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

Adjud. Case #: [redacted]

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

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

[redacted]

By: Erin N. Parker, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

[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 request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, as a Category 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

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: March 8, 2016
Schenectady, New York

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** **Adjud. Case #:** [redacted]

Before: Jean T. Carney
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and neglect. 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 and Part 700 of 14 NYCRR.

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 dated [redacted] of abuse and neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 2[1]

> It was alleged that on [redacted], at [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) and/or physical abuse when you used physical force against a service recipient that was excessive and/or unjustified.
>
> These allegations have been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) and Category 2 physical abuse pursuant to Social Services Law § 493(4)(b).

Allegation 3

> It was alleged that on [redacted], at [redacted], located at [redacted], while acting as a custodian, you committed neglect when you limited a service recipient's movement arbitrarily, left the sally port's control area to verbally and physically confront her and physically restrained her.

[1] Allegation 1 was unsubstantiated.

[redacted]

These allegations have been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. The facility, located at [redacted], is a psychiatric center treating individuals on both an inpatient and outpatient basis, and is operated by Office of Mental Health (OMH), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and neglect, the Subject was employed by OMH as a Security and Safety Officer I and had been employed in that capacity since [redacted] 2001. (Justice Center Exhibit 29, Hearing testimony of Subject)

6. At the time of the alleged abuse and neglect, the Service Recipient had been receiving outpatient services [redacted] since July 2013. The Service Recipient is an adult female with a diagnosis of schizophrenia. (ALJ Exhibit 1)

7. The [redacted] is located in Building [redacted] of the facility. Service recipients can come and go as they please, but ingress and egress is secured and controlled by a sally port which consists of two sets of locked doors, with a holding area between the doors large enough to hold about 6-8 people. In order to gain access, a person needs to be buzzed in the first door, and once that door has closed, the person is buzzed in through the second door. Because this building also contains administrative offices, nutritional services, and a clinic, there is a lot of activity at the entrance. Certain employees have keys to the sally port doors that allow them to enter without having to be buzzed in. (Hearing testimony of Chief [redacted] and Hearing testimony of Clinical Risk Management Specialist [redacted])

[redacted]

8. At all times, the sally port post is manned by a Safety and Security Officer, whose duty is to buzz people in through the sally port, and ask for identification if a person is unknown to the Officer. The Safety and Security Officer is stationed in a reception area behind Plexiglas, called "the bubble," and observes the people seeking entrance. At the time of the incident, the Safety and Security Officer on duty at the sally port post would also periodically walk around the entrance area to ensure safety in front of the building. In addition to the Safety and Security Officer, the telephone operator sits in the bubble. She is authorized to buzz people in through the sally port if the Safety and Security Officer is not available. (Hearing testimony of Chief [redacted])

9. The Subject normally worked the night shift, from 11:45 p.m. until 8:00 a.m. However on [redacted], the Subject was called in early for voluntary overtime. He was assigned to the sally port post from 6:00 p.m. until 8:00 p.m. (Hearing testimony of Subject, Justice Center Exhibit 29, and ALJ Exhibit 2)

10. From the start of the Subject's shift at the sally port post until the incident with the Service Recipient, the Subject buzzed people through the doors about twenty-five times. Several of the same people went through multiple times, and only a small fraction of them showed identification. (Justice Center Exhibits 33 and 34)

11. The Service Recipient went through the doors three times. On her fourth attempt, the Subject did not open the first set of doors. Instead, he engaged the Service Recipient in conversation, telling her that she was going in and out too many times. In response, the Service Recipient told the Subject to stop bothering her. The Subject then stood up and left the bubble. The telephone operator asked him where he was going, but he did not respond. After he left his post, the Subject told the telephone operator to not open the door. (Justice Center Exhibits 6, 11,

[redacted]

33, and 34)

12. In the meantime, the telephone operator buzzed an individual out of the sally port and the Service Recipient used that opportunity to enter the sally port. She waited at the second door to be let out, but at that point the Subject entered the sally port, blocking the Service Recipient's exit. Up until this point, the Service Recipient appeared calm. However, after the Subject entered the sally port, he and the Service Recipient became engaged in what appeared to be a heated discussion with much finger pointing by both. The Subject asked the Service Recipient to show him her identification, and she refused. The Service Recipient attempted to leave the sally port at least twice, but she was unable to leave because the Subject had told the telephone operator not to open the door. (Justice Center Exhibits 6, 11, and 33)

13. The Subject grabbed the Service Recipient's hand as she pointed her finger at him, spun her around, and pressed her shoulders against the Plexiglas, pinning her hands in front of her. The Subject then pushed his knee between the Service Recipient's legs, and pinned her against the wall so that the shelf under the Plexiglas window pushed into her abdomen. As she struggled to turn around, the Subject, who weighed approximately 260 pounds and was considerably larger than the Service Recipient, took the Service Recipient down onto the floor of the sally port, at one point laying on top of her as she was prone on her stomach. The Subject then straddled the Service Recipient, on his knees, holding her left arm against her back between her shoulder blades, and restrained her in that position for several minutes. The Service Recipient remained partly on her stomach, and continued to struggle until a direct care worker arrived and helped calm the Service Recipient down; after which the Subject released her. As the Subject stood up, he pushed down on the Service Recipient's shoulder with his right hand, using her shoulder as leverage to stand up. (Justice Center Exhibit 33, Hearing testimony of

[redacted]

Subject)

14. Thereafter, several more Safety and Security Officers arrived, as well as another employee, [redacted], who was familiar with the Service Recipient. [redacted] took the Service Recipient back to the Service Recipient's residence, where a Medical Specialist examined her for injuries. The Service Recipient was very upset after the incident, and pressed criminal charges against the Subject for Harassment. (Justice Center Exhibits 2, 5, 6, and 33)

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 and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse of a person in a facility or provider agency is defined by SSL § 488(1)(a), to include:

> (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.

[redacted]

> 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.

The abuse of a person in a facility or provider agency is defined by SSL § 488(1)(d), to include:

> (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.

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), to include:

> (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

[redacted]

> article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (2), which is defined as follows:

> (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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, 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 and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts, described in “Allegation 2” and “Allegation 3” of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-30) The investigation underlying the substantiated report was conducted by Clinical Risk Management Specialist , who testified at the hearing on behalf of the Justice Center along with Safety and Security Chief and Director of Staff Development .

The Subject testified in his own behalf and submitted one document. (Subject Exhibit A) Additionally, , a certified instructor in lawful use of force testified on behalf of the Subject.

The Justice Center submitted two visual only videos of the incident, which were extremely helpful and illuminating evidence with respect to the substantiated allegations. (Justice Center Exhibits 33 and 34)

At the close of testimony, the hearing remained open until additional evidence was received, on the Administrative Law Judge's own motion, namely the record of the Service Recipient's post incident exam that was inadvertently omitted from Justice Center Exhibit 5 (ALJ 1); and the audio recording of the Subject's interview (ALJ 2).

The Justice Center proved by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints) when he pinned the Service Recipient's hands against the Plexiglas window, then pinned the Service Recipient to the floor and held her there for several minutes. The Subject committed physical abuse when he pushed the Service Recipient against the shelf under the Plexiglas window, when he placed his entire weight on the Service Recipient, and when he pushed on her shoulder, using it for leverage to stand up.

The Justice Center further proved by a preponderance of the evidence that the Subject

committed neglect when he entered the sally port and confronted the Service Recipient about how many times she entered and exited the building. His actions agitated the Service Recipient, and caused a crisis situation that adversely affected the Service Recipient's emotional and mental well-being.

Allegation 2

In order to show abuse (deliberate inappropriate use of restraints), the Justice Center must prove that either the technique used, the amount of force 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, and limits the ability of a person receiving services to freely move his or her arms, legs or body. (SSL § 488(1)(d)) In this case, the evidence shows that the Subject was not authorized to restrain the Service Recipient because she was an outpatient resident, and pursuant to OMH policy, restraints are only used on inpatient residents. (Hearing testimony of)

At the time of the incident, the Subject had been a Safety and Security Officer for more than twelve years. (Justice Center Exhibit 29) He was up to date on all his training, including Preventing and Managing Crisis Situations (PMCS). (Justice Center Exhibit 26) The PMCS manual and training state that restraints are authorized to be employed on service recipients who receive inpatient services, but not for service recipients who receive outpatient services. (Hearing testimony of and Justice Center Exhibit 30) Therefore, the Subject knew or should have known that he was not authorized to perform a physical restraint on the Service Recipient who was receiving outpatient services.

At the time of the incident, the Subject was assigned to the sally port post at Building .

[redacted]

That building contained outpatient services and administrative offices. Therefore the Subject knew or should have known that the people entering and exiting the building were not service recipients receiving inpatient services.

The Subject performed two separate and distinct restraints on the Service Recipient. The first was when he took her hands, turned her around so that he was behind her, and pinned her hands against the Plexiglas. The Subject held her legs against the wall, pushing the shelf that was located under the Plexiglas, into the Service Recipient's abdomen. The second restraint occurred when the Subject took the Service Recipient down to the floor resulting in her laying prone underneath the Subject, at one point on her stomach, and he held her there for several minutes. The video clearly shows that in both instances, the Subject acted deliberately and his actions limited the Service Recipient's ability to freely move her arms, legs, and body. (Justice Center Exhibit 33)

The parties agree that the Service Recipient was receiving outpatient services and therefore the restraint techniques taught in PMCS were not authorized in this case. In fact, the evidence presented at the hearing shows that outpatient service recipients should not be restrained at all. (Hearing testimony of [redacted]) Therefore, the Subject's actions in restraining the Service Recipient are contrary to OMH policy.

In order to establish a case of physical abuse, the Justice Center does not need to show actual injury. It is sufficient to show conduct by a custodian intentionally or recklessly causing, by physical contact, a likelihood of either physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. (SSL § 488(1)(a)) In this case, the Subject acted intentionally in a manner that was likely to cause physical injury. Furthermore, the evidence shows that the Subject's conduct did cause an actual protracted

[redacted]

impairment of the Service Recipient's physical, mental, and emotional condition.

Additionally, the Service Recipient could have been physically injured several times during the course of this incident. When the Subject pushed her against the Plexiglas, her abdomen was pressed against a shelf that protruded from the wall about 8 inches and was about 1 inch thick. This created the likelihood of physical injury. When the Subject placed the Service Recipient in a prone position on her stomach, he placed his entire weight on her for a few seconds. This created the likelihood of physical injury. When the Service Recipient was prone on the floor and the Subject twisted her arm up on her back between her should blades, he created a likelihood of physical injury. Finally, when the Subject pushed the Service Recipient's shoulder as he stood up after releasing her from the restraint, he created the likelihood of physical injury. (Justice Center Exhibit 33)

Other service recipients and employees witnessed the incident, and the Service Recipient was aware of people watching the event. The video shows a different service recipient trying to get in the door during the incident. When that service recipient saw what was happening in the sally port, he or she started rocking back and forth against the wall. The Service Recipient was visibly upset both during and after the restraint. She was taken up to her unit by an employee familiar with her, and was examined by a doctor for injuries. The Service Recipient reported that she believed she was being arrested, but she did not know why. She also reported that prior to the incident, she was in a good mood, and had no problems. After the incident was over, the Service Recipient decided to press charges against the Subject. (Justice Center Exhibits 33, 5 and 6) Therefore, it may reasonably be inferred that this was a traumatic incident for the Service Recipient, causing serious impairment of her emotional condition.

As a defense, the Subject cited lawful use of force under Penal Code Article 35, also

known as Justification. Justification is a defense against criminal charges brought against a peace officer that renders use of force lawful in certain circumstances. (Penal Code § 35.05; *People v. McManus, 67 NY 2d 541)* In this matter, the applicable law is Social Services Law, which is a civil proceeding, not a criminal proceeding. Therefore, a defense of Justification does not apply. However, the applicable statute in this matter does provide an exception allowing for physical intervention as a reasonable emergency intervention. (SSL § 488(1)(a); SSL §488(1)(d)) Considering the nature of the Justification defense, and applying it to this proceeding, it may be reasonably inferred that the Subject has interposed this emergency exception as his defense.

In support of his position, the Subject asserts that the criminal charge for Harassment in the Second Degree was dismissed. Indeed, the criminal court dismissed the charge after a bench trial; but not based on defense of Justification. Rather, the criminal court found that the People did not prove the third element of the charge, namely that the Subject acted with the intent to annoy, harass or alarm the Service Recipient. (Justice Center Exhibit 2)

The Subject also points to an Opinion and Award arising from a disciplinary matter held pursuant to a collective bargaining agreement between OMH and the Subject's union in support of his defense. The parties stipulated to the admission of the Arbitrator's decision in this proceeding, and the Administrative Law Judge presiding over this proceeding accepted that stipulation with the understanding that this Opinion and Award was to have no collateral estoppel effect in the matter before this Administrative Law Judge. The Subject asserts that the Arbitrator found that the use of physical force was necessary, and therefore, his actions were justified. However, the arbitrator also found that the Subject's own poor judgment created the situation, and led to the use of force. If the Subject had stayed behind the bubble, and had not

[redacted]

attempted to confront the Service Recipient in the sally port, then there would have been no use of force. (Justice Center Exhibit 2)

Chief [redacted] testified quite credibly regarding the duties and obligations of the Safety and Security Officer assigned to the Building [redacted] sally port post. At the time of the incident, the officer could leave the bubble to walk in front of the building, or to respond to medical emergencies, or threats of imminent danger. (Hearing testimony of Chief [redacted]) In this case, the Subject was not faced with an emergency that required him to leave the bubble. Additionally, there was no evidence that the Subject left the bubble with the intent to patrol the front of the building. Therefore, the only explanation for him to enter the sally port was to confront the Service Recipient. Indeed, from the moment the Subject entered the sally port, he confronted the Service Recipient and prevented her from leaving. (Justice Center Exhibits 6, 19, 20, and 33) Because the Subject's own actions were the cause of the incident, he cannot then claim that there was an emergency in which his use of force was necessary in order to protect the safety of any person.

In addition, there were other actions the Subject could have taken in order to de-escalate, rather than escalate, the situation. He could have used a different and more appropriate technique; and the amount of force was not appropriate for this situation. He could have simply stayed in the bubble and not attempted to confront the Service Recipient at all. (Hearing testimony of Chief [redacted], and Justice Center Exhibit 24) Therefore, the Subject's use of force does not fall within the emergency exception to the Statute.

Allegation 3

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject

[redacted]

breached his duty to the Service Recipient, and that this breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL §488(1)(h)) Here, the Subject breached his duty to the Service Recipient in several respects. Including when he entered the sally port, prevented the Service Recipient from exiting the sally port, and performed unauthorized restraints on her. As a Safety and Security Officer, the Subject's duty was to maintain the safety of the premises for the people who live and work in that building.

More specifically, the Subject's duty to this Service Recipient was to ensure her safety and her feeling of security, and to follow all applicable policies in the execution thereof. By confining the Service Recipient in an enclosed space, and refusing to allow her to leave, the Subject caused the Service Recipient anxiety. This anxiety and distress was exacerbated when the Subject performed the unauthorized restraints on the Service Recipient. By her own report, the Service Recipient said that she believed she was being harassed and threatened with being arrested. She had no idea why she was being singled out for this treatment. (Justice Center Exhibits 20, 21, and 22) The Subject's body language upon entering the sally port was aggressive. The Service Recipient tried to leave several times during the confrontation, but the phone operator, on instructions from the Subject, would not open the door. (Justice Center Exhibit 33)

At the hearing, the Subject testified that he went into the sally port because he was concerned about the Service Recipient. He said that she appeared agitated and he was only trying to learn her name so that he could notify her treatment team. (Hearing testimony of Subject) However, the video evidence does not bear this out. Both camera angles show the Service Recipient acting no differently than any other person going in and out of the building.

[redacted]

She does not appear agitated until she is confined to the sally port. (Justice Center Exhibits 33 and 34)

There are other inconsistencies between the Subject's testimony at the hearing and his previous statements that call into question his credibility. At the time of the incident, he reported to several people that the Service Recipient attacked him as a Justification for why he took her down. (Justice Center Exhibits 13, 18, and 23) In addition, in the Subject's Incident Report he stated that when the Service Recipient "entered the sallyport she became out of control lunging at [the Subject's] face with her fingernails and screaming obsinities." (Subject Exhibit A) However, the video evidence clearly shows that while the Service Recipient poked her finger at him, her actions never became aggressive enough to be considered an attack. Finally, at the hearing the Subject testified that he did not take the Service Recipient down in an attempt to restrain her. Rather, he testified that the Service Recipient lost her balance, and he used his body to break her fall. (Hearing testimony of Subject) This assertion is not corroborated by any other evidence. Notably, during his interrogation, the Subject said that he had to take the Service Recipient down to the floor. (Justice Center Exhibit 29 at page 24, and ALJ 2, audio recording of Subject's interrogation) Furthermore, the video evidence does not bear this out. In fact, while reviewing the video of the incident with his supervisor, the Subject admitted that he should not have done that. (Justice Center Exhibit 18) Therefore, the Subject's testimony at the hearing is not credited evidence.

Having found that the Subject breached his duty to the Service Recipient, we now turn to whether this breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The evidence presented clearly shows that the Subject's actions were likely to result in physical

[redacted]

injury when he pushed the Service Recipient into the shelf under the Plexiglas, when he twisted her arm behind her back, when he put his entire weight on her as she lay prone on her stomach on the floor, and when he pushed off her shoulder in order to stand up. In addition, his actions did cause actual serious or protracted impairment of the Service Recipient's emotional condition as evidenced by her visible agitation immediately after the incident, and by her statements taken during the following days and weeks. Further, being confined to the sally port and then being restrained in that confined area constituted a serious impairment of the Service Recipient's physical condition. It is clear from the video that she was unable to move freely, was pacing back and forth in that small space, was being confronted by the Subject, a person in authority who should have been protecting the Service Recipient rather than threatening her. Therefore, based on the credible evidence, the Subject is found to have committed neglect against the Service Recipient.

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

Having established that the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** The Subject confined the Service Recipient in an enclosed space, and used excessive force to take her down in an unauthorized restraint, which seriously endangered the Service Recipient's health, safety and welfare. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 2 act.

[redacted]

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, as a Category 2 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: March 4, 2016
Schenectady, New York