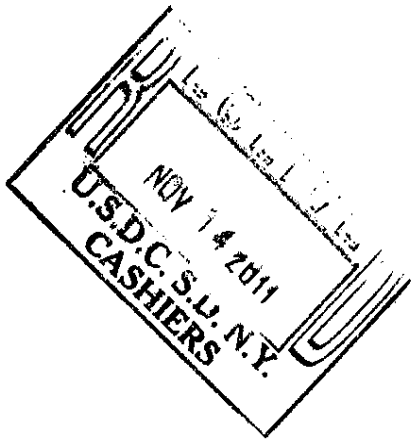
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x



G.B., a minor child, by and through his guardian T.B.,
L.B., a minor child, by and through his parent V.R.,
J.A., a minor child, by and through his parent M.F.,
S.S., a minor child, by and through his parent V.S.,
S.R., a minor child, by and through her parent E.R.,
S.M., a minor child, by and through her parent E.B.,
A.S., a minor child, by and through his parent C.S.,
C.L., a minor child, by and through his parent K.M.,
K.M., a minor child, by and through his parent S.T.,
J.G., a minor child, by and through his parent B.G.,
G.D., a minor child, by and through his guardian L.D.,
M.M., a minor child, by and through his parent L.M.,
D.C., a minor child, by and through his parent J.C.,
N.P., a minor child, by and through his parent D.P.,
B.B., a minor child, by and through his parent S.B.,
and all others similarly situated,

Plaintiffs,

vs.

09 CIV 10582 (PAC)

FOURTH AMENDED CLASS ACTION COMPLAINT

JURY TRIAL DEMANDED

GLADYS CARRIÓN, in her official capacity as Commissioner of the New York State Office of Children and Family Services;
YDA DALE WARE, YDA EDWARD DAVIS, YDA ALEXANDER MCCREADY, MR. DEPORTA, MR. PARIS, MR. THOMPSON, MS. PACETTE (phonetic), MR. COTTON, YDA GAL (phonetic), YDA MOHAN, YDA BILL MCMORRIS, YDA MATTHEW LAUBACH, YDA VISCONI, YDA WISELL, YDA JOEL DEJESUS, YDA GAVIN, YDA CROCKETT, YDA AVILES, YDA JAMELL CAMPBELL, YDA EDDIE MOLLETTE, YDA MITCH YANICK, YDA PHILLIP PALOMINO, YDA WATSON, YDA M. SAWITSKY, YDA LUIS ROSADO, YDA RAJEB MASESI, YDA ERIC VINCENT, YDA R. CURTIS, YDA YOUNG, YDA BANTA, YDA JOANNE LEHR, VICKY HUGHES, YDA ROBERT LACONTE, YDA M. HYACINTH, YDA GULOTTA, YDA JEFFREY BENTON, YDA WILLIAM COULMAN, YDA RYAN CASEY, NANCY JABLONSKI, REC SPECIALIST FLYNN, YDA WATSON, YDA RODRIGUEZ, YDA KAGONYERA, MR. HEWES, MR. BREWSTER, MS. HEPBURN (phonetic), MR. WILLIAMS, MS. ROLETTE (phonetic), MR. GARITY, MR. JENSON, MR. SMITH, MR. GAVOUGH (phonetic), YDA KEITH NASH, YDA W. DAVIS, YDA HOWD, YDA D. MANTI, YDA HOLLENBACK, AOD JOHN PAZ, AOD RUTLAND, YDA DANIEL BERNHARDT, YDA DWAYNE CREQUE, YDA SPENCER, YDA LUCAS, YDA

BRUMFIELD, YDA VONDERCHEK, YDA GREGORY FISH, YDA BRYAN CHAPMAN, YDA SEFARIS (phonetic),YDA WINNICK, SERGEANT BRETT ROCKEFELLER, SERGEANT FRED WELCH, SERGEANT WOOD, FIRST SERGEANT MCENTEE, SERGEANT DALLAS ECCLESTON, SERGEANT PALMER, AOD FIRST SERGEANT TIMOTHY KINCH, SERGEANT MICHAEL TOWNSEND, YDA RICHARD LALOSH, YDA YOUNG, MR. CLOW and JOHN DOES ## 1–27, in their individual capacities,

Defendants.

----------x

NATURE OF ACTION

1. This is a civil rights class action brought by Plaintiffs on behalf of all children who are now or will be civilly confined in the "limited secure" residential centers, "reception" residential centers, and the "nonsecure" Lansing Residential Center operated by the New York State Office of Children and Family Services ("OCFS"), who have been placed for rehabilitative purposes in OCFS custody by New York State Family Court judges as a result of juvenile delinquency proceedings, and who are subject to a pattern and practice of unconstitutional and excessive force by employees of OCFS and deprived of legally-required mental health services while in OCFS care and custody.

2. Despite Defendant Carrión's knowledge of the long-standing and well-documented nature of these deprivations, a scathing August 2009 Findings Letter from the United States Department of Justice ("DOJ") after a Civil Rights of Institutionalized Persons Act investigation, and the recent report of then New York State Governor David Paterson's expert Task Force (hereinafter the Governor's Task Force), which confirmed that these are system-wide problems, OCFS personnel continue to violently and unlawfully restrain members of the Plaintiff class, and the OCFS facilities at issue fail to provide legally-required mental health services.

3. The persistent and unlawful use of force by adult "child care" staff against children who are in OCFS custody for rehabilitation is shocking and is enabled by the policies and practices of

OCFS. The failure to provide even minimally appropriate mental health screening and treatment, despite the histories of trauma, abuse, and mental health needs of the majority of children in OCFS facilities, is unconscionable and contributes to the unnecessary and persistent infliction of improper physical force.

4. The DOJ Findings Letter, issued after DOJ's extensive investigation in 2008 of four representative OCFS facilities, found among other things that "[s]taff at the four facilities consistently used a high degree of force to gain control in nearly every type of situation," "restraints are used frequently and result in a high number of injuries," and "[t]he number and severity of injuries resulting from restraints is made worse by poorly executed or intentionally harmful restraints."

5. The DOJ also concluded that mental health care at the facilities "substantially departs from generally accepted professional standards."

6. Defendant Carrión received the DOJ's Findings Letter in August 2009 and has knowledge of its contents.

7. While the DOJ investigation focused on the treatment of children in only four OCFS facilities, and the DOJ is requiring improvements at those four facilities, the Governor's Task Force report, issued December 14, 2009, concluded that the deficiencies identified by the DOJ are system-wide in OCFS residential facilities.

8. Defendant Carrión received the Governor's Task Force report on or about December 14, 2009 and has knowledge of its contents.

9. While the Governor's Task Force reviewed the entire OCFS residential system, the Task Force has no authority to remedy the problems it identified.

10. Plaintiffs, current residents of OCFS' juvenile facilities, bring this action for injunctive and declaratory relief against the Defendant Commissioner and for money damages for named Plaintiffs against the individual OCFS staff Defendants, to redress the violation of Plaintiffs' rights under the Fourteenth Amendment to the United States Constitution. Plaintiffs also bring this action for declaratory and injunctive relief against the Defendant Commissioner Carrión, to redress the violation of their rights under the Americans with Disabilities Act and the Rehabilitation Act.

11. Plaintiffs and other residents of these OCFS facilities have been subjected to brutal and unlawful use of force in the form of "physical restraints" at the hands of Defendants, and have not been kept safe by the Defendants. They have also been deprived of the mental health evaluations and treatment to which they are entitled while in OCFS custody.

12. Plaintiffs bring this action to redress violations of their civil and constitutional rights perpetrated by Defendants, acting under color of law. The excessive and improper use of force against children, the failure of Defendant Carrión to ensure that children in her custody receive appropriate mental health treatment, and the policies and practices of Defendant Carrión, endanger Plaintiffs' physical health and safety, threaten their emotional and psychological well being, deprive Plaintiffs of adequate care, and deprive Plaintiffs of due process of law.

13. Plaintiffs allege that Defendant Carrión acts with deliberate indifference to the serious medical and mental health needs of children in her custody by failing to provide adequate services, including necessary inpatient and residential mental health programs, by failing to ensure that there are appropriately qualified mental health professionals on staff, and by failing to prevent the use of physical restraints that aggravate and ignore the mental illness of youth in

their care and custody, of which they are aware. Defendant's conduct therefore discriminates against children with mental illness on the basis of their disability.

14. Defendant Carrión does not provide necessary treatment opportunities and access to programs for children in OCFS facilities with mental illness. The Commissioner's failure to provide adequate treatment and programs causes mentally disabled children to deteriorate psychologically and emotionally, and to engage in behavior symptomatic of their illnesses. Defendant's deliberate indifference to the serious mental health needs of these children, despite knowledge of those needs, has resulted in a disproportionately high number of OCFS facility residents with serious mental illness – as compared to children without those mental health issues - being restrained and subjected to excessive use of force by OCFS staff. The failure to provide minimally adequate mental health care to Plaintiffs leads to the unnecessary and persistent infliction of improper physical force in the form of physical restraints and other force.

15. In this action, Plaintiffs, individually and on behalf of the Plaintiff class, seek declaratory and injunctive relief against Defendant Carrión in her official capacity on the grounds that Defendant Carrión has deprived Plaintiffs of their rights under the Fourteenth Amendment of the United States Constitution, as enforced by 42 U.S.C. § 1983, 29 U.S.C. § 794 (the Rehabilitation Act), and 42 U.S.C. § 12132 (the Americans with Disabilities Act). The individual Plaintiffs also seek redress in the form of money damages against the named and John Doe Defendants, in their individual capacities, because the named and John Doe Defendants have deprived Plaintiffs of their rights under the Fourteenth Amendment of the United States Constitution, as enforced by 42 U.S.C. § 1983 by their brutal and unlawful use of force against the Plaintiff children in the form of physical restraints.

JURISDICTION

16. This action is brought pursuant to the Fourteenth Amendment of the United States Constitution, and to 42 U.S.C. § 1983, and pursuant to 29 U.S.C. § 794 (the Rehabilitation Act), and 42 U.S.C. § 12132 (the Americans with Disabilities Act). This court has jurisdiction under 28 U.S.C. §§ 1331 and 1343(a)(3).

17. This Court is authorized to grant declaratory and injunctive relief under 28 U.S.C. §§ 2201 and 2202, and Rules 57 and 65 of the Federal Rules of Civil Procedure.

VENUE

18. Venue is proper in the United States District Court for the Southern District of New York pursuant to 28 U.S.C. § 1391(b). Plaintiffs and proposed class members include children who are or will be placed in OCFS facility custody in that district, and a substantial part of the events or omissions giving rise to the claims occurred in that district.

PARTIES

19. Each of Plaintiffs G.B., L.B., J.A., S.S., S.R., S.M., A.S., C.L., K.M., J.G., G.D., M.M., D.C., N.P. and B.B., is or was held in OCFS custody in one of the OCFS facilities that are at issue in this action. Each named Plaintiff has been or is currently being subjected to Defendants' unlawful conditions, policies and practices in the OCFS facilities, and each has suffered and continues to suffer actual injury as a result.

20. Each named Plaintiff is or was a minor, and sued through his or her parent or legal guardian at the time of the filing of the respective complaints.

21. At the time of the filing of the original Complaint ("Complaint"), Plaintiff G.B. was a 16-year-old boy residing in OCFS' Tryon Residential Center, Located in Johnstown, New York. He

was placed in OCFS custody by a New York State Family Court judge in July 2009. He sues by his legal custodian, T.B.

22. At that time of the filing of the Complaint, Plaintiff L.B. was a 13-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in November 2009. He sues by his parent, V.R.

23. At the time of the filing of the Complaint, Plaintiff J.A. was a 16-year-old boy residing in OCFS' Pyramid Boys Reception Center, formerly located in Bronx, New York. He was later moved to the OCFS Highland Residential Center, located in Highland, New York. Plaintiff J.A. was placed in OCFS custody by a New York State Family Court judge in December 2009. He sues by his parent, M.F.

24. At the time of the filing of the Complaint, Plaintiff S.S. was a 17-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in May 2009. He sues by his parent, V.S.

25. At the time of the filing of the Complaint, Plaintiff S.R. was a 16-year-old girl residing in OCFS' Tryon Girls Residential Center, located in Johnstown, New York. She was placed in OCFS custody by a New York State Family Court judge in August 2009. She sues by her parent, E.R.

26. At the time of the filing of the Complaint, Plaintiff S.M. was a 15-year-old girl residing in OCFS' Tryon Girls Residential Center, located in Johnstown, New York. She was placed in OCFS custody by a New York State Family Court judge in February 2009. She sues by her parent, E.B.

27. At the time of the filing of the Complaint, Plaintiff A.S. was a 16-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in August 2009. He sues by his parent, C.S.

28. At the time of the filing of the Complaint, Plaintiff C.L. was a 14-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in November 2008. He sues by his parent, K.M.

29. At the time of the filing of the First Amended Complaint, Plaintiff K.M. was a 16-year-old boy residing in OCFS' Finger Lakes Residential Center, located in Lansing, New York. He was placed in OCFS custody by a New York State Family Court judge in October 2009. He sues by his parent, S.T.

30. At the time of the filing of the First Amended Complaint, Plaintiff J.G. was a 16-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in September 2009. He sues by his parent, B.G.

31. At the time of the filing of the First Amended Complaint, Plaintiff G.D. was a 15-year-old boy residing in OCFS' Finger Lakes Residential Center, located in Lansing, New York. He was placed in OCFS custody by a New York State Family Court judge in November 2009. He sues by his guardian, L.D.

32. At the time of the filing of the First Amended Complaint, Plaintiff M.M. was a 17-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in August 2007. He sues by his parent, L.M.

33. At the time of the filing of the Second Amended Complaint, Plaintiff D.C. was a 15-year-old boy residing in OCFS' Sergeant Henry Johnson Youth Leadership Academy, located in South Kortright, New York. He was placed in OCFS custody by a New York State Family Court judge in January, 2009. He sues by his parent, J.C.

34. At the time of the filing of the Third Amended Complaint, Plaintiff N.P. was a 15 year old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in April 2011. N.P. is currently in OCFS custody at OCFS' Highland Residential Center. He sues by his parent, D.P.

35. B.B. is a fifteen year old boy who was placed in the custody of OCFS by a New York State Family Court judge. He is currently in OCFS custody at OCFS' Highland Residential Center, located in Highland, New York. He sues by his parent, S.B.

36. Defendant Carrión is the Commissioner of the New York State Office of Children and Family Services and is sued in her official capacity. Pursuant to N.Y. Exec. Law Article 19-G, Defendant Carrión has overall executive responsibility for the operation and administration of all juvenile residential facilities, staff, policies and programs under the administration of OCFS, including the facilities at issue in this action, and has responsibility for OCFS' compliance with and enforcement of applicable laws and regulations. Defendant Carrión's responsibilities include "establish[ing], operat[ing] and maintain[ing] treatment programs and other services for youth placed with or committed to the division," and "promulgat[ing] regulations concerning standards for the protection of children in residential facilities and programs operated or certified by the division, from abuse and maltreatment." N.Y. Exec. Law § 501.

37. Defendant Carrión's agency, OCFS, is responsible for operating and maintaining facilities "for the care, custody, treatment, housing, education, rehabilitation and guidance of youth placed with or committed to [OCFS]." N.Y. Exec. Law § 504.

38. As Commissioner, Defendant Carrión is responsible for the care, custody, and control of all children housed in OCFS' Division of Juvenile Justice and Opportunities for Youth ("DJJOY") residential facilities.

39. Defendants, Youth Division Aide ("YDA") DALE WARE, YDA EDWARD DAVIS, YDA ALEXANDER MCCREADY, MR. DEPORTA, MR. PARIS, MR. THOMPSON, MS. PACETTE (phonetic), MR. COTTON, YDA GAL (phonetic), YDA MOHAN, YDA BILL MCMORRIS, YDA MATTHEW LAUBACH, YDA VISCONI, YDA WISELL, YDA JOEL DEJESUS, YDA GAVIN, YDA CROCKETT, YDA AVILES, YDA JAMELL CAMPBELL, YDA EDDIE MOLLETTE, YDA MITCH YANICK, YDA PHILLIP PALOMINO, YDA WATSON, YDA M. SAWITSKY, YDA LUIS ROSADO, YDA RAJEB MASESI, YDA ERIC VINCENT, YDA R. CURTIS, YDA YOUNG, YDA BANTA, YDA JOANNE LEHR, VICKY HUGHES, YDA ROBERT LACONTE, YDA M. HYACINTH, YDA GULOTTA, YDA JEFFREY BENTON, YDA WILLIAM COULMAN, YDA RYAN CASEY, NANCY JABLONSKI, REC SPECIALIST FLYNN, YDA WATSON, YDA RODRIGUEZ, YDA KAGONYERA, MR. HEWES, MR. BREWSTER, MS. HEPBURN (phonetic), MR. WILLIAMS, MS. ROLETTE (phonetic), MR. GARITY, MR. JENSON, MR. SMITH, MR. GAVOUGH (phonetic), YDA KEITH NASH, YDA W. DAVIS, YDA HOWD, YDA D. MANTI, YDA HOLLENBACK, Administrator on Duty ("AOD") JOHN PAZ, AOD RUTLAND, YDA DANIEL BERNHARDT, YDA DWAYNE CREQUE, YDA SPENCER, YDA LUCAS, YDA BRUMFIELD, YDA VONDERCHEK, YDA GREGORY FISH, YDA

BRYAN CHAPMAN, YDA SEFARIS (phonetic),YDA WINNICK, SERGEANT BRETT ROCKEFELLER, SERGEANT FRED WELCH, SERGEANT WOOD, FIRST SERGEANT MCENTEE, SERGEANT DALLAS ECCLESTON, SERGEANT PALMER, AOD FIRST SERGEANT TIMOTHY KINCH, SERGEANT MICHAEL TOWNSEND, YDA RICHARD LALOSH, YDA YOUNG, MR. CLOW and JOHN DOES ## 1 – 27 were at all times referred to in this the Fourth Amended Complaint as youth division aides, youth counselors, or other OCFS staff responsible for the care and custody of children, employed by OCFS and assigned to OCFS-operated DJJOY residential facilities. These Defendants are sued in their individual capacities. At all times referred to in this the Fourth Amended Complaint, all named and John Doe Defendants were acting within the scope of their employment as employees of OCFS, and acting under color of state law. Plaintiffs do not know the names of the OCFS personnel sued as John Does and will amend the Fourth Amended Complaint to state the true names when they become known.

CLASS ACTION ALLEGATIONS

40. Plaintiffs bring this action on behalf of all present and future residents, sentenced by New York State Family Court judges after a finding of juvenile delinquency, confined in any of the facilities operated directly by OCFS that OCFS classifies as "reception" or "limited secure," as well as the Lansing Residential Center.

41. At the time of the filing of the Complaint, the OCFS facilities at issue were the Pyramid Reception Center in Bronx, New York and the Tryon Girls' Reception Center in Johnstown, New York, which OCFS classified as "limited secure;" the Lansing Residential Center in Lansing, New York, which OCFS classifies as "non-secure;" and the Highland Residential Center in Highland, New York, Tryon Boys' Residential Center in Johnstown, New York, Tryon

Girls' Residential Center in Johnstown, New York, Industry Limited Secure Residential Center in Rush, New York, Finger Lakes Residential Center (until December 2009 known as Louis Gossett, Jr. Residential Center) in Lansing, New York, Taberg Residential Center in Taberg, New York, and Sergeant Henry Johnson Youth Leadership Academy in South Kortright, New York, all of which OCFS classifies as "limited secure" centers.

42. Since the filing of the Complaint, OCFS has closed the following facilities: the Pyramid Reception Center, Tryon Boys' Residential Center, Tryon Girls' Residential Center, and the Tryon Girls' Reception Center.

43. Since the filing of the Complaint, upon information and belief OCFS has designated the Ella McQueen Reception Center facility located in Brooklyn, New York, as its Reception Center for boys and girls entering OCFS DJJOY upon their placement with OCFS by the Family Courts.

44. All of the facilities listed above are directly operated by OCFS, through DJJOY.

45. This action is brought pursuant to the Federal Rules of Civil Procedure, Rules 23(a), (b)(1) and (b)(2).

46. The class meets the requirements of Rule 23 as follows:

a. There are approximately 280 youth confined within the aforementioned facilities at any one time. Defendant Carrión has stated publicly that "more than 80 % of children [residing in OCFS facilities] have mental health needs of clinical significance." Physical restraints are used by staff on children at all of these facilities, pursuant to a system-wide policy and practice. OCFS staff physically restrain children in these facilities on a regular basis. The numerosity of the class makes joinder of all members impracticable; in addition, membership of the class changes continuously, as new

children are placed in the facilities and others are discharged, compounding the impracticability of joinder.

b. The questions of law and fact presented by the named Plaintiffs are common to all members of the class. Such questions include the existence of a pattern of improper and excessive use of physical force and the existence of an OCFS-wide failure to evaluate and treat the mental health needs of children in the agency's care. These practices, policies, and procedures result in both the frequent infliction of severe physical and psychological injuries on children confined in these facilities, and the maintenance of an atmosphere of fear and intimidation. As a result, every youth in these facilities risks being subjected to and injured by these unlawful practices. The claims and practices alleged in this the Fourth Amended Complaint are common to all members of the class.

c. Defendants impose the conditions, treatment, policies and practices challenged in this action on the named Plaintiffs and on the members of the Plaintiff class so that the claims of the named Plaintiffs are typical of those of the class. The entire class will benefit from the relief sought.

d. Each of the named Plaintiffs was confined to an OCFS facility at the time he or she brought suit. The named Plaintiffs will fairly and adequately protect the interests of the class. The Legal Aid Society, counsel for Plaintiffs, is a legal services organization with extensive experience in civil rights litigation including litigation in federal and state courts on behalf of children and adults in the juvenile and criminal justice systems, and litigation regarding the mental health needs of children. Orrick, Herrington & Sutcliffe LLP is a law firm with offices in New York City that has extensive experience in complex federal litigation and class actions.

47. The class also meets the requirements of Rule 23 because Defendant Carrión has acted, or failed to act, on grounds generally applicable to the class, thereby making appropriate injunctive relief with respect to the class as a whole. The policies and practices at issue regarding the use of physical force and the failure to provide mental health treatment to which children in OCFS custody have a right are policies and practices in every facility complained of in this action, and affect all children in the class.

FACTUAL ALLEGATIONS

The Facilities and Treatment of the Youth Confined

48. It is well-documented that children in OCFS custody have a high prevalence of exposure to trauma, including childhood histories involving physical, sexual and emotional abuse prior to their placements with OCFS. As a result many residents have serious mental health issues when they enter placement.

49. Dr. Lois Shapiro, then Director of OCFS' Bureau of Behavioral Health Services, has stated that "[s]tudies indicate that up to 70 % of the youngsters admitted to New York State's juvenile justice system present with significantly complex mental health needs."

Use of Excessive and Inappropriate Force

50. OCFS' 2007 "Use of Physical Restraint" policy limits the circumstances under which staff is permitted to use physical restraints, yet these written limitations do not ensure the safety of residents, as they do not prevent the persistent and unlawful use of force against children in OCFS custody.

51. OCFS' "Use of Physical Restraint" policy defines "physical restraint" as "physically controlling a youth and/or physically holding or escorting a youth from one place to another." OCFS Policy and Procedures Manual, PPM 3247.13.

52. This written policy allows staff to use physical restraints "only under the following circumstances when all other appropriate pro-active, non-physical behavioral management techniques have been tried and have failed: (1) to prevent a youth from harming him or herself, staff members or others; (2) to prevent an escape or AWOL by a youth; and (3) to escort a youth who is causing or threatening to cause an immediate serious disruption that threatens the safety of others; or (4) the youth's behavior is escalating to the point that further de-escalation techniques need to take place in another location."

53. The OCFS physical restraint policy has not prevented OCFS staff from using physical restraints on children in a persistent and egregious manner.

54. OCFS staff use a particularly problematic and dangerous type of restraint, known as the prone restraint technique. Prone restraints involve the child being placed face down on the ground while at least two adult staff members hold the child down and put pressure on the child's body. During the prone restraints, OCFS adult staff hold and/or handcuff the child's hands behind his back.

55. Prone restraints expose children to the risks of difficulty breathing, cardiac and respiratory arrest, back, arm and neck injuries, abrasions, bruises, strained muscles and other musculoskeletal injuries, and head injuries. Children have died or have suffered catastrophic injuries as a result of these restraints. In 2006, a young boy from the Bronx died in OCFS custody after being physically restrained by staff at the Tryon facility. Earlier, a 14-year-old boy "suffer[ed] serious and permanent physical and mental injuries," following successive physical restraints by staff in 1996 at OCFS' Gossett (now called Finger Lakes Residential) facility. See Jackson v. Johnson, 118 F. Supp. 2d 278, 285 (N.D.N.Y. 2000). In both instances, prone restraints were used.

56. Although Defendant Carrion has adjusted the OCFS restraint policy following these tragic occurrences, the changes have not ameliorated the problems with the policy, either as written or as applied. As written, it remains vague and allows too much discretion to staff. In practice, OCFS staff members continue to respond to residents' refusal to follow directives or to other nonviolent speech or behavior with the use of force.

57. Upon information and belief, many OCFS staff routinely ignore the portion of the policy that directs them not to use physical restraint unless non-physical techniques have been tried and have failed.

58. OCFS staff regularly use handcuffs on children in DJJOY facility custody during physical restraints, despite OCFS "Use of Mechanical Restraints" policy which states "It is the policy of OCFS to limit the use of mechanical restraints in its facilities . . . the types that are used, the circumstances under which they are used and the length of time they are used. The use of mechanical restraints as a form of punishment is prohibited. Mechanical restraint shall mean handcuffs and foot cuffs." OCFS PPM 3247.14.

59. The risks of OCFS' restraint practices are well known to Defendants. Plaintiffs' counsel has alerted OCFS to them in letters and repeated meetings. The Legal Aid Society wrote to then-OCFS Commissioner John Johnson and then-Deputy Commissioner for Rehabilitative Services, Ed Ausborn, on November 29, 2006, expressing serious concerns about the overuse and misuse of physical restraints at the OCFS Lansing facility for girls. Plaintiffs' counsel had learned that in the month of October 2006 alone, there were more than 200 restraints performed by staff against residents at Lansing. The consequences to young girls of the trauma of restraint have been and are devastating, particularly in light of the prior experience of many girls in OCFS facilities who have already been victims of sexual abuse and physical abuse.

60. Plaintiffs' counsel also wrote a detailed letter to the Department of Justice's Civil Rights Division in August 2008 and copied Defendant Carrión, bringing to Defendant Carrión's attention the continuing serious issues involving use of force and lack of mental health treatment and the nexus between the two.

61. The Defendant Commissioner knows that the pattern of physical abuse described above existed and still exists in many of the OCFS facilities. The prevalence of these practices and general knowledge of their existence, and the failure of the Defendant to take adequate remedial action despite the fact that the misuse of force in OCFS youth facilities has been repeatedly brought to their attention, constitutes deliberate indifference to the rights and safety of the youth in the agency's care and custody, including those residents named as Plaintiffs in this action.

62. OCFS operates under a system-wide use of physical restraint / use of force policy. All staff are trained by the same training unit, and the agency maintains a centralized office to issue policies and procedures, oversee training, and investigate complaints.

63. OCFS' central supervisory staff receive all reports of physical restraint and injuries to children in OCFS DJJOY facilities. These reports are in writing and also, in some cases, include videotape of the restraints.

64. Upon information and belief, these restraint reports routinely document the infliction of serious injuries on children by OCFS staff.

65. For the month of December 2007, OCFS documented 108 restraints at Tryon Boys, 14 at Gossett (now Finger Lakes), 41 at Highland, 49 at Industry, 37 at Lansing, 4 at Pyramid, 2 at Taberg, 22 at Tryon Girls and 11 at YLA.

66. For the month of February 2008, OCFS documented 71 restraints at Tryon Boys, 25 at Gossett (now Finger Lakes), 58 at Highland, 38 at Industry, 46 at Lansing, 54 at Tryon Girls, and 14 at YLA.

67. In one week of July 2008 alone, the Lansing facility documented that during that week, staff used 40 restraints on girls and Gossett documented staff using 24 restraints on boys in OCFS care.

68. The documented use of restraints on children by OCFS staff has been so excessive that high-level OCFS administrators have called for reductions. For example, in June 2008, Deputy Commissioner Anthony Hough required a "restraint reduction action plan" for the Gossett facility (now called Finger Lakes), also calling for an "explanation for the high volume of restraints."

69. Notwithstanding the fact that high-ranking officials in OCFS' central office know or knew that OCFS staff routinely injured young residents in OCFS-operated youth facilities under circumstances that clearly indicated that staff was utilizing excessive and unnecessary force, Defendant Carrión has failed to implement measures that would curb the unlawful conduct of her subordinates.

70. Defendant Carrión has admitted: "My greatest disappointment continues to be the number of restraints in my system — that we still have a correctional model where kids get hurt." (*New York Times*, December 15, 2009). This conclusion is consistent with the findings of the United States Department of Justice after its investigation of four representative OCFS DJJOY facilities.

71. The use of disciplinary measures against OCFS staff has not deterred the use of excessive force and improper restraints on children in OCFS custody.

72. With rare exception, OCFS facility staff whose misconduct is brought to the attention of supervisory personnel continue to work in OCFS-operated facilities where they have daily contact with children, without any substantial disciplinary action being taken against them.

73. Defendant Carrión has admitted: "I have people on staff that have two, three, four, five cases of abuse or inappropriate restraint, and I can't get rid of them." (*New York Times*, December 15, 2009.)

Inadequate Mental Health Care

74. The mental health services available in the OCFS DJJOY facilities at issue in this action fail to identify and meet the mental health needs of this population, which has a right to mental health care while in OCFS custody.

75. In its mental health training guide for staff, OCFS acknowledges its "ethical and legal obligation to provide [mental health] services" for the children in its care and custody. In that same guide, OCFS concedes that it "do[es] not have all the financial resources, time, staffing, energy, etc" that the agency "need[s] to accomplish all [it] need[s] for the youth in its care."

76. The mental health screening performed at the OCFS reception centers is inadequate to identify children's needs and provide them with continuity of care and appropriate care and treatment.

77. In addition to the inadequate procedures at reception centers, the screening, diagnosis and treatment of children with mental health needs are inadequate at the limited secure facilities and Lansing.

78. OCFS records reveal that treatment plans for children in need of mental health services are largely boiler-plate, contain very little patient-specific information, and do not appear to be updated in a substantive manner to reflect changes in behavior, rule violations, use of restraints,

or the consequences of using restraints on the particular youth given his or her history of exposure to trauma or his or her mental health problems.

79. As a result of inadequate screening and treatment plans, Defendant Carrión fails to provide necessary mental health treatment to young people in OCFS DJJOY custody.

80. Inadequate mental health screening, diagnoses and treatment causes harm to young people, including decompensation of children's mental or emotional state, exposure to the use of force and restraints by staff, improper and inappropriate use of disciplinary procedures in response to behaviors that are manifestations of mental illness, placement of children in more restrictive settings as a means of behavioral control, lengthy or protracted periods of incarceration, and/or multiple placements.

OCFS Substitutes Improper Physical Restraint for Appropriate Mental Health Treatment

81. The lack of mental health treatment has been addressed by OCFS staff with the use of physical force against children in OCFS facilities. OCFS staff use physical force disproportionately against children with mental illness. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by failing to provide disciplinary alternatives to physical restraint as a reasonable accommodation so that the restraints, which exacerbate mental illness, are not imposed.

82. New York State's Office of the Inspector General and the Tompkins County District Attorney's Office investigated the use of force at the OCFS Gossett (now known as Finger Lakes) facility, issuing a report in November 2006. Their analysis "revealed a highly significant correlation between those residents medicated for psychiatric and emotional disorders and the frequency of restraints. . . . 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."

83. Defendant Carrión has knowledge of this investigation and its findings.

84. New York State Executive Law requires that Defendant Carrión "establish, operate and maintain treatment programs and other services for youth placed with or committed to the division and programs . . . ." N.Y. Exec. Law 501. Defendant Carrión has "all necessary powers to see that the purposes of each facility or program are carried into effect."

85. Defendant Carrión is also required to "promulgate regulations concerning standards for the protection of children in residential facilities and programs operated or certified by the division, from abuse and maltreatment. Such standards shall include the prevention and remediation of abuse and maltreatment of children in such residential facilities or programs . . . ." Defendant Carrión's duties include establishing "minimal experiential and educational qualifications" for employees, and "assuring adequate and appropriate supervision of employees." N.Y. Exec. Law § 501.

Placement of Children in Defendant Carrión's OCFS Facilities

86. New York State Family Court Act § 301.2(1) provides that juvenile delinquency proceedings may be brought against children ages 7 through 15 in New York State Family Court. If the court enters a finding that the child committed an act which if committed by an adult would be a crime pursuant to F.C.A. § 345.1, and determines after a dispositional hearing that the child is a juvenile delinquent in need of supervision, treatment or confinement, one possible outcome is that the court may "place" the child, pursuant to F.C.A. §§ 352.1 and 352.2, at a facility operated by the Defendant Commissioner.

87. Family Court Act § 353.3 provides that children placed with the Defendant Commissioner may be placed for up to 12 or 18 months, and may be placed in various settings, including "limited secure" and non-secure facilities operated by or under contract with OCFS. At the conclusion of the child's initial placement period, OCFS may petition the Family Court for an extension of the child's placement pursuant to F.C.A. § 355.3.

88. At the conclusion of his residential stay with OCFS, the child may be released into the community, but may be placed on "aftercare." If OCFS wishes to mandate that a child be on aftercare after the end date of his initial sentence, OCFS must obtain an extension of placement order from the Family Court, pursuant to F.C.A. § 355.3.

89. Children on "aftercare" remain under OCFS supervision. If OCFS staff find that children on aftercare have violated the conditions of the aftercare, the children's aftercare may be "revoked," meaning that the children are placed back into OCFS DJJOY residential care and custody.

Assignment of Children to OCFS Residential Facilities

90. Once a Family Court judge places a child with OCFS, unless the judge specifically directs placement in a contracted facility that is not directly operated by OCFS, OCFS admits the child to one of its two reception centers within approximately two weeks.

91. At the time of the filing of the earlier Complaints girls who entered OCFS DJJOY custody were sent to the Tryon Girls' Reception Center, in Johnstown, New York, and boys who entered OCFS DJJOY custody were sent to the Pyramid Reception Center in Bronx, New York.

92. OCFS has since closed the Tryon Girls' Reception Center and the Pyramid Reception Center. Presently boys and girls who enter OCFS custody are sent to the Ella McQueen Reception Center in Brooklyn, New York.

93. OCFS houses children at the reception centers for approximately two weeks, during which time OCFS is supposed to assess the children's needs and determine which facility placement is appropriate for each child, within the OCFS DJJOY system. OCFS then transports youth to a DJJOY facility, which may be anywhere in New York State.

The Facilities at Issue

94. As of November 16, 2009, OCFS DJJOY operated seven facilities classified as "limited secure," and two facilities classified as "reception." At the time of the filing of the Complaint, the Lansing facility for girls had recently been re-classified from a "limited secure" facility to a "nonsecure" facility.

95. As of November 16, 2009, the limited secure OCFS facilities were Highland Residential Center in Highland, New York, Tryon Boys' Residential Center in Johnstown, New York, Tryon Girls' Residential Center in Johnstown, New York, Industry Limited Secure Residential Center in Rush, New York, Finger Lakes Residential Center (until December 2009 known as Louis Gossett, Jr. Residential Center) in Lansing, New York, Taberg Residential Center in Taberg, New York, and Sergeant Henry Johnson Youth Leadership Academy ("YLA") in South Kortright, New York. As of that date, these facilities had a total population of 451 children, with an available capacity of 562 children.

96. As of September 9, 2011, OCFS DJJOY operated five facilities classified as "limited secure" and one facility classified as the "reception."

97. As of November 16, 2009, the OCFS reception facilities, Pyramid Reception Center in Bronx, New York, and Tryon Girls' Reception Center in Johnstown, New York, had a total population of 40 children, with an available capacity of 57 children.

98. The nonsecure Lansing Residential Center is located in Lansing, New York. As of November 16, 2009, Lansing had a total population of 25 girls, with an available capacity of 50 girls.

99. In total, the facilities covered by this action, as of November 16, 2009, had a total population of 516 children, with an available capacity of 669 children.

100. Defendant Commissioner Carrión has admitted that "more than 80 % of children [residing in OCFS facilities] have mental health needs of clinical significance."

Findings of the U.S. Department of Justice ("DOJ"), the Governor's Task Force and Others

101. The illegal use of force against children in OCFS facilities and deprivation of required mental health services are pervasive and continuing, and well-known to the Defendant Commissioner, as evidenced by a recent United States DOJ Civil Rights Division investigation and Findings Letter focusing on four OCFS DJJOY facilities and subsequent settlement, the recent Governor's Task Force report focusing on the entire OCFS system, and a host of other reports and studies.

102. On August 14, 2009, the DOJ issued a Findings Letter to Defendant in conjunction with DOJ's 2008 Civil Rights of Institutionalized Persons Act investigation of the Lansing, Gossett (now called Finger Lakes), Tryon Boys and Tryon Girls OCFS facilities. The DOJ letter calls for remediation of the deficiencies identified.

103. In its Findings Letter, DOJ states that"[s]taff at the four facilities consistently used a high degree of force to gain control in nearly every type of situation."

104. The DOJ investigation also revealed that "restraints are used frequently and result in a high number of injuries," and that "[t]he number and severity of injuries resulting from restraints is made worse by poorly executed or intentionally harmful restraints."

105. DOJ additionally found and detailed the ways in which mental health care at the facilities "substantially departs from generally accepted professional standards."

106. In connection with the finding of "Use of Excessive Force and Inappropriate Restraints," the DOJ Findings Letter states:

> Staff at the four facilities consistently used a high degree of force to gain control in nearly every type of situation.
>
> A full restraint involves staff ultimately placing the youth face down on the ground with his or her arms behind the back. The youth is frequently handcuffed by staff while in this position.
>
> Anything from sneaking an extra cookie to initiating a fistfight may result in a full prone restraint with handcuffs. This one-size-fits-all control approach has not surprisingly led to an alarming number of serious injuries to youth, including concussions, broken or knocked-out teeth, and spiral fractures.
>
> The number and severity of injuries resulting from restraints is made worse by poorly executed or intentionally harmful restraints.
>
> In particular, the use of prone restraints is controversial and has been banned by many facilities nationwide due to the high risk of serious injury or death. In spite of the known risk of prone restraints, staff at the facilities are trained to use prone restraints. The danger of prone restraints is that if the individual's airway is constricted, he or she is unable to express physical distress. Further, the restrained individual's struggle for air may be misconstrued by staff as resistance, resulting in increased force on the restrained individual. Indeed, in November 2006, a 15-year-old resident at Tryon Boys died following a prone restraint. The youth allegedly pushed a staff member and was then pinned facedown on the floor and handcuffed by two staff. The youth stopped breathing only minutes later, and then died at a nearby hospital. His death was ruled a homicide by the medical examiner. Despite this tragic death, a dangerous combination of high rates of prone restraints and a low standard for initiating a restraint remains at the facilities.

107. In connection with the finding of a "Failure to Adequately Investigate Use of Force Incidents," the DOJ Findings Letter states:

> Many of the investigations our expert reviewed were inadequate, both by agency and generally accepted professional standards. For example, some investigations were superficial and failed to include relevant evidence or any attempt to reconcile conflicting evidence. Some investigations were not conducted by detached investigators, which calls their reliability into question.

108. In connection with the finding of a "Failure to Take Corrective Action Against Staff," the DOJ Findings Letter states:

> Contrary to generally accepted professional standards, administrators in the facilities take no action, impose actions that are inconsistent with the seriousness of the violation, or fail to impose action in a timely manner.

109. In connection with the finding of a "Failure to Provide Adequate Mental Health Care and Treatment," the DOJ Findings Letter states:

> We find that the mental health care at Lansing, Gossett, Tryon Boys, and Tryon Girls substantially departs from generally accepted professional standards. Specifically, we find that: 1) inadequate behavioral management has led to an over-reliance on restraints and other forms of punishment to control youth's behaviors; 2) evaluation and diagnoses are inadequate; 3) the facility follows poor medication administration; 4) treatment planning is inadequate; and 5) substance abuse treatment is insufficient.
>
> Our investigation revealed that, while some attempts had been made to establish individual behavior management plans for youth with mental illness, the facilities failed to address problematic behavior and mental health crises with the least restrictive measures. Restraints were the standard for controlling behavior at all four facilities, and youths with mental illness were restrained more often than other youth.
>
> The majority of psychiatric evaluations at the four facilities did not come close to meeting [applicable criteria]. The evaluations typically lacked basic, necessary information, including justification for the diagnosis and evidence of prior record review. As a consequence, the treatment of youth with serious mental illness was based on poor information and was generally ineffective.

> Failing to properly evaluate and diagnose mental health problems results in ineffective treatment and harm to youth.
>
> Across the four facilities, there was a pervasive lack of documentation of either the target symptoms for the medications or monitoring of the effectiveness (or lack thereof) of medication on those target symptoms.
>
> Our review of the four facilities' psychotropic medication practices showed substantial departures from generally accepted professional standards.
>
> Informed consent procedures at the four facilities substantially depart from generally accepted professional standards. We found that, in practice, staff members calling the parent/guardian to obtain informed consent typically did not have prescriptive authority, and therefore were not able to discuss the medication with the parent/guardian. Consent obtained in this manner is not "informed." Each facility's informed consent process relied on professionals without prescribing authority to contact the parent/guardian for verbal consent.
>
> The treatment plans at all four facilities substantially departed from [applicable] standards. Many youths had complex mental health needs documented in their records, but the treatment plans were superficial, generalized, and in jargon which the youths did not understand.
>
> However, the treatment teams generally lacked critical members, most often the youth and the psychiatrist.
>
> Many youth at the four facilities had well-documented trauma that was left untreated and unaddressed in treatment planning.
>
> Failing to help these youths with past trauma means that they will probably continue to be reactive and aggressive upon their return to the community.

110. The DOJ Findings Letter and their requirement of remedial action focuses only on four OCFS DJJOY facilities: Finger Lakes, Lansing, Tryon Boys and Tryon Girls.

111. Several other investigations and reports have revealed and made known to Defendant Carrión and her predecessor in office the egregious conditions in the OCFS DJJOY facilities.

112. On December 14, 2009, a Task Force of experts convened in September 2008 by New York's then Governor issued publicly and delivered to the Governor a report entitled "Charting a New Course: A Blueprint for Transforming Juvenile Justice in New York State." The task force report documents "alarming conditions" throughout the OCFS DJJOY facilities.

113. The Governor's Task Force's review found "youth with limited access to meaningful services and programs," facilities that "are punitive and feel like adult prisons," and staff who "are sometimes quick to resort to punishment and excessive force in situations that do not warrant such an approach." "Such conditions are unacceptable," the task force concluded, "and indicate that the current system is failing to protect the safety of youth placed in OCFS custody." Addressing the issue of mental health treatment, "[t]he Task Force found that many state-operated placement facilities lack sufficient resources to ensure that youth receive an array of necessary services," agreeing with the DOJ finding that mental health services are "either inadequate or unavailable due to poor assessments and limited staffing."

114. Defendant Carrión received a copy of the Governor's Task Force report in December 2009 and has knowledge of its contents.

115. The portion of the Governor's Task Force report focusing on OCFS' residential facilities finds deficiencies system-wide, but the Task Force has no authority to remedy the deficiencies.

116. In December 2009, the Citizens' Committee for Children of New York, Inc. ("CCC"), issued a report entitled "Inside Out: Youth Experiences Inside New York's Juvenile Placement System." The report was based on a longitudinal study beginning in 2003 of a group of young people who were placed in OCFS DJJOY facilities. The study found inadequate mental heath and youth development services to meet the needs of youth in care, inadequate services planning, gaps and errors in case files, and that "OCFS staff relied heavily on a behavior compliance

approach that too frequently employed the use of physical restraints to manage negative youth behavior." CCC concluded that there is "an enormous disconnect between the pro-social youth development goals that youth are expected to achieve and the corrections-based behavior management approach used throughout placement."

117. Defendant Carrión is on notice of the CCC's findings. According to its report, the CCC shared its preliminary findings with Defendant Carrión and her Deputy Commissioner for DJJOY in early 2007

118. A September 2007 report prepared by the New York State Committee on Restraint and Crisis Intervention Techniques finds that "all forms of physical restraint come with inherent risk due to the hazardous circumstances in which restraints are applied." According to this report, risks to children during the restraint process include exposure to trauma, physical injury and death. The report states that "the use of restraints is recognized as an intervention of last resort." Committee on Restraint and Crisis Intervention Techniques, "Behavior and Management: Coordinated Standards for Children's Systems of Care," Final Report to the Governor, September 2007. Upon information and belief, Defendant Carrión has knowledge of this report and its contents.

119. Disability Advocates, Inc. ("DAI"), a New York State based protection and advocacy group for persons with disabilities, reviewed documents it received from OCFS and found that physical restraints were overused and improperly used in the OCFS facilities. DAI found that the prone restraint technique used by OCFS is a "highly risky method," as is allowing weight-bearing by staff on children during restraints. In an April 2007 letter to Defendant Carrión's Deputy Commissioner Inez Nieves, which was copied to Defendant Carrión, DAI notified

Defendant Carrión of their findings and urged OCFS to implement a restraint policy that would allow "restraints only be used to prevent imminent harm."

120. Referring to OCFS' prone restraint technique, in its letter DAI advised Defendant Carrión that the prone restraint technique is "prohibited by NYS's Office of Mental Health, Office of Mental Retardation and Developmental Disabilities and strictly limited by the Department of Corrections." Defendant Carrión has knowledge of these findings.

121. New York State's Office of the Inspector General and the Tompkins County District Attorney's Office investigated the use of force at the OCFS limited secure Gossett (now known as Finger Lakes) facility and issued a report in November 2006. Their analysis "revealed a highly significant correlation between those residents medicated for psychiatric and emotional disorders and the frequency of restraints." Defendant Carrión has knowledge of this report and its findings.

122. A 2006 Human Rights Watch and American Civil Liberties Union report, based on an investigation of the OCFS Lansing and Tryon Girls facilities, concluded that OCFS' use of force policy was not in compliance with "national and international standards regarding the use of force against children" which permit force to be used only when a child poses an imminent threat of injury to self or others and all other means of control have been exhausted. Upon information and belief, Defendant Carrión has knowledge of this report and its findings.

123. The Plaintiffs in this case have traits that make it difficult or nearly impossible to complete the use of the three-step grievance process in the OCFS facilities at issue in this action and, as a result, to assert their rights to safe and adequate treatment. These barriers include the young age, emotional and mental disabilities and/or mental retardation, and low educational level of age of many of the Plaintiffs and Class members.

124. Upon information and belief, some children in the OCFS DJJOY facilities at issue in this action do not report abuses or complete the three-step grievance process because it fails to assure confidentiality.

125. In some instances, children have received threats of retaliation by staff and other residents if they complain about the conditions of their confinement.

126. The current OCFS grievance system fails to provide an effective means for Plaintiffs to complain about incidents of use of excessive force, unreasonable restraint, or other conditions of their confinement without fear of retaliation.

The Named Plaintiffs

G.B.

127. At the time of the filing of the Complaint, Plaintiff G.B. was a 16-year-old boy residing at OCFS' Tryon Boys Residential Center. He was placed in OCFS custody by a New York State Family Court judge in or about June 2009.

128. He currently resides in Suffolk County, New York with his mother.

129. At the time of the filing of the Complaint, G.B. was approximately 4 feet 7 inches tall and weighed approximately 107 pounds.

130. G.B. has mental health needs and has been diagnosed with moderate mental retardation.

131. When the Family Court placed G.B. in OCFS custody in July 2009, the judge ordered OCFS to provide him a placement with mental health services.

132. OCFS did not place G.B. on a mental health unit until in or about December 2009.

133. Upon G.B.'s entering OCFS custody, OCFS sent G.B. to the Pyramid Reception Center in the Bronx, New York.

134. When G.B. entered OCFS custody, OCFS was aware that G.B. had been psychiatrically hospitalized three times prior to his placement.

135. The most recent hospitalization occurred in or about May 2008. During that hospitalization, G.B. was diagnosed with a conduct disorder, impulse control disorder and a mood disorder. The hospital noted that G.B. is of short stature for his age. During his hospitalization G.B. was prescribed and began taking Abilify, an anti-psychotic medication.

136. Upon his admission to OCFS' Pyramid facility, G.B. received a psychological evaluation and was diagnosed with mood disorder, conduct disorder, impulse control disorder, and moderate mental retardation. The evaluator noted that G.B. had been psychiatrically hospitalized at ages 13, 14, and 15.

137. Educational evaluations reflect that as of in or about August 2009, G.B. was on a first grade academic level in reading, writing, and mathematics.

138. In August 2009, OCFS transferred G.B. to the Highland facility, where he was not placed on a mental health unit.

139. The OCFS Highland social worker who screened G.B. upon his admission recommended a referral to the Committee on Special Education, clinician monitoring, and a referral to a psychiatrist.

140. Upon information and belief, G.B. saw a psychiatrist only once while at Highland, for medication review.

141. Despite OCFS' knowledge of G.B.'s mental health history and its own staff's recommendations for mental health services, OCFS did not move G.B. to a mental health unit until in or about December 2009, after a lengthy Family Court hearing at which his attorney advocated strenuously for mental health treatment for G.B. outside of an OCFS facility.

142. On or about December 4, 2009, G.B. was transferred to OCFS' Tryon Facility to reside in its Mental Health Unit.

143. While G.B. was at Highland, he broke his arm. His left arm was swollen but staff did not address his injury until his grandmother visited and asked that he be taken to the hospital. As it turned out, G.B. had a fracture in his arm and his arm was placed in a cast.

144. Between September 2009 and December 2009, OCFS staff at Highland physically restrained G.B. several times.

145. One restraint occurred in the school when G.B. asked to see a nurse because his broken arm was hurting. When the staff refused, G.B. got up to walk out of the classroom but a YDA stopped him.

146. Without a warning or other attempt to stop G.B. without physical force, YDA DALE WARE threw G.B. to the ground and bent his broken left arm behind his back causing him pain. G.B. later heard the OCFS AOD say that the YDA should not have restrained him because his arm was broken.

147. Another restraint occurred shortly thereafter, when G.B. realized that YDA WARE was in the class despite GB having been told that YDA WARE would not be in his classroom because of the earlier restraint. G.B. got up to walk out of the room. WARE pulled G.B.'s shirt and hit him in the face. G.B. fell to the floor and WARE banged G.B.'s head on the floor causing G.B. pain and again bent G.B.'s broken arm behind his back. G.B. was in pain and had a knot on his head. G.B. had cuts and bruises from the restraint.

148. Later, the AOD told G.B. that this YDA would not be around anymore and that he did not need to press charges.

149. Another restraint occurred after another resident called G.B. "gay" and YDA EDWARD DAVIS laughed. Because DAVIS laughed, G.B. threw paper on the floor. DAVIS told G.B. to pick up the paper, then pushed G.B. and put G.B. in a choke hold. G.B. could not breathe and was kicking to get away when he heard another staff member, JOHN DOE #1, say "take him down." DAVIS threw G.B. to the floor and held him down applying pressure on his chest. After the restraint, G.B.'s chest hurt for a week.

150. Another restraint at Highland occurred after G.B. got into a fight with another resident. The staff did not warn him or otherwise intervene in a non-physical way. YDA EDWARD DAVIS threw G.B. to the floor and bent G.B.'s broken arm behind his back again.

151. An additional restraint occurred in the gym at Highland . Another resident jumped G.B. and said "staff wanted me to do this." G.B. was kicking the other resident to get the attacker off him when YDA ALEXANDER MCCREADY restrained him with a standing restraint.

152. Even after OCFS transferred G.B. to the Tryon facility in early December 2009, OCFS staff continued to physically restrained G.B.

153. For example, while at Tryon, after another resident took a swing at G.B., OCFS staff member MR. DEPORTA restrained G.B. by forcing him to the floor, applying pressure while on top of G.B. and hitting him with his fists. During the restraint G.B. could not breath, was in pain and bleeding.

154. After the restraint, OCFS imposed a "level 3" sanction on G.B., imposing a 90-day hold on his discharge from OCFS custody.

155. After the restraint, a person whom G.B. understands to be from the child abuse hotline came to Tryon and interviewed G.B. about the restraint.

156. G.B. was physically restrained by staff using excessive force on several other occasions for example, near the facility swimming pool, and also while on his unit.

157. G.B. cannot remember each and every time he has been physically restrained while in OCFS custody. G.B. gets upset when he recalls the restraints and how he was treated by staff during the physical restraints.

L.B.

158. Plaintiff L.B. is a 13-year-old boy who was placed in OCFS custody by a New York State Family Court judge in November 2009.

159. L.B.'s home is in Brooklyn, New York, with his father, stepmother, and siblings.

160. OCFS first placed L.B. at the Pyramid Reception Center, where they kept him for two weeks. OCFS then moved L.B. to the OCFS limited secure Taberg Residential Center in Taberg, New York, where he remained for several days.

161. From Taberg, OCFS transferred L.B. to the OCFS limited secure Highland Residential Center, located in Highland, New York, where he currently resides.

162. Prior to entering OCFS custody, L.B. had received community-based counseling services for one year because of problematic school behavior when he was nine or ten years old.

163. In or about January 2009, L.B. was evaluated by the Family Court Mental Health Services ("MHS"), and was diagnosed with conduct disorder, and provisionally diagnosed with a learning disorder and borderline intellectual functioning.

164. The MHS recommended that L.B. receive a psychiatric evaluation and counseling with a focus on judgment, impulse control, decision-making and anger management.

165. In September 2009, the Family Court Mental Health Services again evaluated L.B. and diagnosed him with a conduct disorder, as well as a provisional diagnosis of attention

deficit/hyperactivity disorder. MHS suggested that psychiatric medications be explored.

166. When L.B. was at OCFS' Pyramid Reception Center, a staff member, MR. PARIS, grabbed him by his shirt collar and threw him off the couch, causing L.B. to land on the floor. L.B. does not know why the staff member threw him on the floor.

167. In or about December 2009, while he was in the day area, staff member, MR. THOMPSON, threatened L.B. by saying he was going to "shove [his] foot in [L.B.'s] ass." THOMPSON also walked in the room while L.B. was trying to get dressed and refused to leave. When L.B. asked THOMPSON to leave, he refused and L.B. was forced to get dressed under the covers of his bed.

168. While in OCFS custody, L.B. has witnessed several other residents being physically restrained by staff. On one occasion at Taberg, L.B. saw a resident knock something over. In response, OCFS staff members dragged the boy to the ground. L.B. heard the resident hit the concrete from several feet away. The resident, who suffers from asthma, was screaming that he could not breathe, yet L.B. watched staff hold the boy down for approximately fifteen minutes before handcuffing him and taking him to his room.

169. One evening in or about August 2011, while L.B. was in his room talking through the vents to other residents, a female staff named Ms. PACETTE (phonetic) told him to stop talking and L.B. told her in sum and substance "to get out of here."

170. About thirty minutes later MR. COTTON and YDA GAL (phonetic) grabbed L.B. from his room and dragged him to the "box" near "central" near the AOD's office. The AOD that night was MR. RUTNER or MR. RUTLAND. While they dragged L.B. they demanded "is that how you talk to people?" Once in the box, YDA GAL grabbed L.B's hair and Mr. COTTON elbowed him in the mouth. They then turned L.B over and pulled his arms behind him until they

touched his head, causing L.B. great pain. At which point, L.B. screamed from the pain. They held him down with his arms held forcibly for about 3 minutes. When they released L.B. his lip was bleeding where MR. COTTON elbowed him in the face. He was not taken to the medical office and did not receive medical treatment for this restraint.

171. After staff inflicted excessive force against L.B. AOD RUTNER or RUTLAND came into the room where L.B. was being held, saw him bleeding from his lip, gave him a paper towel and told him to "wipe that off" referring to the blood on L.B.'s mouth and the bed.

172. As a result of this showing of excessive force, L.B.'s arms were sore for several days and his mouth had a cut that lasted for several days.

173. Several days later, L.B. got into an argument with YDA MOHAN. MOHAN called YDA GAL. Approximately ten minutes later YDA GAL appeared in L.B.'s room and confronted L.B. about something L.B. reportedly said to YDA MOHAN. YDA GAL grabbed L.B. by the hair and threw him against a shelf in his room. Then YDA GAL threw L.B. against the wall. YDA GAL did this two times. YDA GAL asked L.B. repeatedly what he said to YDA MOHAN. YDA GAL also said to L.B., "you didn't learn your lesson?" (referring to the incident days earlier when YDA GAL and YDA COTTON removed L.B. from his room, restrained him and struck him in the face). L.B. had pain in his cheek from where his face hit the shelf.

J.A.

174. At the time of the filing of the Complaint, Plaintiff J.A. was a 16-year-old boy residing in OCFS' Pyramid Reception Center, located in the Bronx, New York. He was placed in OCFS custody by a New York State Family Court judge in December 2009.

175. On or about December 31, 2009, OCFS transferred J.A. to the Highland Residential Center in Highland, New York.

176. J.A.'s home is in New York, New York, with his mother, M.F.

177. J.A. has a history of psychiatric treatment and hospitalization. He was diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD") in or about 2005.

178. In April 2009, the psychiatrist who had been treating J.A. for about 10 or 11 years reported that he is learning disabled and that he suffered from hyperactivity and Attention Deficit Disorder. The psychiatrist recommended residential treatment.

179. J.A. has been prescribed Concerta, Methylin, Clordine, and Risperdal.

180. Before being placed with OCFS, J.A. attended school in a special education setting.

181. In December 2009, a New York State Family Court judge placed J.A. with OCFS after a juvenile delinquency finding.

182. The Family Court Mental Health Services evaluation in the delinquency case recommended that J.A. be placed in a therapeutically-oriented residential setting. Family Court Mental Health Services also concluded that J.A. is in the low average range of cognitive functioning, and diagnosed him with a conduct disorder and ADHD.

183. In his first week at Pyramid, J.A. did not have his medication reviewed by a psychiatrist nor was he seen by any mental health professional.

184. When J.A. arrived at Pyramid, he spoke with his unit counselor for about five minutes. The counselor did not ask J.A. about his medications, and did not ask whether he wanted to speak to mental health staff.

185. When he was placed in December 2009, the judge ordered that J.A. should be provided with anger management treatment and domestic violence counseling. J.A. was not given either while he was at Pyramid.

186. OCFS staff did not ask J.A. if he wanted to see a counselor while he was at Pyramid.

187. Despite the recommendation for a therapy-oriented residential setting, J.A. received no therapy at Pyramid except for group counseling led by staff.

188. At the time of the filing of the Complaint, J.A. wanted to engage in therapy or counseling to help him with anger and behavior issues.

189. At the time of the filing of the Complaint, J.A. spoke with a youth counselor one or two times each week. Upon information and belief, the youth counselor is not a trained mental health professional.

190. J.A. has been restrained many times at Highland.

191. On his second day at Highland on December 31, 2009, J.A. was restrained. He asked for a different snack than the snack being distributed. The OCFS staff "pushed the pin" to call for other staff. Two OCFS staff, YDA BILL McMORRIS and YDA MATTHEW LAUBACH, grabbed J.A. and physically restrained him. YDAs VISCONI and WISELL also responded and participated in the restraint holding J.A. on the ground. The staff forced J.A.'s hands behind his back, crossed his feet, and pushed his feet up onto his back.

192. The staff held J.A. down for at least five minutes, then left him in the room for about 45 minutes alone before bringing him to the medical office. After the restraint, J.A. had red marks on his face, and his arms hurt for several days.

193. On January 6, 2010, while J.A. was in the stairway on his way to the unit after dinner, another boy spit on J.A. and laughed. J.A. stopped walking and began to fight with the other boy. Two staff, YDA ALEXANDER McCREADY and YDA JOEL DEJESUS, separated the boys. The OCFS staff then held J.A. down on the floor and leaned on top of him, again causing red marks on J.A.'s face.

194. After that restraint but before bringing J.A. to the medical office, staff brought J.A. to a central location in a room called "the hole." One of the staff restrained J.A. in "the hole," holding J.A.'s arms behind J.A.'s back and throwing J.A. face down onto the mattress. That staff person held J.A. down for about a minute, and the other staff member watched the restraint.

195. As a result of this restraint, J.A.'s arms hurt for the rest of the day.

196. At the medical unit, OCFS staff took photographs of the red marks on J.A.'s face.

197. On February 7, 2010, J.A. fought with another boy while waiting to go to breakfast. OCFS staff, including YDA GAVIN, grabbed J.A. and forced J.A. to the floor. The staff member held J.A.'s arms behind his back and elbowed J.A. in the back of J.A.'s head.

198. As a result of this restraint, J.A. incurred rug burns on the right side of his face and near his left eye. The injuries caused pain for several days. The OCFS Highland medical unit took photographs of J.A.'s injuries.

199. J.A. was restrained on or about May 8, 2010 while at school after he refused to move his seat. OCFS YDA CROCKETT and YDA AVILES forcibly removed J.A. from the classroom and forced him onto the ground face down and held him there until more staff arrived. J.A.'s elbow hurt following the restraint.

S.S.

200. At the time of the filing of the Complaint, Plaintiff S.S. was a 17-year-old boy residing at OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in or around May 2009.

201. S.S.'s home is in Queens, New York, with his mother, V.S., and family.

202. In or about November 2008, S.S., following a psychiatric consultation, was placed on medication to manage feelings of depression.

203. On or about January 27, 2009, a Family Court evaluation found that S.S has significant cognitive limitations. The evaluation recommended therapy and psychopharmacological evaluations.

204. In May 2009, a New York State Family Court judge placed S.S. with OCFS after a juvenile delinquency finding.

205. S.S. spent two weeks at OCFS' Pyramid Reception Center where a needs assessment was performed. The diagnoses included anxiety disorder, disruptive behavior disorder, phonological, reading and mathematics disorders, disorder of written expression and learning disorders. Additionally, S.S. was found to have a history of acute trauma disorder. He was also given a provisional diagnosis of mild mental retardation.

206. OCFS moved S.S. to Highland Residential on or about June 15, 2009.

207. At the time of the filing of the Complaint, S.S. had not seen a psychiatrist or other doctor since he had been at Highland.

208. At the time of the filing of the Complaint, S.S. received counseling from an OCFS staff member and attended group counseling led by an OCFS male staff member or other residents. Upon information and belief, these staff are not mental health professionals.

209. At the time of the filing of the Complaint S.S. wanted to receive therapy.

210. On or about August 12, 2009, S.S. was diagnosed by the Highland Committee on Special Education as having mental retardation.

211. On or about September 15, 2009, Highland OCFS staff's "treatment team plan notes" indicate with regard to S.S. that staff have been "unable to explore his legal problems due to comprehension," and in the same notes state that S.S. "[l]ikes to play dumb so he does not have to work and others do not expect more from him."

212. In or about October 2009, OCFS "treatment team plan notes" indicate limited or no progress in reaching normal behavioral levels of performance for his age. The notes go on to state "youth's cognitive limitations do impact his ability to follow program..."

213. During the time that S.S. has been at Highland, he has been physically restrained several times by OCFS staff.

214. On or about July 28, 2009, S. S. was told to go into his room. He argued with YDA JAMELL CAMPBELL and YDA EDDIE MOLLETTE. They restrained him. A third staff, YDA MITCH YANICK, responded and participated in the restraint.

215. On or about August 10, 2009, YDA PHILLIP PALOMINO and YDA WATSON restrained S.S. after S.S. refused to go back to his unit, causing S.S. pain.

216. On or about August 28, 2009, OCFS staff member YDA M. SAWITSKY restrained S.S. because he would not stop talking while in line, causing S.S. pain.

217. On or about August 20, 2009, staff physically restrained S.S. again. S.S. knocked on the door to his room to alert OCFS staff that he needed to use the bathroom. S.S. has a known bladder problem. YDA LUIS ROSADO told S.S. to wait before he was allowed to go to the bathroom.

218. After S.S. knocked on the door again, ROSADO, came to S.S.'s door, opened it, and told S.S. to apologize before he would let S.S. go to the bathroom. S.S. tried to get past ROSADO because he needed to go to the bathroom. ROSADO started poking the left side of S.S.'s face, asking, "Why are you playing with me?" S.S. pushed the staff member's hand away and ROSADO threw S.S. on his bed.

219. A second male staff member, YDA RAJEB MASESI, ran into the room, grabbed S.S. from the bed, pushed him onto the floor and called for other staff. Two additional male staff,

YDA ERIC VINCENT and YDA VISCONI, arrived and handcuffed S.S. with his hands behind his back. At no point did S.S. resist.

220. After staff handcuffed S.S, they grabbed his hands and pulled them up and away from his back. S.S. screamed because it was painful. The staff members then picked S.S. off the ground and brought him outside and across the grounds to the Central Service Unit. S.S. was barefoot.

221. At the Central Service Unit, AOD Rutland told S.S. that YDA ROSADO said that S.S had punched him, but the AOD told S.S. that he didn't believe S.S. did this. The AOD told S.S. he didn't think S.S. hit anyone because S.S. had no history of doing anything like that. The AOD lowered the write-up of the incident from a Level 3 to a less-serious Level 1 disciplinary write-up.

222. S.S. was restrained another time for arguing with a peer and was pushed to the ground by staff member, JOHN DOE #2. After that restraint, OCFS staff wrote up S.S. with a disciplinary violation so that he would be punished.

S.R.

223. At the time of the filing of the Complaint, Plaintiff S.R. was a 16-year-old girl residing in Tryon Girls Residential Center, located in Johnstown, New York. She was placed in OCFS custody by a New York State Family Court judge in August 2009.

224. Prior to being in OCFS custody, S.R. received in-home counseling services, beginning in March 2009.

225. In May 2009, S.R. was psychiatrically hospitalized at Elmhurst Hospital Center for two days, after which a Family Court judge remanded her to the custody of the New York City Department of Juvenile Justice ("DJJ").

226. S.R. remained in the custody of DJJ through August 2009. Various DJJ staff persons made mental health referrals for S.R., and DJJ determined that S.R. often required one-to-one supervision for her own safety and crisis intervention.

227. In August 2009, a DJJ staff person found S.R. with a t-shirt wrapped around her neck.

228. In August 2009, a New York State Family Court judge placed S.R. with OCFS after a juvenile delinquency finding.

229. S.R. spent two weeks at OCFS' Tryon Girls Reception Center. While at Tryon Reception, an OCFS psychologist diagnosed S.R. with conduct disorder and adjustment disorder with depressed mood, and documented that S.R. had a history of suicidal ideation and attempts, and a psychiatric hospitalization.

230. OCFS transferred S.R. to their Staten Island Community Residential Center, and then on December 2, 2009, to Tryon Girls Residential Center.

231. At Tryon, OCFS conducted a mental health assessment, making a diagnostic impression of conduct disorder and documenting that while S.R. was in the custody of DJJ she was "depressed, frequently express[ed] suicidal statements, and would on occasion cry and scream continuously."

232. This OCFS assessment recommended that S.R. receive individual and group therapy.

233. While at Tryon, S.R. was housed on a regular unit without any special services. S.R. initially made several requests before she finally met with a clinician sometime in January 2010.

234. S.R. has never received family counseling in an OCFS facility. At the time of the filing of the Complaint, she wanted to receive family counseling, to assist with her return home after OCFS placement.

235. While at Tryon, S.R. was physically restrained several times and has seen other girls restrained almost daily.

236. On December 10, 2009, S.R. was physically restrained by OCFS staff in the recreational area of her unit.

237. S.R. and other residents were playing cards when S.R. and another resident began to argue and the other resident threw her cards at S.R. at which point the argument turned physical.

238. Two OCFS staff people ran over and YDA R. CURTIS, grabbed S.R. from behind, moved her several feet away from the other residents, and then threw her on the floor.

239. While staff were holding S.R. face down on the ground, CURTIS pushed down with his knee on her back and held her arms behind her back. S.R. had difficulty breathing. The staff person then locked S.R. in her room.

240. Another time, S.R. had an argument with another resident that became physical at which point YDA YOUNG grabbed S.R. and dropped her to the floor and held her there for about 20 minutes. S.R. felt pain in her back and had difficulty breathing. YOUNG put pressure on her back and YDA BANTA held her feet.

S.M.

241. At the time of the filing of the Complaint, Plaintiff S.M. was a 15-year-old girl residing in Tryon Girls Residential Center, located in Johnstown, New York. She was placed in OCFS custody by a New York State Family Court judge in February 2009. S.M. is currently in OCFS custody in the Taberg Residential Center located in Taberg, New York.

242. S.M.'s home is in New York County, New York, with her mother, E.B., and siblings.

243. During the course of a juvenile delinquency case, the Family Court Mental Health Services found that S.M.'s evaluation scores suggested a reading disability.

244. Family Court Mental Health Services also diagnosed S.M. with conduct disorder and recommended individual and group therapy as well as family therapy.

245. When the Family Court placed S.M. in OCFS custody, the judge specifically ordered OCFS to follow the recommendations of the Family Court Mental Health Services.

246. Upon entering OCFS custody, OCFS sent S.M. to the Tryon Girls Reception Center in Johnstown, New York, where she was housed for approximately two weeks.

247. OCFS then transferred S.M. to Brentwood Residential Center and, in April 2009, to Tryon Girls Residential Center.

248. While at Tryon Girls, S.M. received a psychiatric evaluation and was diagnosed with adjustment disorder, conduct disorder, and attention deficit hyperactivity disorder.

249. OCFS staff have physically restrained S.M. more than 20 times since she entered OCFS custody.

250. On her first day at Tryon Girls alone, OCFS staff restrained S.M. two times.

251. The first restraint on April 7, 2009, took place while S.M. was in the Central Services Unit. When S.M. did not move as OCFS staff had instructed, two OCFS staff, YDA JOANNE LEHR and VICKY HUGHES, responded by hooking S.M.'s arms from behind and pushing her to the floor on her side. OCFS staff held her down for several minutes.

252. The second restraint on April 7, 2009 took place when OCFS staff members tried to escort S.M. to the medical unit. One staff member, YDA LEHR, hooked S.M.'s arms from behind, and S.M. threw herself to the floor. Two staff members, LEHR and YDA ROBERT LACONTE then restrained her, one held her arms and the other held her legs. They held her on the floor for approximately 10 minutes.

253. Upon information and belief, during the second restraint of S.M. on April 7, 2009, S.M. was handcuffed for approximately 10 minutes.

254. S.M. had difficulty breathing during this restraint, and when she told the staff members who were restraining her, they did nothing to adjust their holds so that she could breathe more easily. As a result of this restraint, S.M. suffered pain and a rug burn to her left cheek that took several weeks to heal.

255. On April 29, 2009, YDA LACONTE, and YDA M. HYACINTH, restrained S.M. after S.M. did not follow program rules and moved toward a staff member who was attempting to physically move S.M. out of her room. S.M. suffered an injured shoulder during this restraint.

256. In or about May 2009, S.M. was in the cafeteria with her unit. The unit went outside, and S.M. took off her outer uniform shirt, leaving on the shirt she wore underneath it. Without warning, YDA GULOTTA, hooked S.M.'s arms behind her back and dropped S.M. to the ground. OCFS staff held her arms and legs down and restrained her that way for several minutes.

257. On May 6, 2009, S.M. was restrained by YDA JEFFREY BENTON and YDA HYACINTH while on her unit.

258. On May 23, 2009, S.M. was upset that OCFS staff were physically restraining her friend, and she banged on her room door. Two female staff members physically removed S.M. from her room by grabbing her arms and escorting her to a different room.

259. On the morning of June 4, 2009, while S.M. was just outside the dining room, she had an argument with YDA GULOTTA. GULOTTA and YDA WILLIAM COULMAN pushed her to the floor and placed her in a prone physical restraint, slamming her face on the floor and pulling

her arms behind her back. S.M. suffered pain on her face and in her arms as a result of that restraint.

260. On June 30, 2009, S.M. pushed past a staff member who was standing in the doorway of S.M.'s room after S.M. was told to stay in her room. YDA RYAN CASEY and NANCY JABLONSKI, then pushed S.M. to the floor and placed her in a prone restraint for approximately five minutes.

261. On the morning of July 30, 2009, a Tryon Girls Incident Report states: "S.M. wanted to go to time out. There was not enough staff available." S.M. and another resident began arguing. YDA BANTA, then hooked S.M.'s arms behind her back and threw her to the floor in a prone restraint. S.M. struggled and hit her face on the corner of the wall. S.M. suffered injuries to the right side of her face, including a black eye and swelling to the outer portion of her eye.

262. On October 23, 2009, REC. SPECIALIST FLYNN and YDA WATSON, put S.M. in a prone physical restraint, and held her on the floor for several minutes.

263. Later on October 23, 2009, when S.M. refused to leave the bathroom YDA RODRIGUEZ and YDA KAGONYERA, pushed her to the floor and placed her in another prone restraint in the bathroom.

264. Also on October 23, 2009, MR. HEWES slammed S.M.'s foot in the door causing her pain.

265. Restraints continued throughout S.M.'s placement and additional restraints occurred when S.M. returned to OCFS placement after being discharged to aftercare in 2010.

266. In April 2011, at Tryon, S.M. was restrained along with several other girls in her unit by MR. BREWSTER, MS. HEPBURN (phonetic), MR. WILLIAMS and MS. ROLETTE (phonetic). BREWSTER bent S.M.'s arm behind her back causing her pain.

267. On or about August 12, 2011, at Tryon, S.M. was restrained by several staff causing pain and injury to her arm. MR. GARITY (phonetic) grabbed S.M. and hooked her arm and forced her to the ground. GARITY bent S.M.'s arm back causing pain and bruising. S.M. told him that he was hurting her arm and GARITY said, "I don't care." MR. JENSON, MR. SMITH and MR. GAVOUGH (phonetic) also participated in the physical restraint by holding her down.

268. In late August 2011, following the closing of Tryon Girls, OCFS moved S.M. to Taberg Residential Center where she is currently in custody. S.M. continues to be restrained at Taberg.

269. On S.M.'s second day at Taberg she refused to get up or move from the cafeteria. Approximately five OCFS staff members, JOHN DOES ## 3, 4, 5, 6, and 7, picked her up and put her on the floor, holding her down for approximately twenty minutes.

270. The next day, S.M. attempted to walk into the dining room and was told not to. She continued to walk toward the dining room and approximately four staff members, JOHN DOES ## 8, 9, 10, and 11 grabbed her and put her on the floor, causing pain to her arm.

271. That same week in the "rec" area S.M. was restrained again by approximately four staff, JOHN DOES ##12, 13, 14, and 15. At least one staff member pulled her hair causing her pain.

A.S.

272. At the time of the filing of the Complaint, Plaintiff A.S. was a 16-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in August 2009.

273. Before being placed in OCFS custody, A.S. took the medications Concerta and Risperdal for attention deficit hyperactivity disorder and was in therapy biweekly.

274. OCFS initially placed A.S. at their Pyramid Reception Center in the Bronx, New York.

275. While there, A.S. received no therapy or mental health treatment.

276. After Pyramid, OCFS sent A.S. to the Highland Residential Center, in or around August 2009.

277. At Highland, A.S. was housed on a unit without any special mental health services.

278. While in OCFS custody at Highland, OCFS staff initially told A.S. that he did not need the medication, even though A.S. asked to be put back on the medication after receiving several write-ups because of his behavior.

279. It took approximately six weeks before the psychiatrist who reviews medications for OCFS saw A.S..

280. At the time of the filing of the Complaint, A.S. was taking the medications Concerta and Abilify.

281. OCFS placed A.S. on Arms Length Supervision for approximately two weeks at Highland.

282. A.S. was physically restrained by OCFS staff in or about November 2009. A.S. was in class, and YDA KEITH NASH, grabbed him and signaled for backup.

283. NASH pushed A.S. onto the floor, twisted his arm and held A.S. on his stomach. Approximately eight staff came in response to the alarm signal.

284. After this restraint, an OCFS staff person escorted A.S. downstairs and told A.S. to "shut up" while A.S. was trying to tell him what happened.

285. A.S. was restrained again in front of the Central Services Unit by NASH During this restraint, NASH twisted A.S.'s arm behind his back for several minutes, causing significant pain. A.S.'s arm continued to hurt after the restraint.

286. A.S. did not know why he was being restrained in either instance.

287. A.S. saw other boys be restrained by staff. In December 2009, A.S. witnessed

approximately four OCFS staff take down a boy and twist his arm and leg.

288. In October or November 2009, A.S. was in the cafeteria and witnessed two OCFS staff restrain a boy who was about to hit another boy by putting him on the floor, handcuffing him, and getting on top of him and putting a knee on his back.

289. A.S. saw OCFS staff twist the legs or arms of other boys at Highland.

C.L.

290. At the time of the filing of the Complaint, Plaintiff C.L. was a 14-year-old boy residing in OCFS' Highland Residential Center, located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in November 2008.

291. C.L. was hospitalized multiple times between the ages of nine and eleven due to suicidal ideations. His most recent psychiatric hospitalization was in 2007.

292. C.L. was diagnosed with bi-polar disorder at age nine and depression at age eleven.

293. C.L. was prescribed Abilify and Depakote and referred for counseling three times a week in his community.

294. C.L.'s mother voluntarily placed him in foster care, where he was evaluated at a diagnostic reception center and subsequently placed in a therapeutic foster boarding home before returning home.

295. C.L.'s father filed a Persons in Need of Supervision ("PINS") petition which resulted in another voluntary foster care placement at another diagnostic reception center and then in a residential treatment center.

296. The residential treatment center diagnosed C. L. with conduct disorder and mood disorder. While at the residential treatment center, C.L. engaged in therapy with a social worker.

297. In November 2008, a New York State Family Court judge placed C.L. with OCFS after a juvenile delinquency finding.

298. The Family Court Mental Health Services evaluation in the delinquency case recommended that C.L. be placed in a facility that has psychiatric monitoring and family therapy.

299. C.L. was housed for two weeks at OCFS' Pyramid Reception Center in or about November 2008. OCFS staff at Pyramid diagnosed him with conduct disorder and a mood disorder, and recommended individual therapy.

300. C. L. was then moved to Highland Residential in or about December 2008.

301. While at Highland, C. L. was housed on a regular unit without any mental health services despite his history and the recommendation of the reception center evaluator.

302. In July 2009, despite his history and mental health diagnoses, a Highland treatment team meeting form noted that C.L. did not need any mental health services.

303. While at Highland, C.L. was physically restrained once, as described below, and has seen others restrained almost daily.

304. At Highland, C.L. was physically restrained by OCFS staff in or about June 2009.

305. C.L. was on medical restriction because of his injured finger, but he wanted to play basketball. YDA W. DAVIS told C.L. he could not play because he was on medical restriction. C.L. wanted to play and threw the basketball up toward the hoop.

306. C.L. then told DAVIS that he would walk to the Central Service Unit, because C.L. knew he was going to get in trouble. DAVIS then came up behind C.L., grabbed him and forced him to the ground in a prone restraint.

307. DAVIS banged C.L.'s head on the ground two or three times while he was restraining C.L.

308. DAVIS then called Central Service Unit to have another staff member come and get C.L.

309. While being restrained, C.L. was terrified, and his injured head hurt for the rest of the day.

310. C.L. was never taken to see a doctor or nurse after the restraint. He was not given any medication for the headache he had after the restraint.

311. C.L. has also seen other boys be restrained by OCFS staff at Highland.

312. C.L. saw one boy restrained because the boy did not want to leave his dorm room. C.L. saw staff twist the boy's arm and hold him down, and saw that the boy's face was bloody.

313. Another boy whom C.L. saw restrained by OCFS staff had his arm badly twisted.

K.M.

314. At the time of the filing of the First Amended Complaint, Plaintiff K.M. was a 16-year-old boy residing in OCFS' Finger Lakes Residential Center located in Lansing, New York. He was placed in OCFS custody by a New York State Family Court judge in October 2009, following a finding of juvenile delinquency.

315. K.M. lives in Queens, New York, with his mother and brothers.

316. Prior to being placed, a Family Court evaluator recommended that K.M. receive the psychotherapeutic services with a licensed mental health professional, a psychiatric evaluation to determine the need for psychotropic medication, and comprehensive psychological and educational testing.

317. OCFS first sent K.M. to the Pyramid Reception Center in Bronx, New York, where he spent approximately two weeks.

318. While at Pyramid, according to an OCFS report, K.M. was diagnosed with "Adjustment Disorder w/ Depressed Mood, Intermitted (sic) Explosive Disorder (provisional), Reading Disorder, Math Disorder, Disorder of Written Expression, [and] Phonological Disorder." The evaluator recommended that K.M. receive monitoring or intervention by a psychiatrist or clinician while in placement, and stated that K.M. "needs a psychiatric evaluation for medication at facility."

319. Following his stay at Pyramid, OCFS transferred K.M. to the Finger Lakes Residential Facility, a limited secure OCFS facility located in Lansing, New York.

320. At Finger Lakes K.M. was housed on a unit without any enhanced mental health services.

321. K.M. was restrained by OCFS staff shortly after he arrived there.

322. In late November 2009, while K.M. was in the cafeteria during meal time he was told to stop talking. K.M. told OCFS staff that he was not talking.

323. YDA HOWD, then grabbed K.M. and slammed him on the ground. While he was being forced to the ground, K.M. hit his head on the cafeteria table. YDA D. MANTI and YDA HOLLENBACK , held K.M. down and one staff placed handcuffs on him. The staff held K.M. on the ground for a long period of time. During the restraint, one OCFS staff member punched K.M. in the face and K.M. suffered a rug burn on his face. During the restraint, the AOD JOHN PAZ observed what was happening but did not intervene.

324. As a result of the restraint K.M. had a rug burn on his face, and pain in his head and on his side throughout the night. He used an ice pack to ease the pain in his side, and he could not sleep.

325. K.M. has seen other residents restrained by staff. On one occasion, K.M. saw a male OCFS staff person punch a resident in the ribs during a physical restraint.

J.G.

326. At the time of the filing of the First Amended Complaint, Plaintiff J.G. was a 16-year-old boy residing in OCFS' Finger Lakes Residential Center located in Lansing, New York. He was placed in OCFS custody by a New York State Family Court judge in September 2009 after a finding of juvenile delinquency.

327. Before being placed in OCFS custody, J.G. was diagnosed with bipolar disorder.

328. OCFS first placed J.G. at the Pyramid Reception Center in Bronx, New York. OCFS reports state that J.G. was receiving the psychiatric medications Seroquel and Depakote while at Pyramid, and the reports recommend psychiatric monitoring, individual supportive psychotherapy, and family counseling.

329. In October 2009, OCFS transferred J.G. to the OCFS limited secure Highland Residential Center in Highland, New York.

330. J.G. has been physically restrained at least twice while in OCFS custody.

331. On or about October 30, 2009, J.G. was in the Central Services Unit at Highland from about 6:00 p.m. until about 10:00 p.m. following an argument with another resident. Around 9:30 p.m., he asked when he would be able to go back to his unit, and was told he needed to wait for an administrator.

332. J.G. was upset and banged a wall with his hand.

333. Four OCFS staff members who included AOD RUTLAND and three other staff members, JOHN DOES # 16, #17 and #18, entered the room where J.G. was being held. Two male staff members grabbed J.G. by the arms and threw him on the floor. J.G. fell on his stomach and several staff members held him down face down on the ground.

334. During this restraint, one staff member was holding J.G.'s waist, JOHN DOE # 16 grabbed his leg and pulled his calf towards his back, JOHN DOE # 17 pulled his arm over his head and towards his back, and JOHN DOE # 18 twisted his ankle.

335. During the restraint, J.G. was in pain. Although J.G. said repeatedly that he was calm, the OCFS staff continued to hold him down.

336. As a result of this restraint, J.G. felt pain in his ribs and arm for three days. Staff also told him that his arm was hyper-extended, but did not take him for medical assistance.

337. On or about November 23, 2009, in a classroom in the Highland school, another boy called J.G. names and taunted him about his mother.

338. J.G. became angry and hit the other resident. Without warning, three staff members, YDA DANIEL BERNHARDT, YDA DWAYNE CREGUE and YDA SPENCER restrained him. BERNHARDT and CREQUE grabbed J.G. by the arms and pushed him down on his stomach. CREQUE pushed them behind his back while BERNHARDT pinned him down. SPENCER put his knee on J.G.'s calf muscle and bounced on it with his knee, putting on more pressure.

339. Although J.G. screamed out in pain, the staff member who had been holding J.G.'s arms yanked on them.

340. Another staff member, JOHN DOE #19 came into the room and punched J.G. on his ankle. A different staff member, JOHN DOE #20 came in and stomped on J.G.'s ankle.

341. After this restraint, J.G.'s arms felt numb when he rose from the ground.

342. OCFS staff took J.G. to see the nurse. He had pain in his arms, back and calf, and the nurse gave him Icy Hot muscle rub.

343. After J.G. was restrained, OCFS staff also punished him by imposing a 60-day hold and a "Level 3" violation.

344. J.G. has regularly seen other residents restrained by OCFS staff at Highland, and has often heard residents yelling in pain during restraints.

345. In December 2009, J.G. witnessed a resident cursing at staff. Four OCFS staff, YDA DEJESUS, MR. COTTON , YDA Knox and one more staff ran into the boy's room, picked him up in the air and slammed him on the floor. They pinned his arms behind his back as they had done to J.G. When the resident screamed, the staff told him "shut up" and twisted his ankle. After the restraint, the resident's ankle was swollen, and J.G. saw him still limping two weeks later.

346. In the same month, J.G. witnessed staff Leek (phonetic) telling another boy to close the gap in the line while walking outdoors with other boys. The resident said that he could not catch up, and Leek continued to yell at him. J.G. saw Leek push the resident down to the ground, where one staff member pushed the boy's face onto some rocks, laid on top of him, and screamed and cursed at the boy. J.G. saw the same staff member slam the other boy onto the ground again, then slam him against the hood of a van.

347. J.G. has also been threatened and hit by staff. In December 2009, YDA DEJESUS threatened to put J.G.'s face in the carpet when J.G. asked to go to the bathroom.

348. On or about December 14, 2009, J.G. told a staff member, YDA LUCAS, that the water in the shower was cold. The staff member punched J.G. in the chest and told him to get in the shower.

349. J.G. was in pain from being punched and it became hard for him to breathe.

350. On another occasion, staff member YDA BRUMFIELD slapped J.G. in the face for talking back.

G.D.

351. At the time of the filing of the First Amended Complaint, G.D. was a 15-year-old boy residing in OCFS' Finger Lakes Residential Center located in Lansing, New York. He was placed in OCFS custody by a New York State Family Court judge in November, 2009, after a finding of juvenile delinquency.

352. His home is in Manhattan, where he lives with his aunt who is his legal guardian.

353. After housing G.D. at the Pyramid Reception Center in Bronx, New York, for approximately 14 days, OCFS moved G.D. to the OCFS Finger Lakes Residential Center in Lansing, New York, on or about November 30, 2009.

354. The first day G.D. arrived at Finger Lakes, he saw another boy being restrained by OCFS staff only because the boy walked away from staff.

355. OCFS staff physically restrained G.D. at least once at Finger Lakes.

356. In early December 2009, just a few days after he was moved to Finger Lakes, G.D. was restrained.

357. He was talking to another boy during school and YDA VONDERCHEK told him to stop talking.

358. The teacher then told G.D. to move his chair, and VONDERCHEK said that G.D. moved without permission and restrained G.D..

359. VONDERCHEK grabbed G.D.'s arms behind his back and slammed him on the floor in the classroom.

360. VONDERCHEK was on top of G.D., turned G.D.'s face to the side on the rug and held G.D. down for several minutes.

361. During the restraint, six or seven other OCFS staff responded and came into the room. One of the responding staff told G.D. to wash his face and they took him to the medical office.

362. At the medical unit, a nurse took photographs of G.D.'s injured face.

363. The skin on the left side of G.D.'s face was raw over a large area and he was bleeding.

364. The nurse gave G.D. something to rub on his face every day.

365. The pain from this injury was so severe that G.D. was unable to sleep.

366. VONDERCHEK was moved from the unit where G.D. is housed.

367. Two women came to Finger Lakes and interviewed G.D. about the restraint. They told G.D. they were looking for witnesses and asked him for the names of the teacher and the other children who witnessed the restraint.

M.M.

368. At the time of the filing of the First Amended Complaint, Plaintiff M.M. was a 17-year-old boy residing in OCFS' Highland Residential center located in Highland, New York. He was placed in OCFS custody by a New York State Family Court judge in August 2007 after a finding of juvenile delinquency.

369. M.M.'s home is in Brooklyn, New York.

370. When M.M. was first placed with OCFS DJJOY he was placed at the Pyramid Reception Center in Bronx, New York, where he was housed for two weeks.

371. After Pyramid, OCFS transferred M.M. to Industry Residential Center in Rush, New York, where he stayed for six months. OCFS then moved him to Highland Residential Center in Highland, New York.

372. M.M. was released from Highland on December 2, 2008, and placed on aftercare supervision by OCFS.

373. On January 3, 2009, a Family Court judge placed M.M. with OCFS again.

374. This time OCFS housed M.M. at Finger Lakes Residential Center in Lansing, New York, then released him with aftercare supervision in June 2009.

375. M.M. was sent back to OCFS custody after an aftercare violation in October 2009. He went to Pyramid for approximately two days, and then OCFS placed M.M. at Highland, where he resided at the time of the filing of the Complaint.

376. M.M. was physically restrained by OCFS staff many times during his placement with OCFS. According to OCFS' own records, he was restrained by staff at each residential facility where he was placed: Industry, Highland, and Finger Lakes.

377. One of the physical restraints at Industry occurred in the cafeteria after YDA GREGORY FISH, was teasing and poking M.M. and took M.M.'s belongings. Although M.M. asked him to stop, the YDA did not. When the YDA saw M.M walking away he yelled to another YDA "Get him." Another YDA, BRYAN CHAPMAN, grabbed the back of M.M.'s neck and pushed him on the ground and signaled for other staff. CHAPMAN held M.M.'s legs down, while staff shackled and handcuffed him.

378. Later that same day M.M. was restrained again. This time outside the nurse's office. YDA FISH picked M.M. up by his upper arms and threw him down to the floor and YDA CHAPMAN held M.M.'s legs. M.M. landed under a table and a microwave oven fell onto his back.

379. One of the restraints at Gossett (now Finger Lakes) occurred after M.M. slammed his door and laughed. A YDA told him that he would never go home and that he would never

amount to anything. When M.M. hit the table with one fist, the YDA signaled for more staff. At least five staff members responded. When M.M. walked away, he passed a female staff member. She claimed that M.M. pushed her, and a male YDA SEFARIS (phonetic) slammed M.M. on the floor by holding his arms, and held him down while the female staff member, JOHN DOE # 21 held his legs down.

380. Another restraint occurred at Highland in November of 2008, when M.M. refused to go into his room because he did not want staff to lock him in. JOHN DOE # 22 pushed M.M. and M.M. told JOHN DOE #22 not to touch him. JOHN DOE # 22 signaled for other staff, and three other staff members, JOHN DOES ## 23, 24 and 25 came and pushed M.M. onto the ground, causing skin on his arm to be scraped off on the carpet. This injury caused M.M. pain and left him with a scar approximately two inches long and two inches across his arm.

381. After this restraint at Highland, the YDAs YANICK and WIDDICK told M.M. that if he did not tell anyone about the restraint, they would not tell anyone either.

382. On December 11, 2009, a few days after M.M.'s lawyer telephoned M.M. at Highland, an OCFS Youth Counselor asked him, "Did you speak to someone?" M.M. responded, "My lawyer." The Youth Counselor told M.M. that some people were coming to see M.M. and asked him, "Are you snitching?"

D.C.

383. At the time of the filing of the Second Amended Complaint, Plaintiff D.C. was a 15-year-old boy residing in OCFS' Youth Leadership Academy located in South Kortright, New York. He was placed in OCFS custody by a New York State Family Court judge in January 2009, after a finding of juvenile delinquency.

384. D.C.'s home is in Kings County, New York with his family.

385. First, he was sent to a residential treatment center operated by Children's Village. He was at Children's Village from February 2009 until January 2010.

386. In January 2010, D.C. was moved to the OCFS Pyramid Reception Center where he stayed for about two weeks. While he was at Pyramid, he did not receive counseling or therapy.

387. In January 2010, from Pyramid D.C. was moved to the OCFS Youth Leadership Academy.

388. While at Pyramid, D.C was given a psychological evaluation. In the evaluation, it was recommended that D.C. would "benefit from individual and group interventions, based on the DBT approach to address mood dysregulation and decision-making." It was further recommended that D.C. is "in need of a family therapy intervention . . . "

389. While at Pyramid, D.C. was told by OCFS staff that he was going to receive anger management services. To date he has not received anger management treatment.

390. D.C. has not been offered individual counseling or therapy with any regularity at YLA. He is able to speak to a counselor only when he asks to do so and only if the counselor has time to meet with him. To date he has not received family counseling at YLA.

391. D.C. was restrained one time at Pyramid. He was in the gym playing basketball when another resident and he got into an argument during the game and the argument turned physical. JOHN DOE #26 grabbed him from behind, dropped him to the floor and JOHN DOE #27 held him down for about 10 minutes.

392. The first time D.C. was restrained at YLA was within the first few weeks after he arrived there. One evening, he was upset because he was not able to call his family. He continued to ask staff if he could call his family. Staff refused to let him and they continued to argue about it. SERGEANT BRETT ROCKEFELLER put his hands in D.C.'s face, and D.C. pushed his hand

away. At that point, ROCKEFELLER grabbed D.C. and threw him to the ground. D.C. was on the ground face down. ROCKEFELLER was positioned on D.C.'s back applying pressure to D.C.'s back and chest and SERGEANT FRED WELCH held D.C.'s legs.

393. D.C. felt pain in his back and had difficulty breathing. After the restraint staff took DC to the medical unit where they took photos of him.

394. Following the restraint, D.C.'s face was a purplish color and he had pain and bruising on his back. The pain in his back lasted for a couple of weeks.

395. Another time when D.C. was meeting with OCFS SERGEANT WOOD to talk about "health and welfare," WOOD took D.C.'s shampoo from him. WOOD claimed the shampoo belonged to another resident. D.C. told him that the shampoo was given to him by that resident. After WOOD took the shampoo from D.C., the two argued and D.C. attempted to take the shampoo back. WOOD swung at D.C. and D.C. swung back. WOOD grabbed D.C. and slammed him onto the ground. D.C. got away from WOOD and ran away from him and into the computer lab where the rest of his unit was. Another staff person, 1ST SERGEANT MCENTEE, called D.C. to come out of the computer lab into the hallway. SERGEANT DALLAS ECCLESTON grabbed D.C. under both of his arms (in a "chicken wing" hold) and held him there for nearly 10 minutes.

396. Some days later, on or about February 21, 2010, while D.C. was in his unit at YLA, another resident came up to him and snatched his blanket. D.C. followed him and snatched it back. OCFS staff SERGEANT PALMER AND SERGEANT WELCH told D.C. to stop. PALMER grabbed D.C. by the arm and hooked both of his arms and dragged him off of the unit to the control room.

397. Several OCFS staff were in the control room. They told D.C. to stop talking. D.C. continued to argue with staff. D.C. said, "I didn't do anything" and "we were just playing." A.O.D. 1ST SERGEANT TIMOTHY KINCH said to D.C. "you want to be a tough guy? "And then KINCH said to the staff "dump him on his face." SERGEANTS MICHAEL TOWNSEND AND PALMER then rushed at D.C. and forced him to the ground. D.C. landed on his back and his head hit the floor. Staff flipped D.C. over so that D.C. was positioned on his stomach. In the course of this restraint, first PALMER put pressure on D.C.'s back and at the same time pulled up on his arms. As a result, D.C. could not breathe. He could barely talk but he managed to tell the staff that he couldn't breathe. TOWNESEND held D.C.'s legs.

398. Then YDA RICHARD LALOSH took over the restraint and put pressure on D.C.'s back and chest using his knee. D.C. still had trouble breathing. TOWNSEND continued to hold D.C.'s legs. During the restraint and shortly thereafter, D.C. spit up saliva and vomit. After the restraint his face was purplish and he had a bruise on his back. His arm, neck and back hurt for some time after the restraint.

N.P.

399. Plaintiff N.P. is a 15-year-old boy who is in OCFS custody having been placed there by a New York State Family Court judge in April 2011, after a finding of juvenile delinquency. Presently, N.P. is in OCFS custody at the Highland Residential Center located in Highland, New York.

400. N.P.'s home is in New York County, New York with his family.

401. In May 2011, N.P. was sent to the OCFS Ella McQueen Reception Center located in Brooklyn, New York where he stayed for about two weeks.

402. On or about May 18, 2011, N.P. was moved from Ella McQueen to the OCFS Highland Residential Center where he is currently in OCFS custody.

403. On July 11, 2011, while in his unit, N.P. asked YDA SPENCER for permission to go back to his room to get a chair so that he could sit with the other members of his unit. YDA SPENCER told N.P. to ask another resident for a chair. The other resident refused to give N.P. a chair. This happened several times. N.P. again asked SPENCER for permission to go to his room to get a chair. SPENCER told N.P. "to stop acting like a bitch." N.P. responded, "I am not a bitch." SPENCER got up and approached N.P. and said, "What did you say?" SPENCER then grabbed N.P. near the collar of this shirt and began to slam NP's head against the wall. SPENCER then threw N.P. to the floor and pulled his hair and slammed his face onto the ground several times scraping his face against the carpet causing a rug burn the size of a quarter to his left temple. SPENCER also pulled some of N.P.'s hair out of his head.

404. While N.P. was on the floor face down SPENCER sat on N.P.'s back pressing on his back and arms until N.P. heard a loud popping noise and felt his right arm drop to the floor. Throughout the restraint YDA EDDIE MOLLETTE was holding N.P.'s legs. YDA SPENCER said in sum and substance "I broke his arm." SPENCER AND MOLLETTE left N.P. lying on the floor until the medical staff came to take him to the medical office at Highland. He was in severe pain. After a brief examination at Highland, he was taken to Vassar Brothers Hospital where he was admitted and remained hospitalized until July 13, 2011. He was told that his arm was broken and his arm was placed in a cast and later an orthopedic brace. He continues to wear the brace today and is on medical restriction at Highland. He continues to be in pain. He is told that he will begin physical therapy shortly.

B.B.

405. Plaintiff B.B. is a 16-year-old boy who is in OCFS custody having been placed there by a New York State Family Court judge, after findings of juvenile delinquency. Presently, B.B. is in OCFS custody at the Highland Residential Center located in Highland, New York.

406. B.B.'s home is in Kings County, New York with his family.

407. In late August 2011, B.B. was sent to the OCFS Ella McQueen Reception Center located in Brooklyn, New York where he stayed for about two weeks.

408. While at Ella McQueen, B.B. had an argument with YDA YOUNG. YDA YOUNG refused to let B.B. leave his room. B.B. left his room anyway. YDA YOUNG followed B.B. into the bathroom and grabbed B.B. B.B. tried to walk away from YDA YOUNG and YDA YOUNG punched B.B. in the face and stomach and restrained B.B. face down on the ground. After the restraint the right side of B.B.'s face hurt where YOUNG punched him. He was taken to the medical unit at Ella McQueen and later to St. Barnabus Hospital Emergency Room for an examination.

409. On or about September 7, 2011, B.B was moved from Ella McQueen to OCFS' Youth Leadership Academy located in South Kortright, New York. On or about October 4, 2011, B.B. was move to the Highland Residential Center where he is currently in OCFS custody.

410. On September 8, 2011, at approximately 7:30 a.m., while B.B. was walking with the other members of his "unit" to the cafeteria he was talking with another resident which is against the rules. At one point MR. CLOW told B.B. to "shut the fuck up." B.B. responded in sum and substance "you don't need to talk to me like that, you could've just told me to be quiet." MR. CLOW grabbed B.B. from behind and pulled him off the line. He pulled B.B.'s arms behind his back and slammed him to the ground face first. B.B.'s face hit the ground and his nose started to

bleed. MR. CLOW held B.B. on the ground face down and applied pressure to B.B.'s back, chest and throat. B.B. was unable to breath throughout the restraint and called out to tell MR. CLOW that he could not breathe and that he has asthma. MR. CLOW continued to apply pressure to B.B.'s back, chest and throat and B.B. lost consciousness momentarily. When B.B. came to, MR. CLOW was dragging B.B. across the floor and B.B. sustained rug burns along the right side of his jaw-line and the back of his right ear. In addition, the restraint caused B.B.'s eyes to become bloodshot and vision to become blurry.

411. At some point during the restraint Nurse Susan Shuman appeared. B.B. said that when he complained that he could not breathe and that he has asthma she said "that doesn't work here." MR. CLOW continued to restrain B.B. Before B.B. got up MR. CLOW flipped B.B. over onto his back. Throughout the restraint MR. CLOW kept saying: "you going to fucking listen to me now?" When B.B. attempted to stand after the restraint he felt dizzy and fell back down. He was then taken to the medical office.

412. While at the medical office, B.B. told Nurse Shuman that he was in pain and that his vision was burry. She did not provide him with medical treatment and told him "it would get better."

413. As a result of the restraint, B.B. suffered multiple rugs burns on the right side of his face, ear and back. He was bleeding from his nose, both of his eyes were bloodshot and his vision was blurry. He suffered pain in his head for several days and his shoulder hurt for several weeks from the injuries. Several weeks after the restraint some of his injuries are still apparent and he continued to complain of blurry vision.

414. From September 13, 2011 until on or about September 27, 2011, B.B. was in the custody of the New York City Division for Youth and Family Justice. On or about September 27, 2011

B.B. returned to Ella McQueen for several days. On or about October 3, 2011 OCFS sent B.B. to the Highland Residential Center where he is currently in OCFS custody.

Based on the foregoing factual allegations, Plaintiffs assert the following claims for relief:

CAUSES OF ACTION

FIRST CAUSE OF ACTION: Against Defendant Carrión
Violation of the Fourteenth Amendment to the United States Constitution

415. Plaintiffs and class members are each children under the age of eighteen in the custody and care of OCFS, which is the government agency designated under the laws of the State of New York as responsible for the health and welfare of Plaintiffs and class members.

416. The Fourteenth Amendment to the United States Constitution, which prohibits the deprivation of "life, liberty, or property without due process of law," guarantees to each child in state custody the substantive right to be free from harm and from undue restraints on their liberty. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

417. Defendant Carrión has deprived Plaintiffs, G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C., and similarly situated class members of their liberty without due process of law by failing to provide youth in OCFS facilities who have mental illness with adequate mental health treatment and therapeutic housing options necessary to treat and to prevent worsening of their mental illness. As set forth above, the Defendant Commissioner and her agents have failed to provide treatment for serious mental illnesses actually known to them, have failed to carry out their own agency's instructions regarding mental health treatment for known serious mental illnesses, have failed adequately to assess the medication needs of class members known to have been prescribed mental health medications before admission to the facilities at issue in this the Fourth Amended Complaint, and have failed to provide adequate assessment, diagnosis, and treatment plans for class members whose prior history of psychiatric diagnosis, treatment, and

hospitalization have placed Defendant and her agents on actual knowledge of a substantial risk of untreated serious mental illness. This persistent pattern of inadequate mental health care affecting all of the named Plaintiffs in multiple institutions constitutes a policy and practice of deliberate indifference that is shocking to the conscience.

418. Plaintiffs and class members have been harmed by Defendant's violations of their rights under the Fourteenth Amendment. Plaintiffs and class members' harms include, but are not limited to, psychological and emotional damage and in some cases physical injury during the course of their confinement. They will continue to suffer such harm in the future as a result of the lasting impact of Defendants' conduct.

419. Plaintiffs and class members accordingly seek redress pursuant to 42 U.S.C. § 1983.

SECOND CAUSE OF ACTION: Against all Defendants
Violation of the Fourteenth Amendment to the United States Constitution

420. Plaintiffs and class members are each children under the age of eighteen in the custody and care of OCFS, which is the government agency designated under the laws of the State of New York as responsible for the health and welfare of Plaintiffs and class members.

421. All Defendants including the John Doe Defendants, as OCFS employees, at all times relevant hereto were acting under color of state law.

422. The Fourteenth Amendment to the United States Constitution, which prohibits the deprivation of "life, liberty, or property without due process of law," guarantees to each child in state custody the substantive right to be free from harm and from undue restraints on their liberty. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

423. Defendants have deprived Plaintiffs and Class members of their liberty without due process of law by subjecting them to gratuitous and excessive force and punishment.

Defendants' conduct manifests deliberate indifference to Plaintiffs' constitutional rights and is shocking to the conscience.

424. Defendants have deprived Plaintiffs and other class members of their liberty without due process of law by using physical force against class members who are not physically resisting staff and pose no threat to themselves or others, as set forth above. Rather, physical force is applied as a punishment against class members for no more than verbal misconduct or refusal immediately to follow orders, and in some cases physical force is used without any reason that is apparent to the class member. This conduct results in both physical and mental or emotional injury to class members.

425. Defendants have used physical force against children with mental illness who, because of their mental health condition, cannot control their behavior or understand what is expected of them. The use of force against persons with mental illness can aggravate their illness.

426. Plaintiffs and class members have been harmed by Defendant's violations of their rights under the Fourteenth Amendment. Plaintiffs and class members' harms include, but are not limited to, psychological and emotional damage and physical injury during the course of their confinement. They will continue to suffer such harm in the future as a result of the lasting impact of Defendants' conduct.

427. Plaintiffs and class members accordingly seek redress pursuant to 42 U.S.C. § 1983.

THIRD CAUSE OF ACTION: Against Defendant Carrión, on Behalf of Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and Class Members with Disabilities
Violation of Title II of the Americans with Disabilities Act

428. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, bars public entities from discriminating against any qualified individual with a disability on the basis of disability and from excluding any qualified individual with a disability from "participation in or

the benefits of the services, programs or activities of the public entity" on the basis of disability. 42 U.S.C. §§ 12131-12132.

429. A public entity is required to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). Thus, it is a violation of Title II of the ADA for a public entity to fail to administer services, programs, or activities to qualified individuals with disabilities in the most integrated setting appropriate to their needs.

430. Public entities may not exclude a qualified individual with a disability from participation in or the benefits of their services, programs or activities, whether "directly or through contractual, licensing, or other arrangements." 28 C.F.R. § 35.130(b)(1); see also 28 C.F.R. § 35.130(b)(3).

431. OCFS is a "public entity" within the meaning of the ADA.

432. Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and many members of the Class are qualified individuals with disabilities as defined in the ADA. They have mental impairments that substantially limit one or more major life activity, including but not limited to thinking, concentrating, and interacting with others; they have records of having such impairment; or they are regarded as having such impairment. As youth in the custody of OCFS' Division of Juvenile Justice and Opportunities for Youth, all Plaintiffs meet the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by Defendant OCFS. 42 U.S.C. § 12102(2); 42 U.S.C. § 12131 (2).

433. Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and class members with disabilities are each a "qualified individual with a disability" within the meaning of the ADA. Under the ADA, an "individual with a disability" includes an individual who is "regarded as

having...impairment." 42 U.S.C. § 12102(1)(C). Plaintiffs who have mental health disabilities or have been identified by OCFS as having mental health needs are undisputedly "regarded as having...an impairment" by OCFS.

434. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by knowingly and through deliberate indifference failing to provide necessary mental health services as a means of preventing or reducing the exposure to and the use by staff of improper and harmful physical restraints.

435. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by knowingly and through deliberate indifference failing to provide disciplinary alternatives to physical restraint as a reasonable accommodation so that the restraints, which exacerbate mental illness, are not imposed.

436. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by failing to provide an effective means for Plaintiffs to report incidents of use of excessive force or unreasonable restraint, without fear of retaliation.

437. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities on the basis of their disabilities in violation of the ADA. 42 U.S.C. § 12132.

FOURTH CAUSE OF ACTION: Against Defendant Carrión, on Behalf of Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and Class Members with Disabilities Violation of Section 504 of the Rehabilitation Act

438. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a) states:

439. "No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance or under any program or activity . . . ."

440. The Rehabilitation Act states that "recipients [of federal financial assistance] shall administer programs or activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 CFR § 41.51(d).

441. Furthermore, recipients of federal funds may not exclude a qualified individual with a disability from participation in or the benefits of any aid, benefit, or service, whether "directly or through contractual, licensing, or other arrangements." 28 C.F.R. § 41.51(b)(1); *see also* 28 C.F.R. § 41.51(b)(3).

442. Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and many of the class members are qualified individuals with disabilities as defined in Section 504. They have mental impairments that substantially limit one or more major life activity, including but not limited to thinking, concentrating, and interacting with others; they have records of having such an impairment; or they are regarded as having such an impairment. As youth in the custody of OCFS' Division of Juvenile Justice and Opportunities for Youth, all Plaintiffs meet the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by Defendant OCFS. 29 U.S.C. § 794.

443. Plaintiffs G.B., L.B., J.A., S.S., S.R., C.L., K.M., D.C. and many of the class members are qualified individuals "with a disability" within the meaning of the Rehabilitation Act. Under the Rehabilitation Act, an "individual with a disability" includes an individual who is "regarded as having…an impairment." 29 U.S.C. § 705(20)(B). Plaintiffs are undisputedly "regarded as having…an impairment" by OCFS.

444. Defendant Carrión's OCFS is a public entity. OCFS receives federal financial assistance.

445. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by knowingly and through deliberate indifference failing to provide necessary mental health

services as a means of preventing or reducing the exposure to and the use by staff of improper and harmful physical restraints.

446. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by knowingly and through deliberate indifference failing to provide disciplinary alternatives to physical restraint as a reasonable accommodation so that the restraints, which exacerbate mental illness, are not imposed.

447. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities by failing to provide an effective means for Plaintiffs to report incidents of use of excessive force or unreasonable restraint, without fear of retaliation.

448. Defendant Carrión discriminates against mentally disabled youth in OCFS facilities on the basis of their disabilities in violation of Section 504.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court grant them the following relief:

a. Certify this case as a class action pursuant to Rule 23(a), (b)(1) and (b)(2) of the Federal Rules of Civil Procedure;

b. Issue a declaratory judgment declaring that the acts, omissions, policies, and practices of Defendant Carrión with regard to youth in her custody in OCFS' limited secure centers, reception centers, and the nonsecure Lansing facility violate the Fourteenth Amendment to the United States Constitution; the Rehabilitation Act, 29 U.S.C. § 794; and the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132;

c. Enjoin Defendant Carrión, her agents, officials, employees, and all persons acting in concert with them, under color of State law or otherwise, from continuing the unconstitutional and illegal acts, conditions, and practices described in the Fourth Amended Complaint;

d. Order Defendant Carrión, her agents, officials, employees, and all persons acting in concert with them, under color of State law or otherwise, to take all necessary actions to:

i. ~~provide policies, practices and training that ensure that Plaintiffs will not~~ be subjected to unreasonable physical restraints and use of excessive force by OCFS staff;

ii. establish an effective monitoring system to ensure supervision and accountability of staff with respect to the use of excessive force and physical restraints and to ensure the safety of Plaintiffs who report staff abuse; including an effective means for Plaintiffs to complain of incidents of use of excessive force or unreasonable restraint, without fear of retaliation.

iii. provide adequate mental health assessment and treatment programs and services, including increased and qualified mental health professional staffing to provide adequate mental health screening, monitoring and treatment to children with mental health needs within the OCFS facilities at issue in this case;

iv. train all OCFS staff during pre-service and in-service training programs to recognize the signs and symptoms of mental illness and steps to take to ensure the safety and treatment of residents; and

v. establish an effective monitoring system to ensure supervision and accountability of staff with respect to the provision of mental health services, and to ensure the safety of Plaintiffs who complain, including an effective means for Plaintiffs to complain of OCFS' failure to provide adequate mental health services, without fear of retaliation;

e. Order Defendant Carrión to develop and implement a comprehensive plan for the correction of the unlawful policies, practices, acts, and omissions complained of herein and to submit this plan to the Court and to the attorneys for the Plaintiffs for review and comment before the Court orders the plan;

f. Award Plaintiff G.B. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA DALE WARE, YDA EDWARD DAVIS, JOHN DOE #1, YDA ALEXANDER MCCREADY, MR. DEPORTA(phonetic) for violation of his federal constitutional rights;

g. Award Plaintiff L.B. compensatory and punitive damages in an amount to be determined at trial against Defendants MR. PARIS, MR. THOMPSON, MS. PACETTE (phonetic), MR. COTTON, YDA GAL and YDA MOHAN (phonetic) for violation of his federal constitutional rights;

h. Award Plaintiff J.A. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA BILL MCMORRIS, YDA MATTHEW LAUBACH, YDA VISCONI, YDA WISELL, YDA ALEXANDER MCCREADY, YDA JOEL DEJESUS, YDA GAVIN, YDA CROCKETT (phonetic), and YDA AVILES (phonetic) for violation of his federal constitutional rights;

i. Award Plaintiff S.S. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA JAMELL CAMPBELL, YDA EDDIE MOLLETTE, YDA MITCH YANICK, YDA PHILLIP PALOMINO, YDA WATSON, YDA M. SAWITSKY, YDA

LUIS ROSADO, YDA RAJEB MASESI, YDA ERIC VINCENT, YDA VISCONI, and JOHN DOE #2 for violation of his federal constitutional rights;

j. Award Plaintiff S.R. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA R. CURTIS, YDA YOUNG, and YDA BANTA for violation of her federal constitutional rights;

l. Award Plaintiff S.M. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA JOANNE LEHR, VICKY HUGHES, YDA ROBERT LACONTE, YDA M. HYACINTH, YDA GULOTTA, YDA JEFFREY BENTON, YDA WILLIAM COULMAN, YDA RYAN CASEY, NANCY JABLONSKI, YDA BANTA, REC SPECIALIST FLYNN, YDA WATSON, YDA RODRIGUEZ, YDA KAGONYERA, MR. HEWES, MR. BREWSTER, MS. HEPBURN (phonetic), MR. WILLIAMS, MS. ROLETTE (phonetic), MR. GARRITY (phonetic), MR. JENSON, MR. SMITH, MR. GABOUGH (phonetic), and JOHN DOES #3-15 for violation of her federal constitutional rights;

m. Award Plaintiff A.S. compensatory and punitive damages in an amount to be determined at trial against Defendant YDA KEITH NASH for violation of his federal constitutional rights;

n. Award Plaintiff C.L. compensatory and punitive damages in an amount to be determined at trial against Defendant YDA W. DAVIS for violation of his federal constitutional rights;

o. Award Plaintiff K.M. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA HOWD, YDA HOLLENBACK, YDA D. MANTI, and AOD JOHN PAZ for violation of his federal constitutional rights;

p. Award Plaintiff J.G. compensatory and punitive damages in an amount to be determined at trial against Defendants AOD RUTLAND, JOHN DOES ## 16-18, YDA DANIEL BERNHARDT, YDA DWAYNE CREQUE, YDA SPENCER, JOHN DOES 19-20, YDA DEJESUS, YDA LUCAS, and YDA BRUMFIELD for violation of his federal constitutional rights;

q. Award Plaintiff G.D. compensatory and punitive damages in an amount to be determined at trial against Defendant YDA VONDERCHEK for violation of his federal constitutional rights;

r. Award Plaintiff M.M. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA GREGORY FISH, YDA BRYAN CHAPMAN, YDA SEFARIS (phonetic), JOHN DOES # 21-25, YDA YANICK, AND YDA WINNICK for violation of his federal constitutional rights;

s. Award Plaintiff D.C. compensatory and punitive damages in an amount to be determined at trial against Defendants JOHN DOES ## 26-27, SERGEANT BRETT ROCKEFELLER, SERGEANT FRED WELCH, SERGEANT WOOD, FIRST SERGEANT MCENTEE, ~~SERGEANT DALLAS ECCLESTON, SERGEANT PALMER, AOD FIRST SERGEANT~~ TIMOTHY KINCH, SERGEANT MICHAEL TOWNSEND, YDA RICHARD LALOSH for violation of his federal constitutional rights;

t. Award Plaintiff N.P. compensatory and punitive damages in an amount to be determined at trial against Defendants SPENCER AND MOLLETTE for violation of his federal constitutional rights;

u. Award Plaintiff B.B. compensatory and punitive damages in an amount to be determined at trial against Defendants YDA YOUNG, MR. CLOW for violation of his federal constitutional rights;

v. Retain jurisdiction in this case until the unlawful conditions, practices, policies, acts, and omissions complained of herein at all of the facilities complained of in this action no longer exist and this Court is satisfied that they will not recur;

w. Award Plaintiffs the costs of this action, including reasonable attorneys' fees; and

x. Grant such other and further relief as this Court deems just and proper.

Dated: New York, New York
November __, 2011

Yours,

THE LEGAL AID SOCIETY
STEVEN BANKS, Attorney in Chief
CHRISTINE L. BELLA, of counsel
199 Water Street
New York, New York 10038
(212) 577-3349

By: Christine L Bella/RC
Christine L. Bella

ORRICK, HERRINGTON & SUTCLIFFE LLP
J. PETER COLL, Jr.
RENE KATHAWALA
SCOTT ROEHM
ALISON K. ROFFI
51 West 52nd Street
New York, NY 10019
(212) 506-5000

By: Rene Kathawala

Attorneys for Plaintiffs and Proposed Class