. Dept. Exh. 3; Tr. 1/13/09, pp. 27, 46-51, 53, 59-67, 89, 90.

Conclusions of Law and Discussion

Section 20-195p of the Statutes provides in pertinent part that:

The commissioner may take any action set forth in section 19a-17 if the license holder fails to conform to the accepted standards of the social work profession, including, but not limited to the following: . . . negligent, incompetent or wrongful conduct in professional activities

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Goldstar Medical Services, Inc., et al. v. Department of Social Services*, 288 Conn. 790 (2008); *Swiller v. Comm'r of Public Health and Addiction Services*, CV-95-0705601, Superior Court, J.D. Hartford/New Britain at Hartford, October 10, 1995; *Steadman v. SEC*, 450 U.S. 91, 101 S. Ct. 999, *reh'g den.*, 451 U.S. 933 (1981).

Respondent admits the allegations contained in paragraphs 1, 2, and 5 of the Charges, that at all relevant times he held CT license number 004144 as a clinical social worker and worked as such in a private practice in Mystic, Connecticut.

Count One

With respect to paragraph 3a of the Charges, the Department did not meet its burden of proof that respondent failed to notify ME's mother, YE, that respondent planned to report YE to DCF for mentally neglecting ME. In YE's complaint to the Department, YE stated that respondent "continuously threaten[ed] to call DCF" for several months, and "gave [her] programs to call through DCF." Respondent denies that he "threatened" to call DCF, but instead claims that he "advised" YE that he would contact DCF if she failed to follow his recommendations. Regardless of whether the conveyance of such information can be characterized as a "threat" or as "advice," the evidence is insufficient to establish that YE lacked notice that respondent planned to call DCF, as alleged.

With respect to paragraph 3b of the Charges, the Department did not meet its burden of proof that respondent failed to maintain the confidentiality of ME's records. The Department

bases this claim solely on an assertion respondent made during the investigation. Specifically, when accused of accessing medical records without authorization, respondent replied that Ms. Dumais illegally accessed notes *he* created concerning ME. The Department argues that if Ms. Dumais accessed such patient records without a release, as respondent claimed, then respondent failed to protect the confidentiality of ME's records.

In his Answer, respondent denies the allegation. The only other relevant evidence was testimony by Dr. Crabbe that PMC engages a "double lock system" for the retention of patient records. Patient records are maintained in locked file cabinets inside a locked room. Clinicians, such as respondent, have a key to the room, not to the file cabinets. Barbara Coffey, PMC's Office Manager, credibly testified that although PMC's administrative staff pulls patient files on the day of a patient's appointment and places the file in the clinician's mailbox inside the locked room, respondent "was most inclined to have hand-to-hand passage of files." Respondent exercised more stringent measures to maintain the confidentiality of his patients' records, and the Department lacked any evidence other than respondent's unsubstantiated statement to establish respondent's breach of ME's confidentiality. For example, the Department did not call Dr. Dumais to testify. Based on the foregoing, the evidence is insufficient to establish this claim.

With respect to paragraph 3c of the Charges, the evidence is insufficient to establish that respondent violated the standard of care by failing to make adequate arrangements for ME's future treatments before discontinuing his treatment of ME.

To establish the standard of care, the Department proffered testimony from expert witness, Barbara Pine, PhD, MSW. Citing the Code of Ethics of the National Association for Social Workers ("the Code"), Dr. Pine testified that the standard of care requires that social workers ensure the "transfer, referral, or continuation of services in relation to the clients' needs and preferences." She also stated that social workers are required to ensure that patients have a "smooth transition for continuous treatment." The Code, however, does not reference a "smooth" transition. Dr. Pine also stated that the Code does not anticipate the breakdown of a relationship between patient and social worker such as occurred in this instance.

While expressly applicable to civil actions to recover damages,¹ the Connecticut statutory definition for the "standard of care" is also helpful to review. This definition is found in §52-

¹ Damages, of course, are not an element of proof in proving violations of professional standards of care in licensing matters. See Lawendy v. Connecticut Board of Veterinary Medicine, et al., 2008 WL 2697136 (App. Ct. 2008).

184c of the Statutes which provides that the prevailing standard of care for a health care provider is:

. . . that level of care, skill and treatment which, *in light of all relevant surrounding circumstances*, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Emphasis added.

Given the breakdown in the relationship between YE and respondent, respondent acted in accordance with the standard of care. While ME's transition may not have been entirely "smooth," respondent did effectuate a "transfer, referral, or continuation of services in relation to the clients' needs and preferences" as required by the Code, and did so as well as possible "in light of all relevant surrounding circumstances" by calling YE after her dismissal, writing a follow-up letter to YE on June 15, 2004, four days after YE terminated his services, advising YE of several programs in the area for ME's continued treatment; and, with the assistance of Dr. Crabbe and Ms. Coffey, successfully referring ME to Mr. Fox for continued treatment. The standard of care is always dependent on the surrounding circumstances, which in this case were less than ideal. Thus, the Department failed to sustain its burden of proof that respondent failed to satisfy the standard of care in this instance.

With respect to paragraph 3d of the Charges, the Department did not meet its burden of proof that respondent failed to secure YE's consent for release of YE's medical record before accessing YE's medical record. In essence, the Department alleges that respondent accessed records created by Dr. DuMais concerning YE and maintained by respondent's practice group, without first securing a release from YE.

In attempting to prove this allegation, the Department relied exclusively on an anonymous report made to DCF on June 16, 2006, describing specific incidents that had occurred involving YE and respondent, and YE's diagnosis. It is the Department's claim that respondent made this report and had to have accessed YE's record to have done so. This anonymous report, standing alone, even if made by respondent, is insufficient to establish that respondent improperly accessed YE's records. As for the specific incidents that were described in the report, respondent would not have needed YE's records to describe those incidents since those incidents also involved respondent. As for YE's diagnosis, there is no evidence establishing that the reported diagnosis is, in fact, the diagnosis contained in YE's records, and as

stated by Dr. Madden, respondent's expert witness, respondent could have arrived at the diagnosis independently, without access to YE's record.

Additionally, respondent presented evidence of PMC's process for clinicians to access patient medical records. Ms. Coffey testified that she assists clinicians in securing consent and obtaining such records, and that respondent never requested YE's medical records. Ms. Coffey further testified that Dr. Dumais, who was YE's therapist, personally retained YE's medical records in her possession at all times when they were not locked in the locked file cabinet in the locked records room. As such, respondent had little to no opportunity to obtain YE's medical records without Ms. Coffey's or Ms. Dumais' knowledge.

With respect to paragraph 3e of the Charges, the evidence is insufficient to establish that respondent failed to consult with a colleague regarding respondent's disintegrating relationship with YE. The Department presented evidence that in accordance with Section 2.05(a) of the Code, "[s]ocial workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients." Dr. Pine testified, that a social worker is obligated to consult other professionals for expertise the social worker lacks. Dr. Crabbe credibly testified that respondent consulted with him on numerous occasions regarding respondent's disintegrating relationship with YE, and that he assisted respondent in finding a new clinician to continue ME's treatment. Consistent with his testimony, Dr. Crabbe's written statement to the Department detailed his discussions with respondent and issues they addressed such as: how "transference and countertransference elements thwart the therapeutic process;" reinforcement of patient-therapist boundaries; issues of confidentiality; treatment termination; and, transitioning. Dr. Crabbe provided respondent with academic references and guided him on how to formally terminate the relationship sufficient to satisfy the standard of care for social workers. Based on the foregoing, the Department failed to sustain its burden of proof regarding this allegation.

Count Two

With respect to paragraph 6 of the Charges, the Department sustained its burden of proof that from June through August 2005, respondent treated GW and sent inappropriate electronic mail messages to GW. To establish the standard of care, the Department presented portions of the Code and the testimony of its expert, Dr. Annette Bailey, PhD, MSW. In proving respondent's alleged violation of the standard, the Department presented the testimony of GW

and numerous copies of e-mail correspondence between respondent and GW regarding a billing dispute.

Pursuant to the Code, social workers are required to “respect the inherent dignity and worth of their clients” and “to accept responsibility ... on the basis of existing competence.” As testified by Dr. Bailey the e-mail communications from respondent reflected “strong,” “manipulative” and “abusive” language that “did not take into consideration diagnostic issues with respect to [the] client.” Dr. Bailey further testified that the belittling and inflammatory comments in the e-mails from respondent to GW demonstrate respondent’s lack of competence in communicating with his clients.

In his Answer, respondent denied the allegation; and, during the hearing, respondent questioned the authenticity of the e-mail communications by highlighting the differences in font, headings and structure of the copied product. However, respondent was not present to testify and deny the veracity of the document, and failed to offer any evidence or expert testimony to discredit the validity of the documents. Moreover, GW provided direct testimony that he received the emails from respondent. Based on the foregoing, the allegation is proven by a preponderance of the evidence.

As a clinical social worker, respondent was entrusted with GW’s confidential information and diagnoses. Respondent was privy to GW’s personal fears and concerns, and was expected to help GW deal with or overcome them. Instead, respondent exploited GW’s vulnerabilities and preyed upon GW’s diagnostic weaknesses through hostile e-mail communications to GW. The very information respondent acquired through his counseling of GW, he used against GW for the purpose of bill collection. Respondent failed to treat GW with respect and remain sensitive to GW’s condition-- a basic tenet of social work. Respondent’s e-mail communications to GW were unconscionable, and constitute wrongful conduct in violation of the Code and §20-195p of the Statutes.

With respect to paragraph 7 of the Charges, the Department did not meet its burden of proof that respondent sent facsimiles to GW’s employer stating that GW was abusing narcotics, was a pedophile, and/or had severe psychiatric issues. In his Answer, respondent denies sending the facsimiles in question. The Department submitted copies of facsimiles provided to the Department by GW, but failed to prove that the facsimiles were sent by respondent, or even received by any employer. While GW testified that his employer received the facsimiles, such

testimony is hearsay and insufficient to support a finding of fact in the absence of any direct evidence. Moreover, GW did not even state that respondent sent the facsimiles; he merely stated that he “believed” or “[had] a bad feeling” they were from respondent. This evidence falls short of establishing the Department’s claim by a preponderance of the evidence.

Order

Based on the record in this case, the above findings of fact and conclusions of law, and pursuant to §§19a-17 and 20-195p of the Statutes, this Hearing Officer respectfully recommends the following to the Commissioner in the case of Edwin Feraco, LCSW, who holds clinical social worker license number 004144:

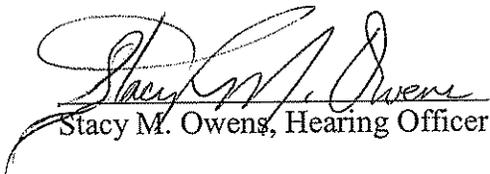
1. Respondent’s license number 004144 to practice as a clinical social worker in the State of Connecticut is hereby reprimanded.
2. Respondent’s license shall be placed on probation for six months under the following terms and conditions:
 - a. During the probationary period, respondent shall attend and successfully complete a course in boundary issues. Such courses shall be pre-approved by the Department. Within thirty (30) days of the completion of such coursework, and prior to the termination of the probation, respondent shall provide the Department with proof, to the Department’s satisfaction, of the successful completion of such course(s).
 - b. During the probationary period, respondent shall attend and successfully complete a course in anger management, pre-approved by the Department. Within thirty (30) days of the completion of such coursework, and prior to the termination of the probation, respondent shall provide the Department with proof, to the Department’s satisfaction, of the successful completion of such course(s).
3. Respondent shall be responsible for all costs associated with the satisfaction of the terms of this Memorandum of Decision.

4. All correspondence should be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

Ms. Pinkerton may also be contacted at (860) 509-7400 and at the following e-mail address: bonnie.pinkerton@ct.gov.

5. In the event respondent is not employed as licensed clinical social worker for periods of thirty consecutive days or longer, or is employed as a social worker for less than twenty hours per week in the State of Connecticut, or is employed as a licensed clinical social worker outside the State of Connecticut, respondent shall notify the Department in writing. Such periods of time shall not be counted in reducing the probationary period covered by this Decision.
6. Failure to comply with any term of this Order may result in further disciplinary action up to and including a revocation.
7. Legal notice shall be sufficient if sent to respondent's last known address of record reported to the Office of Practitioner Licensing and Certification of the Healthcare Systems Branch of the Department.
8. This document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.
9. This Order shall become effective upon signature.


Stacy M. Owens, Hearing Officer

10/28/09
Date

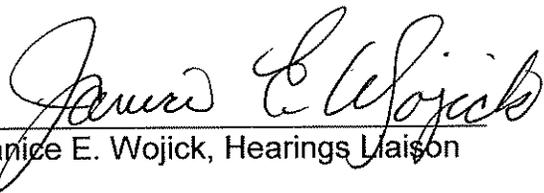
CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes Section 4-180(c), a copy of the foregoing final Memorandum of Decision was sent this 25th day of February 2010, certified mail return receipt requested to:

Michael P. Del Sole, Esq,
Del Sole and Del Sole, LLP
46 South Whittlesey Avenue
Wallingford CT 06492

and by E- Mail to:

matthew.antonetti@ct.gov
Matthew Antonetti, Principal Attorney
Legal Office, MS#12LEG
Department of Public Health
410 Capitol Avenue
P. O. Box 340308
Hartford CT 061343-0308


Janice E. Wojick, Hearings Liaison