



STATE OF NEW YORK  
OFFICE OF THE INSPECTOR GENERAL

AND

OFFICE OF THE TOMPKINS COUNTY  
DISTRICT ATTORNEY

**REPORT ON THE LOUIS GOSSETT JR.  
RESIDENTIAL CENTER**



**November 2006**

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Inspector General

Gwen Wilkinson  
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## INTRODUCTION

At the beginning of 2006, the Office of State Inspector General (OSIG) received a letter from Assemblywoman Barbara Lifton of Tompkins and Cortland Counties relating allegations of physical and sexual abuse made by former and current employees of the Louis Gossett Jr. Residential Center (Gossett) in Lansing, New York. The alleged victims of the abuse were 13- to 17-year old male residents of Gossett, a medium-secure youth correctional facility run by the New York State Office of Children and Family Services (OCFS). Gossett's residents have all been adjudicated Juvenile Delinquents by State Family Courts for acts which, if committed by adults, would constitute crimes. Placements of youths for misdemeanor-level offenses are for periods of up to 12 months, while those for felony-level offenses are for periods of up to 18 months. Many of the acts committed by these residents are of a violent and serious nature.

The allegations included the following:

- Gossett staff is physically abusing residents, indiscriminately causing broken arms and legs as well as other significant injuries. These include abrasions caused by rubbing residents' faces into the facility's carpet, injuries known as "rug burns." These injuries were inflicted, it was alleged, in order to control the residents' behavior through fear and intimidation.
- Sexual abuse was committed against residents by at least one staff member of the facility's Medical Unit.
- Upper management of the facility is aware of this culture of violence and abuse and allows it to continue.

- Gossett’s top management allows an environment of racial hostility and insensitivity to pervade the facility.
- The educational and rehabilitative programs conducted at Gossett are ineffective.

These allegations had appeared in both print and electronic news media, and became the focus of a public access television program. Assemblywoman Lifton took the lead in calling for an investigation of these serious allegations of acts taking place within her District.

Within days of receiving Assemblywoman Lifton’s letter, members of the Inspector General’s Office met with both the Assemblywoman and with a number of current and former Gossett employees alleging abuse by their colleagues. Immediately following these initial interviews, the Inspector General met with Gwen Wilkinson, the Tompkins County District Attorney, at which meeting the Inspector General and the District Attorney agreed to conduct a joint investigation. It was agreed that OSIG would conduct investigative interviews and documentary analyses, while the District Attorney’s Office would review the results of the investigation of each allegation for possible criminal prosecution. This report is the product of the efforts of both Offices.

## **SCOPE AND METHODOLOGY**

The primary focus of this investigation and review was to determine the validity of the allegations of abuse and to ensure the ongoing safety of all Gossett residents. If the allegations of abuse were substantiated, both the Inspector General and the District Attorney would ensure that appropriate and effective action would be taken. If, however,

the allegations were determined to be unfounded, those employees of Gossett who were the subject of the charges of abuse should have their professional reputations restored. Of equal importance, the public deserves to have these highly disturbing allegations addressed in a thorough and credible manner.

While the primary focus of the investigation was the issue of physical and sexual abuse, the investigation addressed a number of other concerns, including the charges of institutional racism and racial bias, and the effectiveness of Gossett's educational and rehabilitative programs, including those dealing with mental health, substance abuse and youth gang issues.

In addressing these issues, the policies, rules and regulations of both OCFS, the parent agency, and the Gossett Residential Center itself were subpoenaed and analyzed. In addition, all relevant State statutes and regulations were reviewed. The period which comprised the primary focus of the investigation was January 2002 through June 2006, although significant allegations or information received beyond this period were pursued and addressed.

More than 20 members of OSIG's professional staff, including attorneys, auditors and investigators, were dedicated to this project, maintaining an almost weekly presence at the facility over a period of approximately six months, logging over 11,000 staff hours. Approximately 400 interviews were conducted. These interviews included all 133 residents present the week of March 27, 2006, as well as those residents who had been transferred to other OCFS facilities subsequent to the time this investigation began. Former residents were located throughout the State and interviewed. Interviewed too

were all 129 active employees, as well as many former employees. Management at both Gossett and OCFS were also interviewed.

Literally thousands of pages of documents were reviewed and analyzed. These documents included relevant policies, procedures, rules and regulations, along with printed reports and logs of the facility itself. Similarly, documents in the records and files of OCFS Central were reviewed and analyzed in the same way. Data analyses were conducted to identify any troubling patterns of abuse committed by specific Gossett staff members, as well as patterns of abuse directed against specific residents or group of residents. Independent studies relating to various operational issues were also conducted. These included alternative approaches to mental health treatment and youth gang counseling.

Along with the specific allegations which provided the initial basis for this review, more than 20 potential cases of physical or sexual abuse were independently identified by OSIG staff and fully investigated. The New York State Police also provided support. In all, more than 40 individual investigations were conducted, with all evidence of potential criminality reviewed by the Tompkins County District Attorney's Office. In the end, an examination of every incident involving a potential criminal interaction between a resident and staff member was conducted, regardless of the source or strength of the information.

Gossett and OCFS management provided both access to documents and individuals, arranging for private facilities for OSIG's staff to conduct its interviews. This cooperation significantly facilitated the carrying out of this project.

## **THE LOUIS GOSSETT JR. RESIDENTIAL CENTER**

The Louis Gossett Jr. Residential Center, located in Lansing, New York, is a facility operated by the New York State Office of Children and Family Services (OCFS). Gossett is one of 10 limited, or medium, secure youth correctional/detention centers operated by OCFS. Gossett's function is to confine males between 13 and 17 years of age 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. The initial Family Court placement with OCFS depends upon the level of offense found by the court to have been committed by the youth (misdemeanors result in placements up to 12 months, while felonies are up to 18 months).

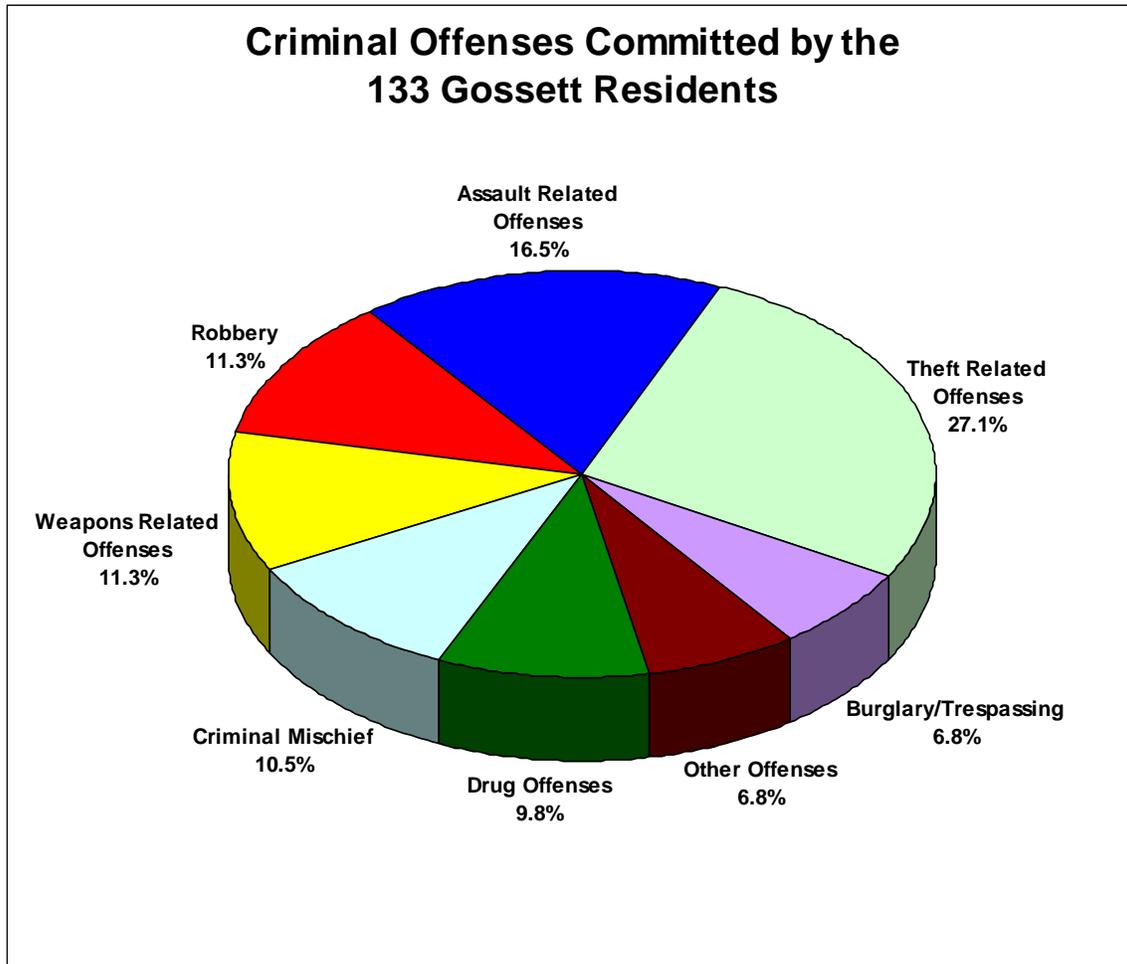


The Gossett campus.

### **GOSSETT'S RESIDENT POPULATION**

Residents have been placed in Gossett for a variety of criminal activities, many of which are violent and serious in nature. Most residents have committed prior violations of law despite their relatively young ages. In fact, nearly three-quarters of Gossett's resident population had previous adjudications in the juvenile justice system prior to the incident which resulted in their present OCFS placements. As reflected in the chart

below, the 133 residents present at Gossett during the week of March 27, 2006 were placed in the OCFS juvenile system for the following acts:



In addition to their violations of laws, the residents often enter Gossett with a wide variety of psychiatric problems, as victims of physical and sexual abuse, as members of street gangs and as children of drug-addicted and incarcerated parents.

The backgrounds of two residents are highlighted here as examples of the multitude of issues that not only the Gossett staff, but OCFS as a whole, must struggle with when attempting to fulfill its mission of responding to the needs of its resident population.

One resident is the adoptive child, along with four other adoptive siblings, of a single-mother. This resident spent his first five years in the custody of child care services until his adoptive mother took custody of him as a foster parent. By the age of 14, the resident's behavioral problems had become sufficiently violent to warrant intervention of the medical community and the assignment of a psychiatrist. The resident's threat to blow up his home resulted in an in-patient psychiatric evaluation and the prescribing of psychiatric medication. He destroyed household property in angry tirades and was suspended from school for displaying a knife during a fight and causing a teacher to fall down a flight of steps. A threat on a neighbor resulted in another admission to a psychiatric facility. During an argument with his sister, the resident displayed a knife and chased her until the police arrived and arrested him. His violent behavior was further exhibited by his attempt to choke gerbils, the classroom pets, and kick a seeing-eye dog. In one fall semester, the resident was absent from school 26 out of 32 school days.

Another resident was born to a crack-addicted mother and, as a result, spent the first three weeks of his life in the hospital. He and his mother's three other children were raised by his maternal grandmother who was awarded custody of the children because of his mother's ongoing drug addiction and a serious illness. Another sibling was murdered at age 17 in an incident related to his mother's drug problems. His father is incarcerated in a maximum security facility. He has admitted to being sexually active, to smoking six to seven blunts of marijuana a day since the age of 10, and to drinking alcohol to get drunk since the age 14.

The resident routinely had threatened to kill his grandmother if she did not give him money, which she would then give him in increments in order to avoid getting him

angry. His grandmother admitted to having no control over him as he stayed out all night almost every night and refused to attend school. The resident admitted to being a member of a street gang and associating only with other members of that gang, many of whom use drugs and have criminal histories. He also admitted to numerous physical altercations with members of a rival gang. He had refused counseling and medication for behavioral problems, and was in Gossett on a drug-related charge.

### **GOSSETT'S OPERATIONS**

In providing for residents ordered there by Family Courts, Gossett's mission is to "offer quality program services that are responsive to the needs of the client population we serve. The services will provide youth an opportunity to learn, grow, and develop in a safe, secure and predictable environment." Those services include educational and vocational programs; counseling, psychological services and psycho-educational skills training; medical services; and recreational opportunities.

As a State-operated facility, Gossett must comply with all applicable State laws, as well as all OCFS regulations, rules and policies. OCFS's Division of Rehabilitative Services (DRS) manages, coordinates and oversees the State's juvenile detention centers including Gossett. The DRS's responsibilities include reviewing all facility "Unusual Incident Reports" (discussed later), auditing the effectiveness of facility programs, and employing regional Facility Coordinators who provide oversight of these facilities.

Gossett is also accredited by the American Correctional Association (ACA), a private, non-profit organization that administers the only national accreditation program for adult

and juvenile correctional facilities. Gossett must meet ACA standards for the quality of services provided, as well as all health and safety conditions.

Gossett is a self-contained, campus-like environment and can accommodate up to 150 residents in 10 separate units. Each resident is assigned to a private bedroom in his particular unit.



The day-room of a unit is where residents study, hold group meetings, and spend their leisure time. In the background are the doors to resident bedrooms.

## **GOSSETT'S STAFF**

Gossett is managed by a facility Director and two Assistant Directors, assisted by support staff. The majority of the 130 employees at the facility are Youth Division Aides (YDA), whose responsibilities include maintaining the security of the facility, monitoring the care of residents, and providing direct oversight of the residents' daily activities. Additionally, Youth Counselors (YC) implement and oversee the residents' treatment plans and coordinate all rehabilitative services. There are also full-time academic and vocational teachers, mental health professionals, medical personnel and recreational staff who provide a range of services.

The minimum qualifications for an entry-level YDA is a high school diploma (or equivalent) or one year full-time paid experience caring for youth in an institution, camp, residential school or community center. As of October 31, 2006, there were 82 YDAs on staff at Gossett. Analysis of the educational backgrounds of staff revealed that 34%, or 28, had college degrees, far exceeding the minimum qualifications for the position. The remainder of the YDAs on staff possessed a high school diploma. Further, approximately 60 YDAs, or 73.2%, had experience in a youth setting, a correctional facility, the military or law enforcement prior to employment at Gossett.

## **INITIAL SURVEY TO ENSURE RESIDENTS' SAFETY**

At the beginning of the investigation, the individuals who had made many of the initial allegations informed OSIG that assaults were continuing at the very time the investigation was going forward. As a result, OSIG made the decision to immediately interview each and every one of the then 133 residents of Gossett to ensure that no abuse was taking place while OSIG was conducting its investigation.

A survey consisting of 36 questions was developed, forming the basis for the resident interviews. The questions were designed to illicit the following information: Were any of the residents subjected to physical or sexual abuse? Were they or other residents injured by facility staff? Did the resident feel safe in the facility? And did the residents know and understand the procedures to lodge a complaint with management? The residents were also asked to assess the effectiveness of facility educational, counseling and treatment programs. Finally, the residents were asked to grade the overall treatment they received from Gossett staff on a five-point scale, ranging from "Poor" (1)

to “Good” (5), and each was given an opportunity to bring to the attention of OSIG any other issues of concern.

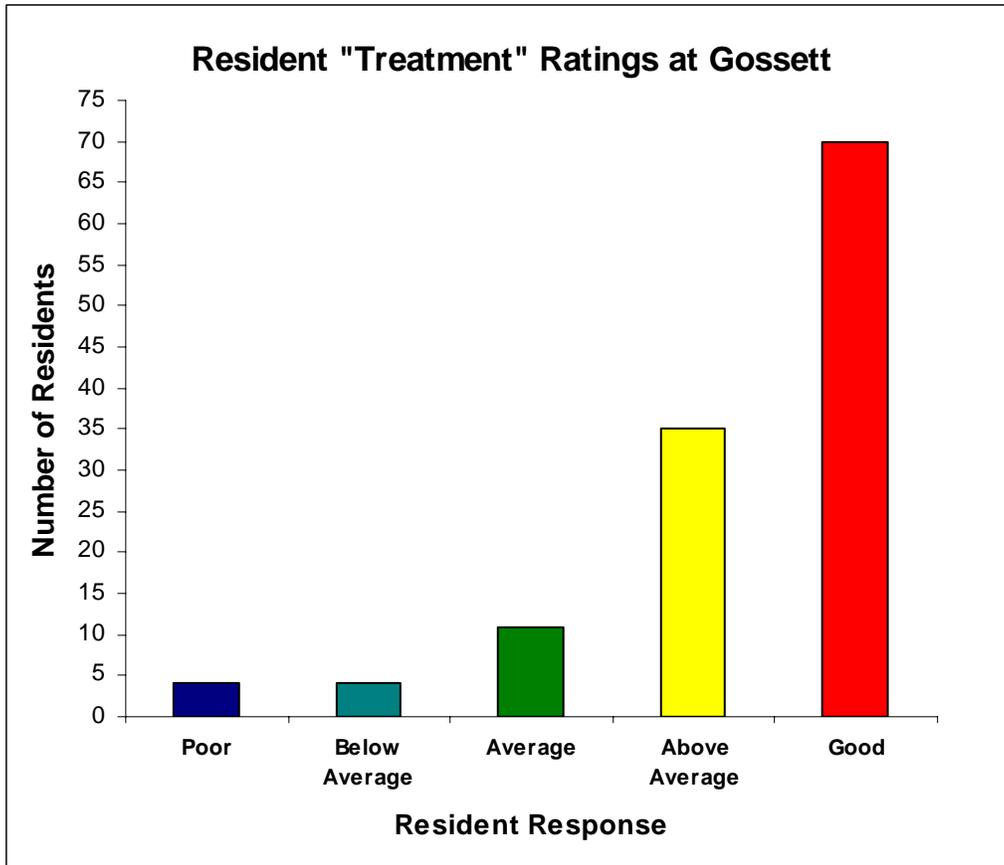
Four teams, of two investigators each, were sent into the facility, conducting their interviews both day and night over three days during the week of March 27, 2006. Each of the interviews was conducted outside of the presence or view of any Gossett staff member.

The results revealed that over 92% of the respondents stated that they felt safe at Gossett. Of the 10 residents who stated that they did not, one said it was because his own “anger problem” causes conflicts with residents and staff; one because staff “squeezed” him during restraints; one because he didn’t “see eye to eye” with a YDA; one because YDAs are disrespectful and stare at him; one because residents and staff call him disparaging names, but now he feels safe on his new unit; one felt safer at home, but didn’t feel threatened at Gossett because “they protect you;” one because something said to him frightened him; one because he began to have friction with one YDA a few days before OSIG’s interview; and two provided no explanation at all.

Of the approximately 10% of the residents who reported that they had, at some time, been injured as a result of physical intervention by the staff, all but three stated that their injuries were unintentional, with most described as either rug burns or cuts and abrasions. Only three claimed that staff had intentionally injured them. Each of these claims was investigated and each was found to be unsubstantiated.

As to an assessment of how Gossett staff treated them in general, 105 residents, or 84.7%, responded that staff treated them in an “above average” or “good” manner, the

two most positive categories of the five. Seventy residents, or more than 56%, responded with the highest rating. Only four residents, 3.2%, rated their treatments as “poor.”



To ensure the validity of its survey results, OSIG located and interviewed former residents of Gossett who had been transferred to other facilities in the OCFS system after OSIG’s investigation became public knowledge. The results were consistent with those from the 133 original interviews, with one former resident even requesting to be sent back to Gossett. In addition, OSIG staff re-interviewed a sample of the original 133 residents in order to determine if Gossett staff had questioned them as to their previous interviews or had attempted to influence them in any way. No such interference by Gossett staff was reported.

## **INVESTIGATION INTO ALLEGATIONS OF ABUSE**

Once OSIG's survey of the 133 residents was completed, its investigation into the initial allegations of abuse resumed. The investigation focused on allegations of abuse that came from former residents, former or current staff members or from media reports. The nature of the allegations ranged from specific incidents of abuse, where an identified resident was injured or sexually abused, to general, non-detailed claims of misconduct unsupported by specific facts.

Regardless of the specificity of the allegation, it was, in OSIG's view, essential to address serious allegations of abuse made against staff at Gossett, especially given the grave public concern raised by the allegations. Current staff and residents were interviewed, and most challenging was locating former employees and residents living in disparate regions of New York State. In addition, pertinent documents relating to these incidents were reviewed and analyzed, including agency files and medical and hospital records. Over 20 OSIG staff members were assigned to this labor intensive and time consuming task.

Throughout the investigation, the District Attorney assessed each case and ultimately both offices agreed that criminal charges were not warranted for any of the matters contained in the allegations. Some allegations were utterly inaccurate claims of abuse. Some of the injuries purportedly sustained by the residents were either non-existent, minimal or caused by the resident himself (e.g., by punching a wall). In some instances there were inconsistent statements, no corroboration or no proof that the injury was intentionally inflicted. Even in those few cases where, arguably, a misdemeanor charge might have been sustainable but for the statute of limitations, Gossett employees

were successfully disciplined for misconduct with penalties, including fines, suspensions and terminations.

As virtually every allegation of physical abuse involved alleged unnecessary or excessive physical force by staff against residents, an overview of OCFS's physical intervention program is required. Given the very nature of the role and mission of Gossett and other OCFS facilities — the care and custody of adolescents who have committed serious criminal acts — there are predictably times when staff members are called upon to physically engage residents. At the same time, however, those physical interventions must fully comply with all relevant rules and regulations.

The rules governing physical interventions or “restraints” define the term as “physically restraining a resident and to physically hold or move a resident against his will from one place to another.” As set out in OCFS's Policy and Procedure Manual, the use of physical force is permitted in circumstances where there is no reasonable alternative and, when used, only the minimum force necessary to bring the resident or situation under control is allowed. The policy goes on to set out the specific circumstances under which such a restraint is permitted:

- To protect one's self
- To protect others
- To protect residents from self-inflicted harm
- To protect property
- To enforce a direct order to a resident for reasons of safety or control
- To prevent escapes or AWOL's (absent without leave)
- To respond to an immediate threat to the safe, secure operation of the facility

OCFS's training manual states that a "team approach" to restraints is the preferred option, and that staff should avoid one-on-one physical interventions without first obtaining back-up assistance. All staff members have radios with an emergency call button to summon a Response Team to the scene. Pushing this button is known at Gossett as "pushing the pin."

The general technique used by OCFS personnel systemwide, including at Gossett, is known as the Primary Restraint Technique (PRT). It is part of a patented, internationally recognized physical intervention program entitled "Handle with Care," and is designed to gain control of an aggressive resident both safely and quickly while limiting injury to both the resident and staff. The team approach, or two-person PRT in which two staff members seek to control a resident, is the preferred technique. A one-person restraint is also authorized in situations where waiting for additional help is not practicable. This one-person technique is similar to the two-person PRT but is applied, as the name would indicate, by a single staff member. The use of the one-person technique has been found to increase the risk to both resident and staff member and is therefore not encouraged.

Following a physical restraint, OCFS's rules require that a physician's assistant or nurse must perform a medical examination of the resident and, where required, medical assistance be provided. The restraint must be recorded in a facility Restraint Log and documented in an Activity/Rule Violation/Incident Report. A "post restraint packet" must be completed in which staff sets out the circumstances necessitating the restraint and the result thereof. The packet includes the time and date of the restraint, the location in the facility in which it took place, the justification for the restraint, statements from the

participants and witnesses, a resident interview and the results of the medical examinations including a description of any injuries. The packet must be reviewed by an administrator as soon as possible, in no event more than 24 hours after the restraint. Finally, the facility Director must review the entire packet to ensure that all requirements have been fulfilled and to determine if any further action is required.

Where a significant injury occurs, or where the incident is deemed to be potentially abusive, an Unusual Incident Report (UIR) must be filed. Allegations of abuse stemming from the incident must be reported to the State's child abuse reporting system. OCFS defines "unusual incidents" for reporting purposes as "an incident which is likely to have a serious negative impact at or beyond the local program level, which adversely affects the health, safety and/or security of residents, staff or community or has a significant impact on the facility or agency." All UIRs must be reported to OCFS Central Office within one hour of occurrence. Facility management must review all UIRs to determine if an internal facility investigation is needed. In addition, OCFS Central Office must also review UIRs and its Special Investigations Unit (SIU) must determine whether the incident requires an OCFS investigation.

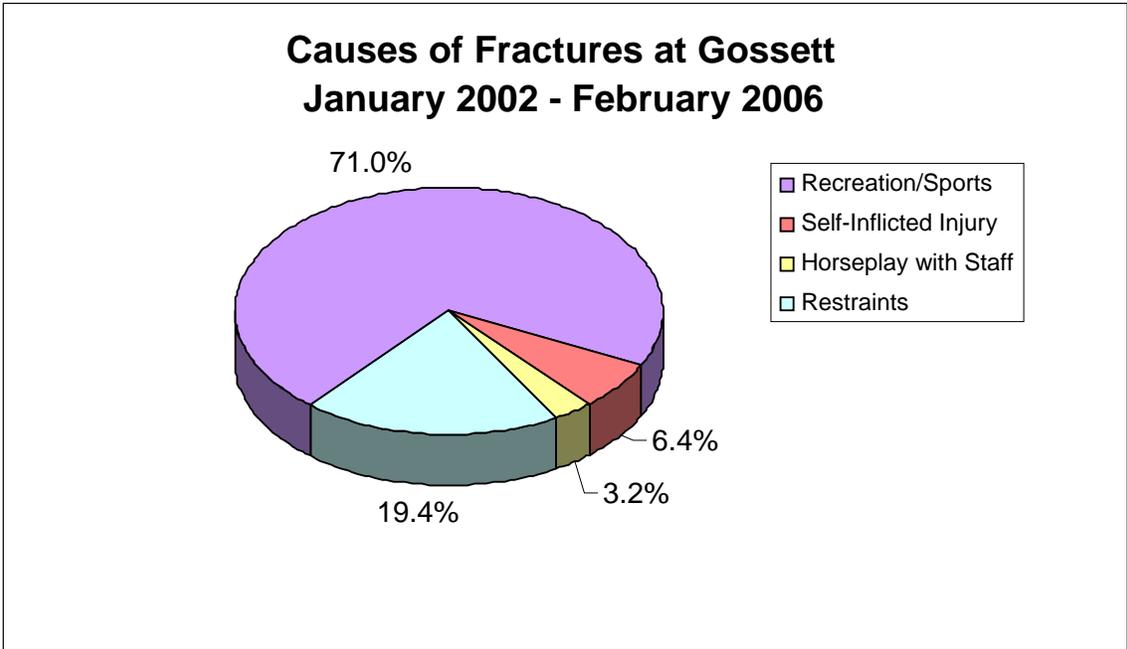
In addition, as noted, allegations of abuse stemming from the incident must be reported to the State's child abuse reporting system, known as the Statewide Central Register (SCR), for appropriate action. The SCR is a separate unit within OCFS that deals solely with allegations of abuse and neglect of children. The SCR, also known as the "Hotline," receives telephone calls regarding allegations of child abuse or maltreatment of children within New York State. Enumerated professionals and employees throughout the State, including all Gossett staff, are mandated reporters,

required to notify the SCR of suspected abuse or neglect involving a child. When an allegation of abuse is reported at any OCFS facility, including Gossett, the SCR relays this to OCFS's Institutional Abuse Bureau (IAB) for investigation, monitors the investigation's progress and identifies any prior abuse allegations. The IAB, in turn, notifies the local District Attorney of its investigation and subsequent findings. In Tompkins County, District Attorney Wilkinson, who came to office in January 2006, has instituted new protocols for screening IAB reports.

The most serious of the allegations was that Gossett staff, through the use of restraints, intentionally broke the limbs of residents. Arms and legs were intentionally broken, it was alleged, as a technique to intimidate the resident population, to maintain control of the facility and to target particular residents for punishment. Each of these was investigated.

OSIG focused upon such injuries sustained by residents of Gossett for the period January 2002 through February 2006. A review of all relevant documents, including all medical records, identified 31 such incidents in which a resident at the facility sustained a fracture or broken bone.

Of these 31 occurrences, fully 22, or 71%, were the result of injuries sustained during recreational activities. Two others were self-inflicted, i.e. the resident punching a wall, and one was the result of what the resident himself described as fooling around or rough-housing with staff. Thus, the total of such injuries actually resulting from restraints over the more than four-year period analyzed was six.



Significantly, when comparing the number of fractures or broken bones sustained during restraints to the overall number of restraints for the same time period, less than one percent of restraints resulted in broken bones or fractures.

Restraints Resulting in Fractures  
January 2002-February 2006

Restraints	1070
Fractures	6
% Restraints Resulting in Fractures	0.5%

**THE INITIAL ALLEGATIONS OF PHYSICAL ABUSE**

As discussed earlier in this Report, the Inspector General’s Office investigated allegations which had been made to both public officials and members of the media. An attempt was made to pursue these allegations, even those bereft of detail or general in nature, where the allegation itself was of a serious nature. This often necessitated locating former Gossett residents, both alleged victims and witnesses, an extremely

onerous and time consuming task. Locating these individuals essentially became mini-investigations of their own. In addition, voluminous Gossett, OCFS and hospital and other medical records were examined in order to identify the specific incidents which were the subjects of the allegations. This was necessitated by the fact that residents' names and/or time frames were often either provided incorrect to OSIG or were unknown.

Following are brief descriptions of these initial allegations and the results of OSIG's investigations. Residents' initials are used to protect their confidentiality.

1. It was alleged that a YDA intentionally broke the arm of resident J.S. and rendered him unconscious. During an incident which OSIG later learned occurred in November of 2004, J.S. stated that he became "sarcastic" with the YDA who called for assistance and attempted to restrain him. J.S. admitted that he punched the YDA and kicked his feet out from under him. J.S. also explained that both he and the YDA fell, and that he fell face forward hitting his head on the floor and knocking himself unconscious. J.S. never claimed to have a broken arm and, in fact, acknowledged to Gossett's mental health staff that the incident was an "accident." The results of X-rays and CAT Scans proved to be negative.
2. It was alleged that a YDA broke A.F.'s arm because A.F. had displayed poor sportsmanship. Medical records and facility reports revealed that in September 2004, A.F. fractured his wrist playing basketball with other residents. When interviewed by OSIG staff, A.F., now a former resident, confirmed the cause of his injury, adding that no staff member was involved.

3. It was alleged that a Gossett staff member intentionally broke the arm of resident D.O. OSIG's review of hospital records revealed that D.O., in fact, had fractured his pinky finger during a basketball game in March 2004.
4. It was alleged that resident T.D.'s arm was broken in an abusive restraint. T.D., who is now an inmate in an adult correctional facility, acknowledged that in August 2003 he had intervened between a YDA and another resident in the cafeteria and, when assistance arrived and he was told to step away, he refused. He also admitted that when the YDA attempted to escort him from the cafeteria, he resisted. T.D. stated that the YDA did not "slam" him to the floor but rather placed him there. T.D. stated that while resisting, his arm "popped." At the hospital, he was diagnosed with a fractured elbow. He characterized the cause of this injury as the result of an "accident." T.D. also described the Gossett staff as "fair and equal" and indicated that after leaving Gossett, he would contact staff for advice when he got into trouble.
5. It was alleged that a YDA physically abused resident F.M., a resident with a history of assaultive behavior and mental health problems. The day before the incident in question, he had refused to take his medication. On the following day (in April 2004), F.M. attacked a YDA and violently resisted the consequent restraint. A review of the medical records reveals that F.M. sustained no broken bones, and as a result of this incident, F.M. was arrested and convicted of a crime.
6. It was alleged that a Gossett staff member intentionally bent the arms of resident A.J. to their breaking points. OSIG found no evidence of any incident

even remotely similar to that allegation, and a search of medical records revealed no diagnosis and treatment for a break, fracture or any other notable injury.

7. It was alleged that a particular YDA inflicted a “dirty” or abusive restraint on resident A.D., but a check of the UIRs and restraint packets did not reveal any restraint resulting in an injury to a resident with that name. OSIG also examined the UIRs and restraint reports for another resident with a similar sounding name, but found nothing consistent with the claim made in this allegation.
8. It was alleged that A.B. suffered from a rare blood disorder and that any restraint “would kill him.” Despite this, it was alleged that Gossett staff, fully knowing the danger, purposely restrained A.B. A search of Gossett’s administrative and medical records, as well as hospital records, revealed no restraint of this resident, nor any injury sustained by him subsequent to his diagnosis.
9. It was alleged that a resident was beaten by Gossett staff in the “spiritual room,” which is used for prayer and meditation. OSIG found no resident by the name provided. OSIG, looking for any similar fact pattern, discovered that in September 2005, a resident with a completely different name (K.G.) was taken to the spiritual room after throwing his food tray and causing a disturbance in the cafeteria. The records reflect that K.G. was restrained in the cafeteria, but when he resisted, was taken to the adjacent spiritual room.

K.G. admitted struggling and resisting staff during the restraint. He also conceded that he often gets out of control and that restraining him, at times with handcuffs, is necessary for both his own safety and for the safety of others. K.G. stated that he had been restrained over 30 times at another facility and approximately 20 times at Gossett, and that he never needed to be treated at a hospital for any injuries sustained during the restraints at Gossett. K.G. stated that no staff member at Gossett had ever beaten him or intentionally tried to injure him.

10. It was alleged that sometime between 2001 and 2002, YDAs assaulted resident H.E. and stomped on his head and face. OSIG discovered that in January 1999, almost eight years ago, similar allegations were made and investigated by OCFS. A review of the relevant records showed that H.E. had become combative, necessitating his placement in handcuffs. H.E., however, continued to struggle, cursing and threatening staff. During what was described as a “significant struggle,” H.E., as well as several staff members, fell into a desk, a file cabinet and a coat rack. During his violent struggling, H.E. bit three staff members and ripped the shirt and inflicted significant contusions and swelling to the side of another YDA’s face.

One YDA, after the struggle had ended, noticed what appeared to be a sneaker mark on the side of H.E.’s forehead, while another saw what appeared to be a “ridge” on the side of H.E.’s head. At the hospital, H.E. was treated for an injury to his lip and photographs were taken. These photographs, closely examined by OSIG’s investigators, did not reveal any such sneaker print on

H.E.'s head or face. OCFS's investigation found no evidence of abuse or maltreatment of H.E. by Gossett staff.

As a result of this incident, H.E. was arrested by the State Police and prosecuted for aggravated assault. Due to his age at the time, the records relating to this prosecution have been sealed. Subsequently, H.E. was transferred to a higher level security facility.

11. It was alleged that in an abusive restraint, a YDA broke the arm of resident R.H. The YDA, it was alleged, picked up R.H. and slammed him to the floor so hard that his arm was broken in two places, and he was rendered unconscious. The YDA, it was alleged, then dragged R.H. across the floor with his broken arm dangling from his body. The individual making this allegation, a YDA out on stress leave, asserted that the injury to R.H. had been inflicted intentionally.

In his interview with OSIG, the YDA who was the subject of the allegation, now a member of a county sheriff's department, stated that in March 2002, R.H. had refused to follow a directive to go into his room and assumed a "fighting" and aggressive posture. The YDA then attempted to restrain R.H. who began to fight. He further stated that the response team arrived, including the very YDA who made this allegation. According to the subject YDA, both he and R.H. then fell together to the floor as the YDA felt his legs go out from under him, resulting in R.H. breaking his arm and cutting his chin.

Another YDA witness, a member of the response team, stated that the complainant YDA came in quickly, tackling R.H. at his legs and both R.H. and

the subject YDA immediately went down. He stated that “they fell over” and that the complainant YDA tried to help, but the restraint “went bad.”

Another YDA stated that the complainant YDA had admitted to him that he came in and took both R.H.’s and the subject YDA’s legs out from under them, and that both fell to the floor. This witness stated that the complaining YDA made a joke of it, finding the whole story rather funny.

Another resident, who observed the event, stated that R.H. appeared “ready to fight” the YDA and that when the YDA tried to restrain him, R.H. “swung at him.”

R.H., in a written statement made after the incident, stated that he was restrained and “then we fell.” In a follow-up interview, R.H. said that he remembered hearing the YDAs saying that they needed to get him medical attention.

None of the witnesses corroborated the complainant YDA’s allegation that R.H. was dragged across the floor with his broken arm dangling from his body. Nevertheless, OCFS imposed discipline including a six-week suspension of the subject YDA for failing to seek and wait for assistance, and because he “failed to account for the known volatility” of the resident.

OSIG was unable to interview R.H. as he had died as a result of a knife fight in May, 2005.

12. It was alleged that in 2004 a “hit” was placed on a resident who, as a result of being “body slammed” to the floor, sustained a broken arm and a concussion

and was refused medical treatment for two days until the complainant insisted the resident be taken to the hospital.

OSIG searched both facility administrative and medical records, as well as hospital records, but could find no resident with the name provided, nor any such incident in or around the time frame set out in the allegation. OSIG did, however, find an incident somewhat similar to that alleged which occurred in May 2003 involving a resident by the name of N.J., and located this now former resident in an adult prison.

OSIG investigated this incident in which N.J., according to Gossett's records, was throwing objects around his room. A YDA directed N.J. to leave his room and requested assistance. While N.J. denied it, the YDAs involved all stated that N.J. was struggling and resisting the YDA as he escorted him into a nearby office. N.J. then stated that the staff members exchanged some kind of signal and slammed him to the floor, knocking him unconscious and breaking his wrist. In two separate interviews, however, N.J. named two different YDAs as the individual who slammed him to the floor.

All staff members agreed that N.J. struggled and fought, causing him and the YDA to fall to the floor. They all denied that any signal was given or that N.J. was intentionally slammed to the floor.

One staff member recalled that, after the incident, N.J. "was acting fine." Over the next two days, N.J. was seen by medical staff who evaluated his condition and eventually determined that his wrist should be X-rayed and that he should be treated at the hospital. N.J. was taken to the hospital where he was

diagnosed as having a fractured wrist and a mild concussion. OCFS's chief medical officer, a pediatrician, stated that "growth plate fractures" similar to N.J.'s are "very mild" and that, prior to positive diagnosis, are simply treated with ice to the area to alleviate any swelling and consequent pain. He stated too that a positive diagnosis of concussion is difficult and that the indicated treatment consists of rest and continued observation.

Given the conflicting nature of the accounts, the conclusions to be drawn from this incident remain uncertain. Nonetheless, OCFS disciplined the YDA for executing a single-person escort, rather than waiting for another staff member to conduct the preferred two-person escort.

13. In a particularly troubling allegation, it was alleged that an unidentified resident was put on a leash by a YDA, and forced to walk around on the floor. A Gossett investigation revealed that in 2001, two jump ropes were placed around resident H.L.'s shoulders and he was walked around on his hands and knees in front of other residents. The resident did not sustain any physical injury to support a criminal prosecution. As a result of its internal investigation, however, Gossett administration initiated disciplinary proceedings against the YDA in question, who subsequently resigned before he could be terminated.
14. It was alleged that in January 2003, resident R.N. was injured as a result of an abusive restraint. A review of the records revealed that after a verbal exchange between R.N. and a YDA, R.N. received a five-inch laceration to his scalp requiring 14 sutures to close the wound. Although the State Police and Gossett staff investigated the incident in 2003, OSIG conducted its own investigation.

R.N. and one staff member witness claimed that the YDA slammed R.N.'s head into the side of a desk. In contrast, the YDA and other witnesses contended that R.N. punched and attacked him, precipitating a struggle that led to R.N.'s injury. Two other witnesses offered evidence to support the YDA's claim. As a result of the conflicting accounts of the event, no arrests were made and there was insufficient evidence to sustain a prosecution. However, the YDA in question resigned his position as Gossett administration sought his termination.

15. It was alleged that sometime in 2001, 2002 or 2003, staff tied up a resident with masking tape and "knocked him unconscious horse-playing." OSIG's review identified this incident which, in fact, took place in 2001. Gossett and IAB investigations found that two YDAs engaged in inappropriate "horseplay" with the resident, but no proof was uncovered of any intent by staff to injure the resident. Gossett administration sought the termination of one YDA and the suspension of the other. One YDA agreed to a suspension and the other, after arbitration, was suspended for two months without pay.
16. It was alleged by a former resident that staff abused resident C.V. during a restraint. OSIG initially reviewed the OCFS investigation files and found that resident C.V. was involved in a restraint in November 2004. However, according to a written statement from a resident witness, C.V. "started swinging" at a YDA and the witness did not see "staff do anything inappropriate" during the subsequent restraint. OSIG also interviewed the staff involved, who stated that C.V. was "putting up a pretty good fight" on the floor.

Medical records revealed that C.V. sustained no injuries other than an abrasion to his face.

17. It was alleged that resident D.R. was abused by a YDA. OSIG reviewed records for all incidents involving resident D.R. and found only one where he sustained any notable injury. Records revealed that D.R. told Gossett staff that he broke a piece of a molar when his jaw hit the floor during a restraint in September of 2002. However, the resident did not allege any abuse. Additionally, the post-restraint medical examination by a Gossett nurse noted that this injury could not have been caused by the impact because there were no facial injuries, bruising or swelling, and no neck injury or complaint of pain. Additionally, she observed that the resident had full jaw motion and a normal bite. The resident was later treated by the facility's dentist, who told OSIG that she did not recall that any inappropriate restraint had caused a fractured tooth.

## **THE INITIAL ALLEGATIONS OF SEXUAL ABUSE**

Included in the initial allegations were complaints of sexual abuse by Gossett staff members, including a number of complaints that a medical staff member conducted unnecessary or improper genital examinations of residents. Each allegation of an identifiable resident was pursued, but none were substantiated:

1. It was alleged that resident J.W. had been sexually abused by a member of Gossett's medical staff during a physical examination. J.W. told OSIG that he had been examined only once at the time of his admission to Gossett, and that he had not been inappropriately touched by any staff member.

2. It was alleged that resident D.V. had been sexually abused, again by the same staff member as above. An extensive review of Gossett and OCFS files and records revealed no resident by the name provided in Gossett's records.
3. During a televised interview, a former resident, T.J., alleged sexual abuse while at Gossett. OSIG attempted to locate him, and in the process learned that there currently is a warrant pending for his arrest.
4. Another former resident, C.L., alleged that following an initial genital examination, he was inappropriately touched by the same medical staff member as above. During OSIG's interview of the resident, he did not describe any unnecessary touching but, in fact, detailed two different types of examinations.
5. It was alleged that a female Gossett staff member had illicit sexual relations with an unidentified resident. OSIG's review found that Gossett administration conducted an investigation almost ten years ago of an allegation that a YDA had kissed resident K.D. Both the resident and the staff member denied this incident.

#### **ADDITIONAL INCIDENTS IDENTIFIED BY OSIG**

OSIG's investigation did not end with the investigations of the initial allegations that gave rise to public concern. Rather than investigate only those incidents identified in the media or by a small group of current and former staff members, the State Inspector

General and the Tompkins County District Attorney expanded the scope of the investigation to include all potentially prosecutable crimes.

Consequently, OSIG staff members examined Gossett, OCFS and hospital records, reviewing all incidents in which a resident was substantially injured during the same period, January 2002 through February 2006. OSIG sought additional evidence of criminal conduct by Gossett employees through nearly 400 interviews of current and former Gossett residents and staff members. In addition, allegations of abuse received while the investigation was ongoing were explored. As a result, in addition to the 22 allegations set out above, more than 20 additional incidents of purported or possible abuse were investigated by OSIG and reviewed by the District Attorney. Fourteen of the more serious alleged incidents are detailed here:

1. During the course of OSIG's investigation, it was alleged by one of the original complainants that Gossett staff intentionally broke the arm of resident A.M. A review of the facts revealed that A.M. announced "I'm going to raise hell tonight" and balled his fists, assuming an aggressive posture. As a result, A.M. was restrained by staff, and complained of a sore shoulder during his post-restraint examination. Although he was able to raise both arms, he was sent to the hospital as a precaution. Once at the hospital, A.M. was diagnosed with a strained shoulder – not a broken arm as first alleged - and Ibuprofen was prescribed.
2. It was alleged by a Gossett YDA that during the most "blatant" restraint he had ever witnessed, resident P.D. was lifted out of his chair by another YDA and was slammed face first into the floor, cutting his lip. In his interview,

P.D. admitted that he had been restrained because “I jumped on him and called him a bitch.” He further stated that he jumped up with “my fists balled like I’m about to hit him.” P.D. explained that after he jumped at the YDA, his head accidentally hit a chair and that when the YDA saw what had happened, he “put me down carefully, so I wouldn’t get hurt further.” A review of the medical records demonstrated that while P.D.’s lip had been cut, it required no sutures. P.D., who is now a resident in another facility, stated that he would like to return to Gossett.

3. It was alleged that a YDA intentionally broke resident A.M.’s shoulder. After a restraint in August 2004, A.M. told a Gossett staff nurse that subsequent to being restrained, during which time he attempted to break free, he was “thrown” to the floor by a YDA. A short time later, however, A.M. admitted that he was not thrown to the floor but that during the restraint, he and the YDA went down in a pile while struggling. He stated that the YDA was not trying to injure him, but was trying to get him under control. He then apologized for his untruthful claim that he was purposely thrown to the floor, and for his behavior that led to the restraint in the first place.

Along with a review of the record in this matter, OSIG interviewed A.M., now a former Gossett resident, who confirmed that he had not been thrown down but rather, that “we all went down to the floor.” As to A.M.’s alleged injury, while hospital records indicate that he sustained an “acromion” (top of the shoulder) fracture and a possible shoulder separation,

A.M. recalled only straining his shoulder, for which he was prescribed Ibuprofen, and he suffers no ill effects today.

4. It was alleged by resident L.H. that in March 2006, during OSIG's investigation, he suffered a serious leg injury while being restrained and that he broke his hand while swinging at staff. However, OSIG's investigation revealed that L.H. broke his hand in 2005, by punching a wall at another facility and was, in fact, receiving treatment for that injury while at Gossett. As for the leg injury, medical staff at Gossett informed OSIG that L.H. had strained a groin muscle during a restraint the previous year at Gossett. Finally, a Mental Health Counselor advised that L.H. was a "less than credible informant who creates stories about himself."
5. OSIG discovered in OCFS records that now former resident C.H. cut his chin during a restraint at Gossett in July 2004. OSIG interviewed the resident who claimed that a YDA intentionally slammed his face against the floor. Interviews with the relevant staff and a review of pertinent records revealed that C.H. had attempted to precipitate a riot in the cafeteria, assumed an aggressive, threatening posture and refused to comply with a directive to desist. A single-person escort was attempted to remove C.H. from the cafeteria, but when C.H. resisted, both he and the YDA fell to the floor. During his post-restraint examination, C.H. informed medical personnel that "I think I hit staff's knee on floor." He said nothing of being intentionally slammed to the floor.

6. In a second incident in July 2005 involving the same resident, C.H. claimed that he was “jumped” and beaten by two YDAs who, in addition, intentionally administered a rug burn to his face. Gossett staff stated that C.H. attacked and punched a YDA and it took five staff members to control him after a violent fight. They also denied intentionally inflicting a rug burn. A review of medical records revealed that the only injury sustained by C.H. was a slightly swollen lip. Moreover, as described in the medical notes, the skin on C.H.’s face was intact.
7. OSIG’s review of OCFS records disclosed that resident J.M. alleged that in April 2004, a YDA provoked a fight and, during the incident, J.M. was punched by the YDA. Though J.M. sustained no injuries more serious than a contusion to his head and though he refused to cooperate with Gossett’s and IAB’s investigations, Gossett sought termination of the YDA who subsequently resigned his position.
8. During a review of OCFS’s Unusual Incident Reports (UIRs), OSIG learned that resident T.D. sustained a fracture to his elbow during a restraint in July of 2004. Investigators located and interviewed this now former resident in an adult correctional facility. He described grabbing a YDA by his sweater and throwing him against nearby windows. As T.D. had the YDA pinned against the window, T.D. was “tackled” by an unidentified male staff member. A third YDA then came into the hallway and restrained T.D. When asked, twice, whether he felt the restraining YDA intended to hurt

him, T.D. explained that the YDA restrained him to “control” him and to “do his job” because T.D. had just attacked another staff member.

9. OSIG investigated an incident involving resident A.A. and a YDA which occurred in February 2006, in which A.A. sustained small lacerations on his chin and tongue. OSIG spoke with both participants as well as all of the staff and resident witnesses. All agreed that the YDA attempted a single-person escort of A.A. after A.A. had thrown a chair in the direction of another resident. Upon entering a nearby office, both A.A. and the YDA went to the floor. A.A. claimed the YDA “kicked” his legs out from under him and “threw” him to the floor “head first,” causing A.A.’s injuries. The YDA and another staff member who was responding to the call for assistance said A.A. tripped the escorting YDA and that A.A. said, “I got you.” However, none of the other residents could hear what was said; nor could they see the YDA’s and A.A.’s feet.

Given the conflicting accounts of the incident, criminal charges were not sustainable. Nevertheless, Gossett administration conducted an investigation and disciplined the YDA for violating its policy regarding single-person escorts.

In addition to those cases enumerated above, a number of others were identified by OSIG for review. No findings of criminality were established.

A number of allegations of sexual abuse were made to OSIG staff during the course of the investigation, or were identified by OSIG through a review of Gossett’s records. Each was investigated and the results follow:

1. It was alleged that resident S.T. had been sexually abused by the same medical staff member previously mentioned above. S.T. told OSIG's investigators that he had never been inappropriately touched by any member of the Gossett staff and that he feels safe at the Facility.
2. Another allegation by now former resident R.W., which previously had been investigated by Gossett administration and found without merit, was re-investigated by OSIG and again refuted by a YDA who witnessed the exam. (It is common practice at Gossett, although not a written policy, to have a staff member witness any genital examinations.)
3. Former resident A.Y.'s allegation of an unnecessary genital exam was disproved by the very eyewitness (another former resident) that A.Y. claimed observed this alleged improper exam. Medical records also did not support A.Y.'s claim.
4. During OSIG's investigation, resident D.H. asserted that he received four genital exams in less than two months. However, neither medical records nor any witnesses corroborated this claim. The medical staff member who purportedly performed these exams adamantly denied doing so.
5. It was alleged that in January 2006, two YDAs repeatedly touched resident L.M. in a sexual manner while he lay in bed and cried for help.

The two YDAs accused of these acts denied the allegation, and four residents in rooms in close proximity to that of L.M. failed to support his claim. In addition, one resident stated that L.M. often made up false stories and false allegations against staff.

During Gossett's internal investigation, L.M. retracted his allegation stating "I made up these stories because I wanted to get moved off the Unit." In addition, L.M. wrote a letter to Gossett's Director in which he admitted that he was a liar, but that he was trying to control the problem. He admitted that he had told lies for as long as he could remember. Members of Gossett's Mental Health staff stated that L.M. is "manipulative" and likely to engage in "fabrication."

6. Resident J.M. alleged that in November 2005, an unidentified Gossett staff member touched his penis. During Gossett's and IAB's investigation of the incident, J.M. admitted that no one had touched him.

One month later, J.M. stated to IAB, "they [staff] touch my penis. All the staff on Unit 7 touch me. A couple of days ago this happened. I don't know exactly who. All the staff did it. No resident saw it."

J.M. claimed that all the staff on his prior unit tried to touch his penis while he tried to sleep, and that the staff of both units pretended to be homosexuals and told him he had to be a homosexual to leave Gossett. He stated further that staff from both units not only tried to make him gay, but tried to make all the residents gay.

Five residents from Unit 7 and four from Unit 8 were interviewed. None supported J.M.'s allegations, with several stating that Gossett staff respects their privacy and does not joke about residents being gay. A number of residents stated that J.M. was a behavior problem on the unit and functions on a very low level. A Gossett Mental Health staff member has

determined that J.M. suffers “minimal retardation.” Both Gossett’s and IAB’s investigations found J.M.’s allegations to be unsubstantiated.

Then in February 2006, J.M.’s mother telephoned Child Protective Services (a bureau within OCFS), alleging that staff members placed J.M. in a sitting restraint and would not release him unless he performed oral sex on five of them, who she named. Gossett conducted an investigation during which J.M. provided a written statement: “People keep playing anger management games. Nobody did anything sexual with me last night. [A YDA] restrained me but he didn’t hurt me. I don’t have anything else to say.” The medical report of a Gossett nurse indicated no injury of any kind. J.M. was transferred to another facility as the Gossett investigation continued; his allegations were ultimately found to be unsubstantiated.

Members of OSIG located J.M. in the other facility and spoke with him in April 2006. J.M. again reported that he had been touched inappropriately by staff at Gossett. He claimed that all of the staff members have sexually abused him. He further alleged that they touched his “butt.” According to J.M., staff told him that in order to leave the facility, he has to be gay; however, he was not able to provide investigators with any names. Furthermore, anytime he was asked to provide further details, he failed to do so.

OSIG subsequently interviewed two YDAs from J.M.’s unit at Gossett, both of whom denied any inappropriate or sexual contact with J.M. One YDA described J.M. as “defiant.” He said J.M. had three or four good

days in a row followed by two or three bad days, usually after a bad phone call from his mother and sister.

In addition to pursuing particularized allegations, all 133 residents present in Gossett the week of March 27, 2006 were asked by an investigator whether they had been touched inappropriately by a Gossett staff member and 100 percent of the respondents replied “No.” Some current and former Gossett staff told OSIG that rumors concerning the genital examinations at Gossett could be attributed to residents’ ploys, past sexual trauma, inexperience with medical examinations, or as one person said it: “Adolescent males don’t like being touched by another male.”

While the allegations of systemic abuse of residents at Gossett were found not to be substantiated by the more than 40 investigations conducted by the Inspector General, and while the independent review by the Tompkins County District Attorney did not find these allegations to be appropriate subjects for criminal prosecution, a troubling practice at Gossett was revealed.

While the Inspector General’s investigation did not rely upon the facility’s incident or restraint reports to resolve these allegations, the importance of accurate and independent initial statements from all participants and witnesses cannot be overstated. This is especially true for events which take place within facilities responsible for the care of young people, like Gossett, and which are not generally open to ongoing public scrutiny. Such statements, committed to writing, are among the most basic building blocks of any effective internal or independent outside review or investigation. The absence or falsification of such statements further complicates these already challenging investigations.

Although OCFS’s Facility Investigations Guidebook states, “if possible, separate the participants and witnesses from one another to avoid discussion of the event,” and a Gossett administrative memorandum to staff states that reports are to be “clear and objective, based on your observation of events,” OSIG found Gossett’s practice to differ significantly from these policies and guidelines. As one YDA described, “nine times out of ten,” YDAs speak together as they write their reports, which “colors” – or influences – what is written.

This practice, apparently, was even more pervasive and institutionalized in the past according to both current and former YDAs. “The Code,” as it was called, and as explained by one YDA, currently a probation officer, bound the YDAs together to protect themselves against administrative discipline following problematic restraints. It, he explained, demanded that a YDA protect his colleagues and, where necessary, required falsification of restraint reports. He went on to state:

[S]taff protected each other and I was protected. If I were restraining a resident, we protected one another. We didn’t have to go to administration. We made sure that we got our report in hand. It was The Code. You knew what your were going to say when the questions were asked, and you protected yourself in that.

He explained further that restraint reports were compared “all the time” to ensure that participants’ reports contained the same facts. Once this was accomplished, he explained, they would say, in effect, “okay, that’s good, we’ll stick with that.”

Another YDA, describing much the same process, termed it “a good old boys’ society.” Another described how, in the past, one of the ringleaders confronted him

regarding an incident, telling him “we gotta stick together” and that he should “absolutely” lie for a co-worker who “screws up.”

A number of YDAs stated that The Code, or as one called it, this “camaraderie,” began to disappear as many of the old-timers left the facility. As a result, one added, restraints decreased.

Gossett administration has, even now, not addressed this issue in an effective manner. When OSIG brought this situation to the attention of Gossett’s management, the Assistant Director, who is responsible for the facility’s internal investigations, responded that “Our YDAs know that their activity reports are supposed to be honest, thorough and descriptive of what occurred, objectively descriptive of what occurred...If they are colluding, that’s lying, and they’re not supposed to do that.”

He further said:

Well, we're certainly not naive enough to think that staff are never talking to each other to coordinate. But that is not our policy. It is not something we look for, encourage, it is not something that we want. What we encourage are good, straight-forward, honest reports.

When asked whether it was practicable to have staff members complete their reports while separated from each other, the Assistant Director replied, “There may be a value in that, I can’t tell you no on that.”

When OSIG brought this to OCFS’s attention, the Deputy Commissioner of DRS responded, “It’s always been a problem, those activity sheets. They’ve always been a problem, and the quality of those things vary greatly.” The OCFS Commissioner stated, “I want everything to be above the board, and that’s the way we need to operate in this

business here. There's just too many negative things [that] can happen if you don't have a good, solid operation."

To ensure the integrity of internal as well as outside investigations, both Gossett management, as well as OCFS itself, must effectively address this issue. It is also essential so that public officials, as well as the public at large, can have confidence that the safety of the residents of OCFS's facilities is assured.

## **ALLEGATIONS RELATING TO ABUSE OF RESTRAINTS**

Among the initial allegations made against staff at Gossett were that restraints were used as tools to both punish and target certain residents, and to make examples of them as a means of control and intimidation. The particular significance of this allegation is clear once it is understood that most injuries to residents and staff as well, result from the physical nature of a restraint.

While specific allegations of abuse have been investigated by the Inspector General and reviewed by the District Attorney, with the results set out above, OSIG, in addition, conducted a comparative analysis of restraints at Gossett and at other similar facilities within the OCFS system. Analyzed, too, were trends at Gossett itself for the period 2002-2005 to test whether the attempts Gossett management states it has been making to reduce the number of restraints have yielded results.

As seen from the chart below, the average number of restraints per 100 residents per month was reduced from 19.4 in 2002 to 13.9 in 2005, a reduction of more than 28%. In addition, a comparison between Gossett and the three similar OCFS facilities, reflected in the same chart, demonstrated that Gossett, for the years 2002 and 2003, was at the

mid-point of the facilities. By 2004, Gossett had become the lowest in frequency of restraints, and by 2005, the most recent year for which complete data is available, Gossett’s frequency of restraints was further reduced by 22%, below the next lowest facility, and fully 64.6% below the facility in the group with the highest frequency of restraints.

Average Number of Restraints per Month (per 100 Residents)

Facility	2002	2003	2004	2005
Gossett	19.4	17.4	18.2	13.9
Highland	21.7	21	22.3	17.9
Industry	14.4	15.4	21.1	39.3
Tryon	19.5	26.7	21.5	31.8

Both current and former employees at Gossett agreed that a dramatic reduction in the frequency of restraints had occurred over recent years, confirming the results of OSIG’s analysis. Gossett in the 1990s was described as a period in which restraints seemed to be constantly taking place. As one YDA put it, “If we had less than 20 restraints a day, it was a good day.” She stated that by 2003 reality had changed as most of the more aggressive YDAs “got weeded out.” As another YDA put it, there has been a big push towards a hands-off approach. In addition, according to Gossett management, the policy of calling for back-up, known in the facility as “pushing the pin,” before physically engaging a resident, has further reduced the frequency of restraints.

OSIG’s analysis also revealed a highly significant correlation between those residents medicated for psychiatric and emotional disorders and the frequency of restraints. Through 2006, fully 71.4% of the interviewed Gossett residents who had been

restrained more than 10 times were taking such medication. As demonstrated by the analysis, residents medicated for psychiatric or emotional disorders were approximately 3.5 times more likely to be restrained than residents not so medicated.

Revealing, too, is the fact that, through June 2006, while a majority of the sample resident population was never restrained at Gossett, approximately 15% of the sample was restrained more than three times each, with some restrained as many as 16 to 18 times.

Of most significance, neither OSIG's investigation nor the District Attorney's review found evidence to support the allegation that restraints are used to target or punish residents. Rather, what the record reveals is a marked decrease in the frequency of restraints consistent with management's efforts to this end.

## **ALLEGATIONS RELATING TO RUG BURNS**

Another of the original allegations was that staff at Gossett intentionally inflicted "rug burns" – or abrasions – on the faces of residents by rubbing their skin into the facility's carpeted floor during restraints. As in the allegation relating to restraints, it was alleged that the intentional infliction of rug burns was used as a form of punishment or control.

Rug burns, according to OCFS medical personnel, affect the outer layer of the skin, the epidermis, and when healed leave no scarring or other permanent damage. Deeper wounds, on the other hand, would reach the dermal layer and would cause significantly more pain and serious damage. The facility's physician assistant and a nurse, OSIG was informed, had not observed any such deeper wounds.

OSIG analyzed the frequency of rug burns at Gossett for the period 2002-2005. On average for this period, there were 79 rug burns per year, with approximately 31% of the 1,019 restraints involving rug burns of varying degree. Significantly, however, incidents of rug burns were down more than 15% in 2005 when compared to the average over the four-year period analyzed, and down fully 23% from the prior year, 2004. Once again, the trend analysis indicates that Gossett's management's efforts to reduce restraints and consequent rug burns have had significant positive effects. Confirming the results of this analysis, medical staff at Gossett informed OSIG that it has seen a marked reduction in both rug burns as well as in restraints in general.

Gossett management has stressed that it has focused on reducing the number of restraints and consequent injuries, including rug burns. As OSIG was told, because of the always present potential for injury to residents and staff alike, restraints should be the intervention of last resort, and should be used only if other remedies have been exhausted or are impractical. As Gossett management pointed out, certain injuries are not uncommon when restraints occur, with rug burns to faces and limbs the most frequent. These managers asserted that it is incorrect to assume that such injuries are necessarily indicative of abuse or intentional wrongdoing by staff.

Medical staff at both Gossett and OCFS Central Office informed OSIG that rug burns often result from residents struggling and resisting while on the floor during restraints. Gossett administrators stated that they have made numerous efforts to reduce the frequency of rug burns, even instructing staff to place a towel or sheet between the resident's face and the rug where practicable. Management, OSIG was told, continues to struggle to find an effective solution to this problem.

While a small number of YDAs stated that they believed a few individuals may intentionally inflict rug burns, none could offer substantiation for this claim. One staff, for example, informed OSIG that she had heard that one resident intentionally had “half his face taken off” during a restraint. But when interviewed, the resident himself stated that he did not even know that he had a rug burn until much later when he felt some stinging on his cheek. Most significantly, the resident stated that he did not believe the YDA in question had intentionally tried to hurt him.

In contrast, numerous Gossett staff members provided alternative explanations for the cause of rug burns. Several witnesses explained residents receive rug burns when they resist a restraint and struggle while on the carpeted floor. Some even suggested that residents intentionally rub their faces on the carpet to get an abrasion as a badge of courage among peers or in an attempt to cause trouble for certain YDAs. One YDA recalled, in April 2006, witnessing a resident – who he claimed was well aware of the nature of OSIG’s investigation – “trying to wipe his face on the floor [and] bang his head on the floor,” while shouting you are “going to hear about this on TV. It’s going to be on TV. It’s going to be in the newspapers. Go ahead, hurt me. I want to get hurt.” Still others blamed the facility’s carpets. Not only do the residents get rug burns but so too do staff. One YDA attributed 99% of the rug burns to the nature of the carpet, explaining: “All you have to do is run your fingers lightly along the fabric of the carpet and you’ll feel the heat from the friction.”

Given this anecdotal and often conflicting evidence, it was impossible to determine that rug burns were inflicted as a form of punishment. Nevertheless, the Inspector General’s Office investigated the most serious, specific allegations that staff

intentionally inflicted a rug burn on a resident. For example, former Gossett resident A.Y. alleged to an OCFS caseworker and to OSIG staff that he received multiple intentional rug burns while at Gossett. However, investigators found no evidence corroborating his claims. Medical records showed he sustained on some occasions only “mild” abrasions. A resident witness, identified by A.Y. himself, was located by investigators in a state prison and interviewed: he did not support any of A.Y.’s assertions. Furthermore, he described A.Y. as “bad” and someone who would often pretend that he was sick or injured in order to get attention. A psychologist who treated A.Y. found him as displaying “clear signs of antisocial personality features,” and added “it should be recognized that antisocial individuals thrive on manipulation, deceit, and getting over on the system.”

The Inspector General’s Office also pursued an allegation that on October 8, 2005, staff rubbed an unidentified resident’s face on the cafeteria carpet in a figure “8.” By reviewing post-restraint records, investigators learned of a restraint on that date in the cafeteria in which resident J.V. sustained a cut above his right eye. Investigators spoke with the alleged perpetrating YDA who denied the allegation and queried, “I don’t know how that would be done – like ice sculpture or something?” He then apologized, saying it was not funny, but said he was befuddled by the allegation. The YDA believed J.V. sustained a cut near his eye during the preceding fight with another resident, who had “scooped him up and slammed his head on the ground.” It then took two YDAs to restrain J.V. because he was “struggling, fighting and cursing . . . throwing elbows . . . out of control.” He also recalled seeing a lot of blood on the floor. This was confirmed

by an inspection of the carpet by investigators, as well as a photograph of it taken near the time of the incident

Investigators also spoke with J.V., who conceded that he and another resident were restrained because they fought each other. J.V. said both residents were already on the ground when staff pulled them apart, and staff placed his arms behind his back. Yet he admittedly continued to struggle and was “trying to get away from staff” when he hit his head, causing a cut over his eyebrow for which he received four sutures. He also told investigators that he feels safe at Gossett.

## **OPERATIONAL ISSUES**

Along with allegations of abuse, the original complainants raised concerns about various operational issues at Gossett. In the course of this investigation, the Inspector General’s Office reviewed key rehabilitative programs, such as mental health services, substance abuse treatment, and education. We also examined other operational issues such as possible racism, gangs and staff training.

## **BREAKDOWN OF OCFS’S SYSTEM OF INDEPENDENT OVERSIGHT AND REVIEW – THE OMBUDSMAN AND THE INDEPENDENT REVIEW BOARD**

### ***BACKGROUND***

OCFS, by State regulations, is mandated to have a Youth Advocacy Office to ensure the protection and promotion of legal rights of youth under its jurisdiction. This office is known as the Office of the Ombudsman and is governed by OCFS regulations contained in 9 NYCRR Part 177. As the New York State Court of Appeals, the State’s

highest Court, has observed, a regulation of a State agency that is consistent with its enabling legislation and is not “so lacking in reason for its promulgation that it is essentially arbitrary” has the force and effect of law. *General Elec. Capital Corp. v. New York State Div. of Tax Appeals*, 2 N.Y.3d 249, 254 (2004).

The regulations require that the Office be composed of a Director of Ombudsman and a staff of individual Ombudsmen. The Director of Ombudsman is to report directly to the Commissioner of OCFS. The Director of Ombudsman and the individual Ombudsmen all must be attorneys admitted to practice law in New York State.

Pursuant to these regulations, the duties of the Office of the Ombudsman include visiting facilities, hearing grievances, investigating allegations of violations of legal rights, monitoring the grievance process at secure facilities, monitoring policies, assisting in the development of the law, assisting youth in obtaining legal representation, serving as a resource to inform youth of their legal rights, and advising the Commissioner of OCFS of significant complaints and allegations. The Ombudsman, along with fulfilling these mandates, must report to the Independent Review Board (IRB, see below) and prepare monthly reports for the Commissioner.

In order to carry out its responsibilities, the regulations authorize the Office to hire non-legal support staff, conduct investigations where the Ombudsman determines there is “reasonable suspicion” to suspect a violation of a resident’s rights, perform facility visits without prior notice, and interview staff and residents. In addition to these duties, while actually representing a resident, the Ombudsman may assist in bringing legal action against OCFSs’ Division of Rehabilitative Services (DRS) or in challenging an administrative decision by filing the appropriate papers with a court and requesting

that the court assign an attorney to represent the resident. When discharging these particular duties, the Ombudsman must notify OCFS's General Counsel's Office.

The regulations also create the Independent Review Board (IRB), composed of between nine and fifteen members knowledgeable in the area of juvenile justice and youth rights. The members of the IRB must include at least one former resident or parent, one psychologist or other clinician, one person knowledgeable in juvenile rights matters, one judge of the Family Court, and one person with knowledge of the criminal justice system. The IRB's duties are to review Ombudsmen-issued reports and meet at least bi-monthly with the Ombudsmen, Director of Ombudsman, the OCFS Commissioner and other appropriate personnel to discuss the reports. The IRB is to advise the Commissioner on issues pertaining to the Office of the Ombudsman, as well as complaint and grievance resolution. To carry out this mandate, the IRB may direct the Ombudsman to conduct specific investigations, make inquiries into matters affecting the legal rights of residents, convene meetings, engage in ongoing communications with the Office of the Ombudsman, evaluate the effectiveness of the Office of the Ombudsman, and visit and inspect Division facilities. (It should be noted that the IRB is the predecessor to the current Independent Review Committee [IRC], a subcommittee of OCFS's Commissioner's Advisory Board).

As the Ombudsman's Office plays a central role in assuring the rights of residents, as well as the conditions under which they are housed both at Gossett and all other OCFS facilities, the Inspector General's Office examined the functioning of this crucially important program. In addition to the extensive resident and staff interviews conducted at Gossett, OSIG obtained documents from the Office of the Ombudsman and

interviewed current and former Ombudsman staff, IRC Board Members, as well as OCFS management. Included were three former Directors of Ombudsman, the current Director of Ombudsman, the Ombudsman Grievance Coordinator, one current and one former IRC member, as well as OCFS's Commissioner, Executive Deputy Commissioner, Deputy Commissioner of the Division of Rehabilitative Services (DRS) and General Counsel.

While interviewing the 133 Gossett residents, investigators found that the overwhelming majority were aware of the Ombudsman program. Over 73% of the residents who responded were aware of the process to contact the Ombudsman, whose posters and contact information are displayed on Unit bulletin boards in every Unit in the facility. In addition, the Resident Manual also refers to the Ombudsman and the residents' right to call the Ombudsman's Office. Over 98% of the resident respondents stated that they had received a copy of the Manual. Despite their awareness of the Office, only 12 residents indicated that they had contacted the Office to make complaints. An analysis of the Ombudsman's Office and the IRC can be divided into three periods; the 1970s, 1980s and 1990s to the present.

### ***THE EARLY YEARS OF THE OFFICE OF THE OMBUDSMAN – 1973 – 1979***

Amid reports of widespread abuse within the then Division of Social Services Youth Facilities, the Office of the Ombudsman was established together with the Independent Review Board.

The Ombudsman's Office began with approximately six Ombudsmen, assigned to the General Counsel's office for administrative purposes, but reporting directly to the

then Director of DFY, now the Commissioner of OCFS. Each Ombudsman was assigned to the various facilities within his/her regional area. They received and investigated complaints concerning a variety of issues, the majority being allegations of physical abuse. They also represented residents at administrative hearings and frequently conducted unannounced visits to the facilities. The Director of Ombudsman during this period stated that staff Ombudsmen conducted visits to these facilities unannounced and at anytime, day or night. The Ombudsmen, according to this past Director, were regular fixtures at the facilities and were well-known to the residents. The larger facilities were visited at least once per week, with the smaller facilities visited several times per year. The Ombudsmen prepared monthly reports and interacted with a very active and engaged IRB.

Two former Directors agreed that, from its inception, the Office of the Ombudsman endured significant resistance from facility staff, and found itself in a constant struggle to maintain its independence. In spite of this, the 1970s were the zenith of the program and, according to both Directors, was the period of its greatest effectiveness.

Similarly, the 1970s was the period of greatest effectiveness for the IRB. Established at the same time as the Office of the Ombudsman, the IRB was composed of members active in the field of child advocacy. The Board reviewed the Ombudsman's work product and monthly reports, made recommendations to the Director of DFY (now OCFS Commissioner), and proposed legislation or regulations to ensure the well-being of facility residents. According to both former Directors of Ombudsman, the then IRB was a proactive and progressive Board.

### ***THE PERIOD 1980 – 1991***

By 1984, the structure, reporting lines and duties of both the Office of the Ombudsman and the IRB had been formally codified in regulations, promulgated and filed with the Department of State.

At the same time, however, according to the then Director, 1984 – 1991 marked the beginning of the decline of the Office of the Ombudsman. He stated that the number of Ombudsmen was significantly reduced and, predictably, so too were the number of facility visits. In addition, the monthly meetings were no longer held. The former Director stated that management was no longer committed to the Ombudsman Program as lawsuits which in the past had been brought by advocacy groups had ended, and the pressure on management had disappeared. Moreover, agency management itself began to take over certain of the formerly independent Ombudsman's roles and responsibilities.

### ***THE PERIOD 1991 – 2006***

Throughout the 1990s to the present, the roles of the Ombudsman and IRB have continued to shrink to the point where, it is fair to say, they exist in name only. This is true in spite of the efforts made by the present Ombudsman to maximize the effectiveness of her now two-person office.

#### **Staffing**

In 1991, the Office of the Ombudsman was reduced to one staff member, the Director himself. This former Director described the program as “perfunctory” at best, as it was impossible for one individual to monitor the entire system and all of its disparate and geographically separated facilities.

The Director informed OSIG that, during this period, the Office of the Ombudsman was “wiped out,” having had all its staff attorneys laid off. Because of budgetary cutbacks which, according to OCFS management, were the cause of the layoffs, the agency only recovered one position, that of the Director himself. From 1991 until approximately 1996, the Director was the only person, professional or support staff level, in the Office of the Ombudsman. In 1996, one non-attorney was hired as support staff and became the Resident Grievance Coordinator.

For many years, in his Monthly Reports to OCFS’s General Counsel, the Director wrote, “the lack of support staff places additional demands on the already limited professional staff in the Ombudsman Office, and reduces the time available to assist residents.” Despite this, the agency did not request permission to add another attorney until the 2003 – 2004 budget cycle. The General Counsel informed OSIG that 2003 was the first opportunity to seek approval for an additional attorney for the Ombudsman Program. The request, according to the General Counsel, was denied by OCFS’s own Internal Budget Office and was never even submitted to the State’s Division of the Budget. As OCFS’s General Counsel stated, it takes a crisis or negative publicity to obtain funding for more staff and more resources. Both the General Counsel and the agency’s Executive Deputy Commissioner asserted that increasing the budget and staff for the Ombudsman’s Office should be a priority during the transition for the next Governor’s administration.

The explanation given by OCFS’s Commissioner, that budget cuts exacerbated after the events of September 11, 2001 caused these dramatic reductions, fails to account for the fact that this Office was allowed to remain in the state it is in today for a period of

more than 15 years. By the Commissioner's own admission, the Office of Ombudsman was just not an OCFS priority. As the Commissioner recently stated to OSIG, he now recognizes that the function of the Ombudsman, in fact, addresses a key agency need.

The lack of staff and its considerable effect was cited over and over again in OSIG's interviews. Not surprisingly, there was virtual unanimity in the view that a staff of two is simply inadequate to fulfill the role of the Ombudsman. For example, OCFS Deputy Commissioner for the Division of Rehabilitative Services (DRS) acknowledged that the staff is not adequate. As he stated, the "biggest problem is the scope...[and] span of control that they've got to try to cover. It's just...an impossible task," for all 2,300 residents of DRS to be covered by one Ombudsman and one support staff member who, in the Deputy Commissioner's words, is "not really an Ombudsman," but is "a very knowledgeable staff-level person." When asked whether he believed the Ombudsman's Office was adequately staffed, he responded: "I don't." To adequately staff the Ombudsman's Office, the Deputy Commissioner stated that it would take a "regional" approach, utilizing "six Ombudsmen...maybe seven." This, he said, would be in keeping with what OCFS does "on the community services side," which utilizes one Community Supervisor for each of the five upstate OCFS regions, and two in the New York City region.

Some OCFS executives, however, attempted to downplay the effect of the dramatic reductions to the Ombudsman's staff by asserting that other entities, such as the individual facilities' internal investigative personnel or OCFS Central's Special Investigative Unit, effectively substitute for the Ombudsman's Office. This explanation fails to recognize the fundamentally different roles of these reactive, after the fact,

internal investigative entities from that of independent and proactive advocate responsibilities of the Ombudsman. It is this independence, which was built into the Regulatory scheme and provided the rationale for the very creation of the Ombudsman's Office in the first place, that is absent from these other Units.

This fundamental difference was certainly not lost on the OCFS Commissioner himself, as his statement to OSIG clearly demonstrates:

I think it is a very key function to have kind of an independent source listening to the complaints and grievances of residents... Yes, I would be in total agreement trying to improve that area.

Leaving the Ombudsman's Office with a staff of two for a period of 15 years certainly leaves significant room for future improvement.

#### Unannounced Facility Visits

As set forth in State Regulation 9 NYCRR § 177.7, members of the Office of the Ombudsman are authorized to visit all division facilities and programs at any time, without prior notice, and without prior approval.

Two former Program Directors stated that, in the early years, unannounced visits were conducted with great frequency, the larger facilities every week and the smaller facilities at least two or three times per year, and garnered numerous complaints that had not previously been communicated to the Office of the Ombudsman. In 1991, when the former Director was rehired as the only staff member for the Office, he stated he was directed by OCFS's General Counsel to no longer conduct unannounced facility visits. There was, he stated, continual resistance from facility staff and, in particular, from the senior staff of OCFS's Division of Rehabilitative Services, to these site visits. DRS, the former Ombudsman explained, perceived unannounced visits as disruptive to facility

operations, despite the mandate of the regulations. He stated too that at monthly meetings with the General Counsel and DRS, staff of DRS were consistently abusive to the Office of the Ombudsman. For the following 13 years, from 1991 to his retirement in 2003, the former Director never made a single unannounced visit to any facility in the system.

The most recent former Ombudsman, who resigned from his position after only five months, attempted to conduct an unannounced site visit in April 2006 to the MacCormick Residential Center. He described to OSIG how, prior to being allowed access to the facility, he was required to speak on the telephone with OCFS's Deputy Commissioner for Rehabilitative Services. During that conversation, the Deputy Commissioner expressed "extreme dissatisfaction" with the Ombudsman stating, "if you want to push, I can push back."

The Deputy Commissioner told OSIG "we have no problem with the Ombudsman going in [to a facility]." The issue, he claimed, was that the visit to MacCormick was not what they had agreed to at a previous meeting. The Deputy Commissioner acknowledged that on the telephone, he asked the Ombudsman "What are you doing? You got a reason to be there?" He indicated that the Ombudsman's visit "caught us a little bit unaware," understandable since it was the first such visit by any Ombudsman for at least 15 years. The Deputy Commissioner stated that he then met with OCFS's General Counsel to set up some "game rules or protocols or procedures." He explained that the General Counsel "wanted to set up some protocols about what would be those things which would . . . in the end produce an unscheduled visit," and come up with "some kind of criteria," such as

“a lot of complaints from kids.” The former Ombudsman told OSIG that he was then instructed to draft a set of protocols for future unannounced visits.

OCFS’s General Counsel stated that she also did not know that the Ombudsman was conducting this unannounced site visit, and thought it was fair to have a standard in place for such visits, this despite the regulations providing for unrestricted access.

The Executive Deputy Commissioner stated the agency’s position is to allow the Ombudsman to conduct unannounced site visits of any OCFS facility. He added that the Deputy Commissioner’s response to the Ombudsman’s attempt to make the unannounced visit to MacCormick was “completely inappropriate” and told OSIG that he has now been reprimanded. He stated further that “formally and officially from the agency, the Ombudsman has free and unfettered access, period. There are no caveats or qualifications to it.”

The troubling fact remains, however, that for at least the past 15 years, only one unannounced site-visit was attempted by an Ombudsman, and this one attempt was resisted by one of the most senior OCFS officials. As pointed out above, the former Ombudsman who attempted to make this facility visit resigned only five months after he was hired.

#### The Ombudsman’s Reporting Lines

From its inception in 1973, the Office of the Ombudsman reported directly to the head of the agency, first to the Director of the Division of Youth, later to the Commissioner of OCFS. This reporting line was established by Regulation 9 NYCRR §177.4 in order to ensure the Ombudsman’s independence within the agency. In 1991, however, the then Ombudsman was told that he would no longer report to the head of the

agency, but instead would report to the General Counsel and, for some period of time, even to a non-attorney interim supervisor. The General Counsel informed OSIG that the OCFS Commissioner did not believe that it was appropriate for the Ombudsman to report directly to the Commissioner. This, despite State regulation requirements. From that point forward, the former Ombudsman stated, the Office had no independence at all and, was simply “window dressing” for OCFS. He stated further that in his view, the only reason OCFS has an Ombudsman at all is because the regulations require it. Up until the day he left his position in 2003, this former Ombudsman believed that the paramount concern of the agency was to “keep things quiet.”

In the view of the Executive Deputy Commissioner, having the Ombudsman report to the General Counsel is inappropriate. He stated, “the Ombudsman’s function needs to be elevated in the agency so that it has absolutely unquestioned authority to be able to do what it needs to do. I think this is a transition issue . . . It certainly will be something we pass on in the transition documents as an issue that needs to be resolved.”

## **THE DECLINE OF THE INDEPENDENT REVIEW BOARD**

State Regulation 9 NYCRR § 177.17 also requires the establishment of an Independent Review Board. The IRB’s function is to advise the OCFS Commissioner on matters pertaining to the Office of the Ombudsman, along with matters relating to complaint and grievance resolution. OCFS’s Deputy General Counsel stated that the IRB was already “pretty much defunct” by the time he arrived at the agency in 1997. In fact, based on OSIG’s investigation, the IRB has been essentially moribund since at least 1994, a period of more than 12 years in violation of State regulations. OSIG was also

informed by one member of the Office of the Ombudsman that the IRB has not met even once since she started at the Office in 1996. In fact, another former Ombudsman was not sure whether the IRB was functioning even as far back as 1989.

In a memorandum dated April 1998, OCFS' General Counsel wrote a memorandum to the agency's Commissioner stating that the IRB had not met since December 1994. In her memorandum, the General Counsel urged the Commissioner to revitalize the "valuable mechanism" of the IRB. She stated:

It is the belief of the Ombudsman that there are many benefits to a well functioning Board. The board provides credibility to the efforts of the Ombudsman Unit to protect collective and individual youth rights. It provides a forum for frank discussion of issues with input from both within and without the organization.

In December 1999, the IRB received a new name. The IRB became the Independent Review Committee (IRC). According to OCFS' General Counsel, the IRC was to replace the moribund IRB and was tasked with advising the OCFS Commissioner on matters directly affecting the quality of life of the residents at all OCFS facilities. Unlike its predecessor, the IRC is required to have at least three members, none of whom is required to have any specific qualifications or expertise. The duties of the IRC are a much diluted version of the duties of the IRB as set forth in 9 NYCRR § 177.17. The IRC can only look into systemic issues which cannot be resolved between the Ombudsman and DRS, has no authority to oversee the Office of the Ombudsman, and no authority to make unannounced site visits.

OSIG's investigation revealed that the IRC, just like its predecessor IRB, and like the Office of the Ombudsman itself, does nothing to carry out even its much reduced

duties. The Chair of the IRC could not name a single accomplishment of the IRC since it was established in 2001, more than five years ago. In 2002, she drafted a letter to OCFS's General Counsel asking for a definition of the IRC's authority and duties. She stated further that she could not recall the last time the IRC met as an independent Board.

One member who served on the IRC for two years until June 2006, a Town Police Chief in New York State, stated that no IRC meetings were held during his tenure. He described his experience as "the worst Board" he has ever been on. He stated that the Advisory Board meetings were merely an opportunity for OCFS management to talk about what a great job they are doing. He stated, "It was a do-nothing Board... I have never seen a Board that had nothing to say." It was his belief that OCFS did not want advice or guidance from the Board. OCFS's Executive Deputy Commissioner acknowledged that the agency had, in fact, attempted to inappropriately assert control over the IRB, a clear violation, he said, of OCFS policy and regulations.

Moreover, OCFS's Executive Deputy Commissioner told OSIG that the IRB (IRC) is a "weak sister. I think its most assertive action is an occasional review of UIRs [Unusual Incident Reports]. I think that is pretty much it. The next administration has to take a very aggressive step, I think, in terms of a full compliment of appointees...." At present, the IRC has one member, the Chair.

During this investigation, OCFS submitted a Notice of Proposed Rule Making to the Governor's Office of Regulatory Reform, seeking changes to 9 NYCRR 177. The revisions essentially revise the regulation to comport with current OCFS practice: the Office of the Ombudsman is to report to OCFS's General Counsel; the IRB is changed to the IRC; and its duties and authority reduced from those of the IRB. The proposed

regulations will also expand the jurisdiction of the Office of the Ombudsman to private agencies authorized to operate by OCFS, but there are no plans to expand the Ombudsman's current staff of two.

## **REPORTING REQUIREMENTS**

OSIG conducted an analysis of Gossett's compliance with reporting requirements relating to restraints and physical injuries. Included in this analysis were Unusual Incident Reports (UIRs), Restraint Logs and post restraint packets, as well as a number of other reports and records. While compliance for UIRs was good, the results for both the Restraint Logs and post restraint packets were less than satisfactory.

An analysis of facility documents from January 2002 through June 2006 revealed that 78 of the 1196 restraints for that period were never entered into Gossett's Restraint Log. In addition, post restraint packets, required for each restraint, for 62 of the 1196 restraints for the same period could not be found in Gossett's records. Facility administrators could offer no explanation for these failures.

## **GOSSETT'S INTERNAL GRIEVANCE PROGRAM**

As have other OCFS facilities, Gossett has implemented a process through which residents can bring grievances and other issues to the attention of facility administrators. Grievance Forms can be filled out and placed in a locked box in the cafeteria. These forms are collected daily and recorded in a Facility Grievance Log. A written response to the resident is required within seven days. A Youth Counselor, not a subject of the grievance, is responsible for investigating and resolving each grievance. If the resolution

does not satisfy the resident, the process provides for two levels of appeal. The first appeal goes to the facility's Director and the second, and final appeal, to OCFS's Deputy Commissioner. Each of the two appeal levels involves an independent review as well as written response to the respondent.

Residents are notified as to the grievance process in the Resident Manual, a guide that outlines the rules governing the residents' stay at the facility, as well as the individual rights of each resident. OSIG's interviews of the 133 residents at Gossett during the week of March 27, 2006, found that 98% of the respondents stated that they had received a copy of the Manual and that 92% stated that they knew how to file a grievance. Of the 133 residents interviewed, 33 stated that they had filed a grievance, with all but two being resolved without an appeal. The two remaining grievances were both resolved at the first appeal level.

## **MENTAL HEALTH ISSUES**

One theme that developed during the course of our review was the increase in the frequency and the severity of youth at Gossett with serious mental health problems. Both staff and administrators at Gossett acknowledged a dramatic increase in the number of residents admitted to Gossett with emotional problems and in need of psychiatric and psychological treatment. OCFS officials mirrored this view, stating that the average resident admitted to the facility has serious emotional problems, such as trauma issues, while many others have even more profound mental health needs. In fact, many of the residents have diagnoses of multiple disorders, as well as substance abuse issues, making

treatment difficult and extremely complex. Such residents, according to OCFS's Commissioner, comprise a "major, major part of the resident population."

OCFS officials state that efforts are made to send residents with mental health issues to facilities that have specialized Mental Health Units (MHU), units which Gossett does not have. However, according to OCFS's General Counsel, such transfers are often difficult to achieve. Such specialized MHUs, staffed with Office of Mental Health professionals, are better equipped and trained to treat residents with more complex and difficult psychiatric conditions. According to OCFS officials, among the services delivered by these units are more intense and frequent mental health treatment and counseling. While MHUs have dedicated mental health staff who treat residents on an intensive and ongoing basis, facilities like Gossett have fewer mental health professionals and significantly less intensive and sophisticated treatment regimens. OCFS's Executive Deputy Commissioner acknowledged the need to develop increased mental health treatment services at the individual facilities.

Gossett staff stated that there has been a significant increase in the severity of mental health problems among the residents at the facility, and that they are housing and treating residents today that would not have been sent to Gossett several years ago. Statistics reflect the high percentage of residents with mental health problems. Of the residents present the week of March 27, 2006, Gossett records reflected that 98.4% were diagnosed with disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders 4<sup>th</sup> Edition (DSM-IV), the main diagnostic reference of mental health professionals, issued by the American Psychiatric Association. Moreover, 65.6 % of the

residents were diagnosed with multiple disorders. Approximately 28% of Gossett's residents (34 residents in total) 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 (who prescribes psychiatric medication). 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. If this psychiatrist were to see each of these residents every month, he would spend just 11 minutes with each to assess the resident's condition, draft a treatment regimen, monitor side effects and make medication adjustments. Gossett's psychiatrist reported that, given the mental health needs at the facility, the number of hours reserved for Gossett was grossly inadequate. When asked about the adequacy of the six hours of psychiatric consultation per month, one OCFS official stated, "I find that inadequate...I don't know how they would have time with only six hours a month."

Mental health staff also expressed frustration at the lack of resources available to handle the Gossett population. They reported that they are forced to concentrate on the residents with greater psychiatric conditions and symptoms for one-on-one mental health counseling, while many of the youth with less significant psychiatric disorders or needs go unseen. OCFS's Executive Deputy Commissioner informed OSIG that his agency had made numerous requests for budget increases to augment current mental health staffs, but that these requests were consistently denied. Clinical staff, he added, are looked upon not as essential, but as mere "frills."

Gossett's monthly reports to OCFS Central Office also reveal the lack of adequate mental health resources at Gossett. For example, the December 2005 Monthly Report noted, "Our list for [Gossett's psychiatrist] has grown to the point that we are no longer in compliance, as we are unable to schedule each resident for a one time per month psychiatric consultation." Another notation, from the January 2004 Monthly Report states: "[B]eing that Gossett is the only CRP [Community Reintegration Program] to take residents on psychotropic medications, we have more than our share of mental health residents but lack the resources to adequately meet their needs."

Moreover, OCFS officials confirmed that of the four OCFS facilities that were identified as similar to Gossett, Gossett was the only facility without discrete Behavioral Health Units, including Mental Health, Substance Abuse, and Sex Offender Units. For example, Highland Residential Center has a Mental Health Unit of ten beds along with a Sex Offender Unit containing 34 beds, as well as a Substance Abuse Unit of 35 beds. Industry Limited Secure Center has a Mental Health Unit of 10 beds, and a Sex Offender Unit of 40 beds, while Tryon Residential Center has a Mental Health Unit of 12 beds and a Substance Abuse Unit of 20 beds. When questioned about the absence of such discrete Units at Gossett, an OCFS official responded, "It certainly seems as though they may need more resources there to help with the level of kids."

OCFS's Commissioner summed up these circumstances stating: "It's all money . . . We're not in denial here. It's a major part [of the resident population]." "I just cringe at how we have been able to . . . escape some of the potential catastrophes in our facilities, because staff has handled it fairly well."

OSIG found a dramatic correlation between residents with significant mental health problems and the frequency of restraints. For the sample population of 133 residents at the facility the week of March 27, 2006, OSIG's analyses determined that there were 233 restraints throughout their placements at Gossett. Strikingly, more than 54% (or 126) of the restraints involved residents taking psychiatric medications. Gossett's residents taking psychiatric medications were approximately three-and-a-half times more likely to be involved in a restraint than those not taking such medications.

For the same sample population, seven residents were restrained more than ten times each during their stays at Gossett. One of these residents was restrained fully 18 times. Of these seven residents, five (71.4%) were prescribed psychiatric medications.

Staff members consistently asserted that they needed additional training in how to deal effectively with residents with psychiatric disorders. One YDA said that he has not received any training for communicating with or relating to mentally ill patients, while another characterized the management of mentally ill residents as "usually trial and error, like walking through a mine field." Gossett medical staff echoed these sentiments. One nurse reported that Gossett had failed to adequately train employees in the management of mentally disturbed residents. She "see[s] these people [YDAs] working with kids and not having the skills to do it." One YDA expressed even stronger and more urgent concerns about the lack of mental health training for staff. He said that there were residents on medication who "absolutely did not belong" at Gossett, because the staff is "not trained" to deal with them and is "not mental health staff.... [W]e're gonna get to a point, if we continue to get mental health cases in here, and we don't have this training; something's gonna to happen. Something's gonna happen to a kid or a staff. "

Perhaps the most compelling and dire description came from OCFS's Deputy Commissioner for the Division of Rehabilitative Services (DRS), who told OSIG "there are groups of kids who come into our agency . . . who we just do not have the services for, we really don't. I mean . . . we had a couple of kids at Tryon who were absolutely, positively bound and determined to kill themselves, no matter what we did." He explained that the entire residential program is "really predicated on . . . some ability to manage yourself." The best that DRS can do with residents who come in with "very, very severe presenting issues" is "to supervise them and not let them hurt themselves. In the last six to eight years, there's just been . . . a tremendous influx of these kids suffering with psychiatric or emotional problems." Due to a lack of pre-placement treatment, "they come in very, very damaged. There's not really a good answer for these kids. We don't really have the specific services for those type of kids. I don't think that the number of professional staff in our budgeted certs has kept up with the amount of kids coming in. It's not that people have ignored the problem. It's getting additional positions out there and saying now we need six psychologists. The overtime that we generate for kids who are on suicide watch is astronomical."

The Deputy Commissioner explained that the problem of lack of resources and appropriate staff is compounded by the fact that the State Office of Mental Health (OMH), with its State-run Psychiatric Centers, is often the appropriate agency to effectively treat many of the most disturbed of OCFS's residents. At the same time, OMH either refuses to accept them into their facilities or transfers them back to OCFS as they are often too violent for OMH to control. As the Deputy Commissioner put it, "these kids go into a psychiatric hospital and bust it up." He explained that OMH staff

“don’t have the wherewithal to manage these kids in these programs,” and so the kids wind up with OCFS, which lacks the resources or expertise to adequately treat them. Thus, the vicious cycle continues, with both residents and staff at risk.

## **SUBSTANCE ABUSE ISSUES**

OSIG’s analysis revealed another troubling finding, this time related to the high rate of substance abuse among Gossett’s residents. More than 40% of residents were diagnosed with some type of substance abuse disorder, both drugs and alcohol, with some residents addicted to both. Further complicating the problem, many of the residents diagnosed with substance abuse disorders were also diagnosed with serious psychiatric and emotional illnesses.

Gossett administrators admitted that 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 or YC’s at the facility. Mental health staff members stated that while this program taught residents the basics about drug use and addiction, the facility lacked any real treatment programs.

Gossett management stated that the facility recently started a new substance abuse treatment program in conjunction with Cayuga Addiction Recovery Services, a private community program licensed by the New York State Office of Alcoholism and Substance Abuse Services. According to facility management, a Cayuga Addiction Recovery Services staff member 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. The administrator added that Gossett is doing the best it can given very limited resources, and pointed out that residents with serious substance abuse problems should be assigned to an OCFS facility equipped to handle such problems. As in the case of psychiatric and emotional disorders, two of the facilities that were identified as similar to Gossett, Tryon Residential Center and Highland Residential Center, have discrete Substance Abuse Units.

## **STAFF TRAINING**

Given the training needs expressed by staff in a variety of service areas, OSIG sought to determine if Gossett had minimum training and education requirements for staff and whether the facility was meeting these requirements. Both OCFS and Gossett policies state that the goal of staff training is to maintain a highly productive and well-motivated work force through a comprehensive system of staff development and training. This includes ensuring that staff members have the basic competencies to carry out their job responsibilities: to enhance staff's knowledge, skills and abilities to perform their jobs more effectively; to help facilities meet internal and external mandates by providing the training necessary to execute agency/facility policies and procedures; and to provide staff with opportunities for continued personal and professional growth.

OCFS policy requires that direct care workers receive 40 hours of training each year after their first year of work. To assess whether Gossett was meeting this standard, training records for staff were obtained and analyzed.

OSIG found that Gossett’s staff members were not receiving the yearly training as required by OCFS policy. As seen in the chart below, 40 staff members, or 38.8%, at Gossett in 2005 failed to meet the required 40 hours of training. Strikingly, this represents a 233% increase over the 2004 figures, in which only 12 staff members did not meet this training requirement.

Number of Employees Not Meeting Annual Training Requirements

Year	Number of Employees
2002	25
2003	4
2004	12
2005	40

These findings were discussed with Gossett’s Training Coordinator, who stated that this lack of training was due to a number of factors. However, OSIG found that significant staffing shortages and increased workloads were major causes of the training deficiencies.

Gossett’s staff and OCFS management agreed. One YC stated that Gossett is severely understaffed, adding that, “YDAs cannot be effective if they are doing two or three double shifts per week.” Another YC stated that the amount of required overtime at Gossett results in bad decisions being made by YDAs. Another staff member stated that there is a shortage of staff and difficulty getting time off, with staff resorting to calling in sick or claiming work-related injuries to receive time off. Another senior YDA summed up the staffing frustration stating, “I am in the top ten in seniority and I cannot get a day off. Absolutely cannot get a day off. I’ve requested every day off this year and every request has been denied.”

Staff expressed frustration at the lack of training opportunities for employees, especially in the high need area of mental health. Gossett “needs a better training program...morale is lousy due to lack of training,” stated one YDA. Another YDA said that he would like to receive more training on topics such as gangs and crisis management; however, because Gossett is so “short of staff,” such training can rarely be carried out. An OCFS official agreed that additional training for staff on mental health issues, adolescent development and non-physical intervention are items that may need to “be looked at.”

Addressing the importance of training, OCFS’s Commissioner said, “We cannot operate in this kind of a business without remaining in the state-of-the-art as to how the best practices can be implemented daily. You know, you just can’t do it.”

## **ALLEGED RACISM**

Along with allegations of physical abuse at Gossett, it was also alleged that there was an environment of pervasive racism at the facility. As evidence of this claim, complainants provided OSIG with a copy of a picture of an individual in Ku Klux Klan garb, which they stated was found in a staff lounge at Gossett. OSIG later learned that the picture was found at Gossett in 1995 or 1996 and later brought up in federal litigation by a former Gossett employee. However, the federal court determined that the image was actually part of an “anti-Klan” publication, the Klan Watch Special Report from spring 1994, entitled “Ten Ways to Fight Hate,” disseminated by an anti-discrimination organization, the Southern Poverty Law Center.

In addition, as part of the original allegations of abuse, a claim was made that African-American residents at Gossett were targeted for abusive restraints, while Caucasian residents were not. To determine if there was evidence of racial bias in the use of restraints, OSIG analyzed all restraints of the 133 residents present during the week of March 27, 2006. Of this sample group, 62 received at least one restraint, with the number of restraints for these 62 residents totaling 233.

The racial composition of all of Gossett’s 133 residents was compared against the racial composition of the 62 Gossett residents who were restrained. As reflected in the chart below, there was no evidence of racial bias among the 62 residents who were restrained. The data for the 62 residents are consistent with the overall racial composition of the facility. Moreover, the percentage of Caucasians restrained was, again, consistent with their percentage of the facility’s overall population, contradicting the allegation of racial bias in the use of restraints.

**GOSSETT RESTRAINT RACISM ANALYSIS**

<b>Race</b>	<b>Gossett Resident Racial Composition</b>	<b>Residents Who Were Restrained (62 residents)</b>
<b>African American</b>	<b>63.2%</b>	<b>61.3%</b>
<b>Caucasian</b>	<b>18.0%</b>	<b>21.0%</b>
<b>Hispanic</b>	<b>5.3%</b>	<b>4.8%</b>
<b>Multi-Racial</b>	<b>13.5%</b>	<b>12.9%</b>

Although racism in the form of “KKK” pictures is overt, other forms of racism are much more subtle and dependent on one’s individual and subjective perceptions, and are thus difficult to assess. Nonetheless, OSIG did explore the current racial environment at Gossett.

OCFS provides all staff with cultural sensitivity training while in attendance at the OCFS Training Academy. Gossett residents also receive cultural sensitivity and diversity training. Indications of attention to these issues were conspicuously evident at the facility during OSIG visits. Examples are seen below.



Two of the bulletin board displays at the Gossett Center observed by members of the Inspector General's Office during a site visit to the facility.

The vast majority of residents at Gossett are from minority populations. Of the residents present during the week of March 27, 2006, the racial breakdown at Gossett was 63.2% African-American, 18% Caucasian, 5.3% Hispanic, and 13.5% identified as multi-racial, which includes residents of mixed racial ancestry. Approximately 76% of the staff at Gossett are Caucasian, according to available data for 2006 Gossett staff.

In order to assess the racial environment at the facility, OSIG inquired of the 133 Gossett residents as to racial issues during their interviews. Of the total, 88% stated that all races were treated equally at Gossett, with 6% reporting that they had been called some form of racial names by staff at the facility. Of particular significance was the finding that when only the responses from minority residents were considered, over 88% of these minority residents responding stated that all races were treated equally at

Gossett, with even fewer minority residents, just 4%, alleging that they had been called racial names by staff.

While the residents' perception of racial issues at Gossett was of foremost concern, OSIG questioned Gossett's staff as to racial issues. Interviews of all active full-time staff at Gossett were reviewed. The overwhelming majority of staff reported no disparate treatment of residents, regardless of race. Almost 79% of all current staff interviewed reported no racial discrimination at the facility. Analyzing the responses from minority employees only, 73% stated that racism was not an issue at Gossett.

However, many Gossett employees raised the need for additional cultural sensitivity training for staff. A number of employees stated that the facility needs ethnic and racial sensitivity training and programs. One employee added that staff from upstate have difficulty relating to youth from downstate areas. This staff member said, "We only get these kids maybe a year, maybe a year and a half . . . we got to be able to give them more than they have ever gotten in the 15 years of their life. . . ."

## **EDUCATION**

As part of the original allegations, it was claimed that educational programs at Gossett were ineffective. OCFS mandates that residents in its care must participate in some kind of instructional program. Residents who do not have a General Equivalency Diploma (GED) or a high school diploma must take mandated minimum instruction in English/Language Arts, Math, Science, Social Studies, and Physical Education. Each resident is given an individual program in which he receives daily instruction during

regularly scheduled periods. These programs consist of both academic and vocational subjects, including both GED and remedial courses.

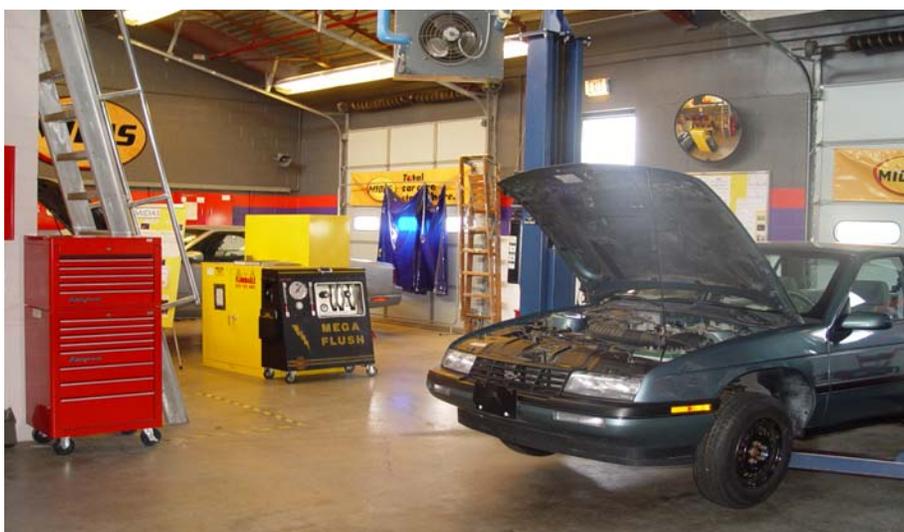
Gossett has both regular and special education school programs that comply with New York State Education Department standards. The program offers GED certificates, as well as regular high school diplomas which can be awarded by the residents' home School District. In addition, Regents examinations are offered, with some residents even taking college-level courses while at the facility. While the basic curriculum is comparable to those of typical public schools, the programs at Gossett are modified to address individual student needs, as the residents at Gossett represent different educational levels and different levels of skill.

The faculty is comprised of a Director and 16 teachers. The Director of the Program has both a Master's Degree and a New York State School Administrator/Supervisor Certification. Of the 10 faculty members that teach in the academic and GED programs, all have Bachelor's Degrees and New York State Teaching Certifications. In addition, six have attained advanced degrees beyond the Bachelor's. Of the five vocational teachers and the one physical education teacher, all have either the appropriate academic or technical training, including two with advanced degrees. Moreover, the majority of the faculty has between 15 to more than 30 years experience.

Interviews with residents revealed that they were highly satisfied with the quality of the educational and vocational programs offered at Gossett. Over 80% of the residents who responded approved of the education that they were receiving. To illustrate, residents were asked to rate their educational experience at Gossett on a scale of 1 to 5, with 1 being "poor" and 5 being "good." The average rating was a 3.7, equating to

between average and above average. Further, almost 90% of the respondents rated their educational experience with a 3 or higher. One resident reported that his classroom education at Gossett was “the best” he had received, and was far superior to his experience in his hometown. Another commented that he came to “respect” the teachers and staff, and stated that he particularly liked the structure of the Gossett program. One former Gossett resident said, “I learned how to read and write at Louis Gossett. When I went there my reading level was a 1.2. When I left, my reading level was an 8.9.”

In addition to educational programs, Gossett also provides a number of vocational education programs. Programs include food services, building trades, Midas automotive training, building maintenance, merchandise training/retail sales, and computers. Similar to the academic programs, residents were asked to rate their vocational experience at Gossett using the same rating scale noted above. Vocational ratings were even higher than the academic ratings, with the average score being a 4.4, falling between above average and good. Almost 96% of respondents score their vocational experience with a 3 or higher.



The Gossett Center has an automotive garage as part of its vocational program.

## **YOUTH GANGS**

OSIG's investigation determined that, in keeping with OCFS's policy, Gossett suppresses gang activity in the facility, but does not provide a formal method to keep or help residents stay out of gangs upon re-entering their communities.

In November 2005 OCFS issued a Youth Gang and Violence Prevention and Reduction Policy Statement that provides a framework for a comprehensive strategy to help juveniles, families and communities to reduce youth gang involvement. The policy promotes programs addressing community support, early intervention, residential and community placements and post-placement reintegration. With respect to serving juveniles who are members or associates of gangs in residential and community placements, the policy recommends the use of educational programming, workforce skills development and pro-social skills development. These support services should focus on establishing positive relationships, mentoring and positive youth development. Post-placement reintegration programs, targeting juveniles returning to the community from residential care, are to monitor and provide services to "displaced gang members" and to gang members wishing to quit the gang.

As a January 2006 follow-up policy memorandum to the OCFS executive staff indicates, the policy only provides a "framework and direction" for addressing the problem of gangs. However, "[e]ach division of the organization can determine how they want to deal with this issue." While the memorandum suggests that the issue of gangs can be addressed by options, such as targeted staff training and establishing community collaborations, it stops short of mandating specific action. Based on this memorandum,

the implementation of the OCFS gang policy appears to depend solely on the initiative, or lack thereof, of the various OCFS facilities, offices and divisions.

In Gossett, the gang policy is one of “zero tolerance” or full suppression. Gangs are not acknowledged or regularly discussed in any formal context at the facility. Youth who engage in gang-related activity, such as symbols, expressions, or dress are dealt with via individualized disciplinary action. Interviews with every resident present in Gossett during the week of March 27, 2006, as well as with Gossett staff and administrators, revealed that gang activity was not tolerated or allowed at the facility. While just over 40% of the respondents acknowledged that some residents at the facility belonged to gangs (having joined prior to OCFS placement), few felt pressured to join a gang or felt threatened by gangs at Gossett. Exactly 96% of the residents who responded stated they were not threatened by gangs while at the facility. Also, not one resident who responded felt pressure to join a gang while at Gossett.

While this “zero tolerance” policy at Gossett is effective at maintaining order and discipline in the facility, it does nothing to encourage or teach residents to abandon the gang lifestyle. Residents do not receive any formal education or counseling on the subject. The residents interviewed during the March 27<sup>th</sup> survey confirmed that gangs are not formally discussed or addressed by the facility. Over 75% of the respondents reported that there were no programs or formal instruction relating to gangs. In fact, one Gossett staff member noted, “it’s kinda taboo to discuss anything like that, or to bring it up at any point, even appropriately.”

Similarly, the Gossett staff receive limited training in identifying gang activity and none in gang extraction. Gossett staff interviewed confirmed that Gossett was very

effective at suppressing gang activity, but expressed concern about their ability to detect gang activity due to lack of training. Gossett's Director commented that "the teachers [at Gossett] don't have a clue" that residents are incorporating gang signs and language into their assignments. Most staff members interviewed indicated that the only agency-sponsored gang training they had received had been "a few hours in the academy" during their initial employee training. In-service gang training reportedly only had been provided to YDCs and a few senior YDAs. The Gossett Training Coordinator confirmed that gang training was the type of training most requested by staff, and Gossett's Director admitted the need for a formal program to deter or discourage gang membership, stating "... we really need a curriculum."

The result of the lack of training for both staff and residents is that residents who are gang members are completely ill-equipped to re-enter their communities. A Gossett YDA reported that some residents intentionally violate regulations at the facility to delay their release back to their communities because of their fear of returning to their gang life. At least one Gossett resident expressed concern to OSIG about how his gang, the Crips, would react if he attempted to leave the gang upon returning to his neighborhood. Another resident told OSIG investigators that he will still be in the gang when he leaves OCFS custody. As Gossett's Director acknowledged, "there are a lot of kids that are gang members [at Gossett]," and the perception among the staff is that Gossett is "sending the kids right back [to their communities] to the same stuff that they left before." Gossett's Director expressed frustration that "there's very little out there" in terms of in-facility programs that teach juveniles to leave gang life.

Division of Rehabilitative Services (DRS) administrators acknowledged that their primary method of addressing gangs at facilities has been one of gang suppression, or as the Deputy Commissioner of DRS stated, “no tolerance” or “don’t ask, don’t tell.”

The OCFS Director of Special Projects, within the Office of Planning and Policy Development, echoed the comments detailed above concerning the limitations of a gang suppression policy. He explained that as early as 1996 he and a former OCFS employee, Dr. Barry Glick (developer of the nationally and internationally recognized “Aggression Intervention Training” program used to teach adolescents to replace aggression and antisocial behavior with positive alternatives) raised concerns about a suppression-only policy and advocated for a revamping of the gang training and treatment programs.

This Director explained that Dr. Glick’s departure from OCFS in 1999 and the Director’s transfer to the Family Advocacy Bureau, which had little involvement with gang-related issues, resulted in no changes to OCFS’s policies for the next almost ten years. Since moving back to the Office of Planning and Policy Development in March or April of 2005, the Director has been making recommendations to the Commissioner’s office for a comprehensive agency gang policy.

OCFS’s top management now appears to recognize the ineffectiveness of OCFS’s limited approach. With respect to OCFS’s efforts at suppressing gang activity, one DRS administrator, with responsibility over counseling, stated that “suppression only lasts so far,” and in fact “does kind of hinder” efforts to identify which residents are gang members. This DRS official continued, “If we’re not going to allow them [residents] to speak about it [gang membership], how do we find out?”

That same official, along with OCFS's Associate Commissioner for Community Partnerships, both expressed a desire for OCFS to change its current policy of forbidding staff from having further contact with former residents, recognizing that residents often form a mentor relationship with staff that could assist them with after-care issues such as gang extraction.

OCFS top management almost uniformly recognized the need for in-facility gang training for both staff and residents. Similarly, OCFS management recognized that OCFS must begin to partner with community groups to provide after-care services for residents to help them get out and stay out of gangs when they return home. As the Associate Commissioner for Programs and Services in DRS recognized, OCFS staff need to present residents "with some options" if they are going to convince residents to leave the gang. This Associate Commissioner believed that OCFS does not ask its staff to advocate that residents leave a gang because "the resources aren't there on the other end."

The Director of Special Projects detailed some of the ideas he has for programs that he would like to see OCFS implement to address gang prevention, intervention and re-entry, in addition to gang suppression. Still "very much in its draft form" is an "assessment tool" used to determine an incoming youth's gang involvement during the intake process. The Director, who has no staff, stated that resources are needed to bring in community groups and mentors. Ideally, he is encouraging either in-house gang experts in each facility or select staff in each region to facilitate a resident's extraction from his gang. The Director recognized that as part of the intervention process, OCFS needs to engage residents' family members to enlist their support in the extraction process.

Lastly, the Director opined that OCFS needs to “re-train” its staff on gang recognition, prevention and intervention techniques. Training was particularly needed, he added, in the area of “cultural competence” in that issues of race and ethnicity were tied to gang membership. Also vital was the availability of staff who speak the resident’s native language in order to determine whether gang-related conversations are taking place. The Director cited the example of one resident who was conversing by telephone for months in Russian with his “crew.”

The Inspector General’s Office contacted several states to learn about alternative gang treatment programs in juvenile correctional settings. While a full analysis of each of these state’s programs was beyond the scope of this investigation, OSIG did contact officials in Arizona, California, Illinois, Maryland, Massachusetts, Missouri and Pennsylvania. While OSIG did not find a state with a comprehensive program that could be adopted in full by OCFS, there were aspects of programs which OCFS should consider. These include gang tattoo removal programs, agency-wide gang databases, institutionalized after-care programs, and mentoring programs that pair residents with “urban specialists” who are selected for their familiarity and experience with gang lifestyle.

In the end, OCFS’s Commissioner acknowledged that gang “suppression is a good step forward, but there’s a need to continue to work on changing the mindset while they [the residents] are in our facilities and have a continuum of that mindset change going into the community... This is something – we need some help here.” OCFS, however, as accurately stated by the Commissioner, has “a long way to go.” If OCFS does not implement a better approach, the Commissioner conceded, “all we will be doing

is passing the child back to the community probably smarter about how to be involved in a gang than they were when they got to us.”

## **RECOMMENDATIONS**

### **OMBUDSMAN AND IRB**

1. OCFS should take all steps necessary to immediately be in full compliance with State regulations, ensuring the independence and effectiveness of the Office of the Ombudsman, including:
  - The right to conduct unannounced and unrestricted facility visits.
  - The right to full and unrestricted access to all residents.
  - The right to hear all grievances and complaints.
  - The right to conduct independent and unrestricted investigations.
2. OCFS should immediately implement the regulatory requirement that the Ombudsman report directly to the OCFS Commissioner to ensure the Ombudsman’s authority and independence.
3. OCFS should promulgate and enforce policies and rules to discipline any employee of OCFS, up to and including termination where appropriate, who interferes with the Ombudsman’s carrying out of his/her responsibilities.
4. OCFS should comply with the State regulatory mandate that the IRB be staffed with between 9 and 15 members having both the credentials and experience set out in the regulation.
5. OCFS should take all necessary steps to ensure that the IRB fulfills those responsibilities and duties set forth in regulation.

## **MENTAL HEALTH**

6. OCFS should provide Gossett with the appropriate staff of mental health professionals to provide the proper care of its residents with psychiatric and emotional needs. This will address the need for meaningful treatment and will reduce the frequency of restraints and other physical confrontations between residents or between residents and staff.
7. Appropriate budget items should be requested to provide the staffing required in the recommendation above.
8. 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.

## **INTEGRITY OF FACILITY REPORTS**

9. Gossett management and OCFS administrators should promulgate and enforce policies and rules ensuring the integrity and accuracy of all internal incident, restraint and other reports, including a requirement that all participants and witnesses be separated.

## **TRAINING**

10. Gossett management and OCFS should provide appropriate training programs in areas relating to residents with psychological and emotional disorders, especially those prescribed psychiatric medications; substance abuse; cultural and diversity sensitivity; and youth gang membership.

## **OVERALL STAFFING NEEDS**

11. OCFS should conduct an assessment of agency staffing needs to reduce mandatory overtime, and make the appropriate budget requests where needed.

## **YOUTH GANGS**

12. 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.

## **PHYSICAL EXAMINATIONS**

13. OCFS and Gossett should educate all residents, well in advance of any physical examination, on the potential genital ailments, the benefits of such examinations, and their rights regarding these exams.
14. In lieu of the current informal practice at Gossett, OCFS and the facility should implement a formalized written policy which mandates that another OCFS employee witness any genital examination.

## **CONCLUSION**

Based on what was, perhaps, the largest and most broad-ranging investigation ever conducted by the Inspector General’s Office, and the review of the results by the Tompkins County District Attorney’s Office, the alleged environment of pervasive violence and intimidation of residents at the Louis Gossett Jr. Residential Center was not substantiated. Further, the Inspector General and the Tompkins County District Attorney 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, however, find serious problems in a number of critical areas. These include a near total breakdown in the staffing and operations of the Office of the Ombudsman and the Independent Review Board, the mandated bodies intended to provide independent oversight of the operations of Gossett and other OCFS facilities. Noted, too, are serious deficiencies in the mental health staffing and resources, an area which impacts not only the ability to provide residents with the professional level of care they so desperately need, but which has a direct impact on the frequency and intensity of restraints within the facility. Problems also were uncovered in the areas of substance abuse treatment, youth gang programs, and employee training. Fundamental flaws in the preparation of incident reports were also found.

The systemic weaknesses were, in almost all cases, acknowledged by OCFS and Gossett management who agreed that they must be immediately addressed. While certain of these issues, such as fiscal and staffing needs, should be addressed in OCFS's budget request proposals, many of these weaknesses can and must be addressed right now. The alternative, we fear, will be that OCFS will no longer, in the words of its Commissioner, continue to "escape some of the potential catastrophes" that may well result.