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October 8, 2014

Kerry A. Delaney
Acting Commissioner
New York State
Office for People with Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

RE: NYS IG 0093-031-2012

Dear Acting Commissioner Delaney:

The Office for People with Developmental Disabilities (OPWDD) referred to my office allegations of misconduct and abuse by employees of the Individualized Residential Alternative facility located at 57 Haymeadow Road in Tupper Lake. The facility, which is managed by the Sunmount Developmental Disabilities Services Office, is home to four individuals who have been in the care of OPWDD for numerous years.

Specifically, OPWDD referred allegations from [redacted] a developmental aide at the Haymeadow Road facility who was suspended for unrelated disciplinary charges in 2009. Prior to his suspension, [redacted] while on duty at the Haymeadow facility, recorded on his personal cell phone several incidents of apparent physical and verbal abuse of residents by staff. Although the audio and video recordings were made in 2009 or earlier, [redacted] did not disclose them to OPWDD until approximately January 2012.

The recordings show misconduct by three specific Haymeadow Road employees. In one recording, Developmental Aide [redacted] appears to strike a resident in the face and verbally threaten the resident. In another recording, Developmental Aide [redacted] is heard calling an unidentified resident an "asshole" and ordering the resident to "shut up." In yet another recording, Developmental Aide [redacted] addresses a resident as an "asshole" while attempting to get the resident to drink water. The

recordings also show a resident confined to the facility timeout room, which was improperly secured by means of what appeared to be a popsicle-type stick inserted in the locking mechanism. Further, the recordings contain a number of scenes of profane language used in the presence of residents. In voluntary interviews with my office, [redacted] and [redacted] denied any improper conduct, even when shown the recordings. However, when later interviewed by the New York State Police, the three employees made significant admissions. [redacted] admitted to the State Police that he struck a resident as depicted in the recording and that he was responsible for confining the same resident to the timeout room by improperly manipulating the electronic lock. [redacted] admitted to calling a resident an "asshole" while transporting the resident in a van. [redacted] admitted to inappropriately speaking to an individual while attempting to get him to drink his water.

Based on their admissions, the three employees were arrested on charges of Endangering the Welfare of a Mentally Incompetent Person, a misdemeanor. All three cases, prosecuted by the Franklin County District Attorney's Office, resulted in one-year conditional discharges. [redacted] resigned from state service. Both [redacted] and [redacted] remain suspended while OPWDD pursues disciplinary action seeking their termination.

In addition to the criminal conduct of the three employees, our investigation revealed a significant lack of supervision at the Haymeadow Road facility. The actions of these employees appeared to be open and known to other staff; indeed, none of the three made any attempt to conceal their behavior. However, no report or complaint regarding this conduct was made until 2012, three or more years after it occurred.

I recommend that OPWDD review its Incident Reporting procedures and implement sufficient training so that all employees are aware of their duty to report incidents of abuse in accordance with NY Mental Health Law §16.13, and understand the legal consequences of failing to fulfill this duty. This training should be a component of the Code of Conduct training we recommended as part of the Uniform Guidelines presented to OPWDD and other agencies in February 2013. Further, OPWDD should conduct a comprehensive review of the operation of the Haymeadow Road facility to ensure that an appropriate and effective supervisory structure is in place during all shifts.

Within 45 days, please provide information concerning your review and actions, including copies of any revised policies. If you require further information about this investigation, please contact Deputy Inspector General Audrey Maiello Cunningham at 518-474-1010.

Sincerely,

[redacted]

Catherine Leahy Scott
Inspector General