Admin. for Children's Services v. Silva

OATH Index No. 1275/15 (June 26, 2015), *adopted*, Comm'r Dec., **appended**

Juvenile counselor used unauthorized and excessive force on a juvenile resident and submitted a false and misleading report related to the use of force. ALJ recommends termination of his employment. Commissioner adopts ALJ's fact finding but notes penalty is moot because respondent resigned before Commissioner issued decision.

NEW YORK CITY OFFICE OF
ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
ADMINISTRATION FOR CHILDREN'S SERVICES
Petitioner
- against -
VICTOR SILVA
Respondent

REPORT AND RECOMMENDATION

TYNIA D. RICHARD, *Administrative Law Judge*

This disciplinary proceeding was referred to the tribunal by the Administration for Children's Services ("ACS" or agency). It alleges that respondent Victor Silva, a juvenile counselor, violated agency guidelines and is guilty of misconduct under section 75 of the Civil Service Law for the use of impermissible and unauthorized force against a juvenile resident and for falsely reporting the incident.

The hearing was conducted before me on February 13, and March 19, 2015. Petitioner's witnesses were Louis Watts, Executive Director of Crossroads Juvenile Center, and Keith Peterson, the Director of Juvenile Justice Training. Respondent testified on his own behalf.

For the reasons set forth below, I find that respondent used unauthorized and excessive force against a juvenile resident and falsely reported the use of that force. For the misconduct proved, I recommend termination of his employment.

ANALYSIS

Respondent is a juvenile counselor employed by ACS since February 2013, and assigned to the Crossroads Juvenile Center ("Crossroads"), a secured residential detention center for adolescent youth (Tr. 192). Respondent is charged in five specifications with violating agency rules and unbecoming conduct for using impermissible and unauthorized force against a juvenile resident (referred to here as "SS") during an altercation on November 17, 2014, and making false or misleading statements and material omissions in his report of the incident. Respondent is also charged with workplace violence for pushing Juvenile Counselor ("JC") Larry Washington while charging at the resident.

Mr. Peterson, Director of Juvenile Justice Training, is a member of the incident review committee that meets monthly to review video footage of incidents that occur in the facility. He trained both respondent and JC Washington (Tr. 133, 137). Executive Director Watts and Mr. Peterson both testified that respondent failed to apply appropriate methods of non-physical intervention and de-escalation taught to staff and that his conduct was excessive and unauthorized.

I. Factual Background

Respondent, a juvenile counselor regularly assigned to B Hall, was working the 3:00 to 11:00 p.m. tour when this incident occurred (Tr. 195, 199). Video surveillance of B Hall captured the incident (Pet. Ex. 8).

The time-stamped video, which contains no audio, begins at 18:30:26 (6:30 p.m.). The incident occurred after 7:00 p.m. as respondent and JC Washington were engaged in recreation with resident SS and resident L. B Hall is a Special Support Hall that provides enhanced resources in a smaller living environment for residents (Tr. 195-96). It houses eight rather than 16 residents. A clinician provides daily group sessions for residents, and there are services for anger management and conflict management, even yoga.

The altercation between respondent and SS occurs when the card game ends so the residents can take their showers and get ready for bed. In the video, respondent, JC Washington, and residents SS and L are seated at a table playing cards from 6:30 until shortly after 7:00 p.m. Respondent and resident SS sit facing one another, while JC Washington and resident L sit facing one another. It is not clear whether they are on teams but all appears amicable. Around

19:03:42, SS leaves the table, walks away from the area, and returns several times, without seeming controversy. Around 19:07:25, resident L gets up from the table and walks to his bedroom to prepare for showers.

At 19:07:20, SS walks into view and stands facing respondent as they talk. SS walks out of view and reappears at 19:08:05; respondent approaches him and immediately puts his arm around the resident's shoulder and pulls; the resident pulls away from him toward the wall. As respondent talks to him, SS frowns and places his back against the wall. Respondent gestures and moves as he talks (19:08:20 to 19:08:39). SS talks to respondent but stands still, appearing resistant. Respondent stands assertively in front of SS, drawing close to him and then stepping back, something he repeats again and again, in a manner that appears unsettling. Petitioner's Manager's Report of Incident characterized respondent's movements the following way: "JC Silva continued to move closer to him not allowing him any personal space" (Pet. Ex. 10 at 2). Notably, both of the resident's arms remain at his sides. Watching this portion of the video, Executive Director Watts noted that, although the resident was "being defiant," he was not a threat to himself or to staff (Tr. 45).

Suddenly, respondent pulls the resident away from the wall by his torso, in a bear hug (19:08:40). The resident tries to pull away. As respondent advances forward, he pushes SS backward and they fall over a grouping of large stiff chairs, which are called "bricks" (19:08:44).[1]

As they land on the chairs, JC Washington rushes over (19:08:46). By this point, respondent is on top of the resident who is flat on his back atop the chairs. Respondent's hands are at the resident's neck, while SS flails around trying to fight back. Respondent's hands are near or on the resident's neck at least from 19:08:46 to 19:08:53, when JC Washington arrives to push respondent off the resident. JC Washington struggles with respondent to get between the two as respondent continues to attack the resident. At 19:08:54 while still beneath respondent, SS tosses playing cards at respondent whose eyeglasses fall off his face. Resident L comes out of his room, rushes over, and places his hand on respondent's back, appearing to try to calm him. While respondent puts his glasses back on, JC Washington stretches across the resident to prevent him from getting up and to provide a protective barrier against respondent who reaches

[1] The chairs because of their hard shell are commonly referred to inside the facility as "bricks." Executive Director Watts testified that a resident received back injuries from being pressed forcefully onto the chairs (Tr. 46).

around Washington in an ongoing attempt to retaliate against SS. This continues until 19:09:23, when respondent stands and backs away from the chairs.

Resident L, who has been supportively touching respondent's back, pats him on the shoulder and arm. Respondent backs further away as resident L talks to him.

Respondent remains in the area watching as JC Washington, who is blocking SS's upper body, tries to calm him as he tries to get up. Resident L walks over to the shower room door. Respondent looks on and eventually moves closer and positions himself near SS's head. He leans down near the resident's head and appears to be speaking. Resident L walks toward respondent and respondent backs away and returns to the area near SS's feet (19:10:18). JC Washington continues to hover over the resident as he and respondent appear to exchange words. At 19:10:35, respondent takes out a handheld radio and makes a call. He then continues the verbal exchange with SS, while shifting from one foot to the other and pacing back and forth.

At 19:11:25, Supervisor Enfield enters and walks over to SS and JC Washington. The supervisor's hands are lowered in a pleading gesture as he approaches. He tilts his head to one side appearing to listen and he leans closer to the juvenile. Respondent walks off camera for the first time. At 19:11:39, both Supervisor Enfield and JC Washington stand up straight and allow SS to get up.

SS stands and walks around the two men as if to leave the area, but he stops and spits in respondent's direction (19:11:42). Respondent charges toward the resident as JC Washington (19:11:46) moves quickly to get between the two. In pursuit of SS who runs away from him, respondent pushes Washington out of the way and Washington stumbles several feet forward. Respondent chases the resident and corners him against the wall. Although the camera angle and distance make it difficult to see exactly what respondent is doing to the resident, he can be seen throwing resident SS to the floor (19:11:47 to 19:12:00). It appears that he could also be hitting him, but the video is not clear. Supervisor Enfield and JC Washington rush over and eventually respondent backs away, as Washington and Enfield attend to the resident. Respondent stands nearby, shifting from one foot to the other and pacing the floor. Resident L stands at the bathroom door watching this unfold.

At 19:12:25, security personnel arrive and JC Washington and Supervisor Enfield guide SS to his room (19:12:36). Respondent walks over to resident L and opens the shower room door so he can enter (19:12:53; Tr. 224).

Respondent's testimony

Respondent testified that he and JC Washington were playing cards, listening to music, and watching television with the two residents when he noticed it was time to "lock in" and start showers, which is the prelude for bedtime (Tr. 206-07). Showers begin at 7:00 p.m. and bedtime is from 8:30 to 10:00 p.m. (Tr. 202). Procedures require that all residents are locked inside their rooms at shower time, while the JC's allow one resident into the shower area at a time (Resp. Ex. A; Tr. 202-03).

According to respondent, he told the two residents that it was time to "lock-in" when suddenly SS's demeanor changed and he got up from the table and walked away, stating that he would not lock in (Tr. 207). Respondent testified that SS threw his cards and a shirt and walked to the other side of the room and began talking to someone outside of the permissible area (Tr. 207). On the video, the table is in full view of the camera. SS can be seen getting up from the table and walking away, but he is not seen throwing anything before or after walking away. Nor is there any reaction from the others at the table to suggest that something of the sort had occurred. Respondent said he pleaded with SS to comply but SS refused to lock in (Tr. 207). Respondent asked resident L to take his shower first and he complied. Respondent started the preparation for showers by, among other things, unlocking the resident's doors.

Respondent said that resident SS became "agitated" as he "verbally counsel[ed]" him to take his shower (Tr. 209). As SS continued to refuse, respondent began to speak to him about his mother who was ill at the time. Respondent said that SS had earlier told him that his mother was ill and in the hospital in part due to "the stress and aggravation that she has because of him" and that his younger sister was acting out in school because she was upset he would not be home for the holidays. So he recounted these facts to SS "to try to motivate him" (Tr. 210, 230-31). Respondent also told SS that any bad reports from the facility would negatively affect the adjudication of his criminal case, which of late was looking favorable for him. Respondent said he had seen instances where residents who were about to be released had been remanded to Crossroads by the judge because they had too many incidents at the facility. So he made this case to SS (Tr. 210).

Respondent said he then tried "a touch prompt" which SS resisted and put his back against the wall (Tr. 210). Respondent recognized standing against the wall as a sign of defiance since residents know that Safe Crisis Management procedures require JC's to approach residents

from behind (Tr. 211, 230). As long as his back was against the wall, respondent could not apply the maneuver.

The touch prompt he described was placing his hand "on" or "around" SS's shoulder "to try to coerce him . . . to go" or lead him in the direction in which he wanted him to go (Tr. 211). He said he had no idea that they were "having an issue with one another" and he "underestimated the situation" (Tr. 211). SS told him not to touch him and "pushed" him (Tr. 212). He tried "to re-engage" the resident but SS "became physically aggressive" and "grabbed" him. Respondent said he tried to walk SS "backwards" towards his room, and SS grabbed him "by the collar, by the arms" (Tr. 213). As the resident held him by the arms, he "attempted to just walk him back to his room" (*id*.). SS "realized what I was trying to do" and became "aggressive" and they tripped over the furniture with respondent "land[ing] on top of him" (*id*.).

At that point, SS "proceeded to start swinging and punching me" hitting respondent in the face and knocking his glasses off (Tr. 214). He placed his hand flat on SS's chest as he tried "to hold him at bay" and "to keep him from getting up" and hitting him. As SS swung at him, respondent had his hand on the resident's chest "pushing away, pulling my head back, trying to secure myself from being hit" (*id*.).

JC Washington responded and adopted what respondent called "a supine position" like a "cross bridge" that prevents the resident from moving (Tr. 214). In this maneuver, one JC would lie across the resident at the top securing the upper torso and one at the bottom securing the legs, although here only JC Washington assumed the position. Respondent said it was not "textbook" because SS "was fighting and [resisting]" (*id*.). He said he "stepped back" as SS fought and cursed him, telling him to "suck his dick" and tell his mother "to swallow his kids" and threatened to "fuck [him] up" (Tr. 215). Respondent walked over near SS's head and counseled him, asking why he was behaving this way and reminding him they had been "having a good day" (*id*.). But the resident still wanted to fight him; so he stepped away and called for supervision and security (Tr. 236).

When Supervisor Enfield responded, he and JC Washington allowed the resident to get up and walk, in violation of policy that requires a resident who has become physically aggressive to be secured, respondent said (Tr. 216-17). He said SS should have been placed in his room until they were able to counsel him, but they let him get up on his own, and he spat at respondent (Tr. 217). The spit, he said, landed on his shirt.

Respondent said he went toward SS "to secure him, to stop him from spitting" because he was "in fear of my safety because he's telling me, 'I'm gonna fuck you up.'" (Tr. 218). He said he did not "want to get attacked again" and did not want SS to "hurt" him, but he was trying to protect SS as well (*id*.). He acknowledged that SS backed up as he approached. Respondent said he then "inadvertently bumped into Mr. Washington" who "went into the corner and he just like kneeled down into . . . the corner" (*id*.). Speaking of the resident, respondent said, "I went to pick him up so I could get him to his room" and Supervisor Enfield intervened and told him, "step away; I have him" (*id*.). Respondent said "then you need to secure him" and walked away. "[T]hey picked him up" and led SS to his room.

Under cross examination, respondent admitted charging at the resident but denied he lost his temper or did so in anger; he said he charged to secure the resident and stop him from attacking him (Tr. 250). He admitted that "charging" is not an SCM technique. He also denied pushing the resident after charging at him, throwing the resident at the wall, throwing a punch at the resident, and having to be physically separated from the resident (Tr. 252). He admitted making contact with the resident, stating that he did so in order to secure him, and recalled that resident L had tried to separate him from resident SS (Tr. 251-52). However, respondent denied having to be physically separated from the resident by co-workers (Tr. 252).

Though he admitted pushing JC Washington, he said it was inadvertent (Tr. 250-51). He denied pushing him in order to reach the resident, but he admitted that he may have pushed Washington so hard that he ended up on the other side of the room.

Respondent's version of events differed significantly from the actual event shown on the video and was incredible. First, the resident did not initiate this altercation or "push" respondent, as he testified. Nor did the resident grab respondent by the arms or collar. The altercation was initiated by respondent as the resident stood still with his arms at his sides. It was respondent's physical contact with SS (placing his arms around him in a bear hug) that occurred first and that initiated the altercation. There was nothing about the encounter to indicate the resident posed a physical threat to respondent. Nor did anything in the tape suggest that respondent had a reason, as he testified, to "fear for my safety" with this slight young man.

Second, the bear hug was inappropriate and dangerous. According to Mr. Peterson, a front bear hug is not taught as a technique and respondent's conduct was evident of no agency authorized physical intervention technique (Tr. 140). Mr. Watts called it a "totally inappropriate

restraint" (Tr. 47). Moreover, given the appreciable size and weight difference between respondent (at 306 pounds) and SS (who was a slight to average sized adolescent), the maneuver could have resulted in significant injury to the resident, who was pushed suddenly by respondent into a prone position on his back onto a hard, immovable object. Mr. Watts and Mr. Peterson testified that the maneuver created a significant risk of injury that could have included lacerations, a sprain, a broken bone, or worse (Tr. 47, 141).

Third, after the resident spat at him, respondent charged at the resident with abandon. There is no question that his conduct was retaliatory and was not an attempt to "secure" the resident. Respondent recklessly pursued the resident, pushing JC Washington in the process, chased the resident into a corner, and threw him to the floor all in an attempt to retaliate for the spitting and insults.

Fourth, respondent was similarly out of control in his repeated attempts to retaliate against the resident while JC Washington was stretched over him (19:09:04 to 19:09:23). In a stunning role reversal, resident L is seen assuming the adult role of trying to calm respondent. Respondent admits that resident L tried to separate him from resident SS and asked if he was alright (Tr. 234, 252). It is unclear how respondent would re-establish his authority over these juveniles having demonstrated such a lack of control and prolonged inability to regain his composure.

I found respondent's lack of reflection, upon subsequent review of the video, an unfortunate failure to acknowledge his serious lapse in judgment and to take responsibility for conduct that was clearly out of control. Respondent offered no insight into how the incident occurred and seemed completely unconnected to his role as a responsible caretaker of troubled juveniles.

I was flummoxed by respondent's claim that his statements to SS (reminding him of his sister's trouble in school, and suggesting that his mother's illness could be attributed to him, and that his failure to follow orders to take his shower might hurt his ability to return home) were meant to be "motivational." I found them inflammatory and mean-spirited, not at all supportive. When asked on cross examination whether agency rules prohibit discussion about a resident's family members, respondent said he was merely repeating information the resident had "confided" in him (Tr. 247). The fact that the resident shared this information with him certainly does not mitigate the cruelty of using it against him. His mother's hospitalization is a subject

that would understandably activate an adolescent's strongest emotions. I found the exchange punitive and likely the reason the resident rebelled against his authority.

II. The Use of Force

Petitioner has charged respondent with violating several agency rules that regulate the use of force against juveniles and that prohibit child abuse and workplace violence (Specifications 1, 2, 3, 4, 5).

Agency procedures and testimony

According to ACS Policy No. 2014/10 on Safe Intervention Policy for Secure and Non-Secure Detention:

> it is the policy of ACS to promote the safety of youth and staff in detention, as well as the surrounding community, using the least intrusive and least restrictive intervention necessary. To accomplish this, staff are expected to employ Safe Crisis Management (SCM), a comprehensive approach to behavior management. This approach requires substantial effort in prevention and non-physical intervention and the use of Emergency Safety Physical Interventions (ESPIs) only after less intrusive alternatives have been attempted and failed or have been deemed inappropriate. ESPIs shall be used without purposely inflicting pain or harm. ESPIs must be employed according to the intervention principles of SCM.

(Pet. Ex. 2 at 1). As Director of Juvenile Justice Training, Keith Peterson is certified in Safe Crisis Management ("SCM") and he supervises and trains the juvenile justice training staff in SCM and other techniques (Tr. 131-32).[2] He explained the methodology.

The SCM approach is to "intervene with the appropriate technique" starting from the least restrictive which is counseling (Tr. 133-34). If a resident was beating up another resident, a more physical technique would be permitted to address the more physical behavior of the resident. Staff are instructed in the use of Emergency Safety Physical Interventions ("ESPIs") which are physical interventions used to engage a resident to help manage their behavior (Tr. 135). These physical interventions are emergency techniques employed in response to physical

[2] Mr. Peterson received an Associate's degree in Early Childhood Education, two Bachelor's degrees one of which reflects a double major in Psychology and Sociology, a Master's degree in Human Services and Public Administration, and he is pursuing his Doctorate (Tr. 128-30). He has 10 years of military service in the United States Army. Since 2005, he has worked for the City of New York as a juvenile counselor, training instructor, operations manager, and in other managerial titles.

aggression by the resident. The ESPI used should match the behavior displayed by the resident, and should be selected in accordance with the least restrictive alternative approach. A JC would not be expected to wrestle to the ground a resident who was refusing to line up with the other residents. *See Dep't of Juvenile Justice v. McCovey*, OATH Index No. 412/05 at 3 (Mar. 22, 2005), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 06-50-SA (Apr. 24, 2006) (juvenile counselor disciplined for hitting resident in the back of the head for leaving the line during an escort). Such conduct should be met first with counseling. Actual physical intervention by the JC requires a level of physical aggression by the resident. To apply a physical intervention, the JC must approach the resident at a 45-degree angle or from behind (Tr. 136).

Mr. Peterson's testimony is consistent with Policy No. 2014/10, which states that the agency "authorizes the use of a continuum of ESPIs ranging from least restrictive and least likely to cause harm to more restrictive," and that all ESPIs must be "appropriate to the level of risk presented by the youth" and "must utilize the least amount of force necessary to stabilize the youth or situation" (Pet. Ex. 2 at 6).

Specification 1 alleges the use of impermissible and unauthorized force when respondent applied a chokehold, an unapproved physical restraint technique, by placing his hand around the resident's throat. This charge is sustained by a preponderance of the evidence. Prince-Richardson on Evidence § 3-206 (Lexis 2008) ("the burden of persuading the triers of fact that the existence of the fact is more probable than the non-existence").

The Chokehold Directive prohibits staff use of chokeholds or use of "unauthorized techniques which may result in chest compression, thereby reducing the resident's ability to breathe" (Pet. Ex. 6). Mr. Watts testified that respondent's actions violated the chokehold policy which prohibits placing one's hands on a resident's neck (Tr. 48). Mr. Peterson testified that choking is not taught as a technique. He pointed out that respondent's hand is seen "near the throat area or collar area of the resident" and that placement of the hand around a resident's throat or collar area is a choking motion, or choke, which is a use of deadly force, because applying pressure to the throat area could stop the individual from receiving oxygen or stop the flow of blood, causing him to pass out or even die (Tr. 139-41).

We have no testimony from the resident indicating to what degree he was choked, his chest compressed, or his ability to breathe obstructed during the altercation. The Manager's

Report of Incident prepared during an investigation of the incident states that residents SS and L both refused to be interviewed and stated that nothing happened that day (Pet. Ex. 10 at 3).

Respondent did not admit choking the resident, despite the video evidence. He said he placed his hand on the resident's chest during part of the altercation but he denied compressing or pushing down on his chest (Tr. 214). Notably, his admission that he put his hand on the resident's chest is not contained in his incident report.

More importantly, his testimony does not comport with the video, which shows respondent choking the resident with his hands at his throat for several seconds as he holds the resident down on the chairs (starting at 19:08:45). Choking is a clear violation of procedure and an improper means of restraining a resident. I also found the rage evident in respondent's actions a demonstration of aggression and not the application of a "restraint." For this, respondent is guilty of misconduct.

Specification 2 alleges the use of impermissible and unauthorized force when respondent pushed resident SS onto a chair, pinned him down and applied force to his throat when the resident was not a danger to himself or others. This charge is sustained by the evidence.

As stated above, the resident stood still with his arms at his sides when respondent initiated physical contact with him by clutching him in a bear hug and pushing him over the chairs. Watching the video, Mr. Peterson noted that SS's hands were at his sides and he displayed no physical aggression (Tr. 137-38). He stated, "the resident wasn't doing anything," and was not displaying any form of aggression (Tr. 142). I saw no evidence that the resident initiated physical contact with respondent or was a danger to himself or others at the time respondent grabbed him.

Respondent claimed to be administering a "touch prompt" when he initiated physical contact with the resident (Tr. 257). According to agency procedure, a JC may enlist a "touch prompt" or supportive touch as a de-escalation technique to help guide the resident in the direction in which the JC wants them to go (Tr. 135). I found respondent's contact with the resident inconsistent with de-escalation and not a proper performance of a touch prompt. As Mr. Peterson noted, respondent failed to stay a safe distance away from the resident where he could have calmed the resident while remaining prepared for any situation that arose. He did not approach the resident from behind. Instead, respondent confronted the resident by walking up to him, face-to-face, which "tends to escalate a situation" (Tr. 138). Respondent could have turned

his body sideways so that his shoulder faced the resident, in a "lead trail position," to eliminate the perception that a "big massive person [is] standing in front" of you (Tr. 139). Mr. Peterson said respondent should have "asked Mr. Washington to step in and deal with the resident, and he could have stepped away" (Tr. 142). These less restrictive alternatives were available, but respondent used none of them.

Respondent testified that a physical restraint was permissible when a resident is "disrupting the flow of the facility or the flow of the program," such as following the nightly shower routine (Tr. 239). When counseling proves unsuccessful and the resident is still non-compliant, respondent said, they may "use restraint to get the resident out of that area" (*id*.).

I credited respondent's testimony that he gave directives that the resident refused to follow. However, respondent's quick action after only a brief passage of time shows only a minimal attempt at persuasion before resorting to physical action. There was no urgency implicated by resident's refusal to take a shower. Respondent's use of physical force under the circumstances constituted misconduct, as such use was unauthorized and, I find, excessive. *See McCovey*, OATH 412/05 at 3 (juvenile counselor's use of force against a resident who offered no resistance and was in the midst of complying with orders "was entirely unnecessary" and constituted misconduct).

Specification 3 charges respondent with the use of impermissible and/or unauthorized force when he charged at resident SS, pushed him against a wall, and attempted to punch and/or strike him several times. This charge is in part sustained by the evidence.

As discussed above, the evidence established that respondent charged at SS and threw him to the floor in retaliation for the resident spitting at him. This was misconduct. Respondent testified that the spit landed on his shirt, which was disputed by petitioner whose investigation concluded it was unlikely the spit made contact with respondent, who was at least six feet away from the resident at the time (Pet. Ex. 10 at 3). The video confirms that respondent was at least several feet away and was not in view of the camera when the resident spat at him. I did not find it credible that the resident spat on respondent given this distance.

In any event, being spat on would not justify respondent's conduct which was retaliatory nonetheless. Mr. Peterson testified that he instructs staff to be prepared for such provocation; they "may be spat on, you may get urine thrown on you, you may get feces thrown on you, you cannot use unauthorized techniques to punish, to get back at" a resident (Tr. 146). He instructs

staff to "tap out" or "go for a time out [and] let your partner or someone else do this intervention" while they compose themselves (*id.*). They are expected to be clear headed when deciding which ESPI to apply. Respondent failed utterly to maintain his composure or follow procedure.

The quality of the video was insufficient, however, to establish whether respondent also attempted to punch and/or strike the resident several times. This part of the charge should be dismissed.

Specification 4 charges respondent with violating agency procedures by engaging in an act that meets agency criteria for child abuse or suspected child abuse when he used corporal punishment by attempting to punch and/or strike the resident. Although this charge cannot be sustained as a separate instance of misconduct because it contains the same factual allegations as specification 3, I find the conduct proven also constitutes child abuse under agency protocols.

According to Directive No. 01/09 on Reporting/Processing Child Abuse and Maltreatment/Neglect Allegations (effective January 23, 2009), it is an act of abuse to subject a child in a juvenile detention facility setting to "[b]eing thrown, shoved, kicked, pinched, punched, shaken, choked, smothered, bitten, burned, cut, or stricken" or to the "use of corporal punishment," unless the act is accidental or performed as an emergency safety intervention (Pet. Ex. 5 at 1-2). Here, in the initial altercation, respondent placed his hands around the resident's throat while holding him down; later, he charged at the resident, chased him into a corner, and threw him to the floor in retaliation for spitting at him. This conduct constitutes child abuse.

Specification 5 charges respondent with workplace violence for pushing JC Washington out of the way as he charged at the resident and for punching and/or striking JC Washington. This specification is sustained in part.

Executive Director Watts testified that all threats or acts of violence are prohibited at the facility (Tr. 38). Agency Directive No. 11/07 on Workplace Violence Prevention (effective Feb. 12, 2009) prohibits workplace violence which is defined as "[t]hreats or acts that include, but are not limited to, the display of any violent, aggressive, or threatening behavior (verbal, written, or physical) that results in physical injury or emotional trauma, or can reasonably place any person's safety or productivity at risk" (Pet. Ex. 7 at 1).

The video evidence shows that respondent pushed JC Washington out of the way as he charged at the resident (Pet. Ex. 8; Tr. 51). The fact that his actions were intended toward the

resident and not Mr. Washington does not exclude them from coverage under the directive. Respondent's conduct was intentional inasmuch as pushing Mr. Washington was the means by which he could get quickly to the resident. Respondent did not bump inadvertently into Mr. Washington; he pushed him out of his way to get to the resident. The act caused Mr. Washington to lose his footing and stumble several feet forward, with sufficient force that could have caused him injury (Tr. 51). Respondent was indifferent to the risk he created. I find that respondent's conduct violates the workplace violence directive and constitutes misconduct. *Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Stafford*, OATH Index No. 519/04 at 6, 12 (Jan. 27, 2004) (respondent pushed two co-workers aside and charged towards his supervisor).

The evidence did not establish that respondent punched or struck JC Washington, as is alleged here. This part of the specification should be dismissed.

III. False and/or misleading report

Respondent submitted an Incident Report within an hour of the incident's occurrence (Pet. Ex. 9). He is charged in Specification 6 with submitting a false and/or misleading report. The agency Standard of Conduct prohibits employees from making "false, deceptive, misleading, incomplete or inaccurate reports, entries, or omissions in or on any record, document, or report" of the agency (Pet. Ex. 1 at 12).

Respondent's report states, in pertinent part, as follows:

> [Resident SS] tried to grab me and during the confusion we fell over the bricks. Resident [SS] began swinging wildly at me punching me in the face and knocking my glasses off my face. JC Washington attempted to help me try and [pl] resident [SS] in a supine position. However resident [SS] was swinging and kicking at me and in the process punched JC Washington [sic] the left eye. Supervision was called to B Hall. Resident [SS] began spitting and shouting profanities about me and my mother saying "suck my dick" "tell your mother to swallow my kids." "Fuck your family." . . . [Enfield] and JC Washington attempted to place resident [SS] in his room when he spit across the room at me I rushed over to secure him from spitting. He then tried to run around the hall.

(Pet. Ex. 9; Tr. 219). The wrong date appears on the report, likely in error (Tr. 220).

Executive Director Watts testified that the report was false in the following respects: (1) respondent stated that SS "tried to grab me" and "during the confusion we fell over the bricks" when in fact respondent pushed the resident onto the bricks (Tr. 61); (2) respondent stated that SS "began swinging wildly at me punching me in the face & knocking my glasses off my face" and Mr. Washington "attempted to help me try" to place SS "in a supine position," when in fact JC Washington was attempting "to shield the resident" from respondent and respondent was "choking the resident" with his hands; he was not pulling him up but pushing him down (Tr. 61-62); (3) respondent stated that after the resident spat at him; he "rushed over to secure him from spitting" and the resident "tried to run around the hall"; in fact respondent is seen not trying to secure SS but "charg[ing] at the resident, chas[ing] him into the corner, grab[bing] him, and throw[ing] him from one end of the corner to the next" (Tr. 63). The executive director's observations are all true, as confirmed by the video.

I find respondent's incident report to be false in these material respects, by omission and by co-mission. *Dep't of Correction v. Cortes*, OATH Index No. 126/07 at 7 (Jan. 22, 2007), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 07-65-SA (June 12, 2007) ("The issue in reviewing whether a statement is materially false or misleading is whether it demonstrates intentional deception or lack of concern for the truth, as opposed to inadvertent error."). Respondent pushed SS into the chairs, landed on top of him, and began choking him around his neck while pushing him down into the chairs. Respondent had to be restrained by JC Washington who made efforts to protect SS from respondent and resident L had to calm respondent. Although SS swung furiously at respondent while pinned down on the chairs, he did so defensively, having been put in the position by respondent's aggression.

This specification is sustained.

FINDINGS AND CONCLUSIONS

1. Respondent is guilty of misconduct for use of an impermissible chokehold on resident SS, which is not approved as a physical restraint technique, as alleged in Specification 1.

2. Respondent is guilty of misconduct for the use of impermissible force on resident SS by pushing the resident onto a chair and pinning him down while applying force to his throat, a physical intervention that is not approved and was

unnecessary because the resident was not aggressive or a danger to himself or others, as alleged in Specification 2.

3. Respondent committed child abuse and violated Safe Crisis Management guidelines by charging at resident SS and throwing him to the floor, as alleged in Specifications 3 and 4.

4. Respondent violated the workplace violence policy and is guilty of misconduct for pushing JC Washington out of the way as he charged at resident SS, as alleged in Specification 5.

5. Respondent violated the Standard of Conduct, section J.1.2, and is guilty of misconduct for making a false, deceptive, misleading, incomplete or inaccurate" incident report, as alleged in Specification 6.

RECOMMENDATION

Upon making these findings, I obtained and reviewed an abstract of respondent's disciplinary history for purposes of recommending an appropriate penalty. Juvenile Counselor Silva was appointed to his position on February 4, 2013. Quarterly evaluations performed during his first year of employment, the only evaluations provided to me, revealed three "conditional" evaluations and one that was "good." He has no prior discipline. In this case, he has served a 30-day pretrial suspension.

The agency seeks his termination for the misconduct proved here. Because of the heightened responsibility given to those who care for juveniles in institutionalized settings, findings of abuse or excessive force must be forcefully punished. Such cases often result in termination. *See, e.g., Admin. for Children's Services v. Green*, OATH Index No. 2153/11 at 18 (June 6, 2011) ("Juvenile counselors are charged with the care and safety of the residents assigned to them. As authority figures, they are required to be in control."); *McCovey*, OATH 412/05 at 7 (termination imposed for counselor's second offense of unnecessarily striking a juvenile resident in five-year tenure).

Respondent has violated agency rules against unauthorized force against juveniles in the facility and the rule against workplace violence against co-workers. He is also guilty of filing a report of the incident that contained material misstatements and omissions of fact. These are serious forms of misconduct, particularly for one entrusted with the care and custody of adolescents. Respondent's short tenure with the agency and minimal work performance weigh against mitigating the penalty.

The evidence proved that respondent not only violated the rules of engagement for a juvenile counselor but that he attacked a resident who was not physically aggressive toward him. The severity of his misconduct should aggravate the penalty. Respondent initiated physical contact with the resident in a way that quickly spiraled out of control and turned dangerous with respondent choking the resident until he was stopped by another juvenile counselor on the scene. It is not clear when respondent would have stopped choking the resident if Mr. Washington had not intervened. Notably, respondent fought off Mr. Washington's intervention for a time before relenting.

The evidence did not decisively establish what lit the fuse (the resident's resistance to his authority or verbal provocation), but the degree to which respondent lost control was greatly concerning. Professional work in a detention facility for juveniles requires a thicker skin, as Executive Director Watts testified. Verbal provocation should never lead to the kind of aggression displayed by respondent. Even assuming the resident directed threats and insults at respondent, they were uttered only after respondent initiated the altercation by pinning the resident down on the chairs and putting his hands around his neck, according to respondent's own account (Tr. 233). It is notable that the verbal provocation that caused respondent so much pique -- insults leveled at his family -- occurred after respondent initiated a provocative and inappropriate discussion of the resident's family troubles.

Respondent continued to exercise poor judgment by remaining in the area after the initial altercation, continuing to agitate the resident, and failing to calm himself. His inability to control himself created a role reversal in which a resident is seen pulling him off of resident SS and several times tries to soothe him. Respondent's effectiveness as an authority figure for these adolescents was obliterated by his conduct and demeanor that day. His appearance at trial did not aid his rehabilitation.

At trial, respondent took little responsibility for what happened and testified falsely and against the weight of the evidence that the resident's aggression caused this incident when plainly it did not. His failure to acknowledge fault or to show contrition demonstrates a lack of maturity and preparedness for the job. Petitioner has no confidence in his future ability to conform to the requirements of the position.

Both the facility's executive director and director of training testified consistent with their written protocols about the standards upon which juvenile counselors are trained and their emphasis on creating a safe environment for residents. They expressed outrage at respondent's

conduct. Executive Director Watts said he is actively engaged in the hiring process for juvenile counselors and places great emphasis upon the need for restraint among those being considered for the position (Tr. 54-56). In interviews he conducts and in pre-service training, he explains that the children Crossroads services often have difficult behaviors and may assault staff; they may spit on them or otherwise provoke them. Nevertheless, a juvenile counselor is expected to "leave [his] ego at the door" and not engage a provocative juvenile or attempt to go "toe-to-toe" with them (Tr. 56). He explains, "if this is not for you, please don't take this job" (Tr. 56). His expectations of staff, as he communicates it to them, is "much higher" than the conduct respondent displayed in the video (Tr. 57). Staff is not there to judge these adolescents based on their alleged crimes, but to provide safety and care (Tr. 51). Respondent failed in these essential responsibilities.

Although a brief tenure with the agency raises the question whether respondent could become a better counselor if given further training and an opportunity to redeem himself and I have considered that, I find compelling the testimony of petitioner's witnesses about their goal to maintain a safe environment for juveniles at Crossroads and find the severity of the violation here "presents an unacceptable risk" to the agency and juveniles in its care. *McCovey*, OATH 412/05 at 7, citing *Dep't of Juvenile Justice v. Carey*, OATH Index No. 2268/04 (Sept. 13, 2004) (termination where counselor who treated juveniles inappropriately lacked remorse). I therefore recommend termination of respondent's employment.

Tynia D. Richard
Administrative Law Judge

June 26, 2015

SUBMITTED TO:

GLADYS CARRIÓN
Commissioner

APPEARANCES:

TIMOTHY POODIACK, ESQ.
ELVIN WILLIAMS, ESQ.
Attorneys for Petitioner

KREISBERG & MAITLAND LLP
Attorneys for Respondent
BY: JEAN O'HEARN, ESQ.

Commissioner’s Decision

In accordance with Section 75 of the Civil Service Law, a hearing was held at the Office of Administrative Trials and Hearings ("OATH") regarding the disciplinary charges preferred against respondent. Administrative Law Judge Hon. Tynia D. Richard sustained the charges and recommended a penalty of termination.

I have carefully reviewed the attached Report and Recommendation of the Administrative Law Judge Hon. Tynia Richard and adopt, without reservation, the findings of fact. However, since respondent have elected to resign on July 9, 2015, the issue of penalty is now moot.

Gladys Carrion, Esq.
Commissioner