PUBLIC

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
FRANCIS W. KELLY, JR., M.D.

CONSENT
ORDER

BPMC No. 03-218

Upon the application of (Respondent) FRANCIS W. KELLY, JR., M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney,

Whichever is first.

SO ORDERED.

DATED: 8/20/03

Michael A. Gonzalez, R.P.A.
Vice Chair
Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

FRANCIS W. KELLY, JR., M.D.

CONSENT AGREEMENT AND ORDER

FRANCIS W. KELLY, JR., M.D., representing that all of the following statements are true, deposes and says:

That on or about March 27, 1990, I was licensed to practice as a physician in the State of New York, and issued License No. 181785 by the New York State Education Department.

My current address is 1695 Saltvale Road, Wyoming, New York 14591, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with nineteen specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I admit to paragraphs A.5, B.5, C.1, D.6, F.5, G.3, H.2, I.1 and J.1 of the seventeenth specification in full satisfaction of the charges against me, and agree to the following penalty:

1. My license to practice medicine in the State of New York shall be suspended for 2 years, with the suspension stayed pending my satisfactory compliance with a 3 year term of probation, in accordance with the terms set forth in Exhibit B, which require, among other things, my successful completion of a clinical competency assessment and a personalized education program.

2. My license to practice medicine in the State of New York shall be limited to prohibit the practice of obstetrics, including, but not limited to, prenatal care. I may apply to the Director of OPMC for a modification of this limitation, which the Director of OPMC in his sole discretion may grant or deny upon such terms and conditions as the Director of OPMC may determine.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within

Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether

administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

DATED 7-18-03

Francis W Kelly

FRANCIS W. KELLY, JR., M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 7/18/03

ROBERT PEARL, ESQ.
Pearl & Smith
Attorney for Respondent

DATE: 7/30/03

TIMOTHY J. MAHAR
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 8/15/03

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT A

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

FRANCIS W. KELLY, Jr., M.D.

STATEMENT

OF

CHARGES

Francis Kelly, M.D., the Respondent, was authorized to practice medicine in New York State on March 27, 1990, by the issuance of license number 181785 by the New York State Education Department.

A. Respondent provided prenatal care to Patient A (patients are identified by name in Appendix A) who delivered by Cesarean section on October 11, 2001 at 33 5/7 weeks gestation at Wyoming County Community Hospital (WCCH) in Warsaw, New York. Patient A's pregnancy was complicated by, among other things, Patient A's past history of Grave's disease and fetal tachycardia. Respondent's medical care of Patient A deviated from accepted standards of care in the following respects:

1. Respondent ordered non-stress tests early in Patient A's pregnancy which were inappropriate.

2. Respondent failed to consider and/or order non-stress tests later in Patient A's pregnancy when medically indicated.

3. Respondent failed to adequately follow-up on a perinatologist impressions concerning the risks of fetal hyperthyroidism, and/or recommendations for monitoring Patient A and/or Patient A's fetus during the prenatal period.

4. Respondent failed to formulate and/or order an adequate follow-up plan at Patient A's October 4, 2001 office visit, at which time the fetal heart rate was documented to be 180 beats per minute.

5. Respondent failed to maintain an accurate and/or adequate medical record for Patient A, including, but not limited to some or all of the following: the failure to include reports of laboratory values, ultrasound reports, consultation reports, and/or the findings at office examinations.

B. Respondent provided prenatal care to Patient B and performed a vaginal delivery on January 30, 2002 at WCCH. The third stage of labor was complicated by incomplete passage of the placenta with portions of the placenta retained in Patient B's uterus. Respondent's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent, following delivery, failed to formulate an appropriate treatment plan for Patient B concerning the retained portions of the placenta.

2. Respondent failed to adequately and/or timely treat, manage or seek an appropriate consult in the care of Patient B's retained placental fragments.

3. Respondent failed to order an HIV test for Patient B during the prenatal period.

4. Respondent on January 30, 2002, wrote an order for an obstetrical consultation for retained placental fragments, among other things. Respondent documented in Patient B's medical record that this order was written at 06:00 A.M., when Respondent knew that the order was actually written at 06:30 A.M. or later.

5. Respondent failed to maintain adequate and/or accurate medical records for Patient B.

C. Respondent provided pediatric care to Patient C on the first two days of her life at WCCH, for tachypnia, among other conditions. Respondent's medical care of Patient C deviated from accepted standards of care in the following respects:

1. Respondent on January 30, 2002 wrote an order for the following in Patient C's medical record:

    1. expedited cord blood for HIV,
    2. a pediatric consult for respiratory distress,
    3. a chest x-ray for respiratory distress,
    4. a heel stick, complete blood count and chemical panel,
    5. an oral-gastric tube.

    Respondent documented in Patient C's medical record that this order was written at 06:45 A.M. on January 30, 2002, when Respondent knew or should have known that the order was written in the record at 07:10 A.M. or later on January 30, 2002.

D. Respondent provided medical care to Patient D during his admission to WCCH on February 6, 2002 and until his death on February 7, 2002. Patient D had a past medical history of, among other things, chronic obstructive pulmonary disease (COPD). On February 6, 2002, it was noted in the emergency department record that Patient D's temperature was 100.3, his pulse was 129, his respirations were 36 and his pulse oximetry was 81% on room air, among other things. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely and/or adequately consider, assess or rule out pneumonia and/or other infections in Patient D.
2. Respondent failed to timely and/or adequately treat Patient D for the possible diagnosis of pneumonia and/or other infection.
3. Respondent failed to timely and/or adequately treat Patient D's respiratory condition during the admission .
4. Respondent failed to seek a timely pulmonary consultation.
5. Respondent placed an arterial line in Patient D, a procedure Respondent was not credentialed to perform, without an adequate medical indication.
6. Respondent failed to maintain an adequate and/or accurate medical record for Patient D.

E. Respondent provided pediatric care to Patient E during his first three days of life at WCCH. On January 3, 2002, Respondent discharged Patient E from WCCH after noting a "yellow tint" to the baby's skin. Patient E was readmitted to WCCH on January 4, 2002 with hyperbilirubinemia and was transferred the following day to Strong Memorial Hospital in Rochester, New York. Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to order liver function tests for Patient E on January 3, 2002 prior to his discharge.

F. Respondent provided medical care to Patient F during her admission to WCCH on February 20, 1999 and until her death on March 7, 1999. Respondent treated Patient F for hypokalemia, hypomagnesium, dehydration, and inadequate nutrition, among other conditions. Respondent's medical care of Patient F deviated from accepted standards of care in the following respects:

1. Respondent ordered a blood transfusion for Patient F without adequate medical indications.

2. Respondent failed on various occasions to adequately monitor Patient F's potassium levels and/or failed to adequately treat abnormal potassium levels.

3. Respondent failed to adequately monitor Patient F's magnesium levels and/or failed to adequately treat abnormal magnesium levels.

4. Respondent failed to adequately treat, manage and/or monitor Patient F's nutritional status and/or hydration.

5. Respondent failed to maintain an adequate and/or accurate medical record for Patient F.

G. Respondent provided medical care to Patient G at his office and WCCH from August 10, 2000 through May 14, 2002. During Patient G's September 21, 2001 hospital admission, Respondent treated Patient G for diabetic ketoacidosis. Respondent's medical care of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately follow-up Patient G's abnormal laboratory values following his September 7, 2001 office visit.

2. Respondent, on various occasions, failed to perform adequate follow-up evaluations and/or assessments of Patient G's clinical status, vital signs and/or laboratory values during his hospital admission.

3. Respondent failed to maintain an adequate and/or accurate medical record for Patient G.

H. Respondent provided pediatric care to Patient H during the first five days of his life at WCCH. On July 29, 2000, Respondent evaluated Patient H for respiratory complications. Respondent's medical care of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform an adequate physical examination of Patient H and/or failed to order and/or timely order appropriate diagnostic tests at the time Respondent evaluated Patient H's respiratory condition.

2. Respondent failed to maintain an adequate and/or accurate medical record for Patient H.

I. Respondent provided obstetrical care to Patient I who delivered vaginally on July 19, 2001 at the WCCH. Patient I's pregnancy was complicated by a past history of placental acreta, among other things. Following the delivery of Patient I's baby on July 19, 2001, Respondent attempted, unsuccessfully, to manually deliver Patient I's placenta. Patient I subsequently underwent a subtotal hysterectomy. Respondent's care of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to make an adequate medical record of his attempt to manually deliver Patient I's placenta on July 19, 2001.

J. Respondent provided medical care to Patient J from April 24, 2000 until her death on December 13, 2001 at his offices and WCCH for Crohn's disease, hyperlipidemia and hypertension, among other conditions. Respondent's care of Patient J deviated from accepted standards of medical care in the following respects:

1. Respondent failed to maintain an adequate medical record for Patient J.

SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(4) by reason of his having practiced medicine with gross negligence, in that Petitioner charges:

1. The facts set forth in paragraphs A and A.3 and/or A and A.4.
2. The facts set forth in paragraphs B and B.2.
3. The facts set forth in paragraphs D and D.1 and/or D and D.2.
4. The facts set forth in paragraphs E and E.1.
5. The facts set forth in paragraphs F and F.2.

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(6) by reason of his having practiced medicine with gross incompetence, in that Petitioner charges:

6. The facts set forth in paragraphs A and A.3 and/or A and A.4.
7. The facts set forth in paragraphs B and B.2.
8. The facts set forth in paragraphs D and D.1 and/or D and D.2.
9. The facts set forth in paragraphs E and E.1.
10. The facts set forth in paragraphs F and F.2.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(3) by reason of his having practiced medicine with negligence on more than one occasion, in that Petitioner charges:

11. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, E and E.1, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, I and I.1, and/or J and J.1.

TWELVETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(5) by reason of his having practiced medicine with incompetence on more than one occasion, in that Petitioner charges:

12. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, E and E.1, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, H and H.1, H and H.2, I and I.1, and/or J and J.1.

THIRTEENTH AND FOURTEENTH SPECIFICATIONS

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) by reason of his having practiced the profession of medicine fraudulently in that Petitioner charges the following:

13. The facts set forth in paragraphs B and B.4.

14. The facts set forth in paragraphs C and C.1.

FIFTEENTH AND SIXTEENTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(21) by reason of his having made or filed a false report, in that Petitioner charges the following:

15. The facts set forth in paragraphs B and B.4.

16. The facts set forth in paragraphs C and C.1.

SEVENTEENTH SPECIFICATION

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Education Law § 6530(32) by reason of his having failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges the following:

17. The facts set forth in one or more of the following paragraphs: A and A.5, B and B.4, B and B.5, C and C.1, D and D.6, F and F.5, G and G.3, H and H.2, I and I.1 and/or J and J.1.

EIGHTEENTH AND NINETEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Education Law § 6530(20) by reason of his having engaged in conduct in the profession of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

18. The facts set forth in paragraphs B and B.4.

19. The facts set forth in paragraphs C and C.1.

DATED: June 25, 2003
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230(19).

2. Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that such information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records and/or hospital charts; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

CLINICAL COMPETENCY ASSESSMENT

9. Within 45 days of the effective date of the Order herein, Respondent shall obtain a clinical competency assessment (CCA) performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC within thirty (30) days of the completion of the evaluation.

    a. Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This term of probation shall not be satisfied in the absence of actual receipt, by the Director, of such documentation, and any failure to satisfy shall provide a basis for a Violation of Probation proceeding.

PERSONALIZED CONTINUING MEDICAL EDUCATION

10. Following the Clinical Competency Assessment above, at the direction of the Board and within 90 days of the effective date of the Order, Respondent shall be enrolled in a course of personalized continuing medical education [PCME], which includes an assigned preceptor, preferably a physician board certified in the same specialty, to be approved, in writing, by the Director of OPMC. The PCME shall be directed to remediating any deficiencies identified in the Clinical Competency Assessment. The Respondent shall remain enrolled and shall fully participate in the program for a period of not less than three months nor more than twelve months, at the discretion of the Director of OPMC.

11. At the direction of the Board and within 60 days following the completion of the clinical competency assessment (CCA) the Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC.

    The Respondent shall cause the Preceptor to:

    a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a timeframe for completion of the remediation program of not less than three months and no longer than twelve months.

b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

c. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.

d. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.

Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program, or to the monitoring physician

12. During the term of probation, Respondent shall practice medicine in either private practice, hospitals or other institutional settings outside of the personalized continuing medical education program, only when monitored by a licensed physician, board certified in an appropriate specialty (practice monitor), proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the practice monitor, including on-site observation. The practice monitor shall be available to consult with the Respondent on a 24 hour basis by telephone, facsimile or in person regarding patient care. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least weekly and shall examine a selection (no less than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC. If Respondent successfully completes the first year of probation, he may petition the Director of OPMC for a modification of the terms of this subparagraph. Any modification of these terms shall be made in the sole discretion of the Director of OPMC.

b. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

c. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

13. Respondent shall cause the practice monitor to report to OPMC on a quarterly basis regarding Respondent's compliance with the approved monitoring plan. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, the monitor's assessment of patient records selected for review, detailed case description of any case found to not meet the established standards of care and Respondent's remediation of previously identified deficiency areas. The Respondent shall cause the practice monitor to monitor Respondent's medical practice in accordance with a monitoring plan to be approved by the Director of OPMC. Such monitoring plan shall include, but not be limited to, provisions for selected medical record reviews, occasional observation of the Respondent in practice settings, required participation in hospital departmental meetings and enrollment in ongoing education courses, if any.

14. Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program or to the monitoring physician.

15. After Respondent completes the PCME, Respondent shall annually enroll in and complete a continuing education program in the areas of the identification and management of high risk factors in adult patients, and pediatric patients, for a minimum of 24 credit hours/year. This continuing education program is in addition to any requirements the Respondent may have for maintaining his board certification. This continuing education program is subject to the Director of OPMC's prior written approval and shall be completed within the probation period, unless the Order specifies otherwise.

16. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.