

**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
AND ORDER
AFTER HEARING**

Adjud. Case #:
[REDACTED]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: April 6, 2018
Schenectady, New York



David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
AAU
SUBJECT

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

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

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:

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

[REDACTED]

By: Benjamin Bodner, Esq.
Hinman Straub PC
121 State Street
Albany, New York 12207-1693

[REDACTED]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subjects) for abuse. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects 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], [REDACTED] of abuse (deliberate inappropriate use of restraints) and physical abuse by Subject [REDACTED] of a Service Recipient.

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

Allegation 1

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed abuse (deliberate inappropriate use of restraints) and/or physical abuse when you conducted a restraint with excessive force and improper technique, which included punching a service recipient.

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). However, because the conduct that is the subject of this finding occurred within three years of a previous finding that [REDACTED] engaged in Category 2 conduct, these new Category 2 findings have been elevated to Category 1 findings.

3. The VPCR contains a "substantiated" report dated [REDACTED], [REDACTED] of abuse (obstruction of reports of reportable incidents) by Subjects [REDACTED]

██████████ and ██████████ of a Service Recipient.

4. The Justice Center substantiated the report against Subjects ██████████ and ██████████.

The Justice Center concluded that:

Allegation 1

It was alleged that on ██████████, at the ██████████, located at ██████████, while a custodian, you committed abuse (obstruction of reports of a reportable incident) when you failed to report a reportable incident to the VPCR.

This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493(4)(c).

5. An Administrative Review was conducted and the substantiated reports were retained.

6. The facility ██████████, located at ██████████, operates several programs, including Residential Treatment, and Day Education. The incident alleged herein occurred in the school, which is licensed by the New York State Department of Education, which is a provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 6)

7. At the time of the alleged abuse, Subject ██████████ had been employed by ██████████ for eight years, the last five years as a Senior Safety Counselor; Subject ██████████ had been employed by ██████████ for 10 years, first as a Safety Counselor and then as a Senior Safety Counselor; and Subject ██████████ had been employed by ██████████ for four years as a Safety Counselor. (Hearing testimonies of Subjects; Justice Center Exhibit 35)

8. At the time of the alleged abuse, the Service Recipient was 16 years of age, and had been a resident of ██████████, as well as a student in the school, for approximately one year. The Service Recipient is a male youth, with relevant diagnoses of attention deficit hyperactivity

disorder, oppositional defiant disorder, conduct disorder, and mood disorder. (Justice Center Exhibit 22; Subjects' Exhibit C)

9. On the morning of [REDACTED], the Service Recipient was confronted by another service recipient regarding a journal the Service Recipient had left in the other service recipient's homeroom. Staff attempted to separate the two youths, but the Service Recipient followed his peer into the hallway, and then into the first-floor office, where punches were thrown, and the other service recipient bit the Service Recipient on the torso. Staff broke up the fight, but the Service Recipient continued to pursue the other youth through the school. (Justice Center Exhibits 7-14 and 34; Hearing testimonies of Investigator [REDACTED] and Subjects)

10. The Service Recipient observed the other youth being escorted upstairs, so he exited the building, and re-entered by a door near a staircase. Staff kept the Service Recipient in proximity, following him and updating other staff on the radio. The Subjects, having been alerted to the Service Recipient's actions, were at the door waiting for him when he re-entered the building. The Service Recipient tried to push past the Subjects, telling them to move out of his way. The Subjects attempted to re-direct the Service Recipient, to take time away and calm down, but the Service Recipient was extremely agitated, unresponsive, and focused on continuing the altercation with the other youth. (Justice Center Exhibits 7-14 and 34; Hearing testimonies of Subjects)

11. Rather than responding to the Subjects' attempts at de-escalation, the Service Recipient escalated. He spat in Subject [REDACTED] face, and punched him. At that point the Subjects determined that they had to initiate a safety hold. At first, the Subjects attempted a standing hold, but the Service Recipient continued to resist. At one point his left arm broke free, so the Subjects took the Service Recipient to the floor in a prone restraint. Subject [REDACTED], who was right-handed,

was on the Service Recipient's left side, Subject [REDACTED] was on the Service Recipient's right side, and Subject [REDACTED] controlled the Service Recipient's legs. The Service Recipient was a large youth, and it normally took two or more staff to safely execute a restraint. (Justice Center Exhibits 7-14 and 34; Hearing testimonies of Subjects and School Supervisor [REDACTED])

12. The restraint occurred just inside the door that was used by employees leading to a parking lot. The Service Recipient was placed face down, on a mat or rug that is normally used in the entryways of public buildings during the winter months to collect slush, dirt and salt that may be tracked in from the outside. (Subjects' Exhibit E; Hearing testimonies of Subjects; Justice Center Exhibit 34)

13. The Subjects released the Service Recipient from the restraint when he complained that he could not breathe. When the Subjects adjusted their positions in response to the Service Recipient's complaint, they noticed blood on the mat, and on the Service Recipient's face. The Subjects called for a nurse, and the Service Recipient was escorted to the infirmary by the nurse and Assistant to the Associate Executive Director [REDACTED], who had just arrived for work after the Service Recipient was released from the restraint. The Service Recipient was later taken to the hospital Emergency Department and diagnosed with a head injury, nasal contusion, right hand contusion, and human bite to chest. Photographs taken after the incident depicted a bump on the right side of the Service Recipient's forehead, dried blood on his right cheek, and scratches on the right side of his nose. (Justice Center Exhibits 21, 29, and 34)

14. While in the Emergency Department, the Service Recipient reported that Subject [REDACTED] had punched him in the face while he was being lowered to the floor, and again after he was prone, face down, on the mat. The day after the incident, Subject [REDACTED] conducted a Life Space Interview (LSI) pursuant to Therapeutic Crisis Intervention TCI and [REDACTED] policy. The purposes

of the LSI are to clarify the events leading up to the restraint, return the youth to baseline, and to repair the relationship with the staff. The Service Recipient did not report being punched by Subject [REDACTED] during the LSI with Subject [REDACTED]. (Justice Center Exhibits 6, 32, and 34; Hearing testimonies of Investigator [REDACTED], [REDACTED], and Subject [REDACTED])

15. Neither Subject [REDACTED] nor Subject [REDACTED] called the Justice Center to report an incident arising from this restraint. (Hearing testimonies of Subjects [REDACTED] and [REDACTED])

ISSUES

- Whether the Subjects have 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.
- Pursuant to Social Services Law § 493(4), the categories of abuse 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 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])

Physical abuse, abuse (deliberate inappropriate use of restraints), and abuse (obstruction of reports of reportable incidents) are defined by SSL §§ 488(1)(a), 488(1)(d), and § 488(1)(f) as:

- (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.

(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.

(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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, and Category 3 which are 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.

(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.

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

If the Justice Center proves the alleged abuse, the reports 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 acts of abuse cited in the substantiated reports constitute the category of abuse as set forth in the substantiated reports.

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subjects committed acts, described as “Allegation 1” in the substantiated reports.

In support of its substantiated findings, the Justice Center presented numerous documents, an audio CD of witness interviews obtained during the investigation, and video recordings of events leading up to the incident; but did not depict the incident itself. (Justice Center Exhibits 1-36) The investigation underlying the substantiated report was conducted by Investigator [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subjects testified in their own behalves. In addition, School Supervisor [REDACTED], [REDACTED], and Registered Nurse Manager [REDACTED] (RN [REDACTED]) testified on behalf of the Subjects. Subjects [REDACTED] and [REDACTED] provided several documents. (Subjects’ Exhibits A-E)

After the close of proof, counsel for Subjects [REDACTED] and [REDACTED] asked to submit written

argument on issues of law pursuant to 14 NYCRR §700.10(i). The Administrative Law Judge presiding over the hearing granted the request and set a scheduling order for submissions, allowing the Justice Center to respond to the Subjects' submission. Counsel for the Subjects objected, stating that the Justice Center is not entitled to have the last word. This assertion is misplaced, as the Justice Center presents its closing arguments after the Subjects, and therefore, does have the last word. More importantly, Subjects' counsel refused to disclose the issue he would like to brief, and then failed to articulate any prejudice to his clients by the Justice Center being allowed to submit its written argument after the Subjects' submission. Finally, the written submissions had no persuasive effect on the material facts and conclusions reached by the Administrative Law Judge. Rather than elucidating an issue of law, the Subjects' brief merely re-iterated their arguments made during the hearing.

Abuse (deliberate inappropriate use of restraints)

In order to prove abuse (deliberate inappropriate use of restraints) the Justice Center must establish that Subject [REDACTED] used a restraint on the Service Recipient in which the technique used, the amount of force used or the situation in which the restraint was used, was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. The term "restraint" is defined by statute as any manual, pharmacological or mechanical measure or device used to immobilize or limit the ability of the Service Recipient to freely move his arms, legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL §488[1][d])

First, it should be noted that despite the fact that three staff members equally participated

in this restraint, Subject [REDACTED] was the only staff member substantiated for this allegation. The Justice Center contends that the amount of force and technique used by the Subject to restrain the Service Recipient were inconsistent with TCI approved techniques.

TCI training emphasizes utilizing non-physical interventions and employing physical interventions only as a last resort. If physical intervention is required, then it should be employed carefully, in a controlled manner, to minimize potential injury to the service recipient. (Hearing testimony of [REDACTED]; Justice Center Exhibit 32) Here, the record reflects that the Service Recipient exhibited classic signs of reactive aggression: highly aroused, angry, loud, shrill, disorganized, and impulsive (Justice Center Exhibit 32) The Subjects complied with Therapeutic Crisis Intervention (TCI) training by removing the stimulus, in this case, the other youth. The Subjects implemented de-escalation techniques by advising the Service Recipient to take time away, a strategy that had proven effective in the past. Additionally, the Subjects attempted to re-direct the Service Recipient, provided verbal prompts and active listening, and directive statements, all of which are approved TCI de-escalation techniques. (Hearing testimony of [REDACTED]; Justice Center Exhibits 2, 22, 23, 32, and 34) Every effort the Subjects made to de-escalate the Service Recipient failed to have an appreciable effect on his behavior. Only after the Service Recipient became uncontrollably violent and hit Subject [REDACTED], in his attempt to go after the other youth, did the Subjects initiate a physical intervention. (Hearing testimonies of Subjects; Justice Center Exhibits 2, 13, 14, 15, and 34)

The Justice Center contends that Subject [REDACTED] should have removed himself from the situation after the Service Recipient spat at him because Subject [REDACTED] was the target of the Service Recipient's aggression. (Hearing testimony of Investigator [REDACTED]) In support of this contention, the Justice Center cites to the TCI training manual which advises the target of aggression to leave the

area. (Justice Center Exhibit 32) However, [REDACTED], who trains all [REDACTED] staff in TCI practice and procedure, testified credibly that Subject [REDACTED] was not necessarily the target of the Service Recipient's aggression when he spat at Subject [REDACTED]. Additionally, staff should only remove him/herself from the situation if it is safe to do so. (Hearing testimony of [REDACTED]; Justice Center Exhibit 32) Considering the facts that the Service Recipient was out of control both emotionally and physically, that he was strong and resisting staff, and he was intent on finding the other youth to continue fighting, Subject [REDACTED] could not safely leave the other Subjects to try and subdue the Service Recipient.

The record reflects that the three Subjects lowered the Service Recipient to the floor. Each Subject positioned himself on one side of the Service Recipient, with Subject [REDACTED] on the left side, Subject [REDACTED] on the right side, and Subject [REDACTED] holding the Service Recipient's legs. The testimony reveals that normally, they would lower the Service Recipient onto his back, but because they were in front of an outside door, they determined that it would be safer to employ a prone restraint, placing the Service Recipient on the rug rather than the concrete steps outside. (Justice Center Exhibit 34; Hearing testimony of Subjects) Based on the competent evidence in the record, it is concluded that the Subjects, including Subject [REDACTED], performed a physical restraint in accordance with TCI techniques.

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 alleged. The substantiated report will be amended and sealed.

Physical Abuse

In order to sustain an allegation of physical abuse in this matter, the Justice Center must show that the Subject was a custodian who had physical contact with the Service Recipient; that

such contact was either intentional or reckless; and that such contact caused either physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition; or caused the likelihood of such injury or impairment. (SSL §488[1][a]) Social Services Law defines "intentionally" and "recklessly" as having the same meaning as provided in New York Penal Law § 15.05. (SSL §488[16]) Under New York State Penal Law, a person acts "intentionally" with respect to a result or conduct when a person has a "... conscious objective ..." to cause a result or engage in such conduct. (PL §15.05[1]) Under New York Penal Law, a person acts "recklessly with respect to a result or to a circumstance" when the person is "aware of and consciously disregards a substantial and unjustifiable risk that such result will occur." (PL §15.05[3])

Here, there is no dispute that the Subject was a custodian pursuant to SSL § 488(2). Likewise, there is no dispute that the Subject had physical contact with the Service Recipient during the course of the physical intervention. However, the Justice Center specifically alleges that the Subject punched the Service Recipient during the restraint, forming the basis of this allegation.

Initially, the Service Recipient reported to hospital staff that Subject [REDACTED] punched him twice in the face, and once in the rib/stomach area. (Justice Center Exhibit 6) During his interview with investigator [REDACTED], the Service Recipient said that Subject [REDACTED] punched him in the face as he was being lowered to the floor. Then the Service Recipient said that Subject [REDACTED] pushed him against the doorway, the Service Recipient pushed back, and then Subject [REDACTED] hit him in the head. Then the Service Recipient said that Subject [REDACTED] hit him in the face three times, after he was face down on the floor. (Justice Center Exhibit 34) These allegations are not supported by the credible evidence in the record.

The three Subjects consistently stated that Subject [REDACTED] was on the Service Recipient's left

side during the restraint. Subjects [REDACTED] and [REDACTED] were each interviewed twice, Subject [REDACTED] was interviewed once, and all interviews were recorded. (Justice Center Exhibit 34) In addition, all three Subjects submitted contemporaneous written reports after the incident. (Justice Center Exhibits 2, 13, 14, and 15) Finally, each Subject testified at the hearing. Having observed the Subjects' demeanor during the hearing, having listened to their audio statements, and read their written reports, the Administrative Law Judge presiding over this hearing finds the Subjects' statements credible regarding this material fact.

It is undisputed that Subject [REDACTED] is right-handed. The injuries to the Service Recipient were all on the right side of his face. In order for Subject [REDACTED] to cause these injuries, he would have had to reach around behind the Service Recipient as he is trying to control the Service Recipient's left arm, get his fist between Subject [REDACTED] and the Service Recipient, and then punch the Service Recipient on the face. By all accounts, the Service Recipient was approximately five feet, 10 inches tall, and weighed about 220 pounds. (Justice Center Exhibit 28) The Administrative Law Judge, having observed Subject [REDACTED] testify at the hearing, can conclude that it would be unlikely for Subject [REDACTED] to achieve that reach.

Furthermore, after the Service Recipient was on the floor, his face was on the rug. Again, it would be unlikely that Subject [REDACTED] could have maneuvered himself so as to access the right side of the Service Recipient's face with his right hand and punch the Service Recipient while keeping him in the restraint. The evidence in the record suggests that it was more likely that the injuries to the Service Recipient's face were caused by him rubbing his face on the rug that had been used to wipe boots of winter debris that routinely collects when walking outside in [REDACTED]. (Hearing testimonies of [REDACTED], RN [REDACTED]; Subjects' Exhibit E; Justice Center Exhibit 34)

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 alleged. The substantiated report will be amended and sealed.

Obstruction of Reports of Reportable Incidents

In order to prove abuse (obstruction of reports of reportable incidents) in this matter, the Justice Center must establish that Subjects [REDACTED] and [REDACTED] were mandated reporters who were custodians, and failed to report a suspected reportable incident upon the Subjects' discovery of the incident. (SSL §488[1][f]) Reportable incidents range from various types of abuse and neglect to "significant incidents" which include acts not rising to the level of abuse or neglect. (SSL §488[1][a] through [i]) The term "discovery" is defined by statute as occurring when a "mandated reporter witnesses a suspected reportable incident ... or has reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident." (SSL §491[1][b]) The Justice Center interprets the relevant statute to mean, and argues that for a report to be timely, the report should be made to the VPCR within twenty-four hours of the incident.

There is no dispute between the parties that Subjects [REDACTED] and [REDACTED] are mandated reporters and custodians as defined in the statute. Additionally, both Subject [REDACTED] and Subject [REDACTED] admit that they did not report this incident to the VPCR. The issues to be decided are when the Subjects discovered the incident, and whether this incident was reportable.

The duty to report is triggered when a mandated reporter discovers a suspected reportable incident either by witnessing the incident, or by being informed of a suspected reportable incident. (SSL § 491[1][b]; 2016 NY St JC Ops 2016-023 [Note: online opinions]) Specifically, the Justice Center's theory was that Subjects [REDACTED] and [REDACTED] witnessed Subject [REDACTED] punching the Service Recipient. Both Subjects have consistently and credibly denied seeing Subject [REDACTED] punch the Service Recipient. (Justice Center Exhibit 34; Hearing testimony of Subjects) Therefore,

Subjects [REDACTED] and [REDACTED] cannot be held accountable for failing to report an incident they did not observe.

Given the information available to the Subjects at the time of the incident, they did not believe there was anything to report. This case may be distinguished from a previous decision where an underlying incident was unsubstantiated, but the subject in that matter still had a duty to report it as a suspected reportable incident. (2016 NY St JC Ops 2016-023 [Note: online opinions]) In the previous matter, the Executive Director determined that the subject had reasonable cause to suspect that a service recipient had been subjected to a reportable incident. (Id) Here, the Subjects had no first-hand knowledge of a suspected reportable incident. In addition, the Subjects were not informed of the Service Recipient's allegations until after the investigation was commenced. Subject [REDACTED] testified that he escorted the Service Recipient to the infirmary along with the nurse and [REDACTED]. The Service Recipient did not report being punched by Subject [REDACTED] at that time. (Justice Center Exhibit 34, Hearing testimonies of Subject [REDACTED], and [REDACTED]) Also, during the LSI Subject [REDACTED] conducted with the Service Recipient the day after the restraint, the Service Recipient did not report being punched by Subject [REDACTED]. (Justice Center Exhibit 34) Therefore, Subjects [REDACTED] and [REDACTED] did not have reasonable cause to suspect that the Service Recipient had been subjected to a reportable incident.

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 alleged. The substantiated report will be amended and sealed.

DECISION:

The requests of [REDACTED] that the substantiated report dated [REDACTED], [REDACTED] [REDACTED] be amended and sealed are granted. The Subjects have not been shown by a preponderance of the evidence to have committed physical abuse, abuse (deliberate inappropriate use of restraints), or abuse (obstruction of reports of reportable incidents).

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

DATED: March 23, 2018
Schenectady, New York


Jean T. Carney
Administrative Law Judge