



STATE OF NEW YORK
OFFICE OF THE INSPECTOR GENERAL
STATE CAPITOL
ALBANY, NEW YORK 12224

61 BROADWAY, 12TH FLOOR
NEW YORK, NEW YORK 10006

DINEEN ANN RIVIEZZO
Inspector General

65 COURT STREET, 5TH FLOOR
BUFFALO, NEW YORK 14202

REPORT BY STATE INSPECTOR GENERAL AND TOMPKINS COUNTY DA FAULTS OPERATIONS AT GOSSETT YOUTH DETENTION CENTER

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New York State Inspector General Dineen Riviezzo and Tompkins County District Attorney Gwen Wilkinson today released the results of a 10-month investigation of the Louis Gossett Jr. Residential Center, a youth detention facility operated by the New York State Office of Children and Family Services (OCFS) in Lansing. The investigation was prompted by allegations that young male residents of the center were the victims of physical and sexual abuse inflicted by staff.

Assemblywoman Barbara Lifton of Ithaca was the first to call for an investigation of conditions at Gossett, which is located in her legislative district, and she and her office provided valuable assistance to the investigation.

The investigation, which is detailed in the 86-page report, concluded that the alleged environment of pervasive violence and intimidation of residents at Gossett was not substantiated. Further, Inspector General Riviezzo and District Attorney Wilkinson agreed that none of the allegations of serious physical abuse or sexual abuse warranted criminal prosecution. In those cases in which Gossett employees were found to have violated OCFS's or facility rules, appropriate discipline was imposed, including fines, suspensions and terminations.

The investigation did find, however, serious problems in a number of important operations at Gossett and OCFS. These problems include a near-total breakdown in the functioning of the Office of Ombudsman, a mandated program intended to provide independent oversight of Gossett and other facilities within the OCFS system, and serious deficiencies in mental health resources and substance abuse treatment provided to Gossett residents.

Gossett, located in Lansing, is one of 10 limited- or medium-secure youth correctional/detention centers operated by OCFS. Gossett's function is to confine males ages 13 to 17 who have been adjudicated juvenile delinquents by Family Courts and

ordered to reside there for conduct that, if committed by an adult, would constitute a crime. Gossett houses up to 150 youths on any given day and employs about 130 persons.

According to Inspector General Riviezzo, the broad-ranging investigation was one of the largest ever conducted by her office. More than 20 members of the IG's professional staff, including attorneys, auditors and investigators were dedicated to this project maintaining an almost weekly presence at Gossett. Approximately 400 interviews were conducted. Former residents were located throughout the State and interviewed. Interviewed too were all active employees as well as numerous former employees. Management at both Gossett and OCFS were also interviewed. Literally thousands of pages of documents were reviewed and analyzed. The State Police assisted in many of these efforts.

The major findings of the investigation include the following:

- More than 40 alleged instances of physical or sexual abuse of Gossett residents by staff between 2002 and 2006 were investigated, including the allegations first brought to our attention and additional allegations identified in the course of the investigation. The Inspector General and District Attorney's agreed that the evidence did not support the filing of criminal charges. Nor was systemic abuse found at Gossett. Significantly, in a number of instances, Gossett employees were disciplined for misconduct with penalties that included fines, suspensions, and terminations

Additionally, in the early stages of the investigation, to allay public concern that abuse at Gossett might be ongoing, investigators interviewed all 133 residents present at the facility during the week of March 27. Nearly every resident said he felt safe and was being treated fairly.

In presenting these findings with respect to alleged abuse, the Inspector General's Office recognizes the inherent difficulties of investigating such incidents months or even years after they occurred. These difficulties are compounded by what Gossett staff said was a common practice of employees getting together to write their post-incident reports, which can lead to collusion and a "coloring" of reports to favor staff's version of events.

- The Office of Ombudsman, an internal oversight program mandated by OCFS regulations, has virtually ceased to exist. Ombudsman staff have responsibility for visiting facilities, hearing grievances, investigating allegations of violations of legal rights, and advising the Commissioner of OCFS of significant complaints and allegations. Beginning in 1991 and continuing to the present, staff and resources of the program have been drastically reduced and the entire program marginalized. Unannounced facility visits are a crucially important tool of the Ombudsman program, yet for at least the past 15 years only one such visit was attempted by an Ombudsman, and the attempt was resisted by a senior OCFS official.

- OCFS regulations also require the establishment of an Independent Review Board (IRB) to advise the Commissioner on matters relating to the Ombudsman. This investigation found that the IRB has been essentially moribund since at least 1994, and the Independent Review Committee, a successor entity to the IRB, was described by one of its members as “the worst board I have ever been on.”
- Mental health services provided to Gossett residents are inadequate. Of the residents present in the facility the week of March 27, 98.4 percent were diagnosed with mental health disorders. Moreover, 65.6 percent had multiple disorders, and approximately 28 percent were prescribed psychiatric drugs. To treat these residents, Gossett’s entire mental health staff consisted of one full-time psychologist, one full-time social worker, one part-time social worker, and a consulting psychiatrist. The consulting psychiatrist allots only six hours per month, one-and-a-half hours per week, to manage the 34 residents taking one or more psychiatric medications.
- The investigation found a dramatic correlation between residents with significant mental health problems and the frequency of restraints. For the sample population of 133 residents at Gossett the week of March 27, 2006, we determined there were 233 restraints throughout their placements at Gossett. Strikingly, more than 54 percent (or 126) of the restraints involved residents taking psychiatric medications. Gossett’s residents taking psychiatric medications were approximately three and one-half times more likely to be involved in a restraint than those not taking such medications.
- Substance abuse treatment services for Gossett residents are insufficient. More than 40 percent of residents were diagnosed with a substance abuse disorder. In addition, many residents diagnosed with substance abuse disorders were also diagnosed with serious psychiatric and emotional illnesses. Gossett administrators admitted the facility has provided limited substance abuse treatment services. In fact, until recently, the entire substance abuse program at Gossett consisted of a rather basic substance abuse educational program taught by teachers at the facility. Gossett management stated that the facility had recently started a new substance abuse treatment program in conjunction with a private community program licensed by the New York State Office of Alcoholism and Substance Abuse Services. The program will provide approximately 20 hours per week of substance abuse treatment for the residents who have the most significant substance abuse problems. One administrator acknowledged what would appear obvious, that the 20 hours per week may still be insufficient, and admitted that Gossett is not equipped to provide effective substance abuse treatment.
- Training for Gossett staff is deficient. OCFS policies require that direct care workers receive 40 hours of training each year after their first year of work. The investigation found that Gossett’s staff members were not receiving the required yearly training. Specifically, 40 staff members, or 38.8 percent, at Gossett in 2005 failed to meet the required training. Strikingly, this represents a 233 percent increase over the 2004 figures.
- OCFS suppresses gangs through a “no tolerance” policy in its detention facilities, and the investigation found that gang activity is not a problem at Gossett. However, OCFS’s

approach to gangs does not provide a formal method to keep or help residents stay out of gangs upon re-entering their communities.

Inspector General Riviezzo and District Attorney Wilkinson expressed their appreciation to OCFS and Gossett officials, who provided full cooperation and access to investigators.

The report includes the following recommendations:

- OCFS should take all steps necessary to immediately be in full compliance with State regulations that ensure the independence and effectiveness of the Office of Ombudsman and Independent Review Board.
- OCFS should provide Gossett with the appropriate staff of mental health professionals to provide the proper care of its residents. Residents with severe psychiatric or emotional disorders should be placed only in facilities equipped to provide appropriate care, such as facilities with discrete Mental Health Units.
- Gossett and OCFS should provide appropriate training programs in areas relating to residents with psychological and emotional disorders; substance abuse; cultural and diversity sensitivity; and youth gang membership.
- OCFS should explore alternative youth gang programs to augment its current “suppression” approach and address the follow-up needs of residents returning to their communities.

State Inspector General Riviezzo said: “Maintaining a safe and secure environment at the Gossett Center serves the interests of staff and residents, as well as the entire community. I am confident that the results of this investigation will lead to significant improvements in the operation of Gossett and the State’s youth detention system as a whole.”

District Attorney Wilkinson said: “Working with the Inspector General’s staff at each step of the investigation, I am satisfied that none of the matters brought to my attention warranted criminal proceedings. I cannot say that no crime against a Gossett resident ever occurred in the period covered by this investigation, but I can say that over 40 incidents that merited review were carefully examined, and none was found to constitute a prosecutable crime.”

Assemblywoman Lifton said: “From day one, I have had great confidence that the State Inspector General’s Office would conduct an open-minded, fair, and thorough investigation of the allegations that came to my office. This report bears out that confidence. The good news is that the residents are not being abused and generally were not in the past. In many regards, the employees at the Gossett Center have done a remarkable job with a very difficult population while being grossly under-resourced. But there are serious problems. This report raises larger societal issues about why we are seeing an increase of serious mental illness among these disadvantaged and troubled teens, and what we should be doing to address this. More immediately, it points to a need

for much stronger State oversight from a revived, proactive Ombudsman's Office and Independent Review Board within OCFS."

For more information, contact Stephen Del Giacco at (518) 474-1010 – office
(518) 461-5240 – cell

The report can be viewed on the Inspector General's website at: www.ig.state.ny.us