STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**FINAL DETERMINATION AFTER HEARING** **ADJUDICATION CASE** [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, , Esq.

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The Subject, [redacted], has not been shown by a preponderance of the evidence to have committed abuse and/or neglect as contained in the substantiated report [redacted]: dated [redacted].

NOW THEREFORE IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
November 21, 2014

David Molik
Administrative Hearings Unit

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**RECOMMENDED DECISION AFTER HEARING** **ADJUDICATION CASE** [redacted]

Before: Gerrard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
Syracuse, New York13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

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By: Juliane O'Brien, , Esq.

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for failing to report a reportable incident. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report [redacted], received on [redacted] of neglect by the Subject, for his delay in reporting, a reportable incident.

2. The initial report alleges, in pertinent part, that from on or about [redacted] committed an act of abuse and/or neglect when he, while acting as a custodian at the [redacted] located at [redacted], delayed reporting a reportable incident. The alleged reportable incident was that an [redacted] employee grabbed a service recipient by the arms and dragged the service recipient across the floor to the service recipient's bedroom. (Justice Center Exhibit 1)

3. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center").

4. On or about [redacted], the Justice Center substantiated the report against the Subject for *neglect*. The Justice Center concluded that:

> From on or about [redacted], while

> acting as a custodian, [redacted] you committed abuse and/or neglect when you delayed reporting a reportable incident, in that on [redacted] you were a mandated reporter, and you claimed to have observed another custodian grab both of a service recipient's arms, while the service recipient was seated on the floor, and drag the service recipient across the floor to her bedroom, and you failed to report this alleged abuse and/or neglect until [redacted]
>
> These allegations of abuse and/or neglect (failing to timely report a reportable incident) have been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

5. An Administrative Review was conducted and as a result, the substantiated report was retained.

6. At the time of the alleged abuse and/or neglect, the Subject was employed by [redacted] and was assigned to an [redacted] operated [redacted], located at [redacted]. The allegedly abused and /or neglected service recipient, [redacted]., is a resident of the [redacted] [redacted] is a person who is non-verbal and suffers from a significant impairment of her intellectual functioning. The Subject was employed as a [redacted] and was employed by an *agency* or *provider* that is subject to the jurisdiction of the Justice Center. The Subject was a mandated reporter of abuse and /or neglect.

7. At the time of the report, [redacted] had been employed by [redacted] for approximately three years on a permanent basis. [redacted] the Subject experienced difficulty maintaining a healthy work relationship which his [redacted] colleagues. The Subject began to arrive at the [redacted] as much as two hours before the scheduled start of his shift. The Subject would also "watch what other [staff] were doing" and "… act[ed] like a supervisor." At times, the Subject would just talk on his phone, as he observed staff. The Subject was counseled by his supervisor

regarding this behavior. (Justice Center Exhibit 21)

8. On about [redacted] the Subject reported to his supervisor, [redacted], that on or about [redacted], while working at an [redacted] located at [redacted], he had witnessed abuse or neglect perpetrated by a co-employee against a service recipient. (Justice Center Exhibit 14) However in [redacted], the Subject failed to immediately report this allegation to the Justice Center and only disclosed this allegation in [redacted], when his job performance was the subject of scrutiny.[1]

9. Following the disclosure of [redacted], and continuing for the next 18 days, the Subject did not work any shift at [redacted].[2]

10. On [redacted], the Subject returned to work at [redacted]. The Subject was assigned an overnight shift at a different [redacted],[3] located at [redacted]. Also working with the Subject during the overnight was [redacted] staff [redacted]. The service recipient [redacted] was a resident of [redacted] and she required hourly bed checks during the overnight of [redacted]. (Justice Center Exhibit 6)

11. During the overnight shift of [redacted] the Subject failed to perform his assigned duties, failed to assist staff [redacted] and mostly slept in a chair. (Justice Center Exhibit 19: recorded interview with [redacted]) The Subject was under the influence of both

[1] The failure of the Subject to report the [redacted] incident did not result in a Substantiated report against the Subject and was not the basis of the underlying conduct upon which this Substantiated report and hearing was adjudicated.

[2] The Subject failed to appear for work as scheduled on [redacted]. When his supervisor requested an explanation, the Subject indicated that he had a "medical emergency." The Subject then utilized several more days of accumulated leave time. (Justice Center Exhibit 27 & 28) However, at the hearing the Subject testified that he had, for some time previous to [redacted], been scheduled to use several days of his accrued leave. At the hearing, the Subject testified that he never claimed a "medical emergency."

[3] While the internal [redacted] and Justice Center investigation of the "[redacted]" were ongoing, the Subject was reassigned to [redacted]. This transfer was undertaken to avoid contact between the Subject and the alleged abusive/neglectful co-employee. (Justice Center Exhibit 7 and hearing testimony of Justice Center investigator [redacted])

antidepressants and pain killer medicine on the evening of [redacted]. (Hearing Testimony of Subject)

12. A third employee, [redacted] began her shift on the morning of [redacted]. Sometime after 7 a.m., the service recipient grabbed the leg of staff [redacted] who then called for assistance from other staff. The Subject failed to act, remained seated and continued sleeping in the chair. Staff [redacted] responded and assisted [redacted] (Justice Center Exhibits 19 & 20)

13. Later during the morning of [redacted], staff [redacted] verbally reported to her supervisor that the Subject refused to assist her on the evening of [redacted], failed to perform any of his assigned duties and mostly slept through the night in a chair in the living room. (Justice Center Exhibit 19: recorded interview with [redacted] and Justice Center Exhibit 32)

14. On or about the evening of [redacted] was contacted by his supervisor and told that he could not return to work at the [redacted]. He was subsequently informed that he was re-assigned to perform administrative functions in the central office. (Justice Center Exhibit 9)

15. The Subject was scheduled to meet with his HR department on [redacted] The meeting was called by HR to address the Subject's failure to appear at work on [redacted] and his "sleeping" on the overnight of [redacted], as well as other issues related to the Subject's job performance. The Subject failed to appear at this meeting (Justice Center Exhibit 30)

16. On or about [redacted] the Subject appeared at work and stated that he was unable to remain at work due to a "personal emergency". On [redacted] the

Subject failed to report to work as scheduled. On or about [redacted] the Subject received written correspondence from HR which documented the latest issues with his work performance. (Justice Center Exhibit 31)

17. Thereafter, on [redacted] reduced her allegations regarding the Subject's behavior during the overnight of [redacted], to a written statement. This written statement was produced by [redacted] at the request of [redacted] or HR. (Justice Center Exhibits 15 and 16)

18. The following day, on or about [redacted] disclosed for the first time, the allegation of abuse against [redacted] to [redacted] Human Resources. The Subject alleged that on or [redacted], at about 7:00 p.m., he observed staff [redacted] forcibly pull service recipient [redacted] by her two arms across the floor, from where she had been lying in the dining room, to [redacted] bedroom. (Justice Center Exhibits 5 & 6) On this date, the Subject also reported the same allegation to the VPCR.

19. The allegation against [redacted] was subsequently investigated by the Justice Center and was not substantiated. (Justice Center Exhibit 6)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

    (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

    (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability

who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading

a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the

category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws,

regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of evidence that the Subject committed the abuse and/or neglect alleged in the substantiated report.

In support of its indicated findings, the Justice Center presented a number of documents obtained during the course of investigation. (Justice Center Exhibits 1-35)

The investigator interviewed the subject, [redacted], staff [redacted] the [redacted] Nurse Manager, the [redacted] Behavior Specialist, [redacted], the [redacted], the [redacted] and the service recipient, [redacted] He obtained the written statements of the subject, staff [redacted], staff [redacted] and of [redacted].

The Subject's direct hearing testimony

At the hearing the Subject testified that the incident or incidents of [redacted], centered on verbal battering of elderly service recipients and the failure to clean the private parts of a service recipient.[4] The Subject testified that he failed to timely report these incidents to the Justice Center because his training on reporting was incomplete and consisted of written materials which were not made available to him in Spanish.[5] However, the Subject testified that he reported the "[redacted]" to his supervisor in [redacted]. Sometime in [redacted] provided the Subject with the VPCR phone number after he inquired about the outcome of the internal investigation regarding the allegations of [redacted] claimed that this was the first time she had heard of such incident. The Subject's supervisor [redacted] also claimed to have never been advised of this issue before [redacted]. (Justice Center Exhibit 12)

With regard to the alleged incident of [redacted] which is the basis of this substantiated report, the Subject testified that he was fearful to report the incident because the "[redacted]" had not been properly investigated[6], and that he had been isolated from his co-workers by the administration. The Subject testified that he was afraid of losing his job and that every administrator at [redacted] was out to "distort" his work and had a goal of getting him "out of [redacted] which they did."

[4] See footnote 1.
[5] The Subject is primarily Spanish speaking and had the aid of an interpreter at the hearing. The Subject did not report this alleged verbal abuse to the VPCR until [redacted]. The Justice Center did not substantiate the subject for his failure to report the incident(s) of [redacted]. However, there was evidence in the record that the Subject was re-trained by [redacted] in his obligation to report to the VPCR, after this issue in [redacted].
[6] The Subject testified that investigators from the Justice Center did speak with him regarding the [redacted] allegation but that it was his belief that they did not speak with any of his "witnesses."

The Subject testified that he never saw the service recipient wrap her arms around the leg of staff [redacted] at any time during his shift. The Subject also denied sleeping during the overnight. In fact, the Subject testified that he organized the basement on the evening of the [redacted] and had even cleaned the bathrooms. The Subject also claimed that he engaged in 15 minute bed checks throughout the evening and that the following morning he completed paperwork and prepared breakfast for the residents.

Cross-Examination of the Subject

During skillful cross examination the Justice Center attorney solicited testimony from the Subject that on the day following his report to the Human Resources department and the VPCR of the "[redacted]", the Subject failed to report to work and continued to be absent from work for 18 days. The Subject testified that this period of absence was a scheduled vacation, but the Justice Center established that the Subject simply failed to appear at work. Documentary evidence supports the conclusion that when the Subject's supervisor inquired of the Subject, the Subject told the supervisor that he had a medical emergency and had been hospitalized. (Justice Center Exhibit 12) However, at the hearing the Subject denied this conversation, and maintained that he was absent due to a scheduled use of his accumulated leave time. The Justice Center produced documents generated by [redacted] indicating that the Subject failed to report to work on [redacted]. The next date which the Subject reported for work was [redacted]. This was the evening of the alleged event underlying this report.

The Subject further admitted under cross examination that he had told a Justice Center investigator he was taking pain killers on the date in question. The Subject also testified that he had completed the "chore" documentation sheet after cleaning the basement on the evening of [redacted]. However, on cross-examination when he was presented with a document

purporting to be the "chore" documentation sheet for the evening of [redacted], the Subject acknowledged that his hand writing was not on the "chore" log. The Subject provided no other testimony or explanation on this issue. It is clear that the Subject did not document the completion of his "chores" on the relevant evening. (Justice Center Exhibit 22)

In this case the Subject argues that the multiple hearsay statements in the record should be afforded no weight. Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances Gray v. Adduci, 73 N.Y.2d 741 (1988), 300 Gramatan Avenue Associates v. State Division of Human Rights, 45 N.Y.2d 176 (1978), Eagle v. Patterson, 57 N.Y.2d 831 (1982), People ex rel Vega v. Smith, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross- examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it would depend upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

It well established that hearsay evidence cannot prevail against a witness's sworn and not inherently incredible testimony. *Matter of Perry* 37 AD2d 367 (3rd Dept. 1971). E.g., *In the Matter of the Claim of Lucy Lopez v. the Commissioner of Labo*r. Slip Opinion 514794 (3rd Dept. January 17, 2013). However, the hearing testimony of the Subject was inherently incredible and there is virtually no corroboration for any of the Subject's assertions in the record. On cross-examination, the Subject was thoroughly discredited.

Additionally, after investigation, the Justice Center did not substantiate the allegation against [redacted] staff [redacted] There is overwhelming evidence in the record that the Subject was failing to meet expectations at work, was behaving oddly and twice reported "incidents" of abuse and or/neglect, only after his job performance was scrutinized. The Subject wrote a letter to the Justice Center entitled "Request to Correct Factual Report." (Justice Center Exhibit 3) This letter is best described as a rambling and labile narrative offered by the Subject to support his belief that he is being persecuted by the [redacted] administration.

Whatever the Subject's motivation for falsely reporting the allegation, it is clear that the alleged abuse or neglect did not occur. It should be noted that the Justice Center investigator recommended that the report should be substantiated against the Subject not only under the theory that the Subject failed to immediately report a reportable incident, but also under the separate and distinct theory that the Subject engaged in "Obstruction: False Report-Intent to Mislead… [The] Service provider [redacted] made a false report to the Justice Center." (Justice Center Exhibit 6. p 3) The conduct which the Subject engaged in was twofold, first the Subject falsely reporting an incident to the VPCR and then he provided a false written statement to the investigator. (See Justice Center Exhibit 9, written statement of the Subject) The statute does not specifically address the situation where a party falsely reports an incident to the VPCR; however the statute clearly contemplates the act of "intentionally making a false statement or intentionally withholding material information during an investigation into such a report," SSL § 488 4 (1) (f). Hence it would appear that the Justice Center could have established this report by a preponderance of the evidence based upon the conclusion that the Subject provided a false written statement to the Justice Center investigator.

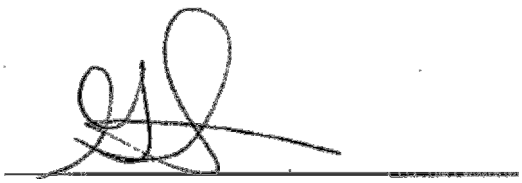
However, despite the investigator's recommendations, ultimately the Justice Center substantiated this report based on the *singular* legal theory that the Subject, a custodian and mandated reporter failed to report a reportable incident upon discovery. (See Justice Center Exhibit 1) The overwhelming proof in the record leads to the conclusion that a reportable incident did not occur on the overnight of [redacted].

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse and/or neglect alleged. The substantiated report will be amended or sealed.

DECISION: The request of [redacted] that the substantiated report [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed the abuse and/or neglect.

This decision is recommended by Gerard Serlin, Administrative Hearings Bureau.

DATED: October 16, 2014
Schenectady, New York



Gerard D. Serlin, ALJ