

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER**

**Adjudication No.**

[REDACTED]

On [REDACTED], the Vulnerable Persons' Central Register received reports of a reportable incident at the [REDACTED], a juvenile detention facility operated by the Office of Children and Family Services, involving subject [REDACTED], a youth division aide at the facility, and one of the facility's service recipients. The Justice Center for the Protection of People with Special Needs (Justice Center) conducted an investigation and, as set forth in its [REDACTED] notification, determined that

“on [REDACTED], at the [REDACTED], [REDACTED] Unit . . . while acting as a custodian, [the subject] committed physical abuse [and] abuse (deliberate inappropriate use of restraints) when [he] failed to deescalate a situation and provoked a service recipient, leading to a physical altercation during which [he] hit [the] service recipient in the stomach, reached for his neck, utilized a disproportionate amount of force, and tackled him to the floor.”

The substantiated report was classified under category two, as conduct that “seriously endangers the health, safety or welfare of a service recipient” (Social Services Law § 493 [4] [b]). The Administrative Appeals Unit of the Justice Center thereafter rejected the subject's request for amendment of the substantiated report, and a de novo hearing was held pursuant to Social Services Law § 494 (*see* 14 NYCRR part 700), following which the Administrative Law Judge (ALJ) issued a report and recommendation, dated [REDACTED].

Having reviewed the hearing record, pursuant to 14 NYCRR 700.13, the Executive Director of the Justice Center hereby adopts the ALJ's report and recommendation, including its findings of fact and conclusions of law, with the following amendment:

The record establishes that the subject's conduct amounted not only to deliberate inappropriate use of restraints, as the ALJ concluded, but also physical abuse. Social Services Law § 488 (1) (a) defines physical abuse as "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." Here, the Justice Center proved by a preponderance of the evidence that the subject's physical contact with the service recipient recklessly caused the likelihood of physical injury, regardless of whether that likelihood was realized.<sup>1</sup>

Though disputed at the hearing, the video footage shows that the subject initiated the physical contact or escalated the conflict at every stage. He approached first and confronted the service recipient, made the first physical contact, pushed much harder when pushed, and, finally, carried out a restraint when the service recipient was clearly retreating. By the time the subject had fully engaged the service recipient, his back was turned and it appears that he had begun attempting to flee a physical conflict. As the subject explained at the hearing, he needed to enter the staff office to do paperwork before the end of his shift, but the service recipient had blocked the doorway with a couch that he was seated in and would not move—a frustrating situation, to be sure, but certainly not one that would warrant the use of physical restraint (*see* NY State

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<sup>1</sup> Although the service recipient did not testify at the hearing, the nurse who examined him after the incident testified that he complained of injury to his chest and throat, and a post-restraint report indicates that he was distraught and complained of pain.

Office of Children & Family Services, Policy and Procedures Manual: Crisis Prevention and Management, PPM 3247.12 [Nov. 25, 2013]).

As to the likelihood of physical injury, the video footage again speaks for itself. Both appearing physically formidable, the subject approaches the service recipient, chest to chest at times, exchanges shoves, grabs the service recipient by the neck and shoulder, and grapples with him until both eventually “[a]ll rather violently to the floor,” as described by the ALJ. An additional six plus minutes of physical restraint ensues.

Finally, the subject’s recklessness in causing the likelihood of injury is readily inferred under the circumstances (*see People v Baker*, 20 NY3d 354, 360-362 [2013]). “A person acts recklessly with respect to a result or to a circumstance . . . when he [or she] is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists” (Penal Law § 15.05 [3]; *see Social Services Law* § 488 [16]). All physical interventions carry the risk of injury, one of the primary reasons they are so heavily disfavored. Here, not only do the events as depicted on the video suggest that the subject must have been aware that such a risk existed, but he also knew that the service recipient had a significant history of violence. The subject and a coworker testified that the service recipient resided on his unit alone, under one-to-one supervision, specifically because of violent behavior. The subject must have known that his unjustified physical intervention was likely to bring about a violent confrontation and the concomitant risk of physical injury to either or both of them.

**ORDERED:** The request of [REDACTED] that the substantiated report and determination dated [REDACTED], [REDACTED], be amended and sealed is denied. A preponderance of the evidence establishes that the

subject committed abuse (deliberate inappropriate use of restraints) and physical abuse.

The substantiated report is properly categorized as Category 2 abuse.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to Social Services Law § 493 (4) (c).

This decision is ordered by Davin Robinson, Chief of Staff, who has been designated by the Executive Director to make such decisions.

Please take further notice that you are entitled to appeal this final determination and order by commencing a proceeding pursuant to CPLR article 78.

**DATED:** April 28, 2016  
Delmar, New York



Davin Robinson

Chief of Staff

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

████████████████

Before:

Gerard D. Serlin  
Administrative Law Judge

Held at:

Administrative Hearings Unit  
New York State Justice Center for the Protection of  
People with Special Needs  
333 East Washington Street  
Syracuse, New York 13202  
On: ████████████████████

Parties:

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: Todd Sardella, Esq

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████████████████

By: Margaret J. Fowler, Esq.  
Levene, Gouldin Thompson, LLP  
PO Box F-1706  
Binghamton, New York 13902-0106

## JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse. 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], [REDACTED] [REDACTED] of abuse by the Subject of a Service Recipient.

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

### **Allegation 1 <sup>1</sup>**

It was alleged that on [REDACTED], at the [REDACTED], [REDACTED] Unit, located at [REDACTED], while acting as a custodian, you committed physical abuse and/or abuse (deliberate inappropriate use of restraints) when you failed to deescalate a situation and provoked a service recipient, leading to a physical altercation during which you hit that service recipient in the stomach, reached for his neck, utilized a disproportionate amount of force, and tackled him to the floor.

These allegations have been SUBSTANTIATED as Category 2 physical abuse and abuse (deliberate inappropriate use of restraint) pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

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

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<sup>1</sup> A second allegation was unsubstantiated.

4. The facility, located at [REDACTED], is a secure facility that houses juvenile offenders and is operated by the New York State Office of Children and Family Services (OCFS), 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, the Subject was employed by the OCFS. The Subject worked as a Youth Division Aide-3 (YDA). The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged abuse, the Service Recipient was sixteen years of age, had been a resident of the facility for an unspecified period, and was in the custody of the Commissioner of the OCFS.

7. During his time at the facility, the Service Recipient resided in his own unit, the [REDACTED]-unit, because he would attack other residents, or other residents would attack him. The facility opened the [REDACTED]-unit, which had been closed for some time, in order to house the Service Recipient. The Service Recipient was subject to one-to-one supervision for the entirety of his placement at the facility. When the Service Recipient disliked a particular facility staff member who was assigned to supervise him, he acted out, and continued to do so until the facility staff member was replaced with a staff member whom the Service Recipient liked. (Hearing testimony of YDA [REDACTED])

8. The Subject and the Service Recipient had a positive relationship, and the Subject was one of only three staff members on the day shift whom the Service Recipient would cooperate with. (Hearing testimony of YDA [REDACTED]) The Subject worked the 6:30 a.m. until 2:30 p.m. shift during the relevant period, and had been assigned, for several months preceding the incident, to provide one-to-one supervision of the Service Recipient. (Hearing testimony of

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the Subject)

9. On ██████████, while supervising the Service Recipient in the █-unit, at approximately 10:30 a.m., the Subject requested relief from his assignment because the Service Recipient was acting out. The Subject was concerned that his presence with the Service Recipient was further escalating the Service Recipient's behavior. The Subject made several requests for relief staff to assume his position in the █-unit beginning at approximately 9:30 a.m. However, no relief staff was available. The Service Recipient placed a couch in front of the door leading into the staff office, effectively blocking access to the staff office. Thereafter, the Service Recipient sat on the couch for some time. The Subject sat at a small table across from the couch. The two conversed for a significant period. (Hearing testimony of the Subject and Justice Center Exhibit 5: video)

10. At approximately 2:20 p.m. on ██████████, nearing the end of his shift, the Subject advised the Service Recipient that he needed access to the unit logbook (which was locked in the staff office) in order to complete his shift paperwork. The Service Recipient responded to the Subject by saying "You are not going home today." (Hearing testimony of the Subject)

11. The Subject called for help by activating his pin pull device. He then stood up, spoke with the Service Recipient, and asked him to move the couch. However, the Service Recipient refused. The Subject then moved the couch away from the doorway, and the Service Recipient stood up from the couch. (Hearing testimony of the Subject and Justice Center Exhibit 5: video) The Service Recipient then blocked the Subject's access to the door with his body. (Justice Center Exhibit 5: video)

12. The Service Recipient began tapping at the Subject's hand as the Subject

██████████ attempted to open the staff office door. (Hearing testimony of the Subject) The Subject then touched the Service Recipient on his stomach as a touch control method (Justice Center Exhibit 5: video 2 minute 22:15 time stamp), and said to the Service Recipient: “Come on, just let me in the door so I can get out of here.” (Hearing testimony of the Subject) However, this contact was not a prescribed OCFS touch control method. (Hearing testimony of OCFS regional trainer ██████████)

13. The Service Recipient then pushed the Subject away from the door and the Subject pushed the Service Recipient to create distance between them. The Service Recipient pushed back against the Subject two additional times. (Justice Center Exhibit 5: video 2 minutes 22:15 time stamp and Hearing testimony of the Subject)

14. The Service Recipient then backed away from Subject and the staff office door. (Justice Center Exhibit 5: video) The Subject moved toward the Service Recipient and placed his hands close to the Service Recipient’s neck or shoulder area. The Subject’s hand remained in this area for approximately one second. (Justice Center Exhibit 5: video)

15. The Subject intended to turn the Service Recipient, who was facing the Subject, and place him in an approved restraint. (Hearing testimony of Subject) The Service Recipient struggled and, in doing so, exposed his back to the Subject (Justice Center Exhibit 5: video), who then initiated a restraint consistent with instruction from OCFS, by penetrating with “high hooks” under the arms of the Service Recipient. (Hearing testimony of OCFS regional trainer ██████████)

16. The Service Recipient resisted efforts to be restrained and the Subject increased the amount of force he was employing. (Justice Center Exhibit 5) Both the Subject and the Service Recipient then fell rather violently to the floor during the restraint. (Justice Center

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Exhibit 5: video and hearing testimony of the Subject) Approximately forty-five seconds after the Subject initiated the restraint, multiple facility personnel arrived to assist. The Subject then removed himself from the restraint. However, the Service Recipient continued to resist the restraint, remained very combative, and was subjected to restraint activity for an additional six minutes. (Justice Center Exhibit 5: video)

17. A post-restraint health assessment performed by facility OCFS Nurse Administrator ██████████ revealed that the Service Recipient complained of pain to his chest and throat but no bruising or redness of the throat was noted. The Service Recipient would not lift his shirt to allow examination of his torso. (Justice Center Exhibit 9 and Hearing testimony of facility OCFS Nurse Administrator ██████████)

### **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 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 and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). SSL § 488(1) (a) defines physical abuse and SSL § 488(1)(d) defines the deliberate inappropriate use of restraints, also a form of abuse, which are as follows:

“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.

“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. (SSL § 488 (1) (d)).

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 committed the act or acts of abuse alleged in the substantiated report

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that is the subject of the proceeding and that such act or acts constitute the category of abuse as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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 of abuse as 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 established by a preponderance of the evidence that the Subject committed the prohibited act described in “Allegation 1” of the substantiated report as the deliberate inappropriate use of restraints. However, the Justice Center has not established by a preponderance of the evidence that the Subject committed the prohibited act described in “Allegation I” of the substantiated report as physical abuse.

In support of its substantiated findings, the Justice Center presented a number of documents, and a video recording obtained during the investigation. (Justice Center Exhibits 1-11) The investigation underlying the substantiated report was conducted by Justice Center Investigator-1, ██████████ who testified at the hearing in behalf of the Justice Center. OCFS regional trainer ██████████ testified in behalf of the Justice Center that she has been employed by OCFS and its predecessor agency since 1985. She was, at the time of the hearing as well as at the time of the incident, assigned to supervise all OCFS training in the Central New York Region.

The Subject testified on his own behalf. OCFS YDA ██████████ also testified in behalf of

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the Subject, as did facility OCFS Nurse Administrator ██████████.

The Justice Center submitted a visual only video of the incident, which was in some respects, illuminating evidence with respect to the substantiated allegations. (Justice Center Exhibit 5: video)

The Service Recipient did not cooperate in the investigation and would not speak with Justice Center Investigator ██████████. (Hearing testimony of Justice Center Investigator ██████████) The Service Recipient was troubled, attention seeking and for a long period was housed in his own unit, the █-unit, because of his violent and provoking behaviors. Prior to the Service Recipient's arrival at the facility, there was another service recipient who was very assaultive and had assaulted numerous personnel in the facility including the facility director. That service recipient ultimately was housed alone in his own unit, and facility staff developed a practice of rotating in replacement facility staff to supervise the service recipient at four-hour intervals. (Hearing testimony of YDA ██████████) This practice continued and during a labor management meeting, the facility director suggested that staff supervising the Service Recipient on the █-unit should be rotated in and out about every four hours as well. (Hearing testimony of YDA ██████████)

However, the Service Recipient ultimately dictated which facility staff member supervised him by acting out until a staff member that the Service Recipient wanted was assigned to supervise him. (Hearing testimony of YDA ██████████) As a result, at the time of the incident there was only three-day shift facility staff members with whom the Service Recipient would typically cooperate with, including the Subject and YDA ██████████. Because there were few staff members who could effectively supervise the Service Recipient, the Subject was frequently mandated to work overtime. (Hearing testimony of YDA ██████████)

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At the hearing, Justice Center Investigator ██████████ testified and characterized the Subject's contact with the Service Recipient's stomach as a "smack" and as a "slap." In the substantiation letter, the contact is referred to as a "hit." (Justice Center Exhibit 1)

During the investigation, and at the hearing, the Subject maintained that the contact with the Service Recipient's stomach was a "touch control." In her testimony, OCFS regional trainer ██████████ characterized the contact as a "tap to the stomach." OCFS regional trainer ██████████ testified that a prescribed touch control is a supportive touch, a calming technique to be applied to a service recipient whose behavior is escalated. As taught by OCFS, the touch is to the hand, arm, shoulder, or back. The stomach tap is not a prescribed supportive touch or touch control.

Justice Center Investigator ██████████ testified that the Subject's unapproved touch control provoked the Service Recipient. However, when asked during her testimony if the touch had provoked the Service Recipient, OCFS regional trainer ██████████ would not render an opinion. There was no other evidence on the issue of provocation. It is plausible that the Subject's unapproved touch control provoked the Service Recipient, however there was no statement provided by the Service Recipient, no audio was recorded of the interaction between the Subject and the Service Recipient, and only a portion of the interaction is captured in the video.

While the contact that occurred between the Subject and the Service Recipient's stomach area is captured in the video, the Administrative Law Judge presiding over the hearing does not find the video to be of sufficient quality to render a conclusion about the nature of the contact.

### **Restraint**

The Commissioner of the OCFS has authorized a restraint, in relevant part: "where [an]

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emergency physical intervention is necessary to protect the safety of any person.”<sup>2</sup> (Justice Center Exhibit 8, pg. 8)

After the physical interaction at the door between the Subject and the Service Recipient, the Service Recipient backed away from the door and the Subject. (Justice Center Exhibit 5: video) The Subject testified that as the Service Recipient backed away, he continued to clench his hands “like he wanted to throw a punch or something.” The Subject testified that the Service Recipient assumed a “boxing stance.” However, the video evidence illustrates that the Service Recipient backed away from the Subject, and an emergency physical intervention was not necessary to protect the safety of any person. The convincing evidence in the record illustrates that the resulting contact between the Subject and the Service Recipient was not warranted by the relevant OCFS policy.

There is no dispute that the Subject’s hand was in the neck or shoulder area during the initial phase of the interaction. The Subject testified that his intention was to place the Service Recipient in the high hooks when his own hand came close to the neck area. However, the placement was actually above the neck and more toward the shoulder. The video evidence illustrates this contact lasted approximately one second. OCFS regional trainer ██████████ testified that intentionally touching a service recipient’s neck would not be acceptable under prescribed OCFS training.

OCFS regional trainer ██████████ characterized the technique employed by the Subject, from the time at which the Service Recipient exposed his back, as consistent with instruction by OCFS in that the Subject penetrated with high hooks under the arms of the Service

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<sup>2</sup> (New York State Office of Children and Family Services, Policy and Procedure Memoranda : *Crisis Prevention and Management* [PPM 3247.12- 11/25/13])

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Recipient. OCFS regional trainer ██████████ testified that: “at this point I think he’s getting in good position to get those two high hooks which is what we tell people to do.”

OCFS regional trainer ██████████ testified that such a restraint should finish with the staff member taking “... a step back, drop[ping] one knee, drop[ping] the other knee, and settl[ing]. If the [service recipient] is resisting, it’s entirely possible that you fall over like that,” referring to the fact that both the Subject and the Service Recipient thereafter fell in a rather uncontrolled fashion to the ground. Ultimately, it was this part of the restraint, which was characterized in the substantiation letter as a tackle.

The Service Recipient provided no information on this portion of the restraint or any of the events at issue, with the exception of his complaint of pain and injury to his chest and throat to the facility OCFS Nurse Administrator ██████████ while she examined the Service Recipient after the incident. However, during the examination, facility OCFS Nurse Administrator ██████████ observed no bruising or redness in those areas. After the Subject removed himself from the restraint, the Service Recipient continued to resist the restraint, remained combative and was ultimately restrained for six additional minutes. Finally, the Service Recipient refused to be photographed and would not remove his shirt for examination.

### **Physical Abuse**

In this case, the video evidence is not of sufficient quality to make a determination that the Subject’s hand, which appears to be in the neck and shoulder region of the Service Recipient for a brief period of time (approximately one second), caused the likelihood of either physical injury, or of serious or protracted impairment of the Service Recipient’s physical, mental or emotional condition. Additionally, it is not possible from the evidence in the record to conclude that the Subject hit, slapped or smacked the Service Recipient in the stomach. Nor does the

video evidence or the witness testimony support the conclusion that the Subject tackled the Service Recipient to the floor. The agency has not established by a preponderance of the evidence that the Subject committed physical abuse.

### **Deliberate Inappropriate Use of Restraints**

Ultimately, the technique utilized by the Subject was a mechanical measure, which limited the ability of the Service Recipient to freely move his arms and therefore, constitutes a restraint. The Subject did not attempt to verbally de-escalate the Service Recipient when he backed away from the Subject and the physical intervention was not necessary to protect the safety of any person. The resulting contact between the Subject and the Service Recipient was not warranted by the relevant OCFS policy. Therefore, the restraint was deliberately inconsistent with generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies. As such, the Subject's actions constitute a deliberate inappropriate use of restraints. Additionally, the Subject utilized a disproportionate amount of force in executing the restraint and this contributed to the Subject, and the Service Recipient falling to the floor in an uncontrolled manner. (Justice Center Exhibit 5: video)

The relevant OCFS policy: "requires staff to utilize the least amount of force necessary to maintain the safety of staff and youth, and that which poses the minimum risk of injury to youth..." (New York State Office of Children and Family Services, Policy and Procedure Memoranda: *Crisis Prevention and Management* pg. 2 [PPM 3247.12-11/25/13]) ... Under the facts and circumstances of this case, the Subject's use of a disproportionate amount of force while performing a restraint was deliberately inconsistent with OCFS policy, and therefore constitutes the prohibited act of deliberate inappropriate use of restraints."

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

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the prohibited act of deliberate inappropriate use of restraints. The Justice Center failed to prove by a preponderance of the evidence that the Subject committed the prohibited act of physical abuse. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse set forth in the substantiated report. The restraint was not warranted under the circumstances and was carried out with more force than necessary. Considering the degree of force utilized, the restraint as performed seriously endangered the health, safety or welfare of the Service Recipient. 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 conduct.

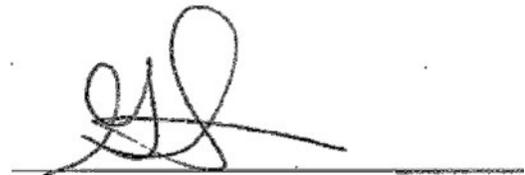
**DECISION:**

The request of ██████████ that the substantiated report dated ██████████, be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints).

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

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

**DATED:** January 19, 2016  
Schenectady, New York

A handwritten signature in black ink, appearing to be 'G. Serlin', written over a horizontal line.

Gerard D. Serlin  
Administrative Law Judge